

**GP Referrals to On-Site Clinical  
Psychologists and Counsellors:  
Analysing the Decisions Behind Referring  
and Not Referring Patients**

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## **Overview**

The literature review examines the research on general practitioner (GP) referral rates and referral decisions. It explores the variation in GP referral rates to medical specialists, addressing the shift from quantitative to qualitative methodologies in studies that have examined GP referral decisions. The final section focuses on GP referrals to mental health professionals and looks at the effects of on-site mental health professionals on GP referrals.

The empirical paper is a qualitative study examining GP decisions to refer, or not refer, patients suffering from minor mental illness to on-site clinical psychologists and counsellors. 14 GPs were asked to compare and contrast matched patient pairs, consisting of a patient who had been referred paired with another similar patient the general practitioner was treating. Three main themes of Patient Choice, Patient Benefit and GP Capacity to Help were identified, each including factors for and against referral.

The critical appraisal reflects on what prompted this research, examines the research process, its strengths and weaknesses, and considers what might have been done differently. The clinical implications of the study are then discussed, alongside possible avenues for future research. Finally, it ends with a personal reflection on how this project has influenced my views concerning qualitative research and my clinical practice.

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## **Part I: Literature Review**

**GP Referrals: From Referral Rates to Referral Decisions and Medical Specialists to  
Mental Health Professionals**

### Abstract

Wide variations exist in the rates at which general practitioners (GPs) refer patients to specialists. Older studies have identified patient, doctor and practice characteristics involved, however these fail to explain much of the variation observed. More recent research has shifted from quantitative to qualitative methodologies and highlights the complexity of GP decision-making. These studies provide a much richer account of GP referrals and highlight many important cognitive and social aspects of the referral process. The majority of studies examining GP referrals do not differentiate between types of referral, and mental health referrals in particular have been overlooked. This review highlights the need for a further shift in the direction of research into GP referrals. The appropriateness of GP referrals warrants investigation, including examining decisions by GPs not to refer patients. Larger scale research into GP referral decisions is also needed, including clinical outcome studies, comparing referred and non-referred patients.

## GP Referrals: From Referral Rates to Referral Decisions and Medical Specialists to Mental Health Professionals

*The decision to refer patients to a specialist service is a crucial point in their management. Despite its importance, however, there has been little research in this area... referrals are complex. They reflect the needs and expectations of individual patients and their families, the knowledge and experience of the individual practitioner, and the range, type and level of services available locally.* (National Institute of Clinical Excellence, 2001, p.2)

General practitioners have acted as gatekeepers and conduits to specialist services since the foundation of the NHS. The gatekeeping role of general practitioners (GPs) is perhaps the most important mechanism for managing demand in the NHS (Coulter, 1998). It ensures that the bulk of patient care is contained within general practice and when specialist care is needed, patients are directed to the most appropriate professional. A GP's decision to refer, or not refer, patients is thus highly important in ensuring that patients receive both the most appropriate and the highest quality of care.

Variation in referral rates between general practices and individual GPs has long been known to exist (Wilkin & Smith, 1987). The extent of variation between individual general practitioners is hard to calculate due to the difficulty in establishing a correct denominator, with studies reporting rates from twofold up to 20 fold. However, it is fairly well established that rates vary between practices by at least threefold or fourfold (O'Donnell, 2000). This variation has raised questions about the appropriateness and quality of care that patients are receiving and also

highlighted financial concerns (Coulter, 1998). Such a large variation in referral rates could suggest an inefficient system, with some patients being referred unnecessarily and others not receiving a referral at all.

Concern about this issue generated many studies whose main focus was GP referral rates. Historically, the majority of studies used survey methodologies to try to isolate factors that might explain this variation. Research looked at the influence of patient demographics and doctor characteristics on referral rates (O'Donnell, 2000; Wilkin & Smith, 1987). More recently qualitative methods have been used to look in depth at the referral process (Dowie, 1983; Evans, 1993; King, Bailey & Newton, 1994; Newton, Hayes & Hutchinson, 1991). By using in-depth interviews and discussing individual referral decisions, these studies have started to shed light on a range of factors that appear to influence GP decisions.

The majority of studies examining general practitioner referral rates and decisions have not distinguished between types of referral. Mental health referrals in particular have been overlooked. This is unfortunate considering the high prevalence of mental health problems in primary care. Approximately one-third of a GP's consultations have a substantial mental health component (Goldberg & Huxley, 1992; Raine, Lewis, Sensky, Hutchings, Hirsch & Black, 2000). However, fewer than 10% of such patients are referred on to mental health services (Verhaak, 1993). It is regrettable that these referrals have not received greater examination, as decisions to refer to mental health professionals are likely to be less straightforward than referrals to physical health specialists, due to the very nature of psychological problems and also

the number of different mental health specialists to whom GPs can refer (Pilgrim, Rogers, Clarke & Clark, 1997).

Like previous reviews this paper will examine the general literature on referral rates and decisions, but in addition it will look at studies that have focused exclusively on mental health referrals. The first section examines the literature on the variation in general practitioners' referral rates to all specialists. The second section looks at studies examining GPs' referral decisions. The final section will focus on mental health referrals.

### Variation in GP Referral Rates

A substantial body of research has attempted to analyse rates of referral from general practitioners to medical specialists. O'Donnell (2000) carried out a recent review and meta-analysis, examining 91 articles from 1970-1997. It examined referrals to any speciality, for any reason, to outpatient and inpatient services. Research that examined doctors' individual referral rates found variations in referral rate ranging from twofold to greater than 20-fold. Wilkin and Smith (1987) reported referral rates that varied from 1, per 100 consultations, to 24. At a practice level, variations were reported of three- to fourfold. O'Donnell (2000) concludes that this variation remains largely unexplained. Key studies that have examined specific patient, practice or doctor characteristics are reviewed below.

*Patient Characteristics*

Wilkins and Smith (1987) reviewed 15 articles dating back to the 1960s. They found that it was possible to identify patient groups that appeared to generate a larger number of referrals than others, such as elderly male patients. However, when they examined referral rates expressed as a percentage of consultations, males in the 20-29 years age range and females in the 30-39 years age range had the highest referral rates. It was harder to show that the variation in patients seen by doctors accounted for the wide range in referral rates. In their own study, the age and sex of patients seen by 'high' and 'low' referring GPs were very similar, with the high referring doctors evenly referring more patients across all ages and sex groups.

O'Donnell (2000) examined the effect of standardising for age and sex on the variation in referral rates in two of the studies reviewed (Morrell, Gage & Robinson, 1971; Roland, Bartholomew, Morrell, McDermott and Paul, 1990). This reduced the observed variation by less than 10%. Adjusting for age, sex and social class also had little effect on the variation observed in two other studies (Cummins, Jarman and White, 1981; Fleming, Crombie and Cross, 1991). For example, in the latter study the referral variation of 7.3% - 24.5% (per consultation) was reduced to 5.8% - 19.1%.

Hippisley-Cox, Hardy, Pringle, Fielding, Carlisle and Chilvers (1997) looked at the relationship between GPs' referral rates and the socio-economic profile of the practice population, rather than individual patients who consulted, using the Jarman Index. They found that practices located in areas with high Jarman Index scores had

high total referral rates. A multivariate analysis was used to examine the contribution of a number of variables on the observed variation. These included the Jarman Index score, age and sex, fundholding status and number of partners. The model explained 29% of the variation in total practice referral rates, with the Jarman Index score as the strongest predictor of referral rates compared to other variables in the model. However, this study was criticized for using the Jarman Index score as the score itself was constructed to measure GP workload. Hence a score indicating high GP workload might be associated with higher referral rates. The group of researchers reanalysed their data, swapping the Townsend Index for the Jarman Index. This still explained 27% of the variation in total referral rates (Hippisley-Cox, Hardy, Pringle, Carlisle, Fielding & Chilvers, 1997). Positive correlations were also reported in studies examining the relationship between high local Jarman Index scores and mental health referrals (Melzer, Watters, Paykel, Singh & Gormley, 1999; Soomro, Burns & Majeed, 2002).<sup>1</sup>

Wilkin and Smith (1987) reviewed three other studies that examined the effect of social class on referral rate. Crombie (1984) showed a gradient in referral rates for males, with the lowest rates in social class 1 and the highest in 5 (1 being 'professionals' and 5 being 'unskilled'), lending weight to the results found by Hippisley-Cox et al. (1997). In contrast, Morrell et al. (1971) showed referral rates that rose from class 5 to 1. Wilkin and Smith's own study and Cummins et al. (1981)

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<sup>1</sup> Jarman deprivation scores give an indication of social deprivation, based on the weight of eight variables: unemployment, overcrowding, single parents, low social class, children under five, lone pensioners, people born in the New Commonwealth and one year migrants. (Jarman, 1983).

The Townsend Index measures multiple deprivation by area. The score is calculated by combining four census variables: Unemployment, overcrowding, non car ownership and non home ownership (Townsend, Phillimore & Beattie, 1988)

supported Morrell's results. However, as Cummins (1981) points out, if the higher number of consultations by lower social classes is taken into account, the gradient is reversed.

The available research on the effect of a patient's diagnostic category on referral rate is also conflicting. In Morrell's study, adjusting for diagnostic case mix reduced the range in referral rates from 15.4–27.3 per 1000 consultations to 16.5–25.3, a reduction of approximately 14%. However, Wilkin and Smith (1987) showed that 'high' referring GPs merely referred a greater percentage of patients evenly across all diagnostic categories.

Thus, studies looking at the effect of patient characteristics on referral rates present a conflicting picture. Age, sex and diagnostic category do not appear to affect GP referral rates a great deal. Social class and social deprivation explain a greater proportion of the variation, although the results are still conflicting and depend on the measure used to quantify deprivation and also whether the measure is based on the individual patients or on the practice population as a whole. On the whole patient characteristics may account for a small proportion of the variation in GP referral rates, but this leaves a great deal unexplained.

### *Doctor Characteristics*

Studies have attempted to isolate GP characteristics that are related to their individual referral rates. Wilkin and Smith's review (1987) includes two citations in which no relationship between a doctor's age and referral rate was found, both

involving large numbers of GPs (Wright, 1968; Forsyth & Logan, 1968).

Additionally, no relationship was found between referral rates and the doctor's age or years of experience in two more recent studies (Cummins et al., 1981; Wilkin and Smith, 1987). Wilkin and Smith's work did show that their 'high' referrer group included a greater proportion of more experienced doctors than low referrers; however, it was unclear whether it was experience that actually influenced their referrals.

A general practitioner's background, training and specialist interests have also been put forward as possible factors behind referral rate variation, but there is conflicting evidence. Morrell et al. (1971) and Cummins et al. (1981) found no link. However, Renolds, Chitnis and Roland (1991), collecting data on referral patterns from a practice of five GPs, showed that doctors with a specialist interest in ENT and ophthalmology had high referral rates to these specialities, even after adjusting for case mix.

Armstrong, Fry and Armstrong (1991) examined GPs' perceptions of pressure to refer from patients and whether this was related to their respective referral rates. Using a survey method, 122 GPs were asked to complete a form for each hospital outpatient referral in one week, stating specifically the 'degree of pressure experienced from the patient for the referral'. Eight hundred and sixty two referrals were looked at in total. Perception of pressure was divided into 'no', 'little' and 'much'. They discovered that younger GPs were more likely to indicate higher perceived pressure. UK and Ireland trained GPs also reported higher perceived pressure compared to doctors who had trained overseas. Psychiatric referrals were

perceived to have the highest pressure associated with them. Significantly, GPs with a higher referral rate experienced higher perceived pressure to refer.

Cummins et al. (1981), looking at referral rates over five years from five GPs at a single practice, put forward a hypothesis that individual GPs might have individual “referral thresholds”. This is the notion that individual doctors each have a personal level at which a consultation produces a referral. They reasoned that this notion would be supported if doctors were observed to refer at different rates even when patient, doctor and practice characteristics were kept the same. They observed a variation in referral rates even after standardising for patient dissimilarities, and no relationship was discovered between GP referral rates and GP factors. The paper concludes with a proposal that referral thresholds may be accounted for by GP characteristics such as training, experience, tolerance of uncertainty, sense of autonomy and personal interests but fails to offer any evidence for this.

There is also little evidence from the literature that GP characteristics such as sex, age or special interests are a source of variation in referral rates. However, studies such as Armstrong et al. (1991) and Cummins et al. (1981) that hypothesise intrinsic psychological variables as influencing GP referral rates are more promising in starting to understand the variation in GP referral rates.

### *Practice Characteristics*

Studies have attempted to examine whether practice characteristics such as number of partners, practice size or geographical location influence referral rates. Early

studies by Wright (1968) and Forsyth and Logan (1968) suggested that single-handed practices had lower referral rates than those in partnerships. Madeley, Evans and Muir (1990) found no difference in referral rates between single-handed practices and partnerships. Confusingly, Hippisley-Cox et al. (1997) showed a significant association between single-handed GP practices and higher referral rates.

Wright (1968) indicated that GPs with high consultation rates show highest referral rates. This is supported by evidence from the Netherlands, where it was shown that referrals increased as GP list size increased (Delnoij & Spreeuwenberg, 1997). However, Wilkin and Smith (1987) found no difference between the list size and number of partners of high and low referring GPs.

A practice's geographical location may influence referral rates. O'Donnell (2000) reports that Madeley et al. (1990) found that rural GPs had significantly lower referral rates than urban GPs. Distance from the GP practice to hospital didn't affect high or low referring GPs (Wilkin & Smith, 1987). However, Jones (1987) showed higher referral rates the shorter the distance from practice to outpatient clinic.

The availability of specialist services and consultants appears to affect referral rates. Noone, Goldacre, Coulter and Seagroatt (1989) showed that the opening of a district hospital led to an increase in practice referral rates for the specialities that now provided a local service. Roland & Morris (1988) also examined whether referrals by GPs are influenced by the availability of consultants. This was a nationwide study that looked at the relationship between the number of local consultants and outpatient referral rates for four specialities: medicine, thoracic medicine, psychiatry and

dermatology. The rate of referral to outpatient consultants was strongly associated with provision of consultants.

Studies examining practice characteristics have produced conflicting results. This might be attributed, as with studies examining patient and doctor characteristics, to the difficulty in controlling for a very large number of variables that might also influence referral rates. The availability of specialist care appears to affect referral rates, but just how much of the variation in referral rates can be attributed to the provision of local services is unknown.

### *Conclusion*

The studies reviewed do not present a complete picture, and the variation seen in many studies examining general practitioners' referral rates remains largely unexplained. Wilkin and Smith (1987) concluded that patient, doctor and practice characteristics cannot account for variations in referral rates. In a more recent meta-analysis, O'Donnell (2000) found that patient characteristics account for less than 40% of the observed variation and doctor/practice factors for less than 10%.

Many of the studies are outdated, raising questions about the extent to which their findings are relevant to primary care in the NHS today. In their reviews, both O'Donnell (2000) and Wilkin and Smith (1987) express doubts about some of the methods used in many studies, especially the means by which referrals were counted and by which patient or doctor characteristics were classified. Additionally, many studies were carried out in single practices on small numbers of GPs (Cummins et al,

1981; Morrell, 1971). These studies might have the advantage of automatically controlling for practice characteristics but they have little scope for looking at GP background/characteristics and the possible link to referral behaviour due to the very small numbers involved. Variations in referral rates in such small studies could indeed simply be due to random variation (Moore & Roland, 1989). Practice characteristics such as the multidisciplinary of teams, the relationships between doctors or the amount of supervision GPs receive have not been investigated. *“It should not be surprising to find that a complex problem doesn’t yield easily to relatively crude and simple methods”* (Wilkin & Smith, 1987, p.165).

The majority of research studies treat referrals as if one can equate one referral to another, and examining referral rates is based on this assumption. Referral rates are unsatisfactory indicators of quality because they can hide failures to refer as well as inappropriate referrals. No studies mentioned above considered patients whom GPs had decided not to refer. Patients may be harmed if referral occurs too late and delay can lead to more major treatment being required at a later stage. Studies are needed that take into account both the GPs’ and patients’ views on referral decisions and also attempt to track patients who are not referred, to determine if they have similar or different clinical outcomes, compared to those who were referred. The fact that referral rates vary is not disputed, but unless questions such as those above are addressed, it is not possible to conclude that this variation is problematic.

### Examining GP Referral Decisions

The majority of papers reviewed above used survey methods, focusing on referral rates and attempting to find significant correlations between GP, practice or patient characteristics. Referral rates were measured and variation looked at in terms of degree of influence of different factors. This failed to yield any conclusive information about why the variation in GP referral rates exists or indeed if it is a problem at all. A different approach is needed to understand general practitioner referrals.

Cummins et al. (1981) proposed the idea of a referral threshold. They listed training, experience, personal interest, tolerance of uncertainty and sense of autonomy as possible factors that influence a GP's decision to refer a particular patient or not. Despite these being purely speculative hypotheses and not tested in their study, this was the first paper to consider that intrinsic psychological variables influence a GPs decision to refer a patient on. More recent studies have focused on the referral decision in detail, using a combination of qualitative and quantitative methodologies, rather than focusing exclusively on collective referral statistics. These have provided a much richer account of GP referrals and highlight many important cognitive and social aspect of the referral process.

#### *Initial GP Decision-Making Models*

Dowie (1983) published the first major qualitative study that explored general practitioners' decision-making. Data was collected on referrals from 65 GPs to

general medicine. Like previous studies a wide range of referral rates emerged.

However, in addition, Dowie carried out in-depth interviews with the GPs about their decisions to refer to consultants and their clinical style. Dowie collated the themes that emerged into a model of the referral decision that was based on Conflict Theory (Jarvis & Mann, 1977) that sees a decision emerging from weighing up risks and uncertainties of different aspects of a problem (see Figure 1). This emphasised the cognitive aspects of a GP's decision to refer, such as their confidence in their clinical judgement, their awareness of the probability of life threatening events, their medical knowledge and their need to sustain the esteem of the consultant colleagues to whom they were referring patients.

Despite approving of Dowie's attempt to develop a theoretical framework of the referral decision, Wilkin and Smith (1987) suggest that the model has limitations. They point out that it focused on decisions of diagnostic uncertainty and not referrals for treatment. It was also based on acute medical conditions and deals inadequately with more chronic and less severe conditions, which are likely to make up a substantial part of a GP's workload. Dowie's model assumes that decisions are made under pressure and that they are based on a model of medical, diagnostic-led decision-making. Wilkin and Smith (1987) highlight the fact that less than 15% of all GP referrals are to general physicians and that diagnosis will not be the only, or most significant, reason for referring. The interviews also focused on decisions to refer patients and no cases were discussed where the GP decided not to refer.

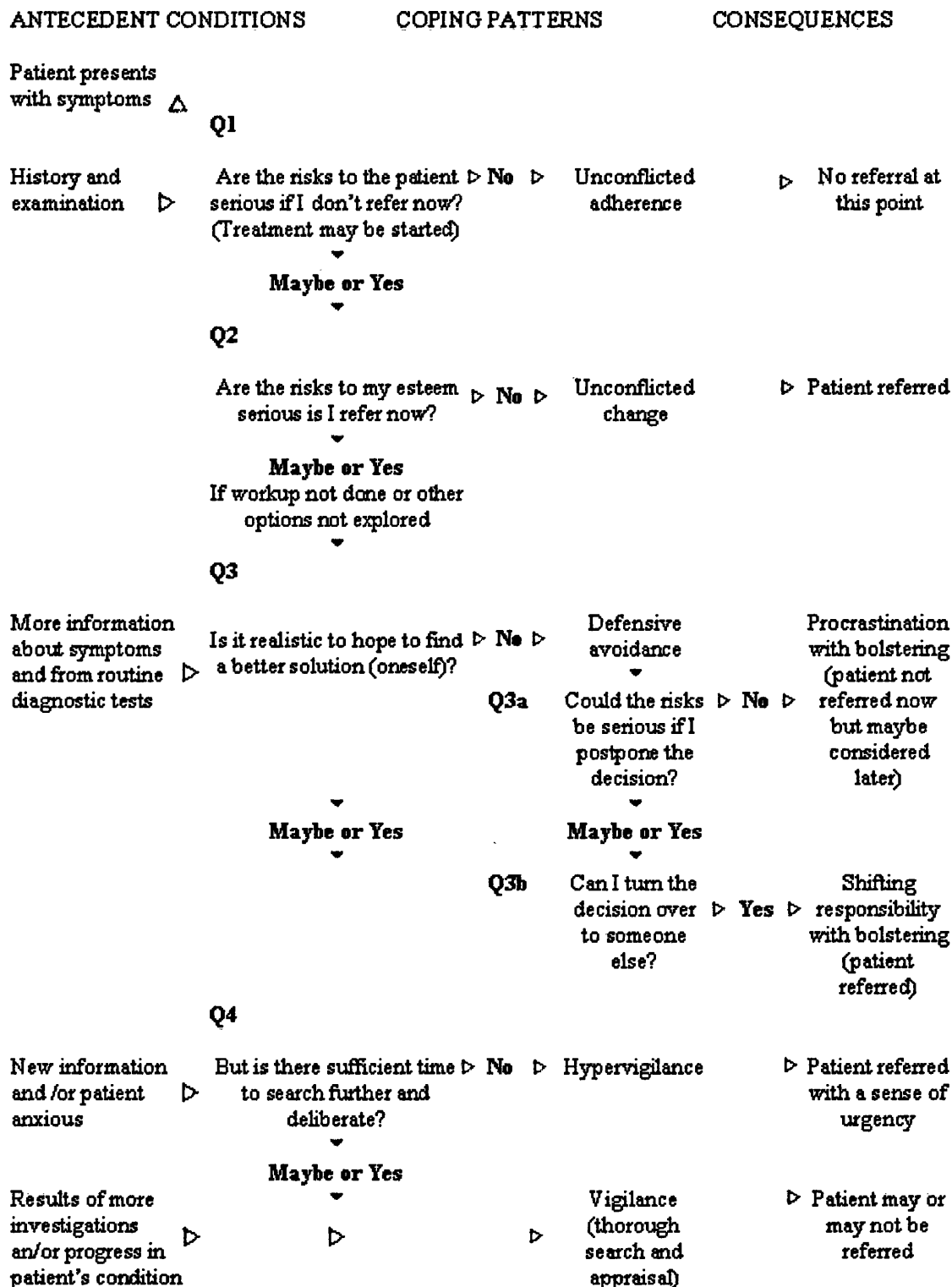


Figure 1. A model of the referral decision. From Dowie (1983).

Wilkin and Smith (1987) proposed an alternative, theoretical model of decision-making. The model was very similar to Dowie's, though it attempted to include all possible reasons for a GP wanting to refer, including the need for advice, management or treatment. Wilkin and Smith's model, like Dowie's, was based on the idea of weighing up the risks and uncertainties of each case. It still included the idea of risk, both to the patient's life if the GP didn't refer and also risks to the GP's esteem. Like Dowie's model, Wilkin and Smith's model treats the referral decision as a very rational step-by-step process that GPs go through with each patient. They claim that their model is more inclusive than Dowie's and that it allows for the possibility of referral of both non-urgent and non-serious problems. The model, however, is purely theoretical and not supported by empirical data.

### *The Environment of Decision Making*

Dowie's study was very influential in broadening the way that GP referrals have since been examined. However, the depiction of the decision-making process as a rational progression through a tree of smaller yes/no decisions is questionable. It is doubtful whether real-world decisions are made in such a logical, rational sequence. More recent studies show that contextual factors also play an important role in a GP's referral decision (Bailey, King & Newton, 1994; Evans, 1993; Newton, Hayes & Hutchinson, 1991).

Newton, Hayes and Hutchinson (1991) undertook a small-scale qualitative study with the aim of attempting to understand the social and cultural variables that might play a role in general practitioners' decisions. Fifteen general practitioners were

randomly selected from both rural and urban settings and from practices ranging in size from two to six partners.

Forty five cases were discussed in total, ranging in their severity. Referrals were usually made when a GP had determined that the patient's problem could no longer be dealt with given their knowledge, skill, time or resources. They were rarely, if ever, based on clinical factors alone. Four groups of factors that influenced a GP's decision to refer emerged from the analysis: doctor factors, patient factors, case specific factors and structural factors, such as a GP's workload or the waiting lists. Throughout the four groups the division between clinical and non-clinical factors was apparent. In addition, these factors didn't operate to increase or decrease referral rates in any predictable manner. Rather, decisions about referral would depend on the context in which the GP and patient found themselves.

Doctor-related non-clinical factors included their willingness to take risks or tolerate uncertainty whereas patient factors were their expectations, personal circumstances or ability to assert their views and feelings. Other major non-clinical variables were the relationships between doctor and patient and doctor and consultant. GPs reported that their good relationships with the majority of consultants allowed them to know more about what consultants expected from referrals, and rarely worried about referring. These findings are contrary to Dowie's interpretation of GPs feeling that they had to keep their esteem high with consultants (Dowie, 1983).

Generally, when a doctor expressed an interest or had special knowledge in a particular area it was thought to reduce their rate of referral. This was also related to

a doctor's confidence in their medical knowledge, with the more confident GPs being less likely to refer. Number of years experience also played a part in decisions to refer with many doctors reporting that they referred fewer patients now than when they were newly qualified.

Newton et al's study is a good complement to studies of decision-making such as those mentioned previously (Dowie, 1983; Wilkin & Smith, 1987). It highlights that decisions are not isolated cognitive events, as other researchers have described them. Decisions must be seen in the context in which the decision maker operates. Unfortunately, the authors failed to examine the doctor-patient relationship in greater detail.

#### *Alternative Model of the Referral Decision*

Evans (1993) attempted to test the models based on a conflict-theory approach such as Dowie (1983) and Wilkin and Smith (1987). Nineteen general practitioners were asked to record data on consultations during which a referral was considered, regardless of whether the referral was eventually made. Doctors were then interviewed with regard to patient and clinical factors, perception of risk, consultant factors and time factors. The GPs recorded data on 170 patients, 131 decisions to refer and 39 not to refer.

Patient factors were the most commonly mentioned factor involved in the referral decisions. Patient involvement in the decision to refer, effect of a particular patient and doctor-patient interaction were the most frequent. Most doctors didn't mind

patients being involved in the referral decision and if the patient asked for a referral the majority of GPs would usually agree. Few consultations were mentioned where the GP was influenced by the patient not to refer where they otherwise would have.

Patient-doctor interaction was identified as the main source of variation in referral behaviour, with high-referring GPs more likely to respond to a patient's request for referral. Pressure to refer did not appear as a major theme and no conflicts with consultants were discussed by GPs. Evans concludes that previous models citing conflict between risk and loss of esteem do not appear to be appropriate to the majority of decisions made in general practice. Patient involvement and the patient's view of whether they should be referred may be more important. An alternative, patient-centred model has been put forward, as shown in Figure 2. Ten years separate Dowie's initial study and Evans' research and the different findings could reflect a more general change in the NHS view on patient choice. The small numbers in the study also make it hard to generalise its findings. Non-referred patients were once again marginalised due to the small number of GPs who recorded decisions not to refer.

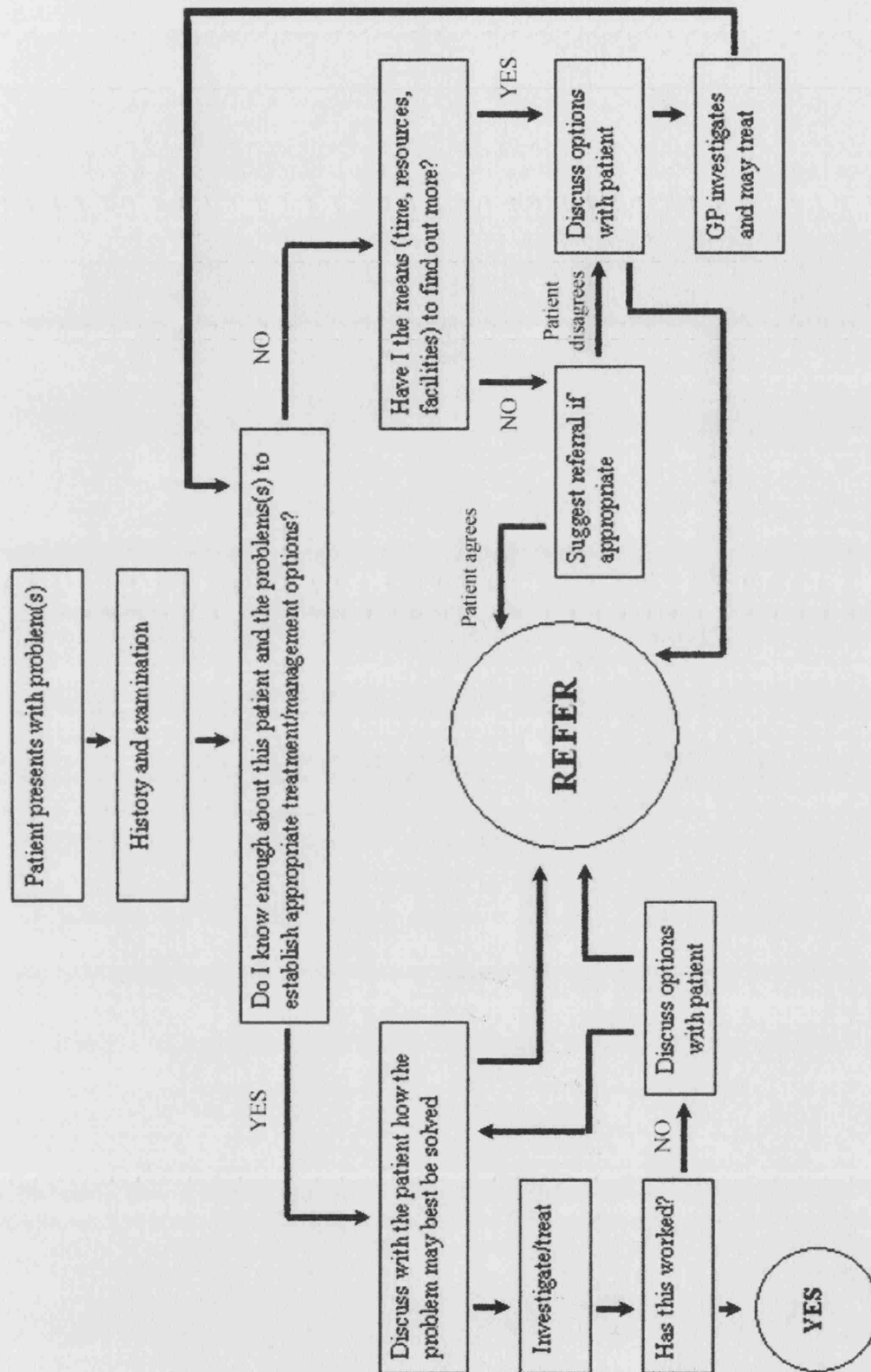


Figure 2. An alternative model of the referral decision. From Evans (1993).

*Combining Qualitative with Quantitative Methodologies*

Bailey, King and Newton (1994) used a creative combination of qualitative and quantitative methodologies in an attempt to explain consistent differences in GP referral behaviour. Newton et al. (1991) had stated in their research that the collection of single factors they identified could work both for and against referral. Bailey et al. (1994) suggested that while this may be true, if factors were grouped into more general categories then maybe differences would emerge, when they were examined at a higher level of analysis. An analytical framework was developed in their first paper (King, Bailey & Newton, 1994) and then this was used to look at how high referrers differ from low referrers in their decisions (Bailey et al, 1994).

Twenty eight GPs were randomly selected from a selection of the highest and lowest referring GPs from urban, rural and suburban settings, the majority of whom were from partnership practices. A total of 165 referral decisions were discussed with the GPs in semi-structured interviews. The interview transcripts were coded for factors 'towards referral' and factors 'against referral'. These were then clustered into Clinical vs. Non-Clinical and Episode-specific vs. Background quadrants. The GPs were classified as low, medium and high referrers and a quantitative content analysis was performed using the 22 higher order factors and four quadrants as units of analysis.

When examining the high and low referrers, the differences between the two were principally to do with episode-specific and not background factors. This supports Newton et al.'s (1994) study that highlighted the importance of contextual factors in

GP decisions. Low referrers mentioned factors related to interpersonal processes significantly more than high referrers. They showed a high proportion of positive factors, i.e. 'for referral', in the non-clinical/episode specific quadrant, mainly made up of "patients' feelings about their condition" and "GP-Patient communication". The researchers hypothesised that interpersonal aspects of the consultation featured more in decisions with low referrers. However, referring back to the qualitative data did not support the view that low referring GPs were more patient-centred.

High referrers reported significantly more negative reasons than low referrers, i.e. they referred 'in spite of' reasons against referral, particularly treatment effectiveness. Bailey et al. (1994) hypothesise that the GPs with higher referral rates were less tolerant of uncertainty in their decision-making. Qualitative examination of the transcripts supported this notion, with more evidence of uncertainty amongst high referrers. However, additional research into these areas is needed to provide further support for these findings.

### *Conclusion*

Quantitative research into referral rates failed to explain the variation in general practitioner referral rates. More recently, a few qualitative studies have looked at individual referral decisions and have shown just how complex a process it is. Decisions to refer are not simply a weighing up of clinical factors that the patient presents with. Additional patient factors such as confidence in asking for a referral, the GP's relationship with their patients and local consultants and intrinsic variables such as a GP's tolerance of uncertainty are all important factors that determine

whether a decision is made. All these factors construct a complex “environment of decision making” (Newton et al., 1991, p.311), containing many interacting components. Bailey et al. (1994) make a noteworthy attempt to combine this research with GP referral rates, providing potential areas of investigation for larger scale quantitative work.

Qualitative studies are by their nature small scale, providing highly detailed information about a particular topic. The few studies mentioned above have used small samples making it hard to generalise their results. For most studies, the lack of any information on patients considered for referral, but not referred, is also a major criticism. As mentioned previously, this omission makes it very difficult to judge the appropriateness of those referrals that are made. However, the findings of this qualitative research are valuable and can be used in the future to guide larger scale outcome studies by highlighting areas that such studies should attempt to measure, such as clinical vs. non-clinical factors.

### Mental Health Referrals

General practitioners have an important role in the assessment and treatment of mental health difficulties, lying in the position of an intermediary between specialist services and the community. Goldberg and Huxley (1992), in their research into mental health referral pathways, showed that between two-thirds and four-fifths of all patients in specialist mental health services access these via their GP. As mentioned above, approximately one-third of a GP's consultations will have a substantial mental health component to them (Goldberg & Huxley, 1992; Raine et al,

2000) and fewer than 10% of such patients are referred on to mental health services (Verhaak, 1993).

In a manner similar to physical health referrals, GPs have been found to vary substantially in their rate of referral to mental health specialists (Ashworth, Clement, Sandhu, Farely, Ramsay & Davies, 2002; Soomro et al., 2002). Ashworth et al. (2002) reported a ten-fold variation between practices in an inner city area. Studying variation in mental health referrals introduces another level of complexity to the already murky picture painted above. Mental health problems are extremely diverse in nature and, additionally, GPs potentially have a choice of which mental health professional or service to refer a patient to.

Very few studies have solely focused on mental health referrals. Some older studies have examined referrals to psychiatric services (Morgan, 1989; Robertson, 1979) whereas more recent studies have examined referrals to Community Mental Health Teams (CMHTs) (Soomro et al., 2002) or clinical psychologists (Creed, Gowrisunkur, Russell & Kincey, 1990; Sigel & Leiper, 2004). Research has also varied widely in the methodologies used, with some studies using survey methods to try to identify factors that influence referrals, and others adopting qualitative methods to examine the referral decision in more detail.

Firstly, studies are examined that looked at individual patient, doctor and practice characteristics and their relationship with referral rates. In addition, the literature on the impact of on-site mental health professionals on referrals is reviewed. Secondly, qualitative research into mental health referral decisions will be discussed.

*Mental Health Referral Rates*

*Patient characteristics.* It is well documented that patients presenting to their GP with serious psychiatric complaints, especially receiving a diagnosis of psychosis, are referred relatively often in contrast to those with neurotic complaints (Goldberg & Huxley, 1992; Robertson, 1979; Verhaak, 1993). Indeed, in Robertson's study, psychotic, alcoholic, suicidal and depressed patients were the most frequently referred patient groups. Men are also more likely to be referred than women and younger patients are more likely to be referred than older ones (Goldberg & Huxley, 1980; Verhaak, 1993).

*Doctor characteristics.* Studies that examined GP factors influencing referral of patients with mental health problems have shown varied results. Older GPs, those practicing in urban areas and those working single-handedly make more referrals to psychiatric services than those working in rural areas and in group practices (Goldberg & Huxley, 1980; Robertson, 1979). However, Verhaak (1993) found that age and other personal characteristics of GPs had no effect on referral rates.

Brown & Kent (1992) examined factors that were associated with referrals for problems of anxiety and sexual dysfunction. GP demographics were not related to their decision to refer, including prior GP experience or training. However, it is unclear what this implies. GPs having no specialist training may feel confident enough in their own skills to administer counselling, whilst it could equally be that GPs with more experience in counselling may recognise their limits in treating a particular patient.

Interest in psychological treatments has been shown to affect referral rates. Both Robertson (1979) and Verhaak (1993) showed that GPs with an interest in psychological treatment carry out more treatment themselves and refer less. Creed et al. (1990) examined referral rates to local psychiatric and psychology services. The respective referral rates to the psychiatry service and psychology service were not related. However, the GPs who wrote the most detailed letters were those who used the psychology service most and the psychiatry least. This study also showed that individual GP referral rates were consistent over five years, supporting the notion of individual referral thresholds mentioned in the previous section (Cummins et al., 1981).

It is possible that the low referral rate of the GPs who wrote detailed letters reflects a more general tendency to refer less, rather than a specific interest in psychology. It was also unclear whether brief GP letters are to do with a lack of knowledge about the patient or simply the feeling that detailed referral letters are unnecessary for specialists who will themselves take a detailed history.

*Practice characteristics.* Soomro et al. (2002) reported a 40-fold variation in general practice referral rates to local CMHTs. These ranged from 0.26 to 10.2 per 1000 practice patients. They also showed positive correlation rates between the local Jarman Index deprivation scores and practice referral rates; however, the correlation coefficients were low. Melzer, Watters, Paykel, Singh and Gormley (1999) also reported a positive correlation between GP referral rates, local Jarman index scores and standardised morbidity ratios. These studies support Hippisley-Cox et al. (1997),

who reported that practices located in areas with high Jarman Index scores had high total referral rates.

Verhaak (1993) showed that GPs practicing in urban areas have higher referral rates than rural GPs. It was also noted that those working in health centres were more likely to refer patients. This appeared to be due to the multidisciplinary nature of health centre teams and the GPs' preference for social worker referrals. Melzer (1999), examining referrals to community mental health teams, in a rural area, reported that practice size and number of partners did not significantly influence referral rates. Additionally, Melzer et al.'s study found that GPs who prescribe more hypnotics referred less to local CMHTs.

*On-site Mental Health Professionals.* The recent rapid expansion in the availability of practice-based mental health workers has prompted research studies aimed at assessing their impact on referral rates. An estimated 30% or more of general practices in the UK now have a dedicated counsellor in their practice (Cape & Parham, 1998; Sibbald, Addington-Hall, Brenneman & Freeling, 1993). A recent study in an inner city area by Ashworth et al. (2002) reported that 21 out of 29 practices (72%) had either an on-site counsellor or clinical psychologist.

Bower and Sibbald (2000) examined 40 studies looking at the effect of on-site mental health workers on the clinical behaviour of general practitioners. Of the 13 studies that specifically examined consultation rates, only three reported statistically significant reductions in rates of referral to secondary services. They tentatively suggest that referring a patient to an onsite mental health professional may reduce the

likelihood of a GP referring patients on to specialist psychiatric services in the short term.

However, Ashworth et al. (2002) criticise many of the studies included in Bower and Sibbald (2000) for including on-site mental health workers in their studies who are not representative of typical modern primary care (e.g. marriage guidance counsellors or liaison psychiatry), failing to control for the number of hours worked by the mental health professionals and also failing to exclude psychotic illness (which is likely to be more appropriately managed in secondary care anyway). In their study they examined 29 practices within an urban inner city area and aimed to test the hypothesis that practices with a greater allocation of on-site mental health workers would have lower psychiatric referral rates for non-psychotic illness. No relationship was discovered between practice psychiatric referral rates and the input of on-site mental health workers, however the highest referring practices were likely to have significantly lower on-site mental health worker allocations.

Other studies have reported an increase in referral rates to secondary services in practices with on-site mental health workers (Cape & Parham, 1998; White, Biljani, Bale & Burns, 2000). Cape and Parham (1998) examined referrals to outpatient psychiatry and clinical psychology services in an inner city area. Practices that had an on-site counsellor showed an increased rate of referral to clinical psychology services but the same rate of referral to outpatient psychiatry services. The authors point out that the majority of practices in the study had only relatively recently initiated the counselling arrangement and that the referral pattern to other services could have been in transition. Cape and Parham (1998) also suggest that if their

results are replicated it might indicate that on-site mental health professionals may lower the threshold for detection and/or referral for psychological therapies, through doctors becoming more aware of such problems and their treatability.

White et al. (2000) examined the impact of on-site counsellors on referrals to community mental health services. Counsellors were employed by approximately 20% of the 135 practices included in the study. The mean referral rate from practices that employed an on-site counsellor was over double that of those that did not. These findings are in contrast to studies that show a reduction in referral to secondary services (Bower & Sibbald, 2000) and also oppose Cape and Parham's findings that only referrals to clinical psychology services were affected. However, they do lend support to Cape and Parham's suggestion that on-site mental health professionals may lower the threshold for mental health problem detection and referral.

*Conclusion.* A patient's diagnosis greatly influences whether they will be referred on to mental health services. Serious psychiatric disorders such as psychosis and severely depressed, and often suicidal, patients are referred more frequently than other diagnoses. These conditions are probably more appropriately managed in secondary care. The limited research that is available points to GPs with an interest in psychological treatment referring less frequently. This might also be due to their feeling more confident in treating patients with mental health difficulties. Lower referral rates were also seen with GPs prescribing more hypnotic medication. More research is needed to investigate this link, also looking at anti-depressant medication prescribing rates. Research into urban and more deprived areas indicates higher referral rates. These results may be explained by research that shows that social

deprivation has significant impact on morbidity for stress-related conditions such as depression and anxiety. These conditions are associated with a cluster of social disadvantages such as unemployment, poor accommodation and low educational status (Pilgrim & Rogers, 1999).

The small number of general practices involved in the comparison between practices with or without an on-site mental health professional makes generalising the results above very difficult. The studies also suffer from the same pitfall of using referral rates as an indicator of good practice rather than examining the appropriateness of GP referrals. Introducing primary care mental health workers was seen by many as a means of saving precious secondary care resources. The results of this change are still unclear, as witnessed by the results of referral rate studies. More research is needed. However, even if on-site mental health workers do lead to an increase in GP referrals, this may mean that many more people are receiving more appropriate care than they otherwise would have and shouldn't merely be seen as potentially inefficient.

### *Mental Health Referral Decisions*

*Referrals to psychiatry.* Robertson (1979) carried out one of the first major interview studies, examining the variations in referral pattern to the psychiatric services by general practitioners. 76 GPs were interviewed about the specific circumstances leading up to the referral of two of their patients to local psychiatric services. As mentioned previously, psychotic, alcoholic and suicidal depressed patients were the most frequently referred patient groups.

Based on case discussions a third of the patients had been referred as the GPs felt that the treatment was beyond the scope of a GP's expertise e.g. electroconvulsive therapy. A third had been referred due to the patient not responding to treatment and the GP wanted a second opinion. Finally, in approximately one fifth of the cases the GP wasn't the main decision maker but the referral had been made as someone had requested it. Requests for a referral were almost always granted. Asking for a referral was seen by the GPs as a clear sign that the patient wanted help, but for that help not to come from the practitioner.

All but one of the general practitioners interviewed saw the treatment of mental illness, in its broadest context, as an integral part of their work. General practice treatment consisted of medication, counselling or a combination of the two.

However, GPs' attitudes may have changed considerably 25 years on, especially due to recent changes in primary care, such as the increase in numbers of counsellors working in their surgeries.

Morgan (1989) examined referral histories of new patients referred by general practitioners to a psychiatric hospital outpatients department. Interviews were conducted with 26 GPs and 106 patients and close relatives who played a significant role in the referral. Failure to respond to treatment was cited in 42% of the referrals, breakdown in therapeutic relations in 28% and a patient or relative requesting it in 38% of the cases.

The period from initial consultation to referral lasted from 3-5 months. This time was described as one of frustration and distress for patient and family. The GPs' efforts predominantly focused on symptoms not problems and seldom explored underlying difficulties. Limited time for consultations was seen as a big issue, with few opportunities to come to grips with the patients' problems. In roughly two thirds of the cases, 'supportive treatment' consisted of medication alone. No GPs offered psychotherapy or counselling or referred to social services, despite the evident social difficulties. Additionally, only a quarter of the referral letters explicitly stated a reason for referral.

Failure to respond to the GP's treatment was mentioned in older studies by Robertson (1979) and Morgan (1989) as the main reason for referral in a large number of cases. This might have changed in modern primary care with the advent of a wide range of newer antidepressant medications. Selective Serotonin Reuptake Inhibitors (SSRIs), currently the main group of drugs used to treat depression and anxiety-related conditions, were only introduced in the late 1980s (Medawar, 1998). This might also explain why the GPs in Robertson's (1979) study cited lack of expertise for specific treatments as another main reason for referral, due to fewer treatment options in primary care.

*Referrals for minor mental illness.* Pilgrim, Rogers, Clarke & Clark (1997) asked 15 GPs to fill out questionnaires about referring to different mental health professionals and also interviewed four doctors. GPs showed a clear referral pattern to different mental health professionals with psychiatrists being the first point of call for psychoses or severe depression. The emphasis on diagnosis was confirmed from the

interviews. It was evident that an illness framework of decision-making was being used by the GPs despite ambiguous distinctions about the skills possessed by each mental health professional. The personal circumstances of the patients discussed were rarely mentioned, whereas the severity and chronicity of conditions played a part in decision making.

Pilgrim et al. (1997) found that referrals to psychologists were mainly for phobias, psychosexual difficulties and other behavioural problems. Counsellors and psychologists were also referred bereavement problems. Again this implies that the GPs used diagnostic considerations when thinking about referral to mental health professionals. Out of 137 reasons given for referral, 103 alluded to a diagnosis. Personal or interpersonal descriptions were less commonly stated in reasons for referral. This may be an indication that patients need a diagnosis to get into certain services, but it may also be an artefact of the questionnaire methodology; that is, that details of the 'process of referral' are missed

Brown and Kent (1992) examined factors that were associated with GP referrals for problems of anxiety and sexual dysfunction. Sixty eight general practitioners were asked to complete questionnaires, consisting of four case studies (two anxiety related and two sexual dysfunction cases). GPs were asked whether they would refer and also asked to comment on a variety of statements such as 'expertise to treat condition' or the 'time taken to treat would have been too long'.

Doctors who said they would refer were more likely to report that the time to treat would be too great and that treatment of such patients was not a GP's responsibility,

and they were more likely to have confidence in the appropriate specialist. In a regression analysis, the three variables that were included in the final equation were the doctor's beliefs about their own expertise, whether they believed that the patients would respond to their treatment efforts and their confidence in the appropriate specialist service. A limitation of this study is that the cases were not actual patients and hence many factors of the patient-doctor relationship could not be examined.

In another qualitative study, Nandy, Chalmers-Watson, Gantley and Underwood (2001) examined GPs' views on referring patients suffering from minor mental illness. Twenty three GPs were interviewed about their general views on minor mental illness, with no individual cases being discussed. The analysis produced two main sets of themes: the notion of GPs being 'conduits vs. containers' and also referrals as being 'referrals to' or 'referrals away'. The latter theme is discussed below in the section 'Patterns of Referral'.

A management strategy of 'containment' was adopted by GPs who saw their role as a GP to keep referrals to secondary services very well regulated. They saw minor mental health illnesses as part of their remit as GPs. On the other hand, 'conduit' GPs saw themselves in a diagnostic role and felt that these patients were best managed by others. Cases did not fall exactly into one or the other category however and there was a continuum of behaviour across different GPs. Containment behaviour was increased by an interest in mental health problems and greater confidence in managing such problems. GPs also reported that having a good supporting structure in place at the practice helped in the management of minor mental illness, as did

good supervision. It was unclear, however, if such a supporting structure increased containing behaviour.

Sigel & Leiper (2004) interviewed ten general practitioners in an attempt to understand how GPs manage psychological problems, from their perspective. The interviews covered the detection and management of psychological problems in primary care and also looked at referral decisions. A theoretical model emerged, consisting of interaction between five components: GPs' views of psychological problems and therapies, containing patients' health problems, referral decisions, interactions with psychologists and an overarching theme of exploring psychological problems.

Referral decisions arose predominantly when a GP felt that a problem was beyond their capacity to treat, and, additionally, when a patient failed to respond to a GP's treatment or the GP felt that they didn't have sufficient time to address the problem. GPs occasionally made referrals without attempting to treat the problem themselves, often when they felt out of depth e.g. in cases of psychosis. Reasons noted for not referring included a sense that the problem was self-limiting or that the patient was too upset to cope with psychological therapy at that point. In addition, patient suitability emerged as a key theme in a GP's decision to refer. Poor access to services, often due to long waiting lists, was also mentioned as a deterrent to referring, and some GPs described using other strategies for gaining access to services; for example, talking in person to the on-site psychologist.

Sigel & Leiper (2004) conclude that referral decisions grow out of a GP's overall strategy of exploring psychological problems and not discrete reasons like the deterioration of the doctor-patient relationship or their wanting to share care with another professional in high-risk cases. However, it is clear from some studies that a patient's diagnosis plays a part in a GP's decision-making, with more severe mental health problems almost always getting referred on to a specialist (Pilgrim et al., 1997). A GP's confidence in their skills and how they view their role as a primary care doctor also seem to play a part in their decision to refer a patient or not (Brown & Kent, 1992; Nandy et al., 2001; Sigel & Leiper, 2004).

### *Patterns of Referral*

Morgan (1989) identified three distinct patterns of referral in his detailed ethnography of the referral process. 'Prescriptive' referrals were those where a patient's problems were rated as "conspicuously psychiatric" and definitely not manageable in primary care; e.g. referrals for psychosis or suicidal tendencies. GPs felt that psychiatric intervention was necessary due to the severity of the behaviour involved. This type of referral is similar to the notion from Nandy et al. (2001) of 'referrals to' a particular professional when the GP has a particular professional in mind or the patient requests the referral. They are quite specific in nature; for example, a referral to a psychologist for treatment of panic attacks. They are accompanied by a strong feeling that the patient would benefit more from referral than from seeing the GP alone, and tend to be thought-out, rational decisions.

Morgan's second category of 'elective' referrals was the most frequent. These referrals were where patients presented with a variety of physical and emotional symptoms and created uncertainty on the part of the GP. The doctors recognised that the patients were in distress but there appeared to be no compelling reason for seeking specialist advice. The referral was based on a choice that the GP had to make and hence was 'elective'. Their decision to refer was based on a number of contingent developments over the course of several months. Recognition of the patients' problems as psychiatric in nature emerged through a process of elimination. The referral, when eventually made, was more likely to reflect a breakdown in doctor-patient communication than a significant change in the patient's clinical presentation. See Figure 3 for a model of this referral process.

Nandy et al.'s (2001) categorisation of reactive, 'referrals away' resembles some aspects of Morgan's elective referrals. They included reasons such as failure of GP treatment or the GP not having enough time to see patients. The majority of referrals were of this type. They were often triggered by certain emotions on the GP's part – frustration, anger and irritation. These were viewed as warning signs that the GP needed help in managing the patient, rather than the patient benefiting from a referral. Other reasons for referral away included lack of time, lack of response to GP treatments, and instances when the GP felt that the patient wouldn't want to discuss intimate issues with someone they knew well. They tended to have a higher instinctual and emotional element to them. Nandy et al. (2001) stated that it was quite noticeable how dominant the emotional decisions were over rational ones.

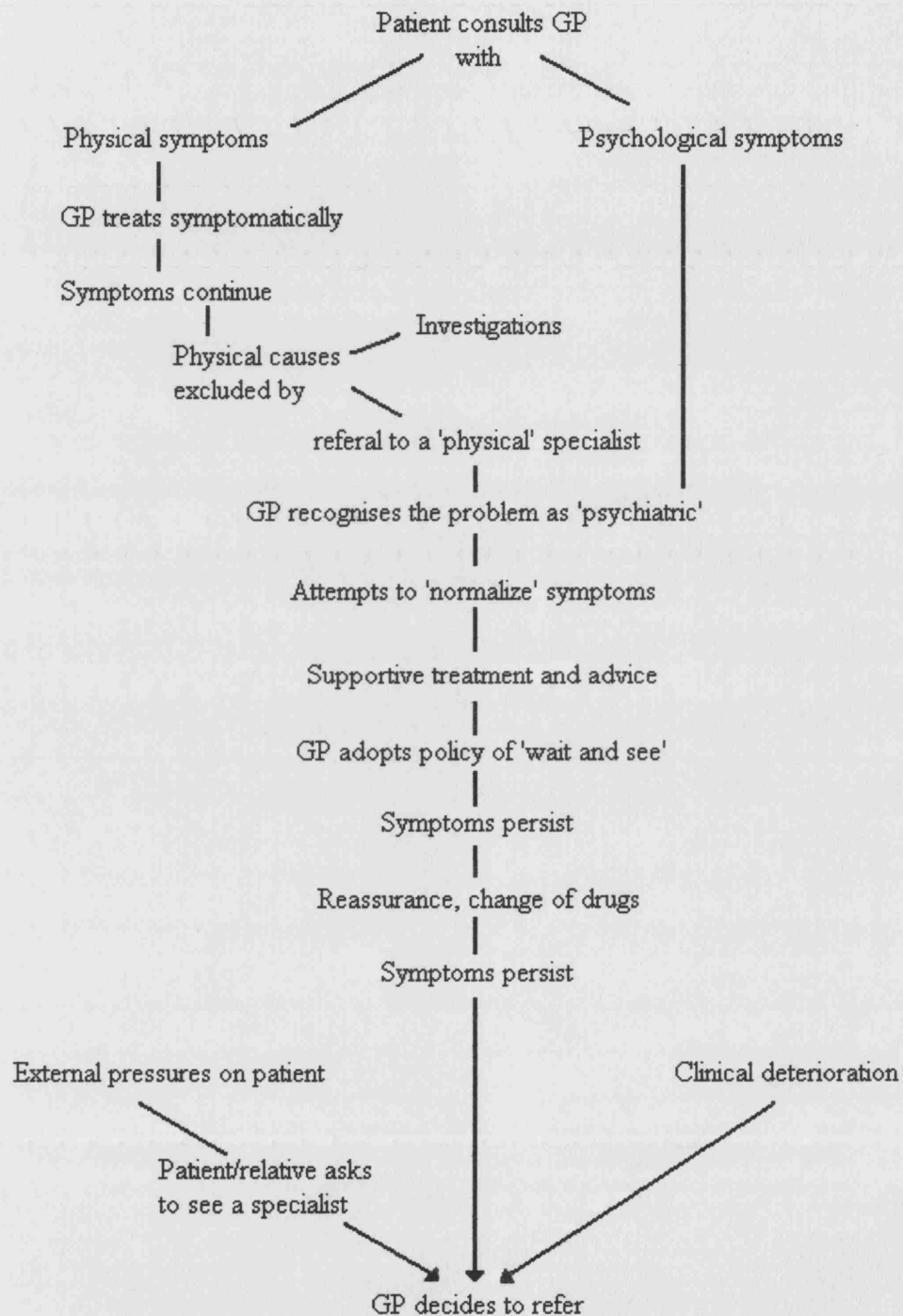


Figure 3. A model of the 'elective referral' decision. From Morgan (1989).

The third referral pattern Morgan named ‘negotiated’ referrals. In these the GP played an intermediary role and was often compliant in arranging a psychiatric evaluation on another person’s recommendation or request (patient or relative).

### *Conclusion*

The studies described above suggest a ‘continuum’ of patterns of referral, ranging from cases initiated solely on clinical grounds to those in which the GP plays a merely administrative role. These findings generally challenge the assumption that patients are referred on the basis of the severity of clinical presentations or the complexity of problems. The process of selection is structured by social and interpersonal as well as clinical events. A patient’s diagnosis, a GP’s confidence in their ability to manage mental health problems in primary care and their views about a GP’s gatekeeping role are examples of factors involved in a GP’s decision to refer a patient with a mental health problem.

### Conclusion

Research into referral rates and referral decisions arose from the large unexplained variance in both individual GP and practice referral rates. This appeared to indicate a system where patients were not receiving appropriate care or being referred unnecessarily and placing a burden on secondary services.

Approximately three decades later the majority of this variation remains unexplained. Many older studies looked at referral rates and attempted to isolate variables that

might explain this. More recently there has been a shift in the methodological approach to this problem and qualitative studies have produced a much richer picture of the complexity and intricate nature of GP decision-making. Many factors that had not been previously considered in older studies have now emerged. A GP's relationship with patients, response to patient's request for referral and tolerance of uncertainty appear to be factors that are involved in a GP's decision to refer. Many of these factors, such as waiting lists, GP workload and limited consultation time, have little to do with the doctor's reasoning processes around clinical issues. From studies that have examined mental health referrals, a patient's diagnosis, a GP's confidence in their ability to manage mental health problems in primary care and their views about a GP's gatekeeping role are more examples of such factors.

As Morgan (1989) highlights, it is important to remember that these decisions take place in the more demanding environment of primary care consultations, of competing and often more pressing claims on a GP's time. It would be important for the professionals receiving these referrals to recognize that a substantial number of patients that filter through to secondary services are just as much a reflection of the pressures and social contingencies on a GP to refer, as firmly established clinical indications of a medical condition or mental health problem.

However, the small scale of many of the studies and the lack of any information on patients considered for referral, but not referred, makes it very difficult to generalise from these studies and also raises the issue of the appropriateness of referrals that are made. Studies need to examine why patients with similar clinical presentations receive a referral or not. In addition, longer-term clinical studies should look at the

pathways of care that referred and non-referred patients enter into and their respective clinical outcomes. With little information on this it is difficult to comment on the quality of care being provided by GPs or practices who are deemed to be 'high' or 'low' referrers.

As O'Donnell (2000) points out in the conclusion to her review, despite the variation in GP referral rates being still largely unaccounted for, it is important not to lose sight of the highly efficient gatekeeping role of GPs and the benefits of this system as a whole. The use of referral rates as an indicator of GP competence appears to have been too simplistic and somewhat misguided, especially as so little is known about the process of referral, the decision making behind the referrals or their appropriateness.

Finally, more research focusing on mental health referrals is overdue. Of people going to GP surgeries, nearly one third have mental health problems. However little is known about why some get referred on to mental health professionals whilst others stay in their GP's care. This is especially pertinent given the recent changes in primary care in the UK, with many more general practices now employing counsellors and clinical psychologists.

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## **Part II: Empirical Paper**

**GP Referrals to On-Site Clinical Psychologists and Counsellors:**

**Analysing the Decisions Behind Referring and Not Referring Patients**

### Abstract

Minor mental illnesses such as anxiety and depression are common in primary care. General practitioners have a central role both in identifying their patients' mental health needs and in deciding how they are best managed. Despite a large volume of research, our understanding of general practitioner referral behaviour, especially decisions not to refer patients on, is far from complete. This qualitative study examined general practitioners' decisions to refer, or not refer, patients suffering from minor mental illness to on-site clinical psychologists and counsellors. General practitioners were asked to compare and contrast matched patient pairs, consisting of a patient who had been referred paired with another similar patient whom the general practitioner was treating themselves. Fourteen general practitioners from eight practices in two inner London boroughs participated in the study. Semi-structured interviews were carried out, focussing on five patient pairs for each general practitioner. The interviews were analysed using a general thematic analysis and three main themes of Patient Choice, Patient Benefit and GP Capacity to Help were identified. Each theme included factors for and against referral. These factors, especially those behind not referring patients on, are discussed in reference to the appropriateness of the GPs' decisions.

**GP Referrals to On-Site Clinical Psychologists and Counsellors:  
Analysing the Decisions Behind Referring and Not Referring Patients**

Minor mental illnesses such as anxiety and depression are common problems in primary care, with approximately one-third of a general practitioner's (GP) consultations having a substantial mental health component to them (Goldberg & Huxley, 1992; Raine, Lewis, Sensky, Hutchings, Hirsch, & Black, 2000). The vast majority of mental health problems are managed in primary care settings, with fewer than 10% of such patients referred on to specialist mental health services (Verhaak, 1993). GPs thus have a central role, both in identifying their patients' mental health needs and in deciding how these needs are best managed.

It is important to ensure that patient care is provided on the basis of clinical need. Patients not receiving the level of care that they require are likely to experience unnecessary distress and their problems may increase in severity. Conversely, inappropriate referrals that lead to unnecessary or ineffective treatment should also raise concern, as they are both wasteful in terms of resources and may delay or prevent other patients from receiving more appropriate care (Ross & Hardy, 1999). GP referral behaviour is therefore also directly linked to ensuring a patient's pathway to appropriate care, managing demand on services and promoting efficiency.

Goldberg and Huxley's (1992) seminal epidemiological work proposed a framework whereby 'filters' exist between different stages on the pathway to specialist mental health care. The third filter in their model refers to people with mental health problems who have been identified by their general practitioner but do not get

referred on to mental health professionals. It was described as the 'least permeable' of all in mental health pathways to care, due to the large drop in numbers of patients using specialist mental health services. Severity of the presenting disorder is undoubtedly one important determinant of passing through the filter.

Understandably, it is likely that GPs feel that they cannot provide an adequate level of care for people with more severe mental health needs and refer them on to specialist services accordingly. However, with more common problems such as anxiety and depression it is less clear why GPs refer some patients, as opposed to others.

Historically, research into GP referral behaviour has focussed predominantly on trying to explain the large variation that exists in GP referral rates to medical specialists. A recent meta-analysis of studies looking at GP referrals to a variety of medical specialist services showed a 20-fold variation between individual GP referral rates, with patient, doctor and practice characteristics explaining less than half the variation observed (O'Donnell, 2000). Qualitative methods have more recently been employed to look in depth at the referral process (Bailey, King & Newton, 1994; Dowie, 1983; Evans, 1993; Newton, Hayes & Hutchinson, 1991). These studies have the advantage of being able to examine individual referral decisions in great detail. They have provided a much richer account of GP referrals and highlight many important cognitive and social aspects of the referral process.

GP referral rates to mental health services also vary (Creed, Gowrisunkur, Russell & Kinney, 1990; Robertson, 1979) and as with physical health referrals this variation remains largely unexplained. GPs with an interest in psychological therapies have

been found to refer less frequently to mental health services (Robertson, 1979; Verhaak, 1993) and doctors who write more detailed referral letters refer more to psychologists than psychiatrists (Creed et al., 1990). Morgan (1989) found that for only 40% of referred psychiatric patients did clinical indications become a decisive factor in the decision to refer. Other significant factors included the previous treatment proving ineffective, the patient or relatives requesting it and breakdown in therapeutic communications. More recently, Nandy, Chalmers-Watson, Gantley and Underwood (2001) found that GP views on what a general practitioner's role should be in managing patients affected their referral decisions; i.e. whether they should 'contain' patients, limiting the burden on secondary services, or act as 'conduits' to specialist services. Sigel and Leiper (2004) reported that GPs 'reaching the limits of their capabilities' and lack of specialised skills were important factors in their decisions to refer for psychological therapies.

Models of GP decision-making behaviour have been proposed by some qualitative studies (Dowie, 1983; Evans, 1993; Newton, Hayes & Hutchinson, 1991). These models include factors intrinsic to the GP, such as the extent of their medical knowledge, as well extrinsic factors such as waiting lists. Unfortunately, these models of GP referral behaviour lack reliability due to the very small numbers of GPs involved in the research. No study has developed a model of GP referral behaviour by building on existing psychological theory. Social cognition models could provide a useful basis for understanding the determinants of GP referral behaviour and behaviour change. Such models view behaviours as the end result of a rational decision-making process based on systematic processing of the available information. They assume that a person's behaviour and decisions are based upon a

complex, but subjective, cost-benefit analysis of the likely outcomes of differing courses of action that they could possibly take (Connor & Norman, 1996).

Over the past 15 years, the number of counsellors and clinical psychologists working in primary care settings has increased substantially (Cape & Parham, 1999). In the last decade, an estimated 30% or more of general practices in the UK had a dedicated counsellor in their practice (Sibbald, Addington-Hall, Brenneman & Freeling, 1993); more recently 72% of practices in an inner city area were reported to have either an on-site counsellor or clinical psychologist (Ashworth, Clement, Sandhu, Farley, Ramsay & Davies, 2002). Part of the reasoning behind this was to improve clinical outcomes for patients (Cape & Parham, 1998). As highlighted above however, GP decisions to refer to mental health professionals are influenced by factors other than clinical need. This raises the question of the appropriateness of GP referrals, an issue that has been overlooked in studies so far. In order to make a judgement on this, patients who were considered for referral, but who were not referred, must be examined alongside patients who were referred.

The aim of the proposed study is to use qualitative interviews to explore GPs' decisions around mental health referrals to on-site mental health professionals. It will use a method of matching referred and non-referred patients (according to age, sex and problem type), in order to focus on the central research question of what additional factors lie behind GPs' decisions to refer some patients, and not others, to counsellors and clinical psychologists.

## Method

### *Overview*

This qualitative study examined general practitioner referral decisions to counsellors and clinical psychologists for minor mental illness. GPs were interviewed about their decisions to refer using a matched-pair design, with each pair consisting of a referred and non-referred patient. The interviews were analysed using a general thematic analysis.

### *Sample*

The general practices were located within two inner London boroughs. Only practices with both on-site counsellors and clinical psychologists were selected. The counsellors and psychologists varied in the number of sessions they were employed by each practice, with the majority contributing on a part-time basis. GPs who participated in the study were identified and recruited by the sessional clinical psychologists. GPs were selected to represent a range of demographic variables and clinical experience.

Ten practices were approached and 14 GPs (seven women and seven men) from eight of these agreed to participate in the study. The majority of GPs were white, worked in large group practices and had a personal interest in mental health problems. Table 1 summarises the characteristics of the final sample of participants.

*Table 1. Participant Characteristics*

ID	Practice	No of GPs in Practice <sup>1</sup>	Sex	Age Group	Ethnicity	Years in General Practice	Interest in Mental Health Problems
1	A	Large	F	50-59	White UK	>20	Yes
2	A	Large	F	30-39	White UK	<10	No
3	B	Large	M	40-49	White UK	>10	Yes
4	C	Large	M	30-39	White UK	<10	Yes
5	C	Large	M	30-39	White UK	<10	Yes
6	D	Large	M	30-39	White UK	>10	Yes
7	D	Large	F	50-59	White UK	>10	Yes
8	E	Large	F	30-39	White UK	<10	Yes
9	F	Medium	F	40-49	White UK	>10	No
10	E	Large	F	40-49	White UK	>10	Yes
11	E	Large	M	50-59	White UK	<10	Yes
12	A	Large	F	50-59	White UK	>20	No
13	G	Small	M	50-59	Black UK	>10	Yes
14	H	Medium	M	30-39	Asian UK	<10	No

<sup>1</sup> Small = One or two GPs, Medium = three to six GPs, Large = greater than six GPs

### *Ethics*

The study received ethical approval from the Camden and Islington Community Health Services Local Research Ethics Committee (see Appendix A for Ethical Approval Letter). Each GP signed a consent form prior to the interview (see Appendix B for Consent Form).

### *Procedure*

Prior to the interviews, both the counsellors and clinical psychologists were asked to identify three to five cases each that the participating GP had referred to them most recently. The criteria for these cases were patients between the ages of 18-65, referred for minor mental illness. The vast majority covered anxiety, depression or both. The patient's names were then passed on to the GP and they were asked to pair five of these cases up with patients they were seeing themselves for similar problems, whom they had decided not to refer to a mental health professional.

A rough matching of age and sex was also attempted. Thus, prior to the research interview, the GP had five patient pairs to discuss. The patient pairs included a mixture of patients referred to counsellors and clinical psychologists. The exact number from each was not specified, and it was left to the GP to choose patients for whom they felt they could find better matches. Additionally, having patients from both mental health professionals meant that a broader sample of patients was discussed. See Appendix C for the Letter to Participants and Appendix D for the Participant Information Sheet.

*Interviews*

The researcher, a white, male, trainee clinical psychologist, conducted the semi-structured interviews. Each patient pair was discussed in turn. The GP was first asked to provide a brief description of the referred patient and then elaborate on the reasons they had referred them on. This was repeated for the non-referred patient. Having both patients fresh in mind, the GP was then asked to compare and contrast the two, with the aim of extracting further information that had influenced their decision-making. Thus, the pairing allowed the interviewer and GP to focus on why one patient had been referred and the other had remained in the sole care of the GP. The interview schedule (see Appendix E) also included prompts for eliciting specific material that had been identified in the literature review as being pertinent to a GP's decision-making. These prompts were only used when the natural discussion of the cases had failed to cover a particular area. GPs had access to their electronic patient files during the interview as an aide memoire. Confidentiality was emphasised and no patient names were used during the interview. The interviews lasted between 30 minutes and an hour. All interviews were audiotape recorded and transcribed.

Five patient pairs were each discussed with the majority of the GPs. However, only four pairs were used in the interviews with five of the GPs. Thus sixty five patient pairs (one hundred and thirty individual cases) were discussed in total.

### *Analysis*

A general thematic analysis was used to identify dominant themes from the transcripts (Barker, Pistrang & Elliot, 2002; Boyatzis, 1998). The analysis was carried out primarily by the named researcher; however, transcripts were also examined by a clinical psychologist with many years experience of working in primary care.

Themes that were specific to each patient pair were analysed separately from general factors around decision-making that arose during the conversation with the GPs. Common themes emerging across the patient pairs were then grouped into higher order categories (see Appendix F for an example of the analysis process). The process was iterative, with the themes emerging from the analysis of the first few interviews being explored further during subsequent discussions with GPs interviewed later on. After a complete analysis of a transcript, the main themes that emerged, both for and against referral, were summarised and fed back to each individual GP.

Several good practice guidelines were implemented in the study (Elliot, Fischer & Rennie, 1999; Yardley, 2000). Details were gathered from the participants and presented in a clear tabular format (see Table 1), allowing readers to judge the type of GP to which the findings might be relevant. Credibility checks were also used in the study. GPs were asked to provide feedback on their interview themes thus allowing the author to check out his understanding of them with that of the original informants. The GPs were required to rate how accurate, clear and complete these

themes were and also asked to comment if they felt that there were any errors or omissions (see Appendix G for GP Feedback Questionnaire). The feedback from the GPs who responded is described in the Results section. This feedback was used to modify the themes that had emerged from the analysis. Furthermore, the majority of the interviews were also analysed by a clinical psychologist with many years experience of working in primary care settings. This provided a form of ‘analytic auditing’, reviewing the data for discrepancies, overstatements and other errors. Additionally, quotes from interviews were used extensively in the Results section, focussing on GP comments about specific patient pairs, allowing the reader to appraise the fit between the data and the author’s understanding of them.

## Results

Three superordinate themes emerged from analysing the patient pairs. These were *Patient Choice*, *Patient Benefit* and *GP Capacity to Help*. All themes were ‘bipolar’: each factor promoting referral had its reverse as a factor opposing referral. Therefore, each theme has been divided into the factors that influenced a GP’s decision to refer, or not refer, patients presenting with similar problems. Table 2 lists the themes and their prevalence across the GPs interviewed.

### *Patient Choice*

This theme describes the role of the patient in either initiating the referral or not wishing to be referred to a mental health professional.

Table 2. Themes Promoting and Opposing Referral

<i>Theme</i>	<i>Prevalence<sup>1</sup></i>
<b>Promoting Referral</b>	
1. Patient Choice	
a. Requested referral/help	Typical
2. Patient Benefit	
a. Suitability (Psychologically minded/intelligent/insightful)	Typical
b. Specific clinical problem	Typical
c. Reliable with appointments	Uncommon
3. GP Capacity to Help	
a. Lack of expertise/time/skills	Typical
b. Severity of problem	Typical
c. Not improving	Variant
<b>Opposing Referral</b>	
1. Patient Choice	
a. Not interested in referral	Typical
2. Patient Benefit	
a. GP felt nothing to be gained from referral	Typical
b. Not psychologically minded/lack of insight	Typical
c. Patient unreliable with appointments	Typical
3. GP Capacity to Help	
a. GP able to treat patient/had skills	Typical
b. Multiple minor problems	Variant
c. Patient improving	Variant

<sup>1</sup>Prevalence of themes across GPs: typical (seven or more GPs), variant (three to six GPs), uncommon (one or two GPs).

*Patient request for help.* Many referred patients explicitly asked their GP for additional help with their problems. This request was either a direct request for referral or a request for something more to be done. Occasionally this request came from a partner or close relative rather than the patient themselves.

All GPs interviewed took a very patient-centred approach, with no GP refusing a patient a referral if they had asked for it. Indeed, one GP referred a patient despite not thinking it would be beneficial, but did so as they had asked to be referred.

*I give patients what they want. I try to please and rarely say no. So, if a patient wants to be referred for counselling or psychology then I will try and do that.*  
(GP 9)

*I feel that the most probable reason why I referred him on was that he asked for it.* (GP 1)

In addition to being patient centred, many GPs stated that requests for referral reassured them, in that the patient was felt to be a suitable candidate for a referral if they asked. The patient had thought about it beforehand, possibly read up on different types of psychological therapies and what was involved and was also showing willingness and motivation to give psychological therapies a go.

*I talked to her about what she wanted to do and she said that she would like to see a counsellor...I think if someone made an appointment themselves, came in*

*with quite a good understanding of what things might help, then I am probably more likely to discuss referring them on. (GP 8)*

A patient asking for a referral also gave a focus to the consultation and as a result saved on consultation time.

*This man asked for a referral, which is a common reason why I refer someone. If they come in here and say, "I want to be referred to a counsellor" why waste time? I will explore it a little and then I will refer them. (GP 9)*

In one GP's mind, a patient asking for a referral had already made a choice about what type of treatment they wished to have and thus it was deemed pointless to refuse their request.

*If the patient asks me that they want to be referred, I personally believe that it doesn't matter what treatment I offer them, they will not respond to it as they have made up their minds that they want to be referred. (GP 14)*

*Patient not interested in referral.* Like patients who actively initiated their referral from their GP, there were an equal number of patients who either refused a referral for psychological therapies or who the GP felt wouldn't be interested and had never discussed it with them. Some patients hadn't found psychological therapy useful in the past or simply could not see how it could benefit them.

*She has a history of anxiety and depression and she has seen a counsellor in the past, which she didn't find particularly helpful. (GP 2)*

GPs who felt that their patient wouldn't accept a referral and thus hadn't discussed it with them, linked this with the patient not being psychologically minded or willing to accept that their problems might have a psychological component to them. This is elaborated on below, under the theme of Patient Suitability.

Other GPs reported that they felt patients were happy with just seeing them and felt that they weren't asking for more to be done.

*She is happy to see me. I may have even asked if there was anything else I could do to help, in a sort of roundabout way, but she doesn't come up with anything like 'Please refer me to the counsellor'. (GP 3)*

### *Patient Benefit*

When considering a referral, GPs commonly considered the benefits of referring the patient on. A patient's suitability for psychological therapies, their clinical presentation and how reliable they were deemed to be were factors in a GP's decision to refer or not. GPs often stated that they did not refer a patient as they simply "would not benefit" and that it was "their lot" as GPs to see such patients.

*Patient suitability.* A GP's decision around whether or not to refer a patient frequently centred on how suitable a candidate they felt the patient was for

psychological therapies. Some patients referred by GPs were more psychologically minded than others and were described by GPs as having much more insight. This included them linking their thoughts and behaviour with how they were feeling rather than presenting with physical symptoms.

*He was someone who I feel that would relate well to psychology because of the way he talked about his problems... he related them. He saw why he was having his problems. (GP 6)*

Some of these patients were also not keen on taking medication and were more open to discussing their problems with someone.

*She initially wasn't too keen on any medication and felt that there were lots of things... her own emotional things that she wanted to explore. She was someone who psychological treatments appealed more to. I feel that she is someone who might do well from having psychological input in that she wants it, she is motivated and she is articulate and probably could reflect on things. (GP 8)*

GPs also commented on certain patient qualities they considered when making a decision. A few GPs commented on traits they considered beneficial when referring a patient for Cognitive Behavioural Therapy (CBT). These included a certain level of intelligence, a reasonable level of education and the ability to learn new skills and appreciate goals.

*He is quite an intelligent man and I thought that he would be quite suitable because he had time to come and he had some knowledge of CBT and I felt he could be helped by it. (GP 2)*

Conversely, many non-referred patients were described by their GPs as “lacking insight” or “not very psychologically minded”. These patients would often present to the GP complaining of relatively minor physical symptoms, for example headaches, back aches or palpitations. Some would request physical examinations whilst others asked for medication to help with their physical symptoms. As mentioned above, GPs would often not offer these patients the option of a referral as they didn’t believe they would accept it. This was also linked to the GP’s belief that these patients would simply not benefit.

*She comes in saying that her life is dreadful, but she isn’t depressed. She has a lot of anxiety problems, but she is not mentally ill. Somehow I just don’t feel that she would benefit... she wouldn’t get that much out of it. She has had multiple physical investigations, but her symptoms are the same. I do try to think psychologically with these patients and try to reflect back... ‘Do you think depression, anxiety or pressure in looking after your family are part of it’, and she says no each time. (GP 3)*

*Specific clinical presentation.* Certain patient presentations, most notably panic disorder, were found to directly influence a GPs decision to refer. Psychological treatments were seen as very beneficial for such clinical presentations. GPs described

CBT for panic disorder as an extremely useful and effective alternative to medication that they felt they could offer patients.

*I do feel that it (panic) is one of those things that is incredibly treatable not using medication. It is much more clear cut, for example, than when I see a depressed patient. I have a lower threshold for panic attacks... I have a slight reflex action in terms of thinking 'Oh, panic attacks. I know someone who can sort this out'. (GP 10)*

Patients suffering from panic disorder would also often present to their GPs in quite a distressed state and occasionally have a panic attack in the consultation itself that strengthened a GP's decision to refer (also see *Severity of presentation* below).

*I referred her pretty much straight away actually because it was pure anxiety, with no depression that I could elicit. Also, because she was quite disabled by it and the severity was quite dramatic. (GP 5)*

Patients presenting with obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and childhood sexual abuse were also much more likely to be referred on. Panic disorder, OCD and PTSD were seen as very specific problems that were much easier to define and the cause of the patient's difficulties more clearly visible than, for example, in depression. These patients often presented with few other problems. However, with these conditions it appeared that the GP wasn't so much aware of the clinical efficacy of psychological treatments for them, but more

that the GP felt completely lacking in skills to help the patient (also see *GP's Capacity to Help* theme).

*Patient reliability.* Most GPs viewed counselling and psychology as a valuable resource and would judge a patient's motivation when considering a referral. A patient being reliable and keeping appointments was rarely quoted as a reason for referring a patient on. However, patients who had a history of not attending, either with their own GP or other specialists to whom they had been referred, were considered unreliable. This was a factor cited by many GPs when discussing reasons why they had not referred a patient on.

*She is someone who is notorious about DNA'ing and is quite unreliable... she is also the kind of person who if she received a letter saying that she would have to wait another 6-8 weeks, she probably wouldn't be interested... you only really want to refer someone who you think will benefit and turn up. (GP 2)*

Additionally, people with unpredictable characters, who appeared to live quite disorganised lives were seen as not only being unreliable attendees but also as incapable of taking on new skills and moving on.

*I don't refer her as I don't think she would be capable of making good use of it. I think she is too chaotic, she is a frequent non-attender, she uses services to suit herself...she wants short-term fixes which are usually tablets, coming to see me or going to casualty. I don't think that she is interested in looking at her life and looking at ways to change things. (GP 9)*

*Patient would not benefit/GP's lot to see.* Some GPs felt that it was “a GP's lot” to see patients with intractable and chronic problems, who in their eyes would not benefit from a referral. These patients on the whole had multiple, minor physical health complaints and were not necessarily improving with the GP's treatment. So, whereas chronicity and lack of improvement were in most cases seen as factors promoting referral (see *GP's Capacity to Help* theme below), with these patients, GPs counted them as factors against referring on due to the perceived lack of benefit or clear outcome from the referral.

*This lady I have been seeing for years. A lot of physical illness, asthma, blood pressure and I think as the years go by, mildly clinically depressed. I have her on AD's, but I am not sure whether they have made much of a difference...whenever I see her and ask how she is, she always tells me how terrible things are and how depressed she is...I don't think I have ever suggested counselling or anything for her...it was a very slow history, no specific anxiety or acute symptoms...if I don't feel that there is going to be any relatively quickly outcome then that does sort of stop me thinking about referring. (GP 13)*

### *GP's Capacity to Help*

GPs stated that they referred patients on when they felt that they couldn't offer the patient what they felt they needed i.e. the referral was needed for the patient to receive more appropriate care. Lack of expertise and severity of the presenting problems were often factors that GPs considered when making such judgments.

Additionally, even if a patient would benefit from a referral GPs often felt that they did not necessarily need to be referred on, especially if they were improving with the GPs treatment. GPs felt comfortable managing such patients, feeling that they were able to help.

*GP expertise/time/skills.* GPs stated that they didn't feel that they had the skills to help certain patients with their problems, as in cases of childhood sexual abuse, OCD or PTSD.

*I didn't know what to do with somebody who has been abused. I could just listen, but that is a bit like a GP trying to treat a heart attack. It's best with the specialists. (GP 4)*

GPs would also comment on just "feeling that the patient needed more" than they felt they could offer them, without specifying exactly what they felt they couldn't provide.

*I have to say with her it felt like there were an awful lot of underlying things. I think I felt she needed more than I could give. (GP 10)*

Another factor was not having enough time and knowing that a counsellor or psychologist would be able to offer them much longer appointments. GPs might refer for an assessment as they simply didn't have the time to go into someone's problems in detail or they referred as they knew what the issues were but wouldn't have the time to address them in 10 minute consultations.

*I don't quite know what makes her tick...she seems OK when I see her and we talk about practical issues like relationships, but I get a different story from her mother. So, I feel that I don't really know what is going on... and maybe the psychologist could spend 50 minutes whereas I can spend just 10 minutes. (GP 3)*

On the other hand, many GPs felt they didn't need to refer a patient as they were able to offer their patients something themselves. Often this was due to the patient responding well to the medication that their GP had prescribed and seemed to be doing "OK" or improving with the GP's treatment. GPs also included writing letters to local MPs to do with housing issues or to the patient's employer to sign them off, as feeling they were providing something for the patient.

*I felt I was offering something. She responded well to medication and she is also easier to talk to. The time we spent together we covered a lot of things and she accepted the mechanisms behind her depression... how the treatment was going to work. (GP 1)*

GPs also cited feeling able to manage a patient with the skills they had as a reason not to refer on. A GPs confidence that they were able to provide appropriate care also played a role.

*She is within my gamut. I can sort of keep her moderately ticking over. She isn't acting out or worrying me in any way. She is not spilling it over onto*

*anybody else, she is a contained depressive and I suppose I feel I have enough skills up my sleeve. (GP 7)*

*Severity of presentation.* The more severe the presentation, the more likely a GP would consider referral. Severity appeared to be judged on various levels. GPs mentioned the extent to which the patients' problems were interfering with their everyday lives, especially work. The frequency with which they presented to the GP within a short time period, was another indicator of severity, and also how distressed they were in the consultation with the GP.

*She was coming to me several times a week and was very distraught. I think the severity... also she normally works and was OK there... everything seemed to be going to pieces and made me feel like I should refer. (GP 10)*

Conversely, GPs were less likely to refer patients whose problems were less severe, clearly linked to a stressful life event or appeared to be transient. These problems made much more sense to GPs and possibly improved the doctor-patient relationship, aiding the patient's recovery.

*This lady presented with some major life events: a death, problems in her marriage, problems at home...with her I felt that it was something that I could deal with. You know, I could most probably relate to the things that had happened to her in life...I felt it was easier to cope with, to deal with a patient like that. (GP 1)*

Additionally, some GPs explained that they hadn't referred a patient as they hadn't felt there was anything "to be uncovered" that might require a counsellor or psychologists input.

*This sort of case... where there aren't really any deep psychological issues and someone needs simple listening, problem solving, empathy and maybe tablets for a short while, maybe not. Those are the sort of patients I tend to keep on myself. (GP 4)*

**Lack of improvement/improving.** Some patients were not improving with the GP's treatment. Their symptoms were either failing to respond to medication or some patients refused to take medication due to concerns about side effects or as they felt they didn't need them.

*She had quite an acute depressive episode where she felt she just couldn't cope. High workload, couldn't cope, went off sick, came to see me and it's really gone on from there. She, if anything, has gone downhill I would say. She hasn't improved on medication. (GP 7)*

On the other hand, a common reason stated by GPs for not referring on was that the patient was doing OK or showing signs of improvement with the GP's treatment. This was linked with the patient seeming happy with what the GP was offering them and not pushing for a referral.

*I didn't refer this patient as I felt that she did well...she responded well to the anti-depressants and I think that it is actually quite a positive thing when somebody comes back and says they are feeling a bit better. It made me feel a better about carrying on seeing her. (GP 1)*

### *Waiting Lists*

During the patient-pair discussions GPs would comment on the current status of a waiting list in reference to their decision to refer, or not refer, a patient. This would then frequently lead to a general discussion about waiting lists. This theme, therefore, emerged from discussions on the wider influences acting on a GP's decision to refer a patient, rather than directly from the patient-pair comparisons.

Waiting lists for counsellors, or more often, for psychologists, were at the back of many of the GPs' minds whilst considering whether to refer a patient or not. As described previously, as talking therapies were a valuable resource, GPs would prioritise patients who they felt would use the referral well and benefit most. The importance of this factor varied predominantly on the practices' resources, which differed greatly. GPs from the largest group practice never mentioned waiting lists as a reason against referral. It is likely they felt very well resourced with two practice counsellors, a clinical psychologist and also local community resources. However, in another smaller group practice that employed a counsellor and a sessional clinical psychologist, the counsellor's waiting list had actually been closed at the time of the interview and thus the GPs there weren't allowed to refer any patients.

*Well, our list is closed at the moment. I can't refer anyone to counselling. It is the biggest factor that affects my decision to refer to counselling. (GP 5)*

However, despite relatively long waiting lists for CBT, GPs generally didn't mind referring as they felt that it was worth waiting for due to its effectiveness.

*Well, I always explain this (waiting lists) to patients. I think they need to know what is involved in CBT, in that is it life-changing and that they need to work on it and that it is worth waiting for. (GP 12)*

### *Respondent Validity*

In order to establish respondent validity each GP was fed back the themes emerging from their interview. They were then asked to comment on the accuracy, clarity and completeness of the themes identified (see Appendix G for the GP feedback questionnaire). Eight GPs responded, with all of them giving positive feedback about the themes as shown in Table 3 below.

**Table 3.** Summary of GP quantitative feedback on quality of themes

	Number of GPs reporting a score of		
	1,2 or 3	4	5
Accuracy	0	4	4
Clarity	0	3	5
Completeness	0	4	4

Note: 1 = low, 5 = high

## Discussion

The aim of the present study was to use individual cases and the decisions made around these as the focus of the interviews. The matched pair design allowed decisions not to refer patients to be examined in detail, and thus upon further analysis, to look at the appropriateness of GP referral decisions. Three superordinate themes were identified as involved in a GP's decision to refer a patient for psychological therapies: *Patient Choice*, *Patient Benefit* and the *GP's Capacity to Help*.

The first theme of *Patient Choice* describes the role of the patient in either initiating the referral or not wishing to be referred to a mental health professional. All GPs referred a patient if they requested it. A patient asking for a referral was seen as positive, in that they had considered seeing a therapist and were motivated to attend and make the most of the referral. GPs also stated that they would not offer a referral to patients whom they felt would not accept a referral, either because the patient did not view their problem as psychological in origin or as they had not found psychological therapies useful in the past and had requested not to be referred.

Whilst contemplating a referral decision, GPs frequently considered *Patient Benefit*. Patients who were more psychologically minded and talked to their GPs about their emotional difficulties were seen as being more suitable for therapy. This was in contrast to patients who would present with many physical symptoms and were focussed on the GP helping them with these, rather than being interested in exploring their root causes. GPs were also more likely to refer patients with specific, clearly

defined presentations, such as panic attacks, as opposed to patients with multiple, chronic problems. Lastly, as psychological therapies were a limited resource at most practices, GPs would not refer patients who were deemed to be unreliable at keeping appointments.

The third theme of the *GP's Capacity to Help* refers to whether or not the GP felt that they were able to provide appropriate care for their patients. Lack of skills, expertise, time and also the severity of the patient's symptoms were reasons that GPs often stated would prompt them to refer. GPs were much less likely to refer patients who were stable or improving in their care or who they felt confident managing by themselves. Waiting lists were also key in GPs' decisions. The notion of not wanting to 'waste' a referral was associated with the lack of resources and long waiting lists that some GP surgeries were faced with. Although not often discussed in the patient pair comparisons, waiting lists were constantly at the back of many GPs' minds when thinking about referrals.

It is important to note that although the results lay out discrete factors that GPs stated were reasons for or against referring a patient, in reality these factors were all interrelated and conditional. Often a GP would be prompted to make a referral due to a combination of two or three factors, with individual GPs placing emphasis on some factors more than others. For example, a patient might not have been showing any signs of improvement on an anti-depressant prescribed by his GP. If the patient seemed happy with seeing their GP and was not pushing for a referral then the GP would be less likely to refer. However, if the patient was asking for more to be done, the GP might then make a judgement about whether they might benefit from a

referral. If the patient were reasonably psychologically minded and reliable, then they might refer; whereas, if the patient focussed on more physical symptoms and the GP could not see them using the referral, they would be more likely to keep the patient on. In addition to these factors, a GP with a newly appointed psychologist at the surgery, with no waiting list, might refer without necessarily considering many of the above.

Many of the factors promoting referral are similar to those in other studies exploring GP referral decisions to mental health professionals. Both Morgan (1989) and Robertson (1979) report a patient's (or relative's) request for referral as a key factor in GPs' decisions. Robertson (1979) also found that, as in this study, no patient was refused a referral if it was requested. Sigel and Leiper (2004) also cite patient characteristics such as insight and ability to articulate problems and GPs feeling that they have nothing more to offer a patient, as reasons for referring patients on. The present study's findings of patient request and unambiguous clinical presentations (e.g. panic attacks) prompting referrals are also described by Nandy et al. (2001) as proactive, 'referrals to' another professional with a specific reason in mind.

The inclusion of non-referred patients in this study allowed a degree of judgement about the appropriateness of the GPs referral decisions. The superordinate themes of *Patient Benefit* and *GP's Capacity to Help* suggest that the GPs involved in the study may, in part, be acting as rational decision makers. The theme of *Patient Benefit* implies that GPs are making judgements on how effective they think a referral would be based on a patient's clinical presentation, their conceptualisation of their problems and their motivation to use the referral. The *GP's Capacity to Help* theme maps on

to the notion of ‘need’, based on a judgment of whether what the GP is offering the patient is sufficient. In the current climate of limited resources and long waiting lists in primary care this rationing and prioritising of patients for talking therapies seems appropriate. Additionally, there was little suggestion of emotional, and perhaps less rational, reasons behind a GP’s decision to refer, as suggested by Nandy et al. (2001). They describe the majority of referrals for minor mental illness being reactive, ‘referrals away’, whereby a referral was triggered by the GP’s feelings of anger, frustration or irritation, as well as a lack of improvement or time on the GP’s part. This could be partly explained by the fact that many of the GPs in the present study stated that they had a personal interest in mental health problems and hence might have been more willing to see patients presenting with such issues, finding them less frustrating to manage.

Drawing upon existing psychological theory on behaviour and decision-making may provide a useful framework within which to consider the results. The theory of planned behaviour (Ajzen, 1991) suggests that the proximal determinants of behaviour are both one’s intention to engage in that behaviour along with one’s perception of control over that behaviour. The behavioural intention component can be further subdivided into one’s beliefs and evaluation about the outcome of a behaviour and also a person’s beliefs about whether significant others think that they should engage in the behaviour or not. The themes emerging from the interviews map onto these concepts very closely. A GP’s intention to refer a patient consists of their beliefs about the outcome of the referral (*Patient Benefit*) along with the patient’s opinion about the referral (*Patient Choice*). The themes of *GP Capacity to Help* and *Waiting Lists* map onto the GP’s perception of control they have over

whether they need to, or are able to, refer the patient on. Further research would be necessary to validate whether or not this framework could be applied more generally to GP's decision making.

The judgement of benefit assumes that the GP knows a fair amount about psychological therapies: which patients may be more suited to them and what has been shown to be clinically effective in treating specific problems. Panic disorder is a good example of GPs being well informed about the efficacy of CBT for this condition and considering a referral as a matter of course. This is in contrast to patients who GPs described as it being "their lot" to see. These patients with multiple, minor problems were unlikely to be referred partly because GPs could not see any positive outcome. This does not necessarily mean, however, that they would not benefit from a referral. Ultimately these patients might not be receiving appropriate care. As GPs' resources are limited they felt that they should not refer these patients with multiple, minor symptoms on, as there were many other patients more in need of a referral.

The study had a number of limitations. As mentioned above, its conclusions are based on a small sample of GPs, who volunteered to take part in the study. This is likely to have produced a sample of GPs who were more psychologically minded than typical GPs. GPs were also asked to reflect retrospectively on decisions they had made weeks before. The paired design and GPs having their electronic patient notes available during the interviews aided recall, but is unlikely to have eliminated all biases. In addition, GPs were asked to find non-referred patients themselves. It is therefore probable that they chose patients they remembered well, or those where

they felt they had made a good decision not to refer on. This perhaps left the more ambiguous cases unexamined. The matching process itself was not always adequately performed. Some GPs struggled to find matches, with many pairs not age or sex matched and a small minority were patients with different presenting problems as well. Thus, although it was still possible for the GP to state reasons for or against referral, incomplete matching meant that these might have been more general factors, e.g. a GP couldn't see any benefit from referring. Unfortunately, the study did not interview patients about their own experience of attending their GP, as it would have been interesting to investigate whether non-referred patients felt that they were getting enough from their GP, or whether they would prefer to have been referred.

The study, however, did adhere to a number of good practice guidelines for qualitative research laid out by Elliott, Fischer and Rennie (1999). Details were gathered from the participants allowing readers to judge the type of GP to which the findings might be relevant. As outlined above, the majority of GPs who participated in this study had a special interest in mental health issues and were likely to be more 'psychologically minded' than other GPs. The study also increased its testimonial validity by feeding back a summary of factors for and against referring patients to each GP following the analysis of their interview. They were asked to comment on the accuracy, clarity and completeness of the themes identified. Over half of the GPs returned their questionnaire, with all of them giving positive feedback about the themes. Furthermore, the majority of the interviews were also analysed by a clinical psychologist with many years experience of working in primary care settings, thus providing a form of "analytic auditing".

To effectively examine how appropriate GP referrals are, much larger, longitudinal outcome trials are required. These would need to examine the clinical outcomes of patients treated by their GP versus those who received talking therapies. This is especially pertinent in light of recent suggestions to current policy (Layard, 2004). This report highlights that there is currently little evidence-based therapy available on the NHS with the majority of resources going to the 1% of population who have psychotic problems. It is stated that amongst people with depression, only 3% have seen a psychologist. Layard (2004) recommends that patients should have the choice of psychological therapy should they want it and also that clients who do not improve with GP treatment should be rapidly referred to mental health services to prevent their problems becoming entrenched. This would entail a large increase in people who can offer psychological therapies, including a doubling of clinical psychology training places and also training psychology graduates in CBT. With many more referrals being made it will be increasingly important to evaluate their outcomes, to ensure that patients are receiving the appropriate level of care.

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### **Part III: Critical Appraisal**

### A Critical Reflection on the Research

This concluding section focuses on topics ranging from deliberations before I began the research to personal reflections upon its completion. It begins with an explanation as to what prompted this research, followed by a discussion of how a qualitative methodology was decided upon. The next section examines the research process, its strengths and weaknesses and what might have been done differently. The clinical implications of the study's results are then discussed, alongside possible avenues for future research. Finally, I will end with a personal reflection on how this research project has influenced my views concerning GPs and psychologists in primary care.

### Background to the Research

It is probably safe to say that putting family and friends aside, a GP is a person's first port of call when they are unwell or distressed. Thus, a GP's judgement of a person's problems and subsequent decision to refer or not could have a significant impact on that person's life.

The vast majority of referrals that I received working on clinical placements during my training have been from GPs. A common discussion in team meetings was regarding how appropriate a referral from a GP was and whether or not we could offer that person help. With most cases that I took on, I would go back to the referrer and discuss the patient with them, gathering more information about why they had referred them and how they thought I could help. All these issues increased my

interest in how patients got to see a psychologist and prompted me to want to examine the referral process in greater detail.

### Choice of Qualitative Methodology

I chose a qualitative methodology for its ability to give a rich, detailed account of a complex topic, about which little information existed. Semi-structured interviews about individual cases allowed a detailed, descriptive account of the clinical material to be obtained. As described in the Literature Review, research into GP referrals had historically focussed predominantly on the observed variation in GP referral rates. It is evident from examining that body of literature that the use of quantitative methods to investigate GP referral behaviour had not produced any conclusive results.

Various different GP, patient and practice characteristics were put forward as potential factors that influenced GP decision making, however, these did not help in understanding *how* GPs made their referral decisions. On the other hand, studies using qualitative methods, examining individual cases, have produced more enlightening results, highlighting many social and psychological variables that played a role in a GP's decision to refer.

A general thematic analysis was chosen over other qualitative methodologies such as interpretive phenomenological analysis (IPA) or grounded theory. It was felt that the question was not necessarily to understand a GP's *experience* of referring patients on, nor to hope to come up with a model of referral behaviour. It was hoped that this exploratory study could identify themes behind GP referral decisions. The matched pair format was implemented partly to act as an aide-memoire for GPs during the

interviews but more importantly to include non-referred patients as comparisons to get to the crux of the GPs' decisions.

Before commencing the study, guidelines for the publication of qualitative studies in psychology were consulted (Elliott, Fischer & Rennie, 1999). It was decided to gather details from the GPs who participated in the study in order to be able to offer a description of the sample, allowing readers to judge the relevance of the findings.

These details were presented in a clear tabular format, summarising all relevant characteristics, retaining the anonymity of the participants. In order to increase the study's testimonial validity, a summary of factors for and against referring patients was fed back to each GP following the analysis of their interview; they were asked to comment on the accuracy, clarity and completeness of the themes identified (see Appendix D). Over half of the GPs returned their questionnaire, with all of them giving positive feedback about the themes. A slight drawback of this process was that it was difficult to ask GPs to comment on the individual patients discussed in the interviews, as it is unlikely that they would have remembered them. Hence the comments from the few GPs who did write them were more general. As such, this information was held in mind when going through that particular interview again, taking it into consideration if it added to the original analysis. Furthermore, the majority of the interviews were also analysed by a clinical psychologist with many years experience of working in primary care settings. Additionally, during the writing up of the results, quotes were used extensively, focussing on GP comments about specific patient pairs, to allow the reader to appraise the fit between the data and the author's understanding of them.

## Reflection on the Research Process

### *Recruitment*

GP schedules are very busy and persuading them to give up between forty five minutes and an hour of their time could have been difficult. Therefore, it was decided to use on-site clinical psychologists to approach GPs with details of the study. However, this led to a possible selection bias. Psychologists are likely to have approached GPs who referred to them more often and hence knew better. These GPs could also have been more knowledgeable about psychological therapies. As such, the sample that was recruited was quite evenly balanced in reference to sex and represented a broad range of experience and personal interest in mental health. My impression of the GPs who were interviewed was that the majority were very empathic and reflective, but varied in their conception of anxiety and depression. Some GPs using very medical terms such as “endogenous vs reactive depression”, whilst others used more colloquial language, talking about stress and life events. Most of the GPs were reasonably knowledgeable about different psychological therapies and their relative efficacies.

In two larger GP practices I gave a presentation about the research with the aim of trying to recruit a greater number of GPs. This did not have the desired effect however, and in one of the two practices where they had a locum psychologist, no GPs asked if they could take part. It appeared that the on-site clinical psychologist was a valuable asset to have in recruiting GPs and a useful strategy to pursue, keeping in mind its associated selection biases.

*Interviews*

Interviews frequently felt pressured. I had to arrange them around the GP's busy timetable and this would often mean between morning and afternoon surgeries, often during lunch, or on the GP's only afternoon off each week. Fitting 10 patients into just under an hour was also limiting, as it meant there was only about five minutes in which to discuss each patient. Some GPs found it hard to keep to these time limits, meaning that other patient pairs were discussed in less detail than was ideal.

Asking GPs to recall information about patients that they might not have seen for a few weeks was another weakness. Reflecting on their choices, retrospectively, could have added bias to their reasons for referral. GPs were relying on how good their memory was to describe the decisions they had made on a few patients amongst the hundreds that they saw each month. They would recall some of the patients more easily than others and were able to describe them more accurately than those they had seen on fewer occasions or further back in time. The reasons for decisions that they gave in retrospect could have been different to the actual ones that passed through their minds during the consultation. Additionally, as the GPs were talking about clinical choices that they had made, that could have put them on the defensive, needing to justify their choices. However, it was hoped that by allowing the GP to look up his notes on the patient and briefly describe each patient before stating the reasons for or against referral, that this would allow them to picture each patient more clearly in their minds and allow them to compare the two. My sense of the GPs interviewed was that they were very honest and thoughtful, with a couple of GPs re-

considering some decisions that they had made and noting them down to go back to afterwards.

The impact of myself being a clinical psychologist interviewing doctors could have had opposing implications. On one hand GPs may have felt less scrutinised by a trainee asking them about clinical decisions than had a fellow GP carried out the interviews. Conversely GPs may have felt more comfortable and talked more openly to members of their own profession.

#### *Patient-pair matching*

As mentioned in the Method of the Empirical Paper, GPs were provided with the names of patients who they had recently referred to the on-site clinical psychologist and counsellor. The GPs themselves were asked to match patients themselves with similar patients that they had decided not to refer and were treating themselves. This method was adopted because patient confidentiality had to be maintained. Had I wished to match the patients myself it would have been likely that I would have had to obtain the patient's permission to open their notes, as I was not working as a clinician in the surgeries where I carried out the research. This would probably have lead to some patients refusing and then having to go back to the psychologist or counsellor for more names of people to approach, thus requiring much more time than I had available. It was also felt that as patient interviews were not part of the research, it was not necessary for me to know their identity and have to approach them for consent to look at their files.

Although asking the GPs to match the patients made things much easier logistically for me, it also added unexpected difficulties to the research process and weakened the matched pair design. Firstly not all GPs had properly read the Participant Information leaflet (see Appendix B) leading to them having to match the patient pairs during the interview, reducing the limited time even further. Another problem was that a few GPs could not think of patients that they were seeing themselves as matches, or were not familiar enough with their computer system to search for them. Additionally, with hindsight, matching the patients for age, sex and presenting problem was expecting a lot from the GPs with their limited free time. This resulted in poorer matched pairs than had been hoped for. Almost all patients were matched for presenting problem as this was easier to match, however, age- and sex- matched pairs were rarer. Having said that, a few very organised GPs had read the information well and had five well-matched pairs ready before the interview, thus proving that it was possible. Conversely, one interview had to be cut short without discussing any patients and two after only discussing two or three patients, either as the GP had not had time to match them or could not find matches during the interview.

I do not feel that this impacted greatly on the results. For example, GPs rarely mentioned that they referred a patient merely as they were older and were much more likely to comment on their character, suitability etc. However, having better matched pairs did appear to make it easier for GPs to identify reasons for referral. Should I undertake a similar project again, with GPs matching the pairs, I would make sure that the method was clear when getting in contact with the GPs. Alternatively, were I to have more time I would have matched the patients myself and possibly combined this with patient interviews as described below.

*Analysis*

The thematic analysis was carried out in various stages. Following transcription of the interviews, the main factors identified for and against referral from each of the patient pairs were summarised for every interview. Any general factors that arose during the interview were also summarised. GPs were provided with a list of frequently occurring factors, both for and against referral, and asked for their feedback (see Appendix D). Having read all the interviews thoroughly two to three times and summarised all the factors, overarching themes were identified and their prevalence noted.

One difficulty encountered whilst analysing the transcripts was achieving a balance between describing discrete themes and conveying the nature in which the GPs had described their decisions. As mentioned in the discussion section of the Empirical Paper most of the factors identified were conditional. That is, a GP would mention a major factor for referring a patient on, but then mention that had it not been for another factor they wouldn't have mentioned the initial one. I felt that presenting the themes as being made up of list of discrete factors detracted from the richness of the transcripts. By presenting overarching themes and linking some of the factors in the main body of the text it was hoped that the quality of the decisions came across more vividly.

### Clinical Implications and Future Research

The GPs in this study varied in their experience and knowledge of mental health difficulties. However, my impression was that on the whole the GPs interviewed were quite knowledgeable about mental health matters and psychological treatments. It could be that this was due to the GPs themselves having a personal interest in mental health problems and hence keeping themselves well informed. On the other hand, it is also likely that the presence of on-site mental health professionals played a role. GPs may become more aware of mental health problems and their treatability through discussions with counsellors or clinical psychologists. Although most GPs in the study appeared aware of the benefits of psychological therapies, other GPs might not be so well informed, especially those with fewer or no on-site mental health professionals.

It is hoped that this study will prompt other GPs to evaluate their own referrals to mental health professionals, especially the patients who they do not refer. Two or three GPs commented on the possibility of rethinking certain decisions that had been discussed. Whilst going through a patient's notes a GP might suddenly realise that they had been seeing a patient regularly for a year but had not reviewed their initial decision not to refer them on. With a GP's high workload it must be easy for them to get into a routine with some patients and find it harder to step back and reassess the possibility of referral. For the GPs taking part in the study, I hope that it influenced their own clinical practice, encouraging them to think more reflexively about their referrals. I believe they found it useful to take the time to reflect on their clinical

decisions, something that most GPs commented they do not normally have the time to do.

This study did not examine the patient's experience of the referral process. As mentioned above, had more time been available it would have been interesting to explore this with the patients who were discussed anonymously in this study. Exploring what made these patients approach their GP for a referral would help GPs and mental health professionals think about how to raise awareness of the services that were on offer at practices. Conversely looking into why some patients did not ask for a referral, would help target patient populations who might not otherwise request help. Combining patients views about how they felt their GP managed their problems with the current findings would also add to the discussion about how appropriate the referrals were. Rather than only having a GP's word that a patient was not very psychologically minded, the researcher would be able to make his or her own judgement. This study could further been enriched by including standardised assessment measures or screening questionnaires. This would allow a comparison of a patient's clinical problems and the likelihood of them receiving a referral from their GP.

### Personal Reflection

This qualitative research project was a considerable departure from my background in experimental psychology. In the past, when reading qualitative studies, part of me had questioned their usefulness in developing psychological theory or improving my clinical practice. However, I have come to see just how useful they can be when

employed to investigate the right type of research question: namely to enrich our understanding of a subject area, rather than testing hypotheses or verifying existing theories. The in-depth analysis of a specific area, as in my study, will undoubtedly raise more questions than those it set out to investigate, thus providing material for future studies.

I feel that my clinical practice has also changed as a result of this study. I find myself discussing patients with referrers much more and obtaining a clearer idea of why they referred. When seeing clients for an assessment I will not automatically assume that they were referred due to their clinical needs, and will explore their referral with them in greater detail. I am, on the whole, much more curious about how a patient has come to be where they are in the NHS.

### References

Elliot, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.

## **Appendices**

**Appendix A:**  
**Ethical Approval Letter**



**North Central London  
Research Consortium**

Dr Paul Fox  
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3<sup>rd</sup> Floor West Wing  
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Phone 020 7530 5375  
Fax 020 7530 3235

28 May 2004

Stavros N Stavrou  
Trainee Clinical Psychologist  
Sub-department of Clinical Health  
Psychology, UCL  
University College London  
Gower Street  
London WC1E 6BT

Dear Stavros

LREC Ref: 04/Q0511/2

Title: *General practitioners' decision-making process in referrals to clinical psychologists and counsellors, for problems of anxiety and depression*

I am pleased to note that the Local Research Ethics Committee has recommended to the Trust that there are no ethical reasons why your study should not proceed.

Projects are registered with the North London Community Research Consortium if they utilise patients, staff, records, facilities or other resources of Camden Primary Care Trust, Islington Primary Care Trust, the Camden & Islington Mental Health and Social Care Trust, Barnet Primary Care Trust, Enfield Primary Care Trust or Haringey Teaching Primary Care Trust. On the basis of the documentation supplied to us, your study has the support of the clinical service manager/assistant locality director of the service in which it will be based.

The Camden Primary Care Trust, Islington Primary Care Trust, and Camden and Islington Mental Health and Social Care Trust therefore grant approval to begin research based on the proposal reviewed by the ethics committee and subject to any conditions set out in their letter of 24 May 2004. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then this approval would become void. The approval is also subject to your consent for information to be extracted from your project registration form for inclusion in NHS project registration/management databases and, where appropriate, the National Research Register and the UCL Clinical Research Network register.

Permission to conduct research is also conditional on the research being conducted in accordance with the Department of Health Research Governance Framework for Health and Social Care:



- Appendix A to this letter outlines responsibilities of principal investigators;
- Appendix B details the research governance responsibilities for other researchers. It also outlines the duties of all researchers under the Health and Safety at Work Act 1974. Principal investigators should disseminate the contents of Appendix B to all those in their research teams.

Further information on the research governance framework for health and social care can be found on the DH web pages at <http://www.doh.gov.uk/research/>. Staff working within trusts covered by the research consortium can also find the information on the Trust Intranet.

Researchers are also reminded that personally identifiable information on living persons must be collected, stored, processed and disclosed in accordance with the Data Protection Act 1998. Such data may be in the form of electronic files, paper files, voice recordings or photographs/scans/X-rays. Further information on the Data Protection Act is available from your organisations Data Protection Officer or from the Consortium R&D Unit. The Medical Research Council also publishes the guidance booklet 'Personal Information in Medical Research' which is available from <http://www.mrc.ac.uk/pdf-pimr.pdf>

Except in the case of commercially funded research projects, the following acknowledgement and disclaimer MUST appear on all publications arising from your work.

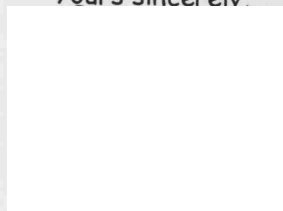
*"This work was undertaken with the support of [\*\*\*Insert Trust\*\*\*] Trust, who received [\*\*\*insert "funding" or a "proportion of funding" \*\*\*] from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".*

\* "a proportion of funding" where the research is also supported by an external funding body;  
"funding" where no external funding has been obtained.

This is a requirement of the contract between the Trust and the NHS Executive in which the Trust receives funding to cover the infrastructure costs associated with performing non-commercial research.

Please make all members of the research team aware of the contents of this approval. I wish you every success with your research.

Yours sincerely



Dr Paul Fox  
Research Operations Director



**Appendix B:**  
**Consent Form**



## CONSENT FORM

Participant Identification Number:

### Title of Project:

General practitioners' decision-making processes in referrals to clinical psychologists and counsellors, for problems of anxiety and depression.

### Name of Researcher:

Stavros Stavrou

Please initial box

1. I confirm that I have read and understand the information sheet dated .....  
(version 1.1) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time,  
without giving any reason, without my medical care or legal rights being affected.
3. I agree to take part in the above study.

☐☐☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Note: 1 copy for participant, 1 for researcher

**Appendix C:**  
**Letter to Participants**

***(Letter to be on headed paper)***

Stavros Stavrou  
Trainee Clinical Psychologist  
Sub-department of Clinical Health Psychology  
UCL  
Gower Street  
London WC1E 6BT

***(Colleague's Address)***

Dear Colleague,

This letter invites you to participate in a research study looking at the influence of various factors in general practitioners' decisions to refer patients suffering from depression and anxiety to psychology and counselling services. It will specifically be looking at the question of why some patients are referred whilst others are not. It is a qualitative study, involving a single interview, estimated to last 45 minutes.

Please read the enclosed 'Participant Information Sheet' that offers full details of the study's content and purpose.

Thank you for taking the time to consider your participation in this research study.

Yours sincerely,

Stavros Stavrou  
Trainee Clinical Psychologist  
University College London

Dr John Cape  
Consultant Clinical Psychologist  
Head of Psychology, C&I MHSCT

**Appendix D:**  
**Participant Information Sheet**

# GP referrals to clinical psychologists and counsellors

## Participant Information Sheet

*You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.*

### **What is the purpose of this study?**

Up to a third of GP consultations concern mental health issues. This study intends to shed light on the clinical decisions made during these visits as few studies have specifically examined general practitioners' referrals to mental health professionals.

The proposed qualitative study aims to examine which factors influence general practitioners' decisions to refer patients suffering from depression and anxiety to clinical psychologists and counsellors. It will be asking general practitioners to compare and contrast individual patients who have been referred to these services with others who the general practitioner continues to treat themselves.

### **Why have I been chosen?**

You have been chosen to participate in this study due to your employment as a General Practitioner, working within the Camden and Islington area.

### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

### **What will be involved if I decide to take part?**

The study will involve you being interviewed once by the researcher. The interview will last for approximately 45 minutes to 1 hour.

The researcher will present you with a sealed envelope containing a list of 3-5 patients, identified by the clinical psychologist and counsellor working in your surgery. Alternatively, the mental health professional will present you with the selected cases themselves. This list will consist of patients who you have referred to the clinical psychologist and counsellor over the last few months, for problems relating to anxiety or depression. The researcher will not be aware of the patients' identities and you will be asked to keep their identities confidential during the interview.

You will then be asked to select 3-5 other patients being treated by yourself, for problems of anxiety and depression, trying to match them roughly for age and gender. Thus, before the interview begins, you will have before you 3-5 patient pairs, consisting of a patient whom you are seeing regularly and a patient whom you have referred to the mental health professional.

The researcher will then ask questions about why one patient was referred whilst the other was not in order to understand the factors influencing your decisions.

The interview will be tape-recorded and later transcribed for data analysis. Tapes will be stored securely in a locked cabinet, as well as any hard copies of transcripts. Electronic

copies of transcripts will be kept on secure University College London and NHS personal computers of the researcher. The tapes used to record the interviews will be destroyed.

You may stop the interview at any time and without giving a reason.

### **Benefits and risks**

It is hoped that this study will be informative and promote self-reflection in the participants regarding their clinical practice.

It is not aimed to be a critical analysis of any single practitioner's clinical practice.

### **What if something goes wrong?**

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

### **Will my taking part in this study be kept confidential?**

All information which is collected about you during the course of the research will be kept confidential. All recordings and transcripts of interviews will be kept anonymous.

### **What will happen to the results of this research study?**

The researcher's analysis of all interviews conducted will be fed back to all participants and they will be invited to comment on the results. This process is designed to increase the validity of the study's conclusions.

A final report of this study will be submitted for publication in a peer-review journal in 2005.

### **Who has reviewed the study?**

The Camden & Islington Community Health Services Local Research Ethics Committee has reviewed this study.

**This study is part of the researcher's PhD studies and is supervised by Dr John Cape, Head of Psychology Services, Camden and Islington Mental Health and Social Care Trust, and Dr Chris Barker, Senior Lecturer & Research Coordinator, University College London.**

### **Contact details for any questions raised by this information sheet:**

Stavros Stavrou, BA  
Trainee Clinical Psychologist  
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Gower Street  
London WC1E 6BT

***Many thanks for taking the time to read this information sheet***

**Appendix E:**  
**Semi-Structured Interview Schedule**

# Semi-Structured Interview Schedule

*Thank you for agreeing to participate in this study.*

*I am carrying out this research in order to help gain insight into the decision making processes involved in your referrals to clinical psychologists and counsellors. I am particularly interested in looking at patients you referred for anxiety and depression related issues and comparing these to patients you are seeing yourselves for these problems. I hope to understand what factors influenced your decision to refer a patient or not. Please treat the next hour or so as a conversation with a colleague and feel free to ask me to clarify any of my questions.*

*I must remind you that I am unaware of the identities of the patients whom we will be talking about. Please refrain from giving out any information that might lead to anybody identifying the patients we are discussing.*

## Patient pair 1

1. Describe patient referred and patient not referred – refresh memory.
2. Could you tell me some factors that you think played a part in your decision to refer the one patient and not the other patient?

### Prompts:

Initiation of referral?  
Risk involved?  
Patient clinical presentation/SES?  
Past treatments tried?  
Why not referred other patient?  
Waiting lists an issue?  
Past experience of similar cases?

Easy/Hard decision to make?  
Other recent referrals to MH profess.?  
Any immediate event before referral?  
Feelings before/after referral?  
Pressure to refer?  
Doctor/MH professional relationship?  
Patient/doctor relationship with both patients?

### Themes to return to:

## **Patient pair 2**

1. Describe patient referred and patient not referred – refresh memory.
2. Could you tell me some factors that you think played a part in your decision to refer the one patient and not the other patient?

### **Prompts:**

Initiation of referral?  
Risk involved?  
Patient clinical presentation/SES?  
Past treatments tried?  
Why not referred other patient?  
Waiting lists an issue?  
Past experience of similar cases?

Easy/Hard decision to make?  
Other recent referrals to MH profess.?  
Any immediate event before referral?  
Feelings before/after referral?  
Pressure to refer?  
Doctor/MH professional relationship?  
Patient/doctor relationship with both patients?

### **Themes to return to:**

## **Patient pair 3**

1. Describe patient referred and patient not referred – refresh memory.
2. Could you tell me some factors that you think played a part in your decision to refer the one patient and not the other patient?

### **Prompts:**

Initiation of referral?  
Risk involved?  
Patient clinical presentation/SES?  
Past treatments tried?  
Why not referred other patient?  
Waiting lists an issue?  
Past experience of similar cases?

Easy/Hard decision to make?  
Other recent referrals to MH profess.?  
Any immediate event before referral?  
Feelings before/after referral?  
Pressure to refer?  
Doctor/MH professional relationship?  
Patient/doctor relationship with both patients?

### **Themes to return to:**

### **Patient pair 4**

1. Describe patient referred and patient not referred – refresh memory.
2. Could you tell me some factors that you think played a part in your decision to refer the one patient and not the other patient?

#### **Prompts:**

Initiation of referral?  
Risk involved?  
Patient clinical presentation/SES?  
Past treatments tried?  
Why not referred other patient?  
Waiting lists an issue?  
Past experience of similar cases?

Easy/Hard decision to make?  
Other recent referrals to MH profess.?  
Any immediate event before referral?  
Feelings before/after referral?  
Pressure to refer?  
Doctor/MH professional relationship?  
Patient/doctor relationship with both patients?

#### **Themes to return to:**

### **Patient pair 5**

1. Describe patient referred and patient not referred – refresh memory.
2. Could you tell me some factors that you think played a part in your decision to refer the one patient and not the other patient?

#### **Prompts:**

Initiation of referral?  
Risk involved?  
Patient clinical presentation/SES?  
Past treatments tried?  
Why not referred other patient?  
Waiting lists an issue?  
Past experience of similar cases?

Easy/Hard decision to make?  
Other recent referrals to MH profess.?  
Any immediate event before referral?  
Feelings before/after referral?  
Pressure to refer?  
Doctor/MH professional relationship?  
Patient/doctor relationship with both patients?

#### **Themes to return to:**

**Appendix F:**  
**An Example of the Analytic Process**

## Thematic Analysis: An example of the process

### Extract from interview with GP 4

#### Referred Patient

	<u>Summary of Factors</u>	<u>Main Themes</u>
GP: "There were lots of issues that she wanted to address properly for the first time. She has difficult history in that she thinks that she was sexually abused as a child. I don't know what to do with somebody who's been abused. I don't know what you are supposed to do. I could just listen but it's a bit like a GP trying to treat a heart attack – its best with the specialists. You are playing with quite a serious thing and if you don't know what you are doing – presumably there is quite a lot of potential for making things worst. I wanted to refer her to someone who could help"	<ul style="list-style-type: none"> <li>• Came asking for help.</li> <li>• Sexual abuse as child.</li> <li>• GP doesn't know what to do with sexual abuse.</li> <li>• Not confident with own skills/experience.</li> <li>• Wants to refer to specialist.</li> </ul>	<p>Patient Choice</p> <p>Patient would benefit from referring to specialist</p> <p>GP Capacity to Help: lack of skills/knowledge</p>

#### Non-Referred Patient

	<u>Summary of Factors</u>	<u>Main Themes</u>
<p>GP: "She suffered from quite dreadful depression for 6 years on an off. I think she is in an awful situation at home and I don't think she is able to really change things. She doesn't have very good insight. She also somatises a huge amount.</p> <p>I had referred her for counselling before, but I don't think that she is very psychologically switched on, and it wasn't very helpful for her. I don't think she engaged very well and I cant really see much hope from her getting benefit in that way."</p>	<ul style="list-style-type: none"> <li>• GP empathises with her situation but doesn't feel that she would benefit</li> <li>• Lack of insight</li> <li>• Somatises</li> <li>• Not psychologically minded</li> <li>• Has tried it before and not found helpful/didn't engage</li> </ul>	<p>GP cant see benefit of referral:</p> <p>Patient Benefit: Not suitable</p> <p>Patient Choice: Referred before and not useful</p>

**Appendix G:**  
**GP Feedback Questionnaire**

GP I.D. Number:



**Doctorate of Clinical Psychology Research Project:**  
GP referrals to clinical psychologists and counsellors

**Comments on Interview Themes**

I found the themes extracted from my interview were (please circle):

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Inaccurate</b>				<b>Accurate</b>

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Unclear</b>				<b>Clear</b>

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Incomplete</b>				<b>Complete</b>

Please comment on your ratings, especially if you feel that there are any errors or omissions in the themes.

**Comments:**

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