Health Service Research

Managing common mental health problems: contrasting views of primary care physicians and psychiatrists

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Abstract

Background. Recent studies have reported a lack of collaboration and consensus between primary care physicians (PCPs) and psychiatrists.

Objective. To compare the views of PCPs and psychiatrists on managing common mental health problems in primary care.

Methods. Four focus group interviews were conducted to explore the in-depth opinions of PCPs and psychiatrists in Hong Kong. The acceptance towards the proposed collaborative strategies from the focus groups were investigated in a questionnaire survey with data from 516 PCPs and 83 psychiatrists working in public and private sectors.

Results. In the focus groups, the PCPs explained that several follow-up sessions to build up trust and enable the patients to accept their mental health problems were often needed before making referrals. Although some PCPs felt capable of managing common mental health problems, they had limited choices of psychiatric drugs to prescribe. Some public PCPs experienced the benefits of collaborative care, but most private PCPs perceived limited support from psychiatrists. The survey showed that around 90% of PCPs and public psychiatrists supported setting up an agreed protocol of care, management of common mental health problems by PCPs, and discharging stabilized patients to primary care. However, only around 54–67% of private psychiatrists supported different components of these strategies. Besides, less than half of the psychiatrists agreed with setting up a support hotline for the PCPs to consult them.

Conclusions. The majority of PCPs and psychiatrists support management of common mental health problems in primary care, but there is significantly less support from the private psychiatrists.

Key words: Health care system, mental health, primary care, psychiatrists, referral.

Introduction

In recent years, the WHO has called for integration of mental health into primary care in response to the high prevalence of common mental disorders, such as depression and anxiety disorders (1). Many studies have shown that the general public tends to visit primary care physicians (PCPs) in their initial contact with mental healthcare (2). Experiences from Australia, USA and UK showed positive outcomes, including increased accessibility, patient satisfaction, continuity of care and efficiency of services (1,3).

Apart from the patients’ help seeking behaviours, the attitudes of the healthcare providers are crucial in determining the service outcomes. Trials reported successful models of collaborative care which commonly involved a PCP, a mental health professional and a case manager (4,5). Collaborative care was often included as a
Managing common mental health problems

In line with the WHO perspective, adequate provision of mental health service is considered central to the future primary care model in Hong Kong. Similar to USA and most Asian countries (21), the healthcare system of Hong Kong is pluralistic (mixed mode of public-private financing) (22). The public doctors are paid a regular monthly salary according to their ranks while the private doctors are paid on a fees-for-service basis. The general public can consult any private doctors including specialists regarding any health issues. There are currently 312 specialist psychiatrists (Specialist Register, 2014) serving 7.15 million people in Hong Kong. In other words, there are 4.4 psychiatrists/100 000 people, which is at an intermediate level by international standard. Being the major healthcare service providers to the community, the 5000 PCPs are expected to play a pivotal role in caring for patients with common mental health problems. Postgraduate mental health training for PCPs has been made available since 2002 (23). Besides, collaborative care involving PCPs, psychiatrists and other healthcare professionals, named as the Integrated Mental Health Program (IMHP), has been started in some government general outpatient clinics (GOPCs) since 2010. However, over 75% of the PCPs work in the private setting, with the majority as solo practitioners or in group practices similar to health maintenance organizations. Their collaboration with psychiatrists largely depends upon the referral system. In contrast to primary care, only about 30% of the specialist psychiatric services are provided by the private sector. The fees charged range from about HK$500 to $2000 (US$64 to $258) per consultation. Most patients attend the public psychiatric services with a very low charge [HK$100 (US$13) per consultation] but often requiring a lengthy waiting time which may take 1 month to 1 year, except for urgent cases. A formal referral from PCPs or other specialists is mandatory.

This study was part of a large project investigating the facilitators and obstacles for PCPs to managing mental health patients. The findings regarding the PCPs’ obstacles are published elsewhere (24). The identified obstacles included consultation time constraint, patients’ reluctance to accept diagnosis of mental health problems and to be referred to psychiatrists (e.g. more stigmatization effects), as well as a lack of feedback from psychiatrists after referrals. The current article focuses on comparing the views of PCPs and psychiatrists on managing common mental health problems in primary care and the strategies for collaboration under a pluralistic health care system. This will address a research gap in Hong Kong and the findings will be useful for international reference.

Methods

A combined qualitative and quantitative approach was adopted for this study. Ethics approval was obtained from the local Institutional Review Board of The University of Hong Kong/Hospital Authority Hong Kong West Cluster (UW 09-326).

Qualitative approach

We started with focus group interviews to explore in-depth opinions of the PCPs and psychiatrists on the study topic. We purposively recruited participants from both public and private settings with a wide range of characteristics and experience. We contacted the departmental heads (including PCPs and psychiatrists who normally work outside the university but appointed to provide teaching on an honorary basis) of the Department of Family Medicine and Primary Care of the University of Hong Kong to recommend participants for the interviews based on their professional network. Invitation letters were sent to them and followed by telephone contacts. We conducted four focus group interviews of 6–10 participants each. There were two focus groups for PCPs with one group working in public setting and another group in private setting; and same arrangement was adopted for two focus groups for psychiatrists. Questions on participants’ views towards management of mental health patients in primary care, referrals and collaboration strategies were raised and discussed in the interviews. We aimed to avoid presumption of attitudes of the participants who were encouraged to share their opinions freely but an interview guide (see Appendix) was used to ensure relevant questions were covered.

A facilitator experienced in focus group led the 90-minute interviews which were audio-taped and then transcribed verbatim. Field notes were prepared by another observer to record any non-verbal responses during the interviews. The facilitator and one of the authors (TPL) checked the accuracy of the transcriptions. Using the conventional content analysis approach described by Hsieh and Shannon (25), coding categories were inductively derived from the text data. The data were coded independently by two investigators of the research team who are experienced in qualitative research. The coding consistency between the two sets was checked and the majority of the codes were consistent. Inconsistencies were resolved by discussion between the two investigators to reach an agreement for a common theme. The key themes on the major collaboration strategies between PCPs and psychiatrists identified from the focus group findings were incorporated in the design of a questionnaire for quantitative survey.

Quantitative approach

Sample

For the PCPs, we invited all members of Hong Kong College of Family Physicians and graduates of the Postgraduate Diploma in Community Psychological Medicine (PDCPM) to complete a structured questionnaire. The target population comprised 1394 College members and 198 PDCPM graduates. The contact details of the graduates were available from our Department, whilst the College members were reached with the help of the College. To avoid duplication, 85 PDCPM graduates who were also affiliated with the College were removed from the mailing list of the College. All 275
psychiatrists on the list of the Medical Council (Specialist Register, 2012) were invited to complete another version of the structured questionnaire. Their addresses were available from the gazette published by the government. A total of three rounds of invitations were sent to both PCPs and psychiatrists.

**Questionnaire**
The questionnaire itself was anonymous but coded with a unique reference number to identify the respondent for subsequent rounds of reminders. The code was known to one research assistant only and not available to members of the research team. The questionnaire was sent with an invitation letter which asked for consent of the subject to fill in the questionnaire. The questionnaire, which mainly asked for descriptive facts and views, was tested for its face- and content-validity with 10 PCPs and 6 psychiatrists with minor modifications made. Questions about collaboration strategies based on our focus group findings are examined in this article, while questions for other themes have been reported elsewhere (24). A 4-point Likert scale (1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree) was adopted for the questions about views, while options of Yes/No, numbers and percentages were used for questions about the personal background and practice characteristics.

**Statistical Analysis**
The quantitative data were analyzed using SAS 9.3. We summarized the responses from PCPs and psychiatrists by frequencies and percentages. Fisher’s exact test was used to test for the difference in response distributions between the respondents in private and public settings. A P-value < 0.05 is considered statistically significant.

**Results**

**Participants recruited**

**Focus groups**
Four focus groups comprising 17 PCPs and 13 psychiatrists from private and public settings were held between November 2011 and January 2012. Among the participants, 80% were males. The mean (SD) years after graduation from medical school was 18.5 (11.17).

**Questionnaire survey**
There were 599 respondents with 516 PCPs and 83 psychiatrists after three rounds of mailing from June 2012 to December 2012. Excluding 10 PCPs and 10 psychiatrists with invalid addresses, the response rates were 34.5% (516 /1497) for PCPs and 31.3% (83/265) for psychiatrists. The details of their personal and practice characteristics are shown in Table 1.

**Views of the focus group participants**

**Opinions on referrals**
The PCPs discussed their views about referrals. They needed to consider the timing of referrals, and they took time facilitating the patients to realize their mental health problems. Several more follow-up sessions to build up trust were often needed to enable a successful referral. Good communication skills are indispensable in convincing the patients.

Most of them do not present because of their mental illness. We are the ones who notice [their mental problem] and further dig into it. The patients are not ready to consult about it. Therefore if we have to manage these patients, we would need to let them realize and understand that this is a [mental] problem so a successful referral can be made. I would take a note and follow up with the patients when I see them again. Then they would place more trust in me. If the patients proactively visit for mental illness, they would be cooperative. (P1, public PCPs group)

Sometimes they want to seek our advice, or they would like to obtain a referral to see a psychiatrist. Occasionally when we have to refer the patient to psychiatric service right from the beginning, the patient would query why having poor sleep is a mental illness. What we need to do is to match their expectations. (P6, public PCPs group)

If the patients with severe condition feel reluctant to visit a psychiatrist, I would frankly advise them that their condition is quite severe, and that they may need further extensive treatment and assessment. I may also tell them that the current sleep loss should in fact be managed by a psychiatrist; many patients with sleeping problems would call for a psychiatric consultation. (P4, public PCPs group)

When asked about the appropriate timing for referrals, some public psychiatrists felt that it would be best for the patients to enter the specialist system at a later time point, after they had gone through the management of the PCPs. The same perspective was shared by some PCPs.

Psychiatrists working in the public sector prefer patients to consult them at a later time. It is possible that they wish to handle cases that are more severe in order to bring their expertise into full play. (P9, public PCPs group)

However, some private psychiatrists commented that the expectation of referrals at a later time point was due to resource availability rather than the best benefits for the patients. Despite the difference in opinions, a portion of both public and private psychiatrists supported the management of common mental health problems by PCPs, provided that there was appropriate collaboration and understanding of their limitations. Some of them pointed out that the decision and timing for referral should be flexible.

In an ideal system, more could be done by the PCPs, particularly mental problems. Psychiatrists should have more collaboration with PCPs and discuss cases together. In other words, the boundaries of care between [psychiatrists and PCPs] should be flexible. (P4, public psychiatrists group)

| Table 1. Personal and practice characteristics of survey respondents during June–December 2012 |
|---------------------------------|------------------------|------------------------|
|                                | PCPs, n = 516          | Psychiatrists, n = 83   |
| Gender                         |                        |                        |
| Male                           | 337 (65.6%)            | 60 (74.1%)             |
| Female                         | 177 (34.4%)            | 21 (25.9%)             |
| Work setting                   |                        |                        |
| Hospital                       | 62 (12.3%)             | 53 (66.3%)             |
| Community                      | 443 (87.7%)            | 27 (33.8%)             |
| Work sector                    |                        |                        |
| Public                         | 224 (43.9%)            | 56 (69.1%)             |
| Private                        | 286 (56.1%)            | 25 (30.9%)             |
| Type of practice               |                        |                        |
| Group                          | 284 (58.8%)            | 61 (75.3%)             |
| Solo                           | 199 (41.2%)            | 20 (24.7%)             |
| Years since graduation         |                        |                        |
| Mean ± SD                      | 20.0 (12.56)           | 22.4 (9.42)            |

Some data in the categories were missing due to respondents’ refusal to answer or invalid response.
Many PCPs are gradually finding something that they are incapable of handling nowadays, and sometimes they want to consult specialists’ opinions. (P6, private psychiatrists group)

Strengths and limitations of PCPs in the system

The PCPs offered their views on why many patients preferred to consult them first, instead of psychiatrists. Apart from less stigmatization effect to consult a PCP, the long term doctor-patient relationship facilitated the patients to express their psychological problems more comfortably.

The patient has been consulting you since young age and hence the patient would be more willing to disclose more to you. The patient would refuse to do so if it is an unfamiliar doctor. That is, if he has confidence in you, he would tell you a lot. (P6, private PCPs group)

Another major reason was that many patients consulted the PCPs for diagnosis to see if their problems had a psychiatric cause before seeing psychiatrists. This could save extra cost and time.

Patients would come to us first to determine if their problem should be handled by a psychiatrist; refer only if it is. Also, some of the patients have got used to consulting us, especially the elderly. We know their problems, such as chest pain and dizziness. We are familiar with these patients. We know the symptoms are not caused by organic disease but something that should be managed by a psychiatrist. (P5, private PCPs group)

The limitations of PCPs in the system were also discussed. For those who felt capable of managing common mental health problems, they often had limited choices of psychiatric drugs to prescribe, especially in the public setting (e.g. availability of tricyclic antidepressants only while no or few selective serotonin reuptake inhibitors being available for patients with depression). A public psychiatrist gave the following comment.

The public PCPs were probably under some pressure not to prescribe sedatives; they tried to handle the case for a while, and without many choices on medicine they would then refer the patients to us. In fact if they had a higher degree of freedom on medicine prescription, they should be able to handle more cases. This is an unresolved issue because they are not permitted to prescribe some of the drugs. They can at most give out some “soothing” medicines. A few are even reluctant and dare not prescribe anything. (P3, public psychiatrists group)

Views in strengthening the collaboration between PCPs and psychiatrists

The PCPs expressed their opinions of strengthening their collaboration with psychiatrists. The public PCPs acknowledged the benefits of the IMHP in the GOPCs.

Indeed the cooperation works better than before, because we now have IMHP which seems building the bridge that connects GOPC and the psychiatric department. Severe patients are to be referred to psychiatrists, whereas those who are not as severe are to be referred to IMHP. The psychiatric department has monthly meeting with IMHP. Also, there are appointed time slots when psychiatrists would need to be on duty in IMHP or GOPC. If a patient is living near IMHP or having a stable condition, the psychiatric department would refer the patient to IMHP. (P7, public PCPs group)

However, PCPs working in the private setting perceived limited support from the psychiatrists. Some doubted the psychiatrists’ willingness to help them. The relationship between us is not mutual. [Internal medicine] Physicians would assist and support us, but I think psychiatrists don’t feel like to provide support to PCPs to handle this kind of problem in the community. (P2, private PCPs group)

They expressed a strong need to strengthen the collaboration with psychiatrists. They suggested setting up hotline and feedback mechanism for their communication with psychiatrists.

We may find a doctor from the psychiatric service whom we can contact directly when there’s a special need. At least we would be able to inquire to make ourselves comfortable by letting us and the patient know more. (P3, private PCPs group)

For example, if I refer a patient whom I can’t manage to a specialist, and he subsequently writes me a reply letter after the patient has been seen, then I can learn from the case. (P1, private PCPs group)

Findings of the survey on PCPs and psychiatrists

The survey respondents were asked about their views on the major strategies shared by the focus group participants. The responses from PCPs and psychiatrists are compared in Table 2. Almost all PCPs and public psychiatrists supported the establishment of a feedback mechanism to notify the PCPs when the referred patients had consulted the psychiatrists. Around 90% of PCPs and public psychiatrists supported setting up an agreed protocol of care, management of common mental health problems by PCPs, and discharging stabilized patients to primary care. However, only around 54–67% of private psychiatrists supported these strategies. Besides, while 79% of public PCPs and 87% of private PCPs wanted to set up a support hotline for them to consult psychiatrists, only about 45% of public and private psychiatrists agreed with this.

Overall, except the responses on setting up an agreed protocol of care, the private PCPs were more likely to agree strongly on all suggested strategies than the public PCPs. Significant differences (P < 0.05) between the responses from private and public PCPs were observed for the strategies on setting up a support hotline, establishing a feedback mechanism and encouraging PCPs’ management of common mental health problems. When comparing the public and private psychiatrists, there were significant differences in their responses regarding setting up a protocol, encouraging PCPs’ management and discharging stabilized patients to primary care. Among all groups of respondents, the public psychiatrists had a distinctly high percentage of ‘strongly agree’ responses (46%) for the strategy on discharging stabilized patients.

Discussions

The qualitative findings of this study explained how the PCPs and psychiatrists saw the need and timing for referral. Both consensus and conflicts in their views were observed. The private PCPs perceived very limited support from the psychiatrists and expressed the need for stronger collaboration. The survey results showed that while PCPs and public psychiatrists generally supported management of common mental health problems in primary care, only two-third of private psychiatrists supported it. This signified the difference in group-interest between the public and private sectors, probably due to financial consideration. A French study had found that PCPs and private psychiatrists were similar but different from public psychiatrists for the proportion of mental health patients with anxiety or depressive disorders (70% versus 65% versus 38%) (26). The PCPs and psychiatrists in the private sector may be interpreted as market competitors to some extent. On the other hand, they have an interdependent relationship.
The private psychiatrists are partially dependent on private PCPs for referral of patients (27). In fact, given the large unmet needs for treatment for common mental health problems (28), both groups can play a significant role in the system. Some focus group participants pointed out that the psychiatrists wanted to utilize their specialty to manage more severe cases. They also explained the strength of PCPs in initial management of the patients in the help seeking pathway. This echoed the concept of stepped care. These factors may be the driving forces which still prompted over half of the private psychiatrists to consult psychiatrists when the referred patient was seen by the psychiatrist the first time. However, the public PCPs were more interested in the study topic. Differences between the two groups were not significant (27).

Despite the supportive attitudes towards PCPs, over half of both public and private psychiatrists disagreed with the proposed strategy of setting a support hotline for the PCPs to consult them. The psychiatrists might regard this strategy as a burden on them. This suggested the gap between their attitudes and behaviours. Although related experience from Australia also showed that proposals to promote more telephone-based consultation services by psychiatrists to PCPs were not supported (29), telephone call was identified as the most common mode of communication between PCPs and psychiatrists in USA. It was reported that 35% of the US psychiatrists often received information back to the referring physician (29). This mechanism is important to check if the referred patients show up at psychiatric clinics and reduce lost to follow-up (30).

The implementation of this mechanism. This is what had been done in USA that about 80% psychiatrists often sent diagnostic and treatment information back to the referring physician (30). This mechanism is important to check if the referred patients show up at psychiatric clinics and reduce lost to follow-up (31). Besides, as pointed out by our survey, the feedback from referring physicians is significantly less support from the private psychiatrists. For a

**Table 2. Comparison of survey responses between PCPs and psychiatrists on collaboration strategies**

<table>
<thead>
<tr>
<th></th>
<th>Public PCPs, n = 224</th>
<th>Private PCPs, n = 286</th>
<th>Public Psy, n = 56</th>
<th>Private Psy, n = 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>To set up a support hotline for PCPs to consult psychiatrists</td>
<td>Strongly disagree</td>
<td>3 (1.4%)</td>
<td>2 (0.7%)</td>
<td>5 (8.9%)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>43 (19.4%)</td>
<td>34 (12.0%)</td>
<td>26 (46.4%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>148 (66.7%)</td>
<td>189 (66.8%)</td>
<td>24 (42.9%)</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>28 (12.6%)</td>
<td>58 (20.5%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P = 0.018*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To set up an agreed protocol of care with psychiatrists</td>
<td>Strongly disagree</td>
<td>0 (0.0%)</td>
<td>2 (0.7%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>12 (5.4%)</td>
<td>19 (6.8%)</td>
<td>5 (8.9%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>154 (68.8%)</td>
<td>191 (68.2%)</td>
<td>43 (76.8%)</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>58 (25.9%)</td>
<td>68 (24.3%)</td>
<td>7 (12.5%)</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P = 0.683</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To establish a feedback mechanism to notify the PCP when the referred patient is seen by the psychiatrist the first time</td>
<td>Strongly disagree</td>
<td>0 (0.0%)</td>
<td>1 (0.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>2 (0.9%)</td>
<td>3 (1.1%)</td>
<td>1 (1.8%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>165 (73.7%)</td>
<td>173 (61.1%)</td>
<td>47 (83.9%)</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>57 (25.4%)</td>
<td>106 (37.5%)</td>
<td>8 (14.3%)</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P = 0.010*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To encourage management of common mental health problems (e.g., depression, anxiety) by PCP</td>
<td>Strongly disagree</td>
<td>0 (0.0%)</td>
<td>1 (0.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>10 (4.5%)</td>
<td>7 (2.5%)</td>
<td>7 (12.5%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>163 (72.8%)</td>
<td>180 (63.2%)</td>
<td>31 (55.4%)</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>51 (22.8%)</td>
<td>97 (34.0%)</td>
<td>18 (32.1%)</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P = 0.013*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To discharge stabilized patients to primary care</td>
<td>Strongly disagree</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>20 (9.0%)</td>
<td>18 (6.4%)</td>
<td>4 (7.1%)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>165 (74.0%)</td>
<td>192 (68.1%)</td>
<td>26 (46.4%)</td>
</tr>
<tr>
<td></td>
<td>Strongly agree</td>
<td>38 (17.0%)</td>
<td>72 (25.5%)</td>
<td>26 (46.4%)</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P = 0.054</td>
<td></td>
<td></td>
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</tbody>
</table>

**Psyc:** psychiatrists. Fisher’s exact test for the difference in responses between public and private sectors.

*P < 0.05.

**P < 0.001.

**Conclusions**

The majority of PCPs and psychiatrists support management of common mental health problems in primary care, but there is significantly less support from the private psychiatrists. For a
successful referral, several follow-up sessions by PCPs to build up trust and enable the patients to recognize their mental health problems first were often required. Some public PCPs acknowledge the benefits of collaborative care, but most private PCPs perceived limited support from psychiatrists. Despite the support for a feedback mechanism after referral, over half of the psychiatrists disagreed with setting a support hotline for the PCPs to consult them.

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Conflict of interest none.

References

Conflict of interest none.

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Conflict of interest none.


Appendix

Relevant questions of the interview guide

For PCP groups

1. How often have you come across patients with mood/mental health problems, and what would you usually do?
2. What do you think are the factors that may make mental health patients seek help from a PCP?
3. What are the possible factors which might have discouraged mental health patients to seek help from a PCP?
4. What factors may hinder or facilitate you to recognize and treat these patients? Is there any real case you can share?
5. How would you evaluate the present collaboration with psychiatrists in offering help to mental health patients? How can it be strengthened?

For Psychiatrist groups

1. How do patients get to come to see you as a psychiatrist?
2. Would you consider suggesting your patients to seek help from a PCP for their mental health problems? If yes, what would be the factors to encourage you to do so?
3. What are the possible factors to discourage you from suggesting your patients to seek help from a PCP for their mental health problems?
4. How would you evaluate the present collaboration with PCPs in offering help to mental health patients? How can it be strengthened?