

Managing child and adolescent mental health problems in primary care: taking the leap from knowledge to practice

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In 2009, a conference at Imperial College London brought together experts on the primary care provision of child and adolescent mental health. The following paper highlights various themes from the conference, and particularly focuses on general practice. Despite international and national guidance, child and adolescent mental health provision in primary care is limited in the UK and globally. We argue that primary care services are in fact well placed to assess, diagnose, and manage child and adolescent mental health problems. The barriers to such provision are considered from the perspective of both service users and providers, and the possible ways to overcome such challenges are discussed. The paper is informed by various epidemiological and intervention studies and comparisons between different countries and health systems are explored.

Key words: child mental health; general practice; healthcare management; intervention; prevention; treatment

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Introduction

The World Health Organization has identified that primary care is in critical need of investment to tackle the suffering and impairment that young people face from mental disorder (World Health Organization, 2005). However, the quality and type of provision remain diverse across different countries. Worldwide, various types of professionals (general practitioners (GPs), paediatricians, nurses, health visitors, and psychologists) operate in numerous settings (primary care clinics, child health clinics, school medical services, emergency

departments, and ambulatory outpatient departments) within different types of systems. Even within Europe, countries range considerably in their organisation of primary paediatric care (Katz *et al.*, 2002).

Despite these differences, all countries share the same problem of lack of capacity and skilled personnel. A number of national policy initiatives have addressed this directly (Health Advisory Service, 1995; US Public Health Service, 2000; Australian Health Ministers, 2003), although most countries, both developed and developing, still lack any specific child and adolescent mental health policy (Shatkin *et al.*, 2004).

In the United Kingdom, the National Service Framework, National Institute for Health and Clinical Excellence (NICE), and the National CAMHS (Child and Adolescent Health Service)

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Review identify primary care (which in the United Kingdom is predominantly general practice) as a key setting to address child and adolescent mental health problems. Arguably, this does not often translate into practice.

In 2009, a conference at Imperial College London brought together experts on the primary care provision of child and adolescent mental health. This paper presents key themes from the conference, with a particular emphasis on general practice. Themes included the barriers to child and adolescent mental health provision in primary care from the perspective of both service users and providers, and ways in which these challenges may be addressed. This paper also cites the relevant literature from the writings of conference attendees, as well as literature discussed at the meeting itself.

Service-user attitudes towards primary care services

With stigma and poor accessibility often cited as arguments against specialist mental health services, and with concerns over the confidentiality of visiting school-based counsellors, primary health care in the form of general practice should be well placed for young people in need of help for mental health problems. However, although families and young people will be familiar with their local general practice as a source of help for physical problems, many do not realise that they can turn to them for support for emotional difficulties; others do not believe that such professionals are adequately trained to deal with such problems (Biddle *et al.*, 2006). Even when young people do recognise general practice as a potential source of help, many are reluctant to discuss their emotional difficulties, particularly if there are concerns about the confidentiality of the consultation (Churchill *et al.*, 2000; Martinez *et al.*, 2006). Meanwhile, parents often do not express their concerns to GPs (Ellingson *et al.*, 2004; Sayal and Taylor, 2004). Nevertheless, young people can be clearly appreciative when appropriate interventions are offered in general practice (Gledhill *et al.*, 2003).

What makes a young person with depression decide to see their GP? Ferrin *et al.*'s (2009) case-control study looked at adolescents with

high levels of depressive symptoms, and compared those attending general practice with those not attending. Attendance was associated with lower socio-economic status, non-White ethnicity, non-intact families, and not believing that doctors are only interested in physical symptoms. Furthermore, logistic regression analysis showed gender differences: attendance in males was associated with more physical and less marked depressive symptoms, in females by non-White ethnicity and not believing that doctors are only interested in physical symptoms. The study shows that – over and above demographic and clinical features – a young person's expectation of the attitude of the practitioner may influence whether they seek help through their GP for mental health problems, particularly for females. Research in paediatric primary care also shows that adolescents particularly value practitioners' communication and interpersonal skills, as well as their respect (Byczkowski *et al.*, 2010).

With regard to younger children, help-seeking primarily originates from parents. Sayal *et al.* (2010) used focus groups to explore which factors influence parental help-seeking for children with mental health problems. Echoing the research above, a trusting relationship in the GP who can validate parental concerns, show an interest in the child and family, and offer continuity of care, were cited as key factors to facilitate help-seeking. Barriers, however, included: embarrassment, stigma, and concerns about being labelled, for example, as a 'poor parent' or the child receiving a diagnosis. Parents also felt that short appointments did not offer sufficient time to address their child's problems.

Practitioner attitudes towards children and mental health

Young people are not the only ones reluctant to discuss their emotional difficulties. Primary care clinicians themselves frequently avoid exploring such issues with them, despite this being a critical factor in detecting psychological problems (Martinez *et al.*, 2006). General practitioners vary in their construction of mental health problems: many remain sceptical about the diagnostic validity of psychiatric disorders; a number of them believe that conditions such as hyperkinetic disorder

are over-diagnosed; others report lack of confidence in diagnosis (Klasen and Goodman, 2000) and management (Churchill, 2008); many are concerned about 'over-medicalising' normal distress (Iliffe *et al.*, 2004) and stigmatisation (Churchill *et al.*, 2000; Churchill, 2008), or advocate that responsibility lies in other agencies such as schools, community organisations, and specialist services.

Such concerns are understandable, but they do not reflect current medical knowledge or health service policy. This makes it imperative for primary care staff to be appropriately trained in recognising, understanding, and managing common psychiatric disorders in young people. There are strong arguments for primary care to have a role in addressing child and adolescent mental health problems, particularly as physical symptoms, psychosocial problems, and psychiatric disorder often occur together in the children and adolescents who are consulting them. As such, primary care is ideally placed to contribute to mental health promotion, prevention, and early intervention. This is particularly enhanced by the GP's often intimate and long-standing knowledge of the family.

Identifying child mental health problems in primary care

What do we already know about the identification of child mental health problems in primary care? In the first place, it is well established that young people generally have regular contact with primary health-care services. Within the United Kingdom, over 90% of pre-school children and two-thirds of 5–14-year-olds will consult primary care, and half of 13–17-year-olds will consult their GPs, at least once a year (OPCS, 1995; Kramer *et al.*, 1997). In the United States, over 70% of adolescents see a physician at least once a year (Frankenfield *et al.*, 2000).

Moreover, epidemiological research shows that mental health problems, with accompanying suffering, impairment, and continuity, are common in childhood and adolescence. Such difficulties often remain hidden during consultations: whereas only 2–10% of child and adolescent primary care consultations are *explicitly* for emotional or behavioural complaints, 10–25% of younger children and 40% of adolescents who attend primary care have

an underlying psychiatric disorder (Garralda and Bailey, 1986; Costello *et al.*, 1988; Gureje *et al.*, 1994; Kramer and Garralda, 1998).

The key is to look beyond the description of physical symptoms. Young people may present with physical disorders, but contributing psychological factors (eg, stress-exacerbating asthma) have been identified in a fifth of schoolchildren attending primary care and half in paediatric clinics (Garralda and Bailey, 1990). Furthermore, young people commonly present with recurrent unexplained functional physical symptoms, a somatised expression of stress often accompanied by psychiatric disorder. One study identified a comorbid anxiety disorder in over three-quarters of 8–15-year-olds attending primary care with recurrent abdominal pain, and 43% had a depressive disorder (Campo *et al.*, 2004). Nevertheless, rates of recognition of psychiatric disorder in young people attending primary care are poor (Garralda and Bailey, 1986; Chang *et al.*, 1988; Kramer and Garralda, 1998; Sayal and Taylor, 2004). Studies in the United States and Australia show that many young people have contact with primary care in the month before suicide or self-harm (Pfaff *et al.*, 2001; Luoma *et al.*, 2002); however, fewer than half of primary care physicians report screening their adolescent patients for suicide risk (Frankenfield *et al.*, 2000).

What then influences the recognition of child and adolescent mental health disorder in primary care? Studies show that recognition is associated with severity of the problem, explicit expression of concerns by parents during consultations, as well as with social factors such as age (more in middle childhood), male gender, receiving benefits, and broken homes; it is also linked to clinician–patient alliance (Goldberg *et al.*, 1984; Horwitz *et al.*, 1992; Kramer and Garralda, 1998; Sayal and Taylor, 2004; Martinez, *et al.*, 2006). All of these factors make it likely for young people to reach thresholds for referral to specialist care by primary health services.

The challenge – in addition to ensuring wide recognition and referral of severe problems – is in increasing recognition of less severe and overt problems that may respond to a primary care intervention. Training professionals may improve overall recognition rates, as might screening questionnaires (Luby *et al.*, 2004), such as the Strengths and Difficulties Questionnaire.

Questionnaires, however, might also over-identify the number of children and adolescents requiring further assessment, and thereby risk further burdening limited resources. In addition, some GPs have expressed some scepticism over the utility of questionnaires, such as those used in the Quality and Outcomes Framework (QOF) for depression (Dowrick *et al.*, 2009). Questionnaires are perhaps best used to guide further psychological and psychosocial routes of enquiry.

Preventing and treating child mental health problems in primary care

Improving the identification of child and adolescent psychiatric disorder raises the question as to who then intervenes. A study in the United States showed that even when mood or anxiety disorders were identified in primary care, young patients were not particularly likely to receive counselling in this setting, but instead tended to be referred to specialised services (Wren *et al.*, 2005).

Yet, primary care is well placed for managing child and adolescent psychiatric disorders. Interventions such as psycho-education, brief cognitive/behaviour therapy, medication management, and parenting support are effective and can be feasibly delivered. Such treatments may also be enhanced when there are long-standing therapeutic relationships with the primary care clinicians.

The majority of research into child and adolescent psychiatric intervention occurs in specialised settings, but a notable exception is a randomized study on adolescents with depression carried out in the United States by Asarnow *et al.* (2005). Compared with usual care, a 'quality improvement intervention' (which included expert leader teams with care managers supporting a range of interventions, that is, cognitive behavioural therapy (CBT), medication, combined CBT with medication, care manager follow-up, or specialist referral) resulted in significantly fewer depressive symptoms, higher quality of life, and greater satisfaction with mental health care after six months, although almost a third of young people continued to show severe depressive symptoms.

Primary care could also play an important role in preventative mental health care. After all, the primary care team already delivers public health programmes targeting relevant risk and resilience

factors, such as family planning programmes, prenatal care, promotion of nutrition, and child safety information. There is empirical evidence supporting the implementation of parent training programmes (Webster-Stratton *et al.*, 1989; Olds *et al.*, 1998; Scott *et al.*, 2001), and an Australian study of preventative GP consultations during a child's first four years showed favourable outcomes 6 and 20 years later (Cullen and Cullen, 1996). Dissemination of information on child health, development, behaviour, and positive parenting programmes could realistically be achieved in primary care, particularly through teamwork with professionals such as nurses and health visitors. The UK government's '*No Health Without Mental Health*' pledges to increase the health visitor workforce to offer all families support when they become parents, and aims to ensure that health visitors and school nurses are equipped to identify and help parents and young people who need support with their emotional or mental health (Department of Health, 2011).

Any such intervention relies of course upon people actually attending primary care for their mental health problems; as discussed above, this may not always be the case. Public education efforts may therefore help young people and parents identify mental health problems in the community and direct them to primary care for advice.

Training primary care practitioners

To improve identification and management of child and adolescent mental health problems, primary care professionals need to be adequately trained. A range of such initiatives have been successfully carried out (Bernard *et al.*, 1999; Gledhill *et al.*, 2003) but are generally scarce (Levav *et al.*, 2004). The following programmes were presented to the conference:

In London, the *Therapeutic Intervention in Depressed Youths* programme has trained GPs to screen and identify depressive disorder, and provide initial management within a 10-minute appointment. Management of mild to moderate depressive disorder includes psycho-education, promotion of self-help, and advice about coping strategies; information is given both verbally and in leaflets. Preliminary research shows feasibility (Gledhill *et al.*, 2003), user-acceptability,

and increased detection rates while a randomized trial is being planned.

The *Adolescent Health E-learning project* developed by a collaboration including the Royal College of Paediatrics and Child Health, E-Learning for Healthcare, and the Department of Health, includes a module on adolescent mental health (Department of Health). Each of the seven self-directed 20-minute sessions includes learning objectives, visual images, interactive material, and self-assessment. E-training can be freely operated 'anytime, anyplace, and at any pace'; material can be easily updated and used in parallel with other learning. The programme has yet to undergo thorough peer-evaluation and accreditation.

In South Australia, the *Headstart* programme arose in response to government incentives for GPs to train in mental health. The programme helps GPs construct patient stories and genograms, assess patients' normal feelings, and review functioning. The 6-hour training session is facilitated by an educator and attended by local CAMHS clinicians to promote local links. Following training, regular E-bulletins help consolidate learning and GP graduates have telephone access to consult specialist staff on clinical cases.

In the North-East of England, a toolkit has been prepared by the Charlie Waller Memorial Trust and the Mental Health Foundation to assist primary health-care professionals in the recognition and management of psychological problems (Mental Health Foundation). This consists of specific tools to help identify problems and to advise on problem-solving skills and mental health promotion.

The interface between primary care and specialist child mental health services

Even in countries with well-developed specialist child and adolescent mental health services, limited resources mean that only a small proportion of young people with psychiatric disorder currently receive help (Rushton *et al.*, 2002). Specialist services are often working to capacity with long waiting lists for treatment (US Public Health Service, 2000). In the United Kingdom, GP referrals consistently make up a large proportion of all referrals made to CAMHS services. As already mentioned, referral rates correlate with disorder severity, male gender, antisocial

symptoms, relationship problems, psychosocial disadvantage, and parental request (Garralda and Bailey, 1988; Bailey and Garralda, 1989; Briggs-Gowan *et al.*, 2000; Sayal *et al.*, 2002).

The relationship between primary care and specialist service need not be just one of transferral of care. Various models of primary and specialist care interface have been proposed, and need not involve exclusive care from one or the other. For chronic problems such as Attention Deficit Hyperactivity Disorder, a comprehensive model of care could include long-term monitoring within primary care with intermittent involvement of specialist services for medication review or adjuvant behaviour therapy.

The '*Shifted out-patient*' model, meanwhile, sees specialist services operating *within* primary care. As identified in Bower *et al.*'s (2001) systematic review, interventions tend to be brief (6–12 sessions) and include psycho-education, cognitive behaviour therapy, family therapy, counselling, group work, psychodynamic therapy, and psychiatric evaluation and guidance. Unfortunately, studies identified tended to be poor in quality. Comprehensive coverage of this model would also require marked expansion of specialist services and is unlikely to be cost effective.

A less expensive approach may be the '*Consultation liaison*' model, where specialist services support primary care professionals by providing ongoing training. Bower *et al.* (2001) only identified one study on consultation (Neira-Munoz and Ward, 1998), and although Connor *et al.*, (2006) describe a similar model, neither includes data on patient outcomes. A survey of CAMHS services in England demonstrated that a dedicated liaison service enhanced such collaborative work with primary care (Bradley *et al.*, 2003).

The United Kingdom has developed the Primary Mental Health Worker role to work with both primary and specialist child and adolescent mental health services, and to bridge the gap between the two (Macdonald *et al.*, 2004). PHMWs are usually nurses, but sometimes social workers or psychologists. Although available to take cases, their main function is consultation liaison and to support recognition of disorders and referral to specialist services (Department of Health, 2004). A similar model has been developed in a service in South Africa (Pillay and Lockhat, 1997) and in the United States

(Campo *et al.*, 2005) where primary care clinicians refer young people to Advanced Practice Nurses for further evaluation; patients are then either transferred to specialist care or more frequently returned to the primary care clinician. There is now a need for a systematic study of patient outcomes.

Future developments

Countries may vary in their primary care systems, but they experience similar challenges when it comes to child mental health provision (Veit *et al.*, 1995; Jacobson *et al.*, 2002). Difficulties include financial and time constraints, and the lack of practitioner training and confidence in detecting and managing disorders. Such challenges are exacerbated by a global lack of child and adolescent mental health policy (Shatkin *et al.*, 2004).

A sound policy base is critical for future investment in and expansion of the respective programmes of research, professional training, and national guideline development, in conjunction with service delivery based on locally determined, culturally sensitive needs assessment (Rahman *et al.*, 2000). These programmes are mutually dependent. Research should focus on pragmatic evaluations of primary care, such as on disorder-specific management techniques, the interface between primary and specialist care, and the utility of training programmes. Evidence should then be used to influence attitudes and to inform guidelines and national standards. The attitudes of professionals and service users will influence quality standards to inform commissioning priorities. Within the United Kingdom, a specific QOF would help to prioritise child and adolescent mental health provision in general practice. Political investment brings research investment, thereby continuing the cycle.

Service quality standards and indicators for child and adolescent mental health in primary care are currently being developed by a research study led by Kapil Sayal, which was presented at the conference. The study ascertained perspectives from both parents and a range of other stakeholders, via a series of focus groups and Delphi consultation. Having such quality standards would not only help describe quality of mental health care, but also inform commissioning priorities

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and influence the interface between primary care and CAMHS.

In practice, multifaceted programmes that integrate improvements in detection, treatment and follow-up, and include combinations of clinician and patient education, nurse case management, enhanced support from specialist services and monitoring of medication, are likely to be most effective (Gilbody *et al.*, 2003; WHO Regional Office for Europe's Health Evidence Network, 2004). Policy developments could also encompass other agencies involved with young people, including pre-school, education, welfare, and juvenile justice, as has already been demonstrated in the United Kingdom and the United States (Health Advisory Service, 1995; US Public Health Service, 2000).

History has unfortunately not seen political and financial investment in child mental health in primary care despite decades of rhetoric supporting this. Nevertheless, the political tide in the United Kingdom may be changing: Lord Darzi's legacy of health-care reforms includes an increased political focus on primary care and early intervention work; the Department of Health's recent '*No Health Without Mental Health*' initiative highlights the importance of early intervention with young people, and GP consortia are well placed to understand the broad range of mental health problems experienced by people in the locality (Department of Health, 2011); the former chairman of the Healthcare Commission has identified adolescent mental health as a priority (Kennedy, 2010), and both previous and current prime ministers have advocated the prioritisation of children and adolescents in policy development. Although the current economic downturn will inhibit public sector spending in the near-to-mid future, policymakers should consider that preventing and treating child mental health problems may lead to economic savings later down the line.

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