

A Toolkit for GPs

Dr Maryanne Freer

Second Edition: 2015



The Mental Health Consultation (With a Young Person)



Royal College of
General Practitioners

Raising awareness fighting depression



Foreword

The first aim of the Charlie Waller Memorial Trust is to educate people, particularly young people, in the symptoms of common mental health problems so that they can recognise when they, but as important others, need help. That help has to come primarily from GPs who have a tough job with all that they have to deal with. They need all the assistance that can be given to enable them to recognise and deal with the mental health problems of all their patients. We believe that Dr Maryanne Freer has produced a toolkit that will provide that assistance.

We are grateful for the support of the Royal College of GPs particularly in making the toolkit available to all their members and we sincerely hope that GPs will use it and be assisted by it in recognising and treating mental health problems particularly in young people.

We would like to thank the GPs who have worked with Dr Freer on this toolkit. Some have contributed real “cases” and experiences to increase the breadth and depth of the toolkit whilst others have acted as external reviewers so that you can be confident that this toolkit reflects the current knowledge base. Some of their comments are included below.

We hope you find this tool kit fulfils these aims.

Yours sincerely

The Right Honorable Sir Mark Waller

Chair of the Charlie Waller Memorial Trust

External Reviewer's comments

“The Toolkit addresses an important gap. Mental health problems in young people can be serious, with important long term consequences. Given the strong anecdotal evidence that GPs are reluctant to address the emotional and psychological needs of young people because they feel that they lack the skills to deal with them, the provision of simple tools to aid the process will hopefully increase their confidence to attempt to do so. Although many GPs may initially be reluctant to ‘take on something new’, most of the skills described in the Toolkit are not ‘new’ but simply the application of core competencies that all GPs are expected to develop – generic skills, appropriate for generalists. In the toolkit, it is also the development of the patient’s story over time, and the emphasis on the longitudinal nature of general practice, which adds a vital extra dimension that has often been omitted from similar resources in the past. The reference to managing clinical uncertainty, a core feature of general practice, adds further authenticity to the stories.

Some GPs may consider some of the suggestions too idealistic: many GPs feel unable to offer sufficient time for mental health problems, whilst providing effective follow-up can sometimes prove difficult for others. Unfortunately the competing pressures of financially rewarded health outcomes currently detract from providing good quality care in other important clinical areas such as this which receive no direct remuneration. However these considerations should not detract from the overall purpose of the Toolkit – and hopefully it will be welcomed by the majority of GPs who use it.”

Dr Dick Churchill, GP, Assistant Professor in Primary Care

Nottingham University and former chair of the RCGP Adolescent Health Group

“Young people with mental health problems are often reluctant to disclose them to their GPs making recognition and assessment difficult. This excellent resource will equip GP registrars and GPs with the skills needed to engage their young patients more confidently and effectively in everyday consultations. Dr Freer and colleagues are to be congratulated on this practical and helpful toolkit.”

Professor André Tylee

GP academic, Kings College London

“It is excellent – very accessible to busy GPs and can be dipped in and out of. I particularly like the cases and ‘what the GP might have done’ discussion.”

Dr Carolyn Chew-Graham

GP, Co-Chair RCGP Primary Care Mental Health Forum, Professor of Primary Care, University of Manchester

“Congratulations on tackling such a vast area and coming up with a very practical approach.”

Dr Jane Roberts

GP, Chair of the RCGP Adolescent Health Group

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The Charlie Waller Memorial Trust

Founded by his family to commemorate Charlie Waller, the Charlie Waller Memorial Trust (CWMT) aims to raise awareness of the nature and dangers of depression, reduce stigma, provide training to primary care staff and encourage those who may be depressed to seek help. It may be found at www.cwmt.org.uk.

Acknowledgements

This *Toolkit* has come about through the request of GPs. It is built on the original CWMT *Toolkit* for school nurses and young people's mental health. The *Toolkit* prototype has been improved and refined through a number of GP training events mainly in North East England. Many thanks are given to those who have participated in this training for their invaluable feedback.

Included are a number of anonymous and re-constructed cases of young people working with their GP to overcome mental health difficulties. The *Toolkit* is dedicated to these young people and those like them whose lives may be hard, usually through no choice of their own, and who have sought and accepted assistance.

Particular thanks, appreciation and acknowledgment must go to:

The Charlie Waller Memorial Trust; Sir Mark and Lady Rachel Waller and Naomi Garnett who have recognized, valued and backed the work as part of the charity's huge commitment to young people. The GPs who have contributed their case studies, especially Assistant Professor Dick Churchill, GP and Chair of the RCGP Adolescent Health Group; Dr Guy Clements, Northumberland GP and Young Person Mental Health lead; Dr Alison MacDonald, GP and Lead for the Northumbria GP Vocational Training Scheme; Dr Guy Pilkington, Newcastle GP and GP Trainer; Dr David Shiers, GP and GP adviser for RC Psychiatrist Schizophrenia Audit and Professor John Spencer, GP and Professor of Medical Education, Newcastle Medical School.

Thanks to the RCGP for their endorsement of the toolkit.

The Author

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In her CWMT role Maryanne trains GPs in the mental health consultation working particularly with GP Vocational Training Schemes and GP trainers nationally and regionally. She is a phase I course director on the Newcastle Medical degree leading in areas including general practice, public health, professionalism and patient safety. Maryanne speaks regularly at national conferences and has a number of publications in the field of general practice mental health.

Critical Readers

Many thanks are given to Professor André Tylee, GP and Professor of Primary Care Mental Health, The Institute of Psychiatry, London, Dr Dick Churchill, GP, Assistant Professor in Primary Care, Nottingham University and former chair of the RCGP Adolescent Health Group, Dr Carolyn Chew-Graham, GP, Former Co-Chair RCGP Primary Care Mental Health Forum, Professor of Primary Care, University of Manchester and Dr Jane Roberts, GP, Chair of the RCGP Adolescent Health Group.

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This *Toolkit* has been written with the intention of being of practical use to GPs in their work. It contains consultation tools that may be photocopied and used freely. If materials are used for teaching purposes, presentations or other wider purposes, acknowledgement should be given to both CWMT and the author.

More information and related training

For more information on the *Toolkit* or if you are interested in training related to the *Toolkit* for GPs practice teams, GP trainees and GP trainers across the UK, please contact CWMT at admin@cwmt.org or Dr Maryanne Freer at maryanne.freer@pcpartners.org

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I. Introduction

Case

You are a GP and a 16 year old girl comes to see you called Michelle. Michelle is a quiet girl who does not make eye contact. She is very slim. Michelle sits twiddling her fingers. She is not very forthcoming. Michelle has come for a review of her combined oral contraceptive prescribed 3 months ago for contraception and pre-menstrual tension (PMT). Michelle complains of increased moodiness and irritability – i.e. her PMT is worsening and can the combined oral contraceptive be changed? Through the 15 minute appointment, the history taken is piecemeal and slow. Overall though, Michelle has a low mood, probably since before going on the combined oral contraceptive. Generally she is feeling low, has a poor appetite and feels nauseated when she eats. She is not sleeping very well and says she has poor concentration at school. She is not going out with her boyfriend any more. Michelle's weight was not documented last time she came but she doesn't think she's lost any weight. She is not obviously underweight, but certainly is thin. Her blood pressure is normal. She lives with both parents and older brother. Michelle denies any anorexia/bulimic symptoms.

As a GP, what are your thoughts about this real GP case?

- What would you do?
- Is this PMT?
- Is this linked to the oral contraceptive pill?
- Is this part of being a teenager?

If we say that **1 in 3 young people presenting to a GP** have a diagnosable mental health problem (1), does this change your thinking?

If you are told that depression in young people continues into adulthood in about 30% of cases (2) and that 50% of all adult mental health conditions are diagnosable by the age of 14 years (3), does this throw a different light on Michelle's story ?

Maybe...

With young people's mental health GPs often ask:

- Is this teenage turmoil? Will "it" pass?
- Should I make a diagnosis which could be stigmatizing and stay on someone's records for life?
- If I ask will it open up a Pandora's box? How do I get a teenager to open up and talk to me?
- What about the teenagers who present with fleeting and changing physical symptoms each week such as headaches one week, abdomen pain next week?
- If I ask, what if there is no further help available?
- What about prescribing?
- How do I access cognitive behavioural therapy (CBT)?

Complex and hard to deal with, particularly in a 10 minute consultation with a young person presenting with a physical health problem, this *Toolkit* will help address these questions. This *Toolkit* offers the GP, GP Trainer and GP trainee a way to develop expertise in this area including generic teenager communication skills as well as more specifically for the consultation with young people with mental health problems.

2. Is This *Toolkit* for Me?

The *Toolkit* is a practical educational guide for the GP for mental health. It focuses specifically on a young person experiencing mental health problems, but can be used across any age range. It introduces some practical consultation tools to assist the GP. Young people are seen to be between the ages of 14 to 18 years.

The *Toolkit* includes two simple, evidence based, CBT tools and one evidence-based intervention check list that can be used during a consultation.

The *Toolkit* looks at the consultation rather than the individual mental health diagnosis and condition. It does not cover specific mental health symptoms, signs and ICD diagnosis. Nor does the *Toolkit* specifically cover prescribing, self-harm, clinical risk or child protection. Its use is predicated on prior knowledge of these areas. Core messages and learning points are presented with signposting to further reading for those who want additional information.

The *Toolkit* assists by building on existing core GP practice , with some adjustment to focus on the mental health aspects. It keeps GPs in role as generalists, family practitioners and health promoters and does not ask the GP to develop specialist-type, mental health skills. The *Toolkit* provides a structure to the brief consultations within the continuity of “cradle to grave” care that a GP can offer. It will increase understanding of young people’s mental health demands and presentation. It will support CPD professional training and contribute to the GP’s appraisal portfolio and re-validation in the future.

Included in the *Toolkit* are some learning exercises. Once read, it is suggested that one of the three tools is used with 1-2 teenage consultations over 2 weeks. If using the tool is successful, use one more tool next week with a further 2 teenage consultations. In this way use and expertise can be built up progressively over time and become embedded practice.



3. Fast Facts

Here are two quick quizzes to complete.

Quick Quiz 1: Patient Demand

Question	Your answer
How many young people have a diagnosable mental health problem?	
What age are the majority of mental health problems established by?	

Here are the answers:

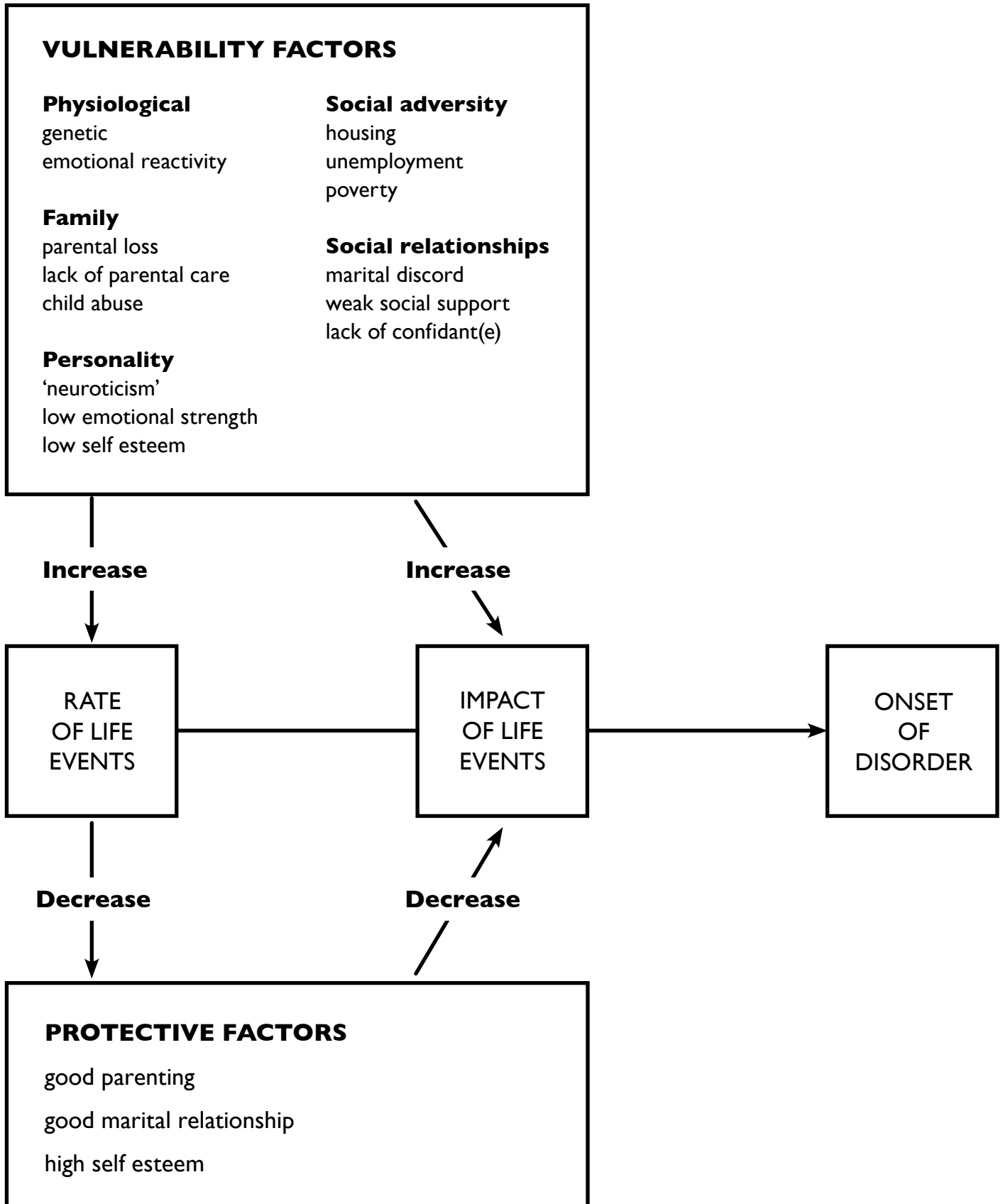
Question	Your answer
How many young people have a diagnosable mental health problem?	10 % of young people have a diagnosable mental health problem (4). This is 3 teenagers in each class (if class size is 30)
What age are the majority of mental health problems established by?	50% of mental health problems are laid down by the age of 14 years (3).

These figures show that many young people have mental health problems and a considerable number go unrecognised until the mental health problem causes problems in adulthood.

What causes such large numbers and at such an early age? The long established and highly influential primary care, Model of Mental Health developed by the GPs Goldberg and Huxley seems to offer an explanation of value. In this model the impact of life events (such as loss) are mediated through protective and vulnerability factors, such as family, social relationships and education. This way of thinking fits nicely with the GP health promotion role. The diagram below sums the model up.

A model of the aetiology of depression

(after Goldberg and Huxley)



Quick Quiz 2: Young People's Help Seeking Behaviour with the GP

Question	Your answer
Which health professional do young people most frequently seek help from?	
How many times a year does a young person consult the GP on average?	
What are the most common presentations to the GP of a young person?	
How many young people, who consult their GP, have a diagnosable mental health problem?	
How many young people with mental health problems are identified by the GP?	
How many GPs are reluctant to make a stigmatizing mental health diagnosis with a young person?	
What is the adherence rate with young people?	
Does the rate of GP consultation increase or decrease before a young person commits suicide?	

Here are the answers.

Question	Your answer
Which health professional do young people most frequently seek help from?	GPs are the most sought out health professional by young people (5).
How many times a year does a young person consult the GP on average?	A young person consults a GP on average 2-3 times per year (6). Of course this varies: within one study 28% of young people had no GP attendances and some had as many as 18. (7)
What are the most common presentations to the GP of a young person?	Young people commonly present to the GP with sexual health problems, contraceptive requests, infections and sports injuries. (7)
How many young people, who consult their GP, have a diagnosable mental health problem?	One out of three young people have a diagnosable mental health problem compared with 10-20 % in the community (1). This implies that the young people who consult have a higher prevalence than those who don't consult. The figure also shows that physical and mental health problems are concurrent in young people. For example, young people who smoke are 3 times more likely to have a mental health problem than those who don't. (8)
How many young people with mental health problems are identified by the GP?	38% of young people with mental health problems are identified by the GP. However, with the continuity provided through GP care, this figure rises considerably. (9)
How many GPs are reluctant to make a stigmatizing mental health diagnosis with a young person?	Most GPs are very reluctant to make a stigmatising mental health diagnosis in a young person. Many prefer a watchful waiting stance to see if the problem may resolve itself. (10)
What is the adherence rate with young people?	The adherence rate with young people is between 10 – 95%. (11-12)
Does the rate of GP consultation increase or decrease before a young person commits suicide?	The rate of GP consultation increases before a young person commits suicide. (13)

In summary:

- Young people do seek help from the GP and many see a GP on a regular basis reflecting the very important GP role in prevention and acting as a confidante to young people.
- Young people who visit their GP are significantly more likely to have mental health problems than the ones who do not.
- Physical and mental health problems are often concurrent in young people.
- GPs are often reluctant to make a stigmatising diagnosis.
- The continuity offered by GPs enables a higher number of young people with mental health problems to be detected early.
- Concordance is an issue with young people reflecting the importance of a mutual, shared management plan.

For more information on the role of the GP in young people's mental health:

Freer M, Shiers D, Churchill C. *Meeting the Mental Health Needs of Young People: A GP's perspective in I Goldie (Ed). Public Mental Health: A handbook. 2010. Brighton: Pavilion.*

For more information on mental health conditions diagnosis, symptoms and signs in primary care:

R Jenkins et al(Ed). *WHO Guide to Mental and Neurological Health in Primary Care. 20 UK Edition. The Royal Society of Medicine Press Ltd.*



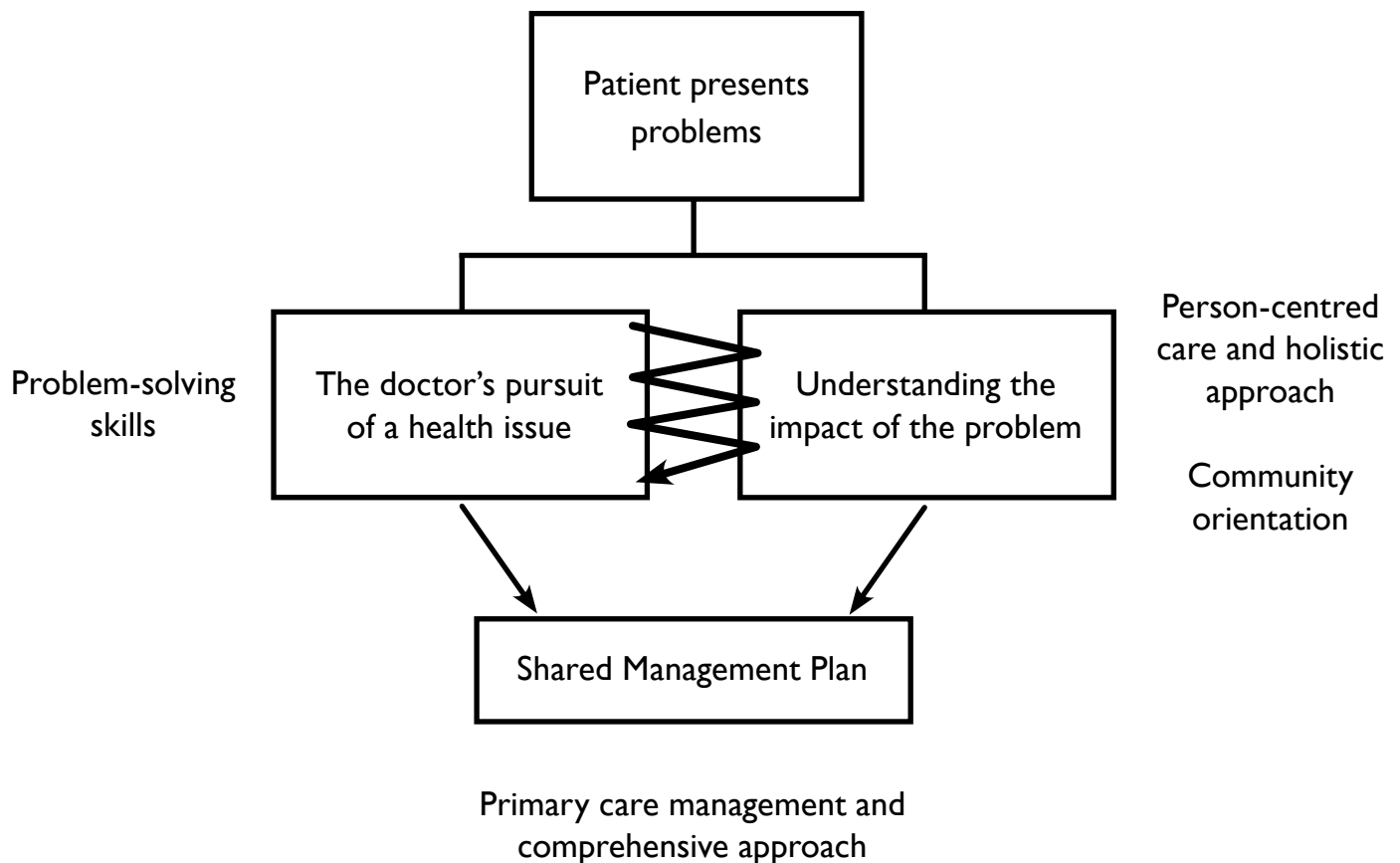
4. Core GP Clinical Practice and the Young Person's Mental Health Consultation

The NICE guidance for Young People and Depression gives an indication of some of the evidence-based roles for GPs in young people's mental health. The roles described by NICE include detection, risk profiling, watchful waiting, prescribing, referral and (mental) health promotion through guided CBT self-help. To understand this further, it is necessary to consider how some of these roles, described by NICE, fit into existing core GP clinical practice.

The GP consultation is designed to be brief and structured to last ten minutes. Whilst the consultation may be brief, it is unique in that GPs offer "brief consultations over a life time", "cradle to grave", and a continuity that no other health professional can. For example, it may be that the youngster has seen the GP for their baby vaccinations aged 1, with ear infections aged 7, spots aged 14. There is a huge body of GP research and expertise around the ten-minute consultation with the Calgary Cambridge model widely used, as well as the GP, person-centred, clinical method encapsulated by the RCGP core competencies.

The diagram below outlines the GP person-centred consultation and the RCGP core competencies of problem-solving, holistic care and primary care management.

Figure 1. The GP person centred consultation.



Source: Levenstein JH, Belle Brown J, Weston WW et al. Patient Centred Interviewing. In M Stewart and D Robert (Eds), Communicating with medical patients. Sage 1989

If we consider these RCGP competencies in more detail

The Problem-Based Approach

The RCGP DVD *Talking the Talk: Using Case Based Discussion in Medical Assessments*, describes how people do not present to the GP with 'symptoms' alone, but with 'problems'. With young people these may not be the symptoms and signs of a diagnosable mental health condition, although the 'problems' nevertheless may have an impact on mental health. For example, "I can't top-up my mobile phone, my girlfriend has left me, my parents are on my case, my teachers are pressurising me, I have no money". A young person very rarely presents saying they are low in mood, exhausted and feeling guilty, all the ICD criteria for depression. As the *Talking the Talk* DVD describes, within this primary contact with a GP, the young person may present with unselected and often simultaneous multiple physical problems and co-morbidities, often being brought in by a parent.

The GP is not just establishing whether a clinical diagnosis is present, but is attempting to clarify the problem and determine whether there is a mental health issue for which help is needed. A number of brief consultations with a young person for a physical health problem may give the GP the opportunity to draw together a more complete mental health summary as well as allowing an emotional difficulty to self-resolve, thus avoiding a stigmatising mental health diagnosis. The GP tolerates clinical uncertainty whilst exploring probability and minimising risk. To illustrate the clinical uncertainty GPs may work with, consider the two real GP case examples below:

Case

A 17 year old girl, Sarah, presented to the GP with recurrent left iliac fossa pain over several months. She had an extremely difficult family situation with a mother with significant mental health issues herself. She was seen by several gastroenterologists and gynaecologists who found nothing significantly wrong. She herself denied it was anything related to stress or mood problems.

Case

Abbie is 16 and due to take her GCSEs soon. Her mother has brought her to see the GP because she frequently needed to pass urine. Abbie was so worried about it that she was afraid to go into some school lessons where teachers were strict about pupils leaving the class, and she would not catch the school bus because of fear of being 'caught short' on the 10 minute journey. She had no other urinary symptoms, and dipstick urinalysis and MSU have both been negative. She denied being sexually active. The situation was causing some parental conflict because Abbie was asking for lifts to and from school.

With both of these cases the GP had to work with clinical uncertainty for many months until eventually more information was gained which pointed towards a mental health condition.

The table below summarises this problem-based approach as applied to young people's mental health.

Principle	Tasks for the GP
Young people do not present with mental health symptoms alone but with problems.	• Clarify the problem • Determine if there is a health issue needing help • Use continuity of care to gain information • Manage clinical uncertainty • Explore probability

The Holistic Approach

An effective doctor-patient relationship will need to be developed that builds rapport with the young person. The GP tries to understand the young person's subjective experience of 'illness' or the 'problem' by exploring the young person's ideas, concerns and expectations (ICE), their patient agenda and preferences. The GP will take a holistic approach and find out how the ways in which the problem affects the young person's life. The GP also may see how the problem might be addressed by community resources.

The table below summarises the holistic approach as applied to young people mental health.

Principle	Tasks for the GP
The need to understand the young person's condition, experience and the impact on their life.	• Gaining of patient's ideas, concerns and expectations • Clinical information gathering • Problem clarification • Understanding how the problem affects the patient's life and those around them.

The Primary Care Management and Comprehensive Approach

The GP will work to find common ground with a young person and negotiate a mutual plan. The main focus will be on promoting a young person's mental health and reducing risk factors by promoting self-care, as well as managing the concurrent physical health problems. The plans may not only address the problems represented by 'primary care management of mental health', but also address more challenging situations including dealing with comorbidity. As concordance is an issue with young people such a plan is far more likely to need the young person's shared commitment.

In summary

Principle	Tasks for the GP
Arrive at a mutually acceptable management plan.	• Negotiate mutual plan • Reduce risk factors through self-care • Manage appropriately mental health problems • Manage comorbidity • Manage referral if needed

For more information on the RCGP core competencies

http://www.rcgp.org.uk/training-exams/gp-curriculum-overview/~media/Files/GP-training-and-exams/Curriculum%20previous%20versions%20as%20at%20July%202012/curr_archive_I_Being_a_GP_v1_I_jan07.ashx (cited 22.1.2015)

5. Key Roles and Tasks in the GP Young Person's Mental Health Consultation.

Having considering the primary care competencies we will now move on to look at some more of the specifics. Please read the case of Zoe below and ask yourself what you would do?

As a GP what would you do?

- 1) What do you think is the problem likely to be?
- 2) How do gain the other information you require?
- 3) If you waited what would you be looking for? Can you live with the uncertainty?
- 4) What decisions do you make? What are their implications?
- 5) What options do you think you have to manage the problem?

Please read Zoe's story.



Zoe's Story

In a first consultation with a GP, Zoe's mum brings 15 year old Zoe in as Zoe has another sore throat. Over the last 6 months Zoe has consulted relatively frequently with sore throats, and is usually given either no prescription or a script for antibiotics. Zoe's mother is having to take time off work to look after Zoe when she has 'yet another' sore throat and Zoe is missing a lot of school time. Zoe's mother talks about her concerns regarding Zoe – recurrent sore throats, Zoe's moodiness, and Zoe's isolation from the rest of the family. Recently there has been a lot of tension at home and especially between Zoe and her mum. Zoe's parents divorced 6 months ago and now a new 'stepfather' lives with them.

You look through the notes of Zoe's previous and numerous presentations with a sore throat. You see that Zoe has never actually presented with sore throats and accompanying viral symptoms, enlarged lymph nodes or reddened, enlarged tonsils. Throat swabs have been negative as well as her EBV antibody test with normal white blood cells.

You successfully negotiate seeing Zoe and her mother separately, offering Zoe's mother her own consultation as she seems stressed.

When alone, Zoe confides that she has been finding school difficult, feeling ignored. This is pretty much how she feels at home too. She admits to persistent low mood and puts her problems down to school pressure.

You do not prescribe antibiotics and ask Zoe to come back in 2 weeks time to see you again. Zoe agrees, but actually requests to see you earlier next week.

A week later in the second consultation, Zoe tells you how she is convinced deep down that her sore throats are due to something very serious, like cancer, as she has had the sore throats so many times. She thinks antibiotics help. Zoe goes on to say that actually the main problem is that her sore throats stress her mum out as her mum takes time off work to look after her. Zoe and her mum then argue. You ask some general questions and with rapport having been established previously, Zoe bursts out saying how stressed she is. Her boy friend left her 6 weeks ago. She didn't tell her mother, but reacted by going out with her friends at least 3 nights a week and drinking heavily. Her sore throats returned.

Since then for the last 6 weeks, 2-3 days per week Zoe feels so unhappy that she struggles to get up and out of bed. Zoe cries herself to sleep often. She can't sleep at night. She has ended up taking many days off school which has meant her mother was continually 'on her case'. Her mother has also been upset about having to take time off work to look after Zoe. Previously close, the two of them fell out 4 weeks ago. Zoe says she used to go to dance classes, but stopped 2 weeks ago as she can't be bothered and is too tired. Zoe goes on to admit that she is not hungry. She wants to get thinner. Zoe finishes by saying very hesitantly how she thinks she does everything wrong and she really hates herself. She feels very lonely.

This is what the GP could have done.

With Zoe, a Strep throat or glandular fever were eliminated as a differential diagnosis and the sore throats did not fit into a viral picture. Concurrent with the sore throats in Zoe's history, there were symptoms and signs of mild to moderate depression. The GP took a watchful waiting stance, as after gaining more information, it seemed that Zoe thought the main problem was her fall out with her mother and not that she was depressed. Antidepressants weren't appropriate nor would Zoe have taken them correctly. The GP also wanted to avoid making a stigmatising diagnosis.

The GP brought Zoe back for 2 further ten-minute consultations. In these consultations the GP monitored the sore throats and her low mood whilst offering Zoe an explanation of how her sore throats may be connected to stress. At the same time the GP helped Zoe to problem-solve and resolve the issue with her mother. The GP also encouraged Zoe to look at some of the mental health self-help sites on the Internet. With very little time and intervention from the GP, Zoe plucked up the courage to talk to her mum who was very supportive once she knew the whole picture. Zoe's mood improved, the family stress diminished and Zoe did not present again with sore throats or low mood as a teenager.

The GP also saw Zoe's mum separately. Zoe's mother was going through her own problems and had had mental health problems herself in the past. She was not interested in further direct help. Zoe's mother did see however that some practical tips on teenage parenting might help and took away the web address and telephone number of a parent support site that she did use.

The NICE guidance for depression in children and young people (15) considers GPs to be CAMHS tier 1 and 2 workers and thus have the following roles as outlined in the diagram below.

Focus	Action	Responsibility
Detection	Risk profiling	Tier 1
Recognition	Detection in children presenting with mental health issues	All tiers
Mild depression including dysthymia	Watchful waiting Non-directive supportive therapy/ group cognitive behavioural therapy, guided self-help	Tier 1 Tier 1 or 2
Moderate to severe depression	Brief psychological intervention +/- fluoxetine	Tier 2 or 3



These are useful evidence-based roles for a GP to take. However, bearing in mind the fact that young people usually present with physical health problems, so leaving very little time to manage a concurrent mental health problem in the brief consultation, practical ways to put these roles into action need to be considered.

The key tasks can be broken down as follows:

Initial GP consultation key tasks	Second GP consultation/s key tasks
• Dealing with parents • Explaining confidentiality • Rapport building • Asking mental health opportunistic screening questions	• Establishing a mental health ✓ Summary ✓ Diagnosis ✓ Risk • Problem Solving • Primary Care Management

6. The Initial GP Consultation

Dealing with Parents

Many teenagers are brought to see the GP by a parent. Parents may bring their teenager in to see the GP or alternatively mention their worries about their youngster in their own GP consultation. If the young person has capacity, it is usually good practice to consider seeing the young person alone.

However, it is important to consider the role of the parent and how to facilitate. One study reported that the GP negotiating seeing a teenager alone and any plans with the parent would produce better health outcomes for the young person (15). If you are a parent yourself and have teenage children, you may well recognise this as essential. Parents sometimes may not know a lot about the inner workings of their teenager. Parents, however, are really important in making things happen for their teenagers.

The real GP case below illustrates the importance of working with parents further.

Case

A 14 year old girl, June, consulted the GP with her mother. 'You will have to do something about her, there is something seriously wrong with her' said her mum. As you might picture, the 14 year old girl sat there looking cross and uncommunicative. Her mother expanded by describing a girl who went out, stayed out late with older teenagers, refused to be disciplined by her mother, 'talked back', used foul language. Her mother was going to throw her out unless something was done to sort her out, maybe 'give her something to calm her down'. Her father had recently moved out, was known to be a bit of a drinker and her parents had had a turbulent relationship. Mum didn't expand further and there was no known history of domestic violence but a suggestion that this turbulence might have involved violence.

When mum had gone to sit in the waiting room, June seemed to loosen up and began to talk. She felt her mum didn't understand her and she was frustrated and angry about the demands that were being made on her. June felt she always was getting into trouble, even when she had done nothing. She described her behaviour in much less wild terms, explaining that she liked the company she kept, that they drank a little, that she wasn't taking drugs and hadn't yet had sex. June knew about Streetwise and had been down on one occasion, got some condoms and a C-card, but had never yet needed to use one. She understood how her mum might be feeling very anxious about her and how stressed she would be herself, given the nature of her relationship with her partner.

The consultation ended with June and her mother in the consulting room together, with the suggestion that talking more and understanding each other better should go a long way to defuse the situation. The GP suggested they come back with a double appointment in a couple of weeks' time, so they could talk more and hear how things were going.

Explaining Confidentiality

Confidentiality is a key issue for young people when they are seeking help. Better health outcomes for the young person are achieved if confidentiality is explained and discussed with the parent. If one was to put one's self into the shoes of being a parent how you would feel if your child was talking to a professional and you didn't know anything about it.

Asking Mental Health Opportunistic Screening Questions

With the levels of diagnosable mental health problems being so high in teenage GP consultations, there is a case for asking an opportunistic mental health screening question in every teenage consultation. This is especially the case with any teenager who has had one or more adverse and destabilising life events in the context of high risk factors.

High risk factors include:

- Family history of psychiatric disorders
- Domestic violence
- Physical and sexual abuse
- Family and matrimonial breakdown
- School difficulties including bullying, exam failure
- Social isolation
- Comorbidity and long term physical illness
- Friendship problems
- Bereavement
- Biochemical effects (14)

Rapport Building

GP consultation style and rapport building may be hugely influential in the teenage consultation (10) and this applies to teenagers with physical health problems too. If rapport is not developed then the teenager is likely to say little and a 'brick wall' situation may arise. If rapport is not built, the teenager may not come back for that all-important second consultation where the problem may be clarified. 'Do Not Attend' (DNA) rates are high with teenagers (15).

Rapport may be built using Calvary Cambridge communication skills and the mental health consultation framework (described later that enables common ground and a shared understanding to be developed. In the HEAR DVD there are good examples of the GP building rapport with Zoe. As an indication of rapport building at the end of the consultation, the GP offers Zoe another consultation. Zoe not only agrees but wants to come back earlier a practical way to gauge rapport building.

7. The Second Consultation and Beyond

Bringing back the young person and using continuity to gain more information is essential with teenagers. Once back in the second consultation establishing a mental health summary can be tricky.

i) The mental health consultation framework

Consider the real GP case below and how you might go about making a mental health summary.

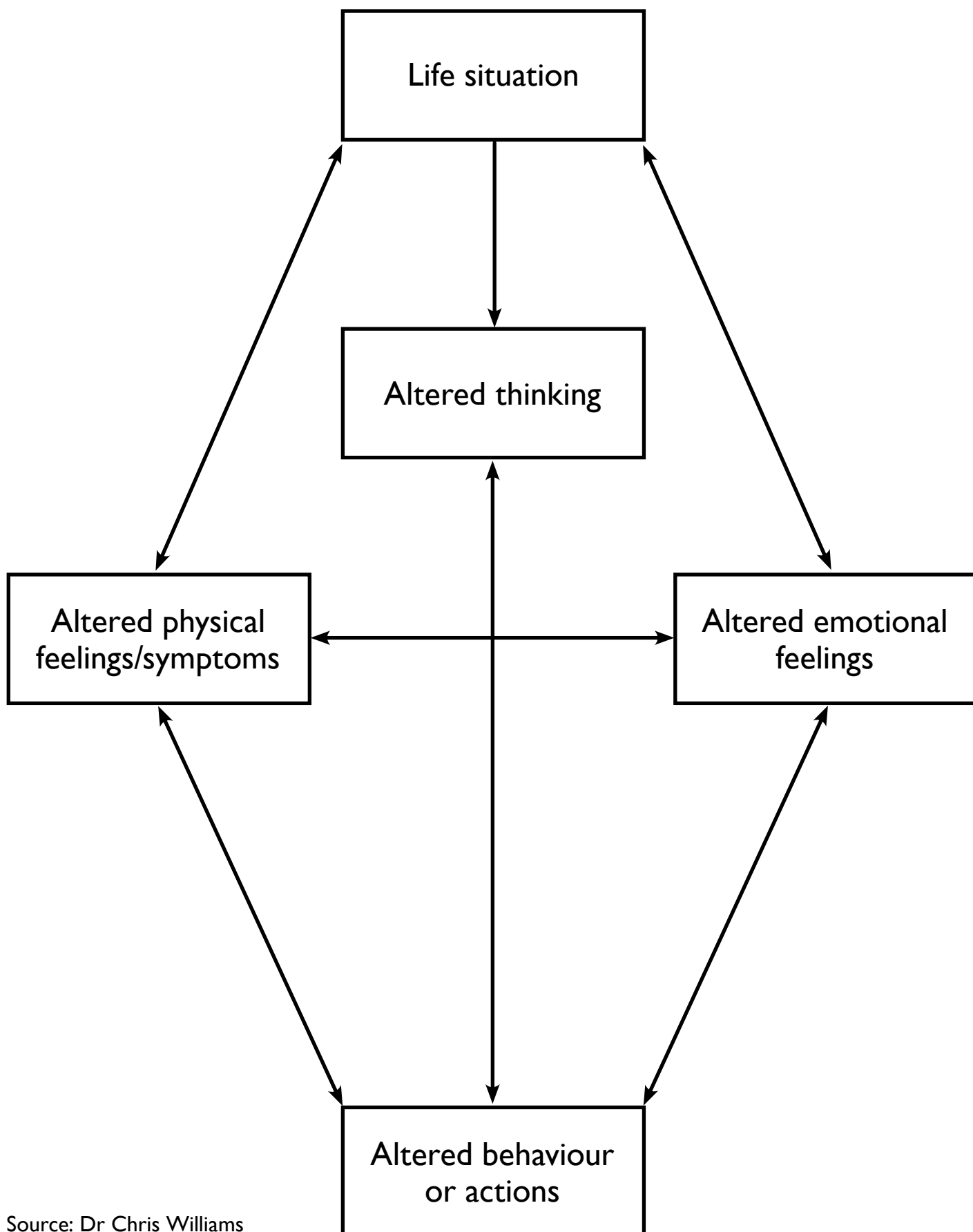
Case

Duncan is 17 and an only child. His mother came to see you a few weeks ago because she was worried about him. He dropped out of an art course at college a few months ago and has spent most of the time since in his bedroom playing computer games and watching the TV till the early hours of the morning, then sleeping all day. He rarely eats with his parents but comes down to the kitchen in the night and raids the fridge. He seems to lack motivation either to work or go out, and he lost his friends and girlfriend several months ago. He seems to be in a world of his own.

The Mental Health Consultation Framework may be of assistance. This is an evidence-based, CBT framework based on the 5 areas approach developed by Dr Chris Williams, a psychiatrist at Glasgow University. The 5 areas CBT approach is already widely used by primary care. The Mental Health Consultation Framework gives a way to structure and organise the patient information in a brief consultation. The Mental Health Consultation Framework follow overleaf.



The Mental Health Consultation Framework



The 5 areas covered within the framework are:

- life events
- thoughts
- feelings
- physical symptoms
- behaviour

Within a consultation the patient's symptoms and problems may be briefly recorded in these 5 areas, thus gathering a large amount of information and enabling rapid analysis. The end formulation is non-stigmatising and makes sense to the young person. At the same time, the completed Mental Health Framework enables the clinical picture to be seen more clearly and flag up any indicators of a major mental health diagnosis and clinical risk issues which may then be enquired further into with relevant action taken as per your normal practice. With the information clarified and organised, the Framework helps inform a watchful waiting stance if appropriate.

Here are some practical pointers that may assist your use of the framework:

- The Mental Health Consultation Framework can be printed off as an A4 sheet, laminated and then used as a desktop guide during the consultation.
- The Framework can be filled in either jointly with your patient or by yourself as part of your consultation or post consultation record keeping.
- All the information the patient gives you does not need to be recorded. Just the key points which helps establish what the problem is, if there is a clinical or risk issue underneath and to help reach a shared formulation with your patient.
- Information from the first consultation can be added to during subsequent appointments as you bring back the young person to manage the presenting physical health problem or take a 'watchful waiting' stance.

Let us see how the mental health consultation framework works with Zoe.

Here's Zoe's story again as a reminder:

Zoe's Story

In a first consultation with a GP, Zoe's mum brings 15 year-old Zoe in as she has another sore throat. For the last 6 months Zoe has consulted relatively frequently with sore throats, and is usually given either no prescription or a prescription for antibiotics. Zoe's mother has to take time off work to look after Zoe when she has 'yet another' sore throat and Zoe is missing a lot of time from school. Zoe's mother talks about her concerns about Zoe – recurrent sore throats, Zoe's moodiness, and Zoe's isolation from the rest of the family. Recently there has been a lot of tension at home, especially between Zoe and her mum. Zoe's parents divorced 6 months ago and now a new 'stepfather' lives with them.

You look through the notes of Zoe's previous numerous presentations with sore throat. You see that Zoe never has presented with sore throats with any accompanying viral symptoms, enlarged lymph nodes or reddened, enlarged tonsils. Throat swabs have been negative as well as her EBV antibody test with normal WBCs.

You successfully negotiate seeing Zoe and her mother separately offering the mother her own consultation as she seems stressed.

When alone, Zoe confides that she has been finding school difficult, feeling ignored. This is pretty much how she feels at home too. She admits to persistent low moods and puts her problems down to school pressure.

You do not prescribe antibiotics and ask Zoe to come back in 2 weeks time to see you again. Zoe agrees, but actually requests to see you earlier next week.

A week later in a second consultation Zoe tells you how she is convinced deep down that her sore throats are caused by something very serious, like cancer, as she has had the sore throats so many times. She thinks antibiotics help a lot. Zoe goes on to say that actually the main problem is that her sore throats stress her mum out as her mum takes time off work to look after her. Zoe and her mum then argue.

You go on to ask some general questions and, with rapport having been established previously, Zoe bursts out saying how stressed she is. Her boy friend left her 6 weeks ago. She didn't tell her mother, but reacted by going out with her friends at least 3 nights a week and drinking heavily. Her sore throats returned. Since then for the last 6 weeks, 2-3 days per week Zoe feels so unhappy that she struggles to get up and out of bed. Zoe cries herself to sleep often. She can't sleep at night. She has ended up taking many days off school that has meant her mother was 'on her case' continually. Her mother has also been upset about having to take time off work to look after Zoe. Previously close the two of them fell out 4 weeks ago. Zoe says she used to go to dance classes, but stopped 2 weeks ago as she can't be bothered and is too tired. Zoe goes on to admit that she is not hungry. She wants to get thinner. Zoe finishes by saying very hesitantly how she thinks she does everything wrong and she really hates herself. She feels very lonely.

To use the Mental Health Consultation Framework, you would start gathering information relating to the life situation area. This is often the most important area to the young person and their day-to-day life.

Fill in the life situation area below from Zoe's case study.

Life situation

Here is what could have been written from Zoe's story and case.

Life situation
• My boyfriend left me 6 weeks ago • My parents split up 6 months ago (but it doesn't bother me now)

Note that the divorce of Zoe's parents may be an adverse life event and also a high risk factor for depression even though Zoe says it doesn't affect her now.

When completing a box:

- Be as specific as possible. For example: how long ago the event happened and exactly what did happen. 'Cone' down from the general to the specific using a mixture of open and then closed questions.
- Make sure it is the young person's words you are using.
- Concentrate on the day-to-day problems and life situations relevant to the teenager.

After completing the **life situation** area the next area to complete is the **thoughts** area. The life situation will have made the young person think something. For example: "My boyfriend left me 6 weeks ago, this makes me think..."

Completing this box is equivalent to eliciting the patients Ideas, Concerns and Expectations (ICE) and establishing the patient's agenda – part of core, GP person-centred practice. When eliciting a patient's ICE, use open questions and focus on statements the patient uses such as 'I think that', 'I am worried that', 'I expect that...'

In the boxes below, fill in the **thoughts** from Zoe's story.

Thoughts

This is what could have been written from Zoe's story.

Thoughts
• I think that antibiotics help my sore throats • I am concerned that the sore throats are because of something serious like cancer • I think I get everything wrong * • I really hate myself * • I want to get thinner

The cognitions are a very useful indicator of an underlying mental health problem. With a mental health problem the cognitions of young people are those of polarization, over-dramatisation, and black and white thinking. For example: 'Nobody likes me'; 'I can't do anything'; 'I will never get a boyfriend'.

If suicidal, the cognitions may become very negative. For example: 'There is no point'; 'I think I won't be here next week'; 'I will never get through this'.

Of course these thoughts can be part of teenage turmoil and developmental changes. However, this may not be the case and with such a high level of mental health problems in teenagers being seen by a GP, such cognitions should sound a note of warning. The Mental Health Framework provides a way to recognize and highlight such cognitions. Such cognitions should be marked with an asterix (similar to red flag indicators) and then explored further using good, general communication skills, a standardised risk approach or a standardised depression assessment rating questionnaire such as the 'Feelings and Mood' questionnaire.

For further information on standardised assessment rating questionnaires in young people:

The National Institute for Health and Clinical Excellence, Depression in Children and Young People: identification and management in primary, community and secondary Care. Clinical Guideline. Vol. 28. 2005, London: NICE.

After completing the **life situation** and **thoughts** areas, the next area to complete is the emotions area. The life event has made a young person think certain thoughts which go on to have the knock on effect of making the teenager feel a certain way. The things that a teenage patient says that start with 'I feel...' should go in this area.

Go back to Zoe's story and in the box below add in what could have been written about Zoe's feelings from her story.

Emotions

The completed area might look like this:

Emotions

- For the last 6 weeks, every few days I feel so unhappy that I struggle to get up and out of bed and cry myself to sleep *
- I feel stressed out
- I feel really lonely
- For the last 2 weeks I can't be bothered *

Again the feelings may be important indicators of a mental health diagnosis or risk issues. Any feelings which fit in to an ICD diagnosis may be marked with an asterix and explored further, using good communication skills and/or a mental health assessment rating questionnaire as before. Remember, with depression it is not necessarily the severity of the symptoms, but more the frequency of the symptoms. Remember also that anxiety is more prevalent in teenagers than depression.

An example of a feeling that may indicate a mental health diagnosis may be 'I feel really down every day, so down that I can't get out of bed or hardly move.'

An example of a feeling that may indicate a risk issue may be 'I feel useless, hopeless and very pessimistic.' The Framework allows you to sieve, sort and explore further.

The next area to complete is the physical area. The life situation has made Zoe think thoughts that in turn have made her feel down. This in turn has an impact on her physically. The physical area is one of the reasons why the Framework works so well for GPs and primary care workers. It makes the links between physical symptoms (the main presentation to a GP) and mental health problems. This may be the very first time a young person presenting with somatisation is helped to make a connection between what they think and how their body reacts.

From Zoe's story, fill in the physical box.

Physical

This is what could have been written from Zoe's case.

Physical
• For 6 weeks my sore throats have returned • For 6 weeks I haven't been able to sleep at night * • I am very tired * • I am not hungry.

The next and final area to complete is the behaviour area. What could you write for Zoe?

Behaviour

This is what could have been written from Zoe's story.

Altered behaviour
• 6 weeks ago I started going out with my friends and drinking a lot. • 6 weeks ago I started to miss a lot of time off school • 4 weeks ago I fell out with my mum after arguments about her taking time off work to look after me and me having time off school • 2 weeks ago I gave up dance classes.

Zoe has clearly deteriorated over the 6 weeks since her boyfriend left her. Indeed more and more problems are beginning to develop which of course will have an impact and go on to become life situations in their own right: a downhill spiral; easy to get into, hard to break.

Now the Mental Health Consultation Framework is completed a shared and non-stigmatising mental health summary can be made.

Zoe's boy friend left her 6 weeks ago which made her think she gets everything wrong and hates herself. These thoughts have made Zoe feel low, lonely and that she can't be bothered. This has had a knock on impact on her physically with her sore throats returning and her sleep being disturbed. The overall consequence has been for her to miss school, go out with her friends 2-3 nights per week, increase her drinking and fall out with her mum, her main confidante. This is all in the context of a parental divorce 6 months ago with her mother's new partner now living in the house.

This explanation would make sense to Zoe and you.

This is basically it. Zoe is an everyday girl who is bright and could achieve a lot, but is getting depressed after splitting up with her boyfriend and beginning to move into a new peer group who drink and smoke, and consequently influence her to drink more. This situation was coupled with Zoe's family breaking down through divorce 6 months previously. A common story. If ignored, Zoe is at risk of not only having depression one year later that could continue into adulthood, but also laying down other significant mental and physical health risk factors, such as drinking and smoking. School exclusion is a real risk too. Zoe is in danger of not achieving her full potential. This all needs to be addressed before it all goes further and spirals downhill more. The good news is that with a small helping hand there is a good chance that Zoe will get back on track with her life and probably not need to see you or anyone else again.

What next? Working on the assumption that Zoe may meet the diagnostic criteria of a mild to moderate depression, and so a referral is not needed, a shared mutual plan needs to be established. This can be based on the use of two tools both of which keep the GP in the generalist role and draw upon the core competencies of a problem-based approach and community and holistic orientation. These tools should be used together, but for the purposes of learning, they will be described separately.

ii) The Problem-Solving Guide

Problem-solving is an evidence-based approach which is part of guided CBT self-help and recommended in NICE steps 1 and 2 for depression management in young people. Problem-solving is part of mental health resilience, the capacity to cope with stress and adversity. Resilience enables one to not only overcome a life situation, but to deal with the next life situation and the next one and the next one. Not to be negative (!), but an example might be the boyfriend leaving aged 16 years, divorce happening aged 35 years, loss of job aged 42 years, death of parents aged 52 years and diagnosis of cancer aged 70 years. Resilience is a protective factor for mental health throughout life.

As many young people approaching GPs are presenting with life situations, problem-solving can help deal with the life situation and get the youngster back to normal life, so preventing further mental health problems developing. You will be amazed just how effective problem-solving can be, how little it takes of your time and what it can reveal. Of course problem-solving is not new to GPs who are usually extremely good at the skill and indeed use it continually. What might be new however is to know that CBT problem-solving is an evidence-based intervention and therefore very worthwhile.

This *Toolkit* advocates the use of the (CBT) Problem-Solving Guide. It can take 3 minutes to complete and the young person can bring the Problem-Solving Guide back to the next consultation to check progress. Alternatively, the young person can be tasked to go away and complete the Problem-Solving Guide like homework. Young people respond very well to this!

The guiding principle is to work with the young person on a small, practical and solvable, day to day problem within the young person's domain and ability to solve. This is the first lesson in self-help and just one small step on the ladder. Other steps will follow but right now the young person needs to be helped to feel confident and that they can achieve something (no matter how small). Success does breed success. Zoe needs to feel good about herself and to realise that she is able to do things and get them right. One of the biggest mistakes health professionals make is to set the bar too high and ask young people to do things they feel unable to do; to reach too high on the ladder.

Overleaf is an example of a problem-solving guide.

Problem-Solving Guide

Step 1: Work out which problem to sort out.

What are the specific problems you are dealing with? Break them down into smaller parts if necessary. Use your own words.

Choose one to try to sort out. Make sure it is one that is not too hard to start off with.

Step 2: List all possible solutions, with as many ideas as you can

What things would solve the problem?

Any helpful ideas?

What have you tried that worked in the past?

What would other people say?

What would you suggest to a friend with the same problem?

Step 3: Advantages and disadvantages of solutions

What are the pros and cons of each idea?

Step 4: Choose the best solution

Step 5: Review the solution

What went well? Did it help the problem? What could you try and use again?

Write down how well the plan worked, and which parts need to be changed.

To understand problem-solving further, let's consider Zoe's case study. Which problem could Zoe start to work on which would be relatively easy for her to deal with? Write a list of possible problems Zoe could work on:

1.

2.

3.

4.

Just be aware that whilst as part of primary care person-centred practice we would always try to see the problem from the young person's view, we may need to use our adult and professional views to guide the young person to the problem that is most do-able.

In our example Zoe choose to work on the problem of falling out with her mum. This makes excellent sense as Zoe has a great relationship with her mother. If patched up her mother will be a confidante as well as help her sort out all the other problems e.g school.

Over the page is a completed problem-solving guide for Zoe.

Problem Solving Guide – Zoe

Step 1: Work out which problem to sort out.

What are the specific problems you are dealing with? Break them down into smaller parts if necessary. Use your own words.

1. My boyfriend leaving me
2. Missing school
3. Falling out with Mum
4. Feeling ill
5. Things getting out of hand when I go out

Choose one to try to sort out. Make sure it is one that is not too hard to start off with.

Falling out with Mum

Step 2: List all possible solutions, with as many ideas as you can

What things would solve the problem?

Any helpful ideas?

What have you tried that worked in the past?

What would other people say?

What would you suggest to a friend with the same problem?

Step 3: Advantages and disadvantages of solutions

What are the pros and cons of each idea?

1. Say sorry to Mum.

Advantage: Mum would like it.

Disadvantage: I am not 'sorry'. Why should I say so?

2. Ask my Step-dad to tell Mum I want to make it up.

Advantage: My Step-dad will help.

Disadvantage: They argue. Mum might think I am closer to my Step-dad than her.

3. Be nice to Mum and make her happy – offer to help make tea.

Advantage: Mum would love it and we can get to talk without any big fuss.

Disadvantage: ??

Step 4: Choose the best solution

Be nice to Mum and make her happy – offer to help make tea.

Step 5: Review the solution

What went well? Did it help the problem? What could you try and use again?

Write down how well the plan worked, and which parts need to be changed.

I did help Mum with tea. While we were making tea, I found myself telling her how miserable I was since my boyfriend left me. Mum backed me completely. Mum and I are close again now. She talked to school and sorted it out with the teachers. I can sleep again.

iii) The Primary Care Management Check List

The Mental Health Consultation Framework and a Problem-solving Guide are complete. However, these are not quite enough. It is necessary to keep a wider overview, ensuring no(mental) health promotion options have been missed and best use is being made of all the relevant primary care management possibilities.

The Primary Care Mental Health Checklist will assist in this aim. It is a check list of primary care management options or evidence-based, community and family-orientated interventions for health (mental) promotion. This falls into the core GP competencies of community and holistic orientation and primary care management. The interventions included will positively build the young person's mental well-being, help prevent diagnosable mental health problems developing or deteriorating and help the young person move ahead in their life.

To use the checklist go through the options swiftly with the young person in a consultation, ticking off what may be appropriate. Possible options can then be discussed with further work to establish how the young person will get that help can be completed. The Problem-Solving Guide can be used to work out a way for the young person themselves to approach a person or organisation to get the help indicated.

The Primary Care Management Check List over the page has some resources filled in.



Primary Care Mental Health Check List

INTERVENTION	RESOURCE
Support	Family, friends, positive role models
Self help	Web-based: http://studentsagainstdepression.org/ (cited 22.1.2015) www.youngminds.org Books: CBT self-help Books on prescription schemes Parent self-help: http://www.familylives.org.uk/ (cited 22.1.2015) Parentline Plus – Tel: 0808 8002222
Talking things over, self-esteem	Youth and community clubs, peer mentors. Family and friends
Physical activity	Sports coaching, gym, dance classes
Education	College access advisers, school nurse
Money and work	Connexions Citizens Advice Bureau
Creative activities	Dancing, music, DJ-ing, art
Support with domestic violence	Child protection procedures www.childline.org.uk Childline – Tel: 0800 1111
GP Care	Watchful waiting, prescribing, concurrent physical health care, family practice
Mental Health Specialist interventions	Primary Mental Health Workers CAMHS Early Intervention in Psychosis teams

As a general rule of thumb when considering options always look towards family and friends first. This is based on the principle that most family are there for the long haul over many years. For those youngsters without family, friends can be equally important.

These primary care management options may be particularly important if the young person is in a complicated, chaotic, family situation with very few choices. Obviously complex cases need specialists, but this does not mean that such young people do not attend their GP too. Sometimes the (mental) health promotion requirements of young people with complex mental health needs and backgrounds may not be being given quite sufficient attention. Of course, GPs are the experts in health promotion per se.

Mental health promotion interventions may provide positive opportunities for a young person and keep them going whilst they grow up, so supporting them to reach their potential as adults. Often the main drive may be to keep a young person in education, whatever their complex situation, so they can gain employment and a career they desire and deserve so gaining their freedom and choices as adults. Surprisingly these often over-looked interventions are sometimes the ones that unlock the whole situation for a young person.

Here is a real GP case example which illustrates this further.

Case

A 16 year old girl, Linda, is brought in to see the GP by the girl's mother with the mother saying 'do something about her'. The family are well known to the practice and are seen as 'chaotic'. The girl herself has been excluded from school, has multiple sexual partners, behavioural problems and substance misuse. Linda has a number of professionals involved already but very few professionals have been able to engage with her. She is only seeing the GP because her mother has forced her to. The GP takes a pragmatic approach and in the consultation straightforwardly goes through the primary care mental health check list with Linda without her mother present.

When going through the 'creative box' on the check list, the GP discovers, unbeknown to anyone, that Linda is very keen on style and really likes hairdressing. She always does her friends' hair before they go out partying. The GP suggests that Linda might like to think about starting a hairdressing course (the educational intervention). Because her GP asks her, Linda does look into and start a hairdressing course at the local college. This is great. She is in with a new set of friends and, what's more, she has a new and very important positive, adult role model in her hair-dressing tutor. Linda's behaviour remains, but she does stick at her course. Regardless, Linda is back on the track with vocational education – a significant mental health protecting factor for her now and later as a adult.

Here is a real GP case that illustrates what can happen if mental health promoting resources are taken away.

Case

Carl was an 18 year old lad with mental health problems, a mild learning disability and epilepsy. He came to see the GP in surgery accompanied by his anxious mother, Tracy. She did the talking while Carl sat smirking with his arms folded and an impish grin on his face. For most of his teen years he attended a day centre run by the mental health trust for young people with mental health problems on a regular basis. In addition once a week, most weeks, he gained work experience as a helper in a local charity shop. He apparently enjoyed his time both at the day centre and the shop, and no problems were reported. However, when he reached 18 years of age, some 4 months ago, he was no longer eligible for trust support and his care was transferred to the adult service. His attendance at the day centre also came to an end. Since then he has stopped going to the shop, indeed has stopped going out altogether, and has apparently become sullen and sulky. He spends most of his time at his computer, has so far refused to see the specialist in adult mental health allocated to his case, and becomes angry and aggressive whenever his mother suggests he should do so. He has occasionally threatened to take an overdose of his epilepsy tablets. Tracy, in tears, says to the GP that she couldn't cope.

One or two of the options on the Primary Care Management Check List should be discussed in more detail.

Mental health self-help is an evidenced-based, intervention when based on CBT. It can be extremely effective. The Problem-Solving Guide is part of CBT self-help and so CBT self-help has already been introduced. Most young people should be pointed towards CBT self help even if they do not take it up. CBT self-help is part of the GP health promotion role. Self-help has been designed as something you do for yourself and so is safe and readily available (though most young people do not know of it). The mental health, self-help approaches have had millions put in to their development and a huge amount of expertise and knowledge behind them. They are also readily available online, a medium which is very young-people friendly. Just think for a moment if you had a problem what would you do? Most people who use computers, type the problem in to Google search engine and see what comes up. If you do this for 'young people mental health self-help' you will come up with a large number of web-based, self-help sites. A young person may coincidentally do this for themselves. Or you may assist them and maybe suggest a few sites for them to explore. Some sites are even more accessible and have podcasts and Twitter options, another method of 'young people friendly' communication. Some sites also have confidential help lines, including crisis lines. Every young person should know about such help. Posters and cards are available with the site contact details. To facilitate a young person helping themselves, without even consulting, you can display these in your reception area.

If your patient is a student then the site *Students Against Depression* (www.studentsagainstdepression.org) may be of interest. The Charlie Waller Memorial Trust supported the development of this site which is evidence-based and underpinned by CBT self-help. It was designed together with students and has student bloggers available through it.

There are also websites to support parents. These often give confidential help lines which can be invaluable.

In addition we have a number of CBT, self-help books. They can cost up to £20 which may seem expensive and certainly is for many families to purchase. But again consider if you were a parent and your teenager was struggling, would you want to buy the book and have an attempt? It is highly likely you would and most parents and families would feel the same way. Self-help books often have workbooks and sections for parents too which is an extra bonus.

Some areas, such as Wales, have a “books on a prescription scheme” for young people and their mental health issues. The GP will give out a prescription (for books) and the young person or parent goes to their local library to borrow the books suggested. These books are usually based on CBT, self-help. This may be available in your area.

Exercise is another interesting primary care mental health management option. There is a good evidence base to support the beneficial effects of exercise. Exercise can also involve some of the other interventions on the primary care mental health check list. For example, joining a sports team can provide exercise, adult role models in a sports coach (the ‘support’ option), prizes and awards (the positive ‘self-esteem’ option) and new friends (the ‘support’ option).

Prescribing should be guided by the relevant NICE guidance. Prescribing is beyond the scope of this *Toolkit* but suffice to say there has been much debate about prescribing of anti-depressants to children under 18 years old by GPs. GP anti-depressant prescribing to under 18 year olds, as outlined by NICE, is very limited without specialist assessment and concurrent psychological therapy (14). Young people do not have a high adherence rate and the ability of the young person to take an antidepressant consistently needs to be considered. Research shows that young people are very concerned about being put on antidepressants. (9)

For more information on the prescribing of anti-depressants in young people:
Quick Summary NICE. Depression in Children and Young People. September 2005. NICE

Referral should be guided by the mental health and risk assessment. If the GP is satisfied that any clinical concern is minor, there is a wealth of community and voluntary sector organisations to consider whose work fit into the primary care management list. To assist referrals to a specialist, it may be necessary to contact your local CAMHS team/primary mental health worker or Early Intervention in Psychosis (EIP) Team and ask them to visit the practice to discuss referrals in general and what to do if you or the practice team has a query. Consultation models of working between primary and secondary care are often more successful.

To illustrate this read through the following real GP case:

Case

At a GP consultation about persisting back pain with the mother of Paul, a 16 year old, she became tearful and admitted that she was very worried about her son. Paul's teacher had commented on his poor school performance and how he seemed distant and preoccupied. At home Paul seemed troubled and preferred to spend his time alone in his bedroom reading science fiction and fantasy books. However, it was not until a recent holiday away when Paul's mood became particularly volatile that Paul's mother began to suspect that there could be something wrong. The GP suggested Paul's mother encouraged Paul to attend.

The following week Paul consulted with the GP over sleep problems and bad dreams as his mother has insisted. He brightened up a little when the GP started to question him about his interest in science fiction. He agreed that he has been finding school difficult. An occasional spliff helped him relax after a particularly bad day at school, but he denied frequent use. He denied persisting low mood and put his problems down to school pressure. The GP booked another appointment for him.

Mum returned with Paul a week later, very concerned. Paul had had a bad week – refusing to go into school, muttering to himself, distracted, pacing his room into the early hours. He looked slightly dishevelled and dejected, makes little eye contact, and his replies to you were monosyllabic. The GP asked Paul the screening questions prompted by the RCGP guidance sheet on early psychosis and checked out with mum whether there was any family history of severe mental illness. There was not, but the GP's questioning of Paul revealed paranoid thinking and some bizarre thoughts such as a description of the TV and radio talking to him. The GP thought about risk issues. Paul denied thoughts of harming himself; and although he admitted to feeling angry inside he had not been outwardly aggressive to his family.

The GP's assessment was that Paul was likely to have a major mental health diagnosis. He felt Paul may have an emerging psychosis and requested an urgent psychiatric opinion from the contact number for the Early Intervention in Psychosis service. Within that same day a specialist nurse from the team assessed Paul at home, and confirmed that the service was pleased to be able to offer Paul and his family a home-based package of intensive support and monitoring to establish the nature of the problem and how best to help.

For further information: The Primary Care Guidance: Early Intervention in Psychosis. IRIS, RCGP, MHF, Rethink, NMH DU, RCN. <http://www.iris-initiative.org.uk/silo/files/pc-guidance-about-early-detection-of-psychosis-and-physical-health.pdf> (cited 9.1.2011)

8. Next Steps

In this *Toolkit* we have looked at the frequency and presentation of young people with mental health problems to the GP, together with some practical GP consultation tools to assist.

We know that this area is an important one because of the high patient demand and because much can be done to prevent lifelong problems developing. It is a key area of clinical uncertainty and a clinical risk area to be aware of.

So what are the next steps forward?

Consultation practice and skills are developed through use and ultimately a patient coming back and saying, '*that really helped*'. There can be no better recommendation. All of this takes time and expertise must be developed step by step. It is suggested that using one tool or suggestion from this *Toolkit* in one teenage consultation next week is a useful approach. If it helps and is of interest, try out another tool and use the two of them on two cases over a two-week period and take it from there.

Support with the use of these tools is very helpful. Peer support or CPD groups could be helpful. The CWMT do run training courses for GPs and GP trainers that may be of assistance. Other people to approach may be your local CAMHS or EIP team worker who may be able to offer some advice, support and further training. It is worth contacting them to see. The RCGP Adolescent Health Group is very helpful and has many resources to offer.

It is highly likely that through using the *Toolkit*, other learning needs may get identified such as teenage mental health risk assessment. Again your local CAMHS team may be able to assist and we at the CWMT will try to help even if that is only to point to other possibilities.

Overall we wish you good luck and if the CWMT can be of further assistance please do not hesitate to contact us. We will try our utmost to help.



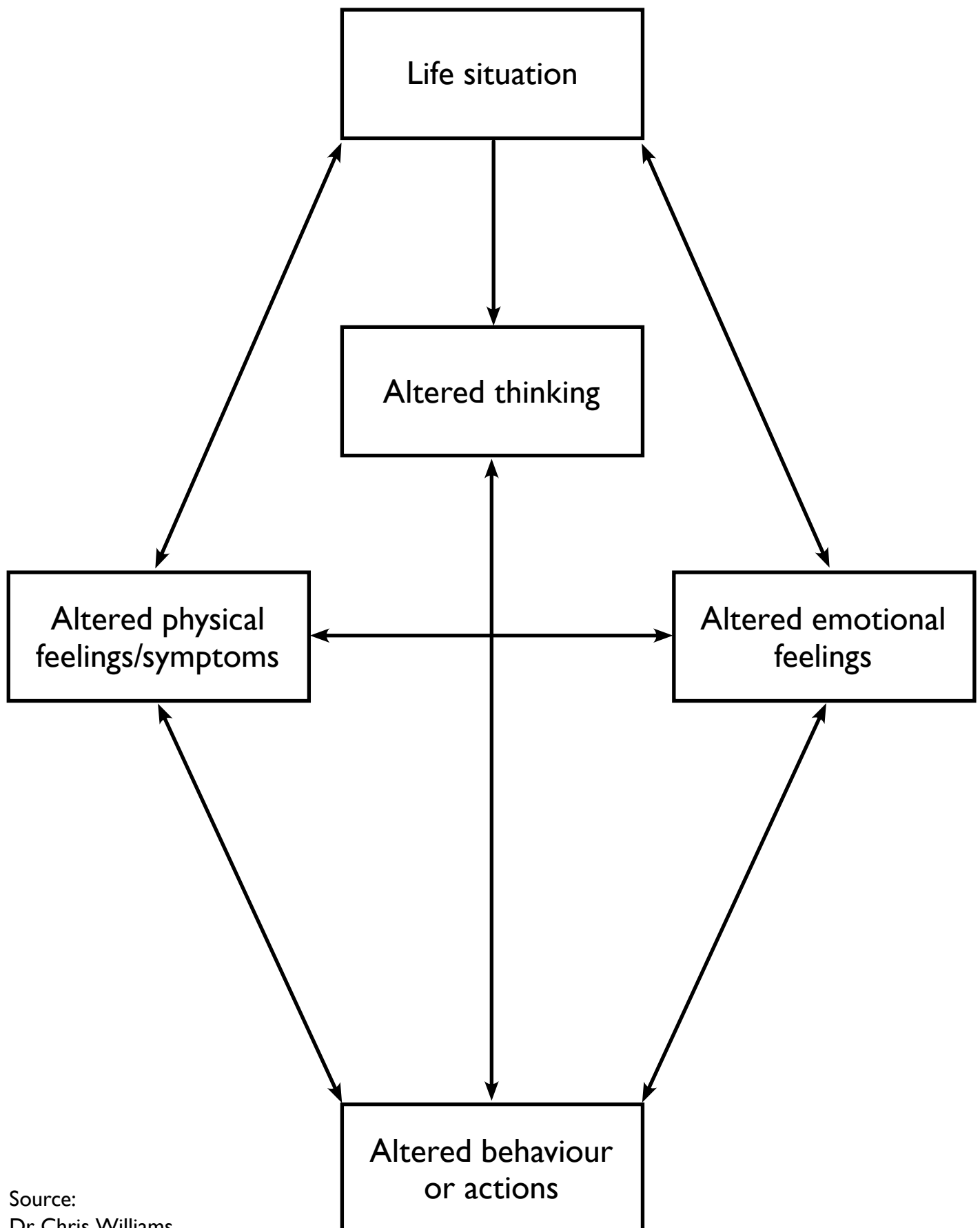
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10. Appendices

The GP consultation tools

i) The Mental Health Consultation Framework



Source:
Dr Chris Williams

ii) The Problem-Solving Guide

Step 1: Work out which problem to sort out.

What are the specific problems you are dealing with? Break them down into smaller parts if necessary. Use your own words.

Choose one to try to sort out. Make sure it is one that is not too hard to start off with.

Step 2: List all possible solutions, with as many ideas as you can

What things would solve the problem?
Any helpful ideas?
What have you tried that worked in the past?
What would other people say?
What would you suggest to a friend with the same problem?

Step 3: Advantages and disadvantages of solutions

What are the pros and cons of each idea?

Step 4: Choose the best solution

Step 5: Review the solution

What went well? Did it help the problem? What could you try and use again?
Write down how well the plan worked, and which parts need to be changed.

iii) The Primary Care Mental Health Check List

INTERVENTION	RESOURCE
Support	Family, friends, positive role models
Self help	Web-based: http://studentsagainstdepression.org/ (cited 22.1.2015) www.youngminds.org Books: CBT self-help Books on prescription schemes Parent self-help: http://www.familylives.org.uk/ (cited 22.1.2015) Parentline Plus – Tel: 0808 8002222
Talking things over, self-esteem	Youth and community clubs, peer mentors. Family and friends
Physical activity	Sports coaching, gym, dance classes
Education	College access advisers, school nurse
Money and work	Connexions Citizens Advice Bureau
Creative activities	Dancing, music, DJ-ing, art
Support with domestic violence	Child protection procedures www.childline.org.uk Childline – Tel: 0800 1111
GP Care	Watchful waiting, prescribing, concurrent physical health care, family practice
Mental Health Specialist interventions	Primary Mental Health Workers CAMHS Early Intervention in Psychosis teams

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