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DEVELOPMENT

Improving primary health care services for young people experiencing psychological distress and mental health problems: a personal reflection on lessons learnt from Australia and England

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Background: Australia and England show high rates of psychological distress and mental health problems in young people. Both are high-income countries and have stated their intention to improve the delivery of health care to young people in primary care settings. Australia has an international reputation for improving care through innovative services and educational initiatives. England has taken a different direction and has concentrated more on developing policy and making recommendations to improve access for young people. **Aim:** To describe a Churchill Fellowship visit to Australia to observe initiatives in primary care based youth-friendly mental health care and to reflect upon the observations, comparing and contrasting with the English model. **Methods:** The observations and reflections presented draw on field notes from site visits and meeting with key players, accessing web resources and referring to the literature, both grey and published. **Findings:** Australia offers plurality in health care delivery and innovative responses to addressing youth mental health. There are two key approaches. The first is the development of services specializing in youth mental health. The second approach is to build capacity of existing primary care services to recognize the particular bio-psychosocial needs of adolescents (and their families). In contrast, England has tended to focus primarily on policy development and improving youth access. **Conclusions:** The paper draws attention to a number of political, clinical and educational developments in both Australia and England. Both countries demonstrate different strategies in response to the high levels of psychological distress in young people. Learning from colleagues in other settings can inform our own practice. Ultimately responding to young people's mental health needs is best served by youth-friendly policy which prepares clinicians for effective practice, informed by applied research and supported by adequate resources. Investment in young people's health must be a priority for us all.

Key words: educational and clinical initiatives to support youth-friendly health care; young people's mental health in primary health care

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Introduction

Young people face a number of challenges to their health and well-being as they deal with the increasing complexity of societal expectations (Tylee *et al*., 2007) at the same time as adjusting to the changes happening to their bodies, cognitive capacities and emerging social identities. Most young people will negotiate these challenges with few problems. However, a significant proportion will experience psycho-social difficulties. Mental health problems in adolescence are not uncommon, occurring on a scale representing a significant global public health challenge (Patel *et al*., 2007). Current estimates for the United Kingdom suggest 10% of 5–15-year-olds experience symptoms that impact on their daily function (Green *et al*., 2005) and 14% of 16–19-year-olds have a diagnosable mental health disorder (Singleton *et al*., 2001). Australia, another high-income country, has been shown to have a higher prevalence of mental disorder with national surveys estimating one in four young people to be suffering from a mental health disorder, most commonly depression or anxiety (often complicated by substance misuse; AIHW, 2003).

Mental health problems peak in adolescence (Kessler *et al*., 2005), yet detection rates in primary care are low (Kramer and Garralda, 2000). Data from Australia suggest general practitioner (GP) identification of psychological problems has remained relatively stable at less than 15% of presentations (Hickie *et al*., 2007). In Britain research indicates 75% of mood disorders in young people are undetected (Andrews *et al*., 2002; Coyle *et al*., 2003) and data from the United States suggest there is a 5–15-year delay before young people with common anxiety or depressive disorders receive care (Kessler *et al*., 2005). Despite the high levels of need young people (aged between 12- and 25-year-olds; Patel *et al*., 2007) have been poorly served by health services globally, described as a 'forgotten group caught between bureaucratic barriers and professional spheres of influence' (Kennedy, 2010: 38).

Nations vary in their response to adolescent mental health. Since the mid-1990s Australia has developed an international reputation for prioritizing adolescent health through landmark policy documents, investment in schools and preventative health strategies (Patton *et al*., 2005). This practice is bolstered by the recognition of adolescent health as a discipline in its own right. New initiatives have been supported by centres of academic and research excellence including the Centre for Adolescent Health in Melbourne, which offers medical training programmes in adolescent health and the Centre for the Advancement of Adolescent Health (CAAH) in Sydney.

Also based in Melbourne, Orygen Youth Health is a unique service undertaking research and providing clinical care for youth mental health. Specialized research programmes in young people's health also exist within the Departments of General Practice at the University of Melbourne and University of Sydney.

As an academic GP with an interest in child and adolescent mental health, practising in the North of England, I was keen to learn more about the developments in Australia. In 2010, I was awarded a Churchill Fellowship to visit three states in southern Australia to look at the role of primary health care in supporting the mental health of young people in community settings. This paper presents a personal reflection on the strengths and limitations of the different approaches to adolescent primary mental health care based on field observations, and compares the Australian models with examples of good practice from the British context. It does not seek to provide a comprehensive review of developments in both settings and the reader interested in knowing more is advised to refer to the 'Bibliography' section for further reading.

Background

Australia, has a population of 22 million people, 18% of whom are young people aged 12–24 years (ABS 2007 census). It is the sixth largest country in the world, 32 times larger than the landmass of the United Kingdom, and is divided into six states, each of which has their own legal framework and differing ways of providing health care. Some health initiatives are funded at a federal level with Commonwealth money and are offered nationwide and others operate at an individual state level with no continuity across state borders. Hence, there is a considerable organizational diversity of services offered at primary care level. Plurality of care pathways is underpinned by an unregulated structure based on open access to

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GPs with no obligatory system of registration with a practice in order to access primary health care services. Funding for GP services is provided through two routes: a fee-for-service for GPs where patients are charged a fee over and above the amount rebated by the government under the national health insurance scheme (Medicare) or direct salaries for doctors working in state-funded services or non-government organizations. This blended system can introduce complexity when developing new services.

From my observations there appear to be two major approaches to providing youth-friendly services for adolescent mental health in Australia. The first is the development of services specializing in youth mental health. The National Youth Mental Health Foundation aims to provide enhanced primary mental health care to young people aged 12–25-years through its *headspace* sites. Its focus is primarily on mental health and substance use issues but it also addresses sexual and reproductive health concerns, general health concerns and offers vocational counselling for clients. The second approach is to focus on building capacity of existing primary care services to recognize the particular bio-psychosocial needs of adolescents (and their families) within the life cycle, and to incorporate a youth-friendly focus to improve access and acceptability of care for young people. This approach incorporates the potential for detection of and early intervention with mental health disorders and/or co-existing risky behaviours.

Specialist youth mental health care provision

headspace is the boldest and biggest youth mental health initiative in Australia and ambitiously aims to deliver across the vast continent having been seed funded with Commonwealth money (McGorry *et al*., 2007b). It is beyond the scope of this paper to enter into a detailed analysis of the complex structural organization of *headspace*, but what I hope to capture here is the essence of its vision and an experiential sense of two of its many centres. *headspace* was launched in 2006, in response to 'the recognition that the existing health care system needed to be more accessible and effective for young people with mental and substance use disorders' (McGorry *et al*., 2007a). It prioritizes early intervention for mild-to-moderate mental health issues that its proponents consider are not being well served by existing models of care (McGorry *et al*., 2007a), such as conventional general practice and secondary care mental health services. Given that the majority of adult mental health illnesses first present in adolescence and yet mostly go undetected until adulthood (Kessler *et al*., 2005), early intervention is advocated as a means to address the high rates of adult mental illness and alleviate distress earlier.

The organizational vision is for a nation-wide system of integrated service hubs and networks. Originally, the intention was for services to be based in stand-alone centres functioning as 'one-stop shops', akin to those available in New South Wales (NSW) since the 1990s. These youth health centres provide not only youth-friendly holistic health care but a range of services such as hot showers, food, art rooms and internet access. It has proved ambitious to deliver care in such stand-alone centres and *headspace* now operates a more blended system of offering health care based on local existing provision, working with health and social care providers and independent GPs in each locality. Each *headspace* is run by a locally constituted consortium, which draws upon local expertise in youth and drug work, community nursing, psychiatry and primary health care found in that community. Regional divisions of general practice are frequently involved as lead organizations in the consortia. GPs are seen as the key medical providers with psychiatrists generally providing up to four sessions a week in the busier centres.

However, recruitment of GPs to offer regular sessions has been challenging, largely due to a reduced supply of GPs in Australia. Hence, a pragmatic approach has evolved with many GPs conducting the more detailed assessments of young people, who have first accessed a local *headspace* centre, within their own surgery. This evolved model demonstrates the mutuality of the two approaches with GPs skilled in a youth-friendly approach inevitably working more effectively in this mutually complementary system.

I visited a number of *headspace* centres including one at Elizabeth, south of Adelaide in the state of South Australia and the other at

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headspace Sunshine in West Melbourne, Victoria. The two centres are united by the common distinctive logo and approach to providing 'focused psychological therapies' such as cognitive behavioural therapy, motivational interviewing and relaxation techniques, yet very different in their presentation. *headspace Elizabeth* is led by the Division of General Practice and has its access rooms for young people located in the Division's smart, corporate, organizational head quarters, in a 'down town' neighbourhood. Attracted by the highly visual and well-distributed publicity on public transport and billboards and its website (http://www.headspace.org.au), many clients will self-refer; others might have been referred, for example, by a teacher and are not always ready to ask for help. A key strength of the *headspace* centres and one which was particularly flagged up at *headspace Elizabeth* was the role of the youth worker in engaging young people with the services available. The youth worker will arrange to meet the young person 'off-site', perhaps in a cafe, skate park or 'video-game parlour', and will begin building up a social relationship with the teenager or young adult until they are ready to meet with the GP for a formal review. The review process follows a national health system agreed proforma: 'the mental health care plan' and generates a fee for the GP under Medicare. The *headspace* model values detailed tracking information, which begins from the young person's first encounter with the Access team whom they meet on arrival. The Access worker will do a preliminary assessment to identify the next step, for example vocational counselling or a GP assessment, and will then continue to offer ongoing support to the young person.

Sunshine headspace, West Melbourne is housed in a centrally located two-storey purpose-built youth centre, the *Visy Hub*, which was vibrant with life on the afternoon I visited. On arrival there were youth workers helping teenagers with homework on the ground floor, a busy coffee bar with free internet access and art room; upstairs was a packed waiting room. The *Visy Hub* houses an accommodation officer and social worker, occupational therapy and psychology with a visiting psychiatrist. It is also a *headspace* research centre and recruits young people using the service to active research studies supervised by Orygen Youth Health.

At the time of my visit there were two GPs who offered regular sessions four or five times a week, with appointment scheduled at 30-min intervals. One of the most satisfying aspects for GPs working in a *headspace* centre is the access to supervision, usually from Psychiatry and Psychology, which allows professional development and offers clinical support when working with young clients who have complex narratives of emotional distress. The clinicians I talked with spoke of seeing high rates of distress at first assessments, often with co-morbidities around drug and alcohol use, unsafe sexual activity and registering high scores on formal assessments using psychological screening tools. There was also a view that there were frequent first disclosures of abuse once clients developed trusting relationships with *headspace* staff, which might require intense follow-up. The relatively easy access to other professionals for peer support was seen as an adjuvant to this emotionally and professionally challenging work. A one in four 'no-show' rate by clients meant that an insecure remuneration from working such sessions was a less appealing aspect of the job.

There are currently 30 centres throughout Australia, concentrated in areas of highest population density (usually coastal locations), and more are planned, with a recent commitment of further additional government funding.

Enhancing GP skills for youth-friendly primary health care

The other major Australian approach observed during the Fellowship visit is the strategy that favours developing the skills of all those who work in primary care to be more confident and effective in their clinical practice with young people. This view seeks to demystify young people as a 'special group', while highlighting their particular needs and the skills required of the clinician to work effectively. It is an approach which encourages clinicians to understand the developmental stage of adolescence and the health burdens for this aged group, notably mental health concerns and the consequences of risky health behaviours such as smoking, drug and alcohol use, road safety risks and unprotected sex.

A holistic approach to adolescent health care is advocated that does not prioritize mental health, in the way that the *headspace* model seeks to, but sits closer to conventional general practice, which

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operates on a person-centred rather than system-focused approach to health care delivery. The main mechanism of dissemination is through tailored education, for practitioners and practices, and through building and maintaining a research programme that aims to produce the evidence to inform good practice.

The Department of General Practice at the University of Melbourne has a 'youth health in primary care' research stream led by Associate Professor Sanci. The main aim of research in this stream is to improve the health and well-being of young people through effective primary care services. Sanci developed a multi-faceted educational initiative in adolescent health care designed according to evidence-based principles for learning and promoting change in clinical practice. Evaluated with a randomized-controlled trial (Sanci *et al*., 2000) the intervention proved effective at enhancing the knowledge, skill, perceived competency and self-reported change in practice for participating GPs. The structure of this educational programme has since become embedded in the Royal Australian College General Practitioner curriculum, and has contributed to the production of other training resources, notably the Adolescent Health GP resource kit (Chown *et al*., 2008).

The sustainability of educational interventions is often problematic, both in the evaluation and in providing the longer-term support necessary to maintain the improvements achieved. The sustainability of the programme devised by Sanci *et al*. was assessed using the self-report by participating GPs rather than direct observation. GPs' self-rating of competency was maintained five years after this training (Sanci *et al*., 2005). However, routine and opportunistic screening of adolescent patients for psycho-social health risks by the same group of GPs was reported as being inconsistent. This finding led to a post-doctoral qualitative work investigating barriers and enablers of youth-friendly primary care and culminated in the currently funded cluster randomized trial of a screening and motivational interviewing intervention for young people presenting to general practice: the PARTY (Prevention Access and Risk Taking in Young people) study (http://www.party.unimelb.edu.au/).

The study aims to test whether the introduction of screening tools, and office procedures to enhance their use, offers any further advantages over brief clinician training alone (control group) in order to increase the detection of risky behaviour and mental health issues in young people attending general practice; and whether training clinicians in a brief intervention for health risk behaviours results in better health outcomes compared with usual care. A second phase of the trial will add a 'whole practice' organizational change component, designed to assist intervention practices to become more youth friendly using a quality improvement framework. The outcomes, due in 2014, include young people's commitment to their own health care, parents' attitudes and practice system and staff behaviour changes that support the youth-friendly care model.

The CAAH in Sydney has also examined the way different services put in place youth-friendly principles and have highlighted the importance of system changes in sustaining youth-friendly care models.

The youth focus at the Department of General Practice, Melbourne, demonstrates the value given to young people's health by this centre of academic general practice and the priority it has been accorded in the Unit's research profile. The department is supported by a strong and productive collaboration with the nearby Centre for Adolescent Health in Melbourne, at the Royal Children's Hospital. As with all the site visits I made, the visual appeal of the building's interior design is taken seriously and there are bold artistic images, which adorn the walls at the Centre, designed to appeal to young people's imagination. The widespread use of art work achieves a warm, welcoming and fun approach and also shows respect for the culturally and linguistically diverse young population in Australia; a social group who face particular challenges as they navigate adolescence and often competing social and domestic pressures and expectations.

Lessons learnt

The plurality of health care delivery in Australia and the diversification of approaches to developing youth-friendly health care make sweeping generalizations unhelpful and counter-productive. It is the vitality of the range of options and the concerted effort to improve the delivery of care that makes a visit to Australia so intellectually invigorating. Health care innovation and delivery

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appear infused by a 'can-do' approach, which I found in a diversity of settings and contexts. However, it should be added that such an enthusiasm has not always been universally extended and aboriginal youth (and the indigenous population in general, compromising 2.6% of the total population) continue to experience the highest levels of morbidity and mortality than any other social group, and experience the poorest access to health care (Thomson *et al*., 2010).

That said, reflecting on Australia's dual approaches to improve the quality of care for young people with mental health problems, it is evident that they both have their particular strengths and weaknesses, depending on what is prioritized and the aims to be achieved. It is likely that both will enhance each other and both are necessary. Opponents to a specialist youth mental health service have argued that integration with existing systems is more important than developing a new service approach and prioritizing 12–25-year-olds will mean less resources for the under 12s (Birleson, 2009). From a primary care perspective the 'cradle-to-grave' model persists with often a lifelong fidelity to the same local general practice so 'up-skilling' all GPs potentially widens the net benefit. For those individuals with a mental health disorder and receiving input from secondary care, a skilled and confident GP can provide continuity through the transition period from children's to adult services when psycho-social problems are often a concern. However, aiming to enhance skills for all GPs relies on a degree of self-motivation and not all GPs are keen to work with young people.

The English context

England shows a different picture with regard to adolescent health, with most activity directed at improving access for young people. For the last decade it has been largely government driven and national policy has been the key driver in shaping practice. In the 1990s and early 2000s members of the Royal College of General Practitioners (RCGP) Adolescent Task Group contributed empirical research and a review of current practice at the time, which informed early policy development (Jacobson *et al*., 1994; 2002; Churchill *et al*., 2000) and served as an important catalyst. The group successfully lobbied for governmental support to make general practice more adolescent friendly through a number of initiatives, led by founding members Chris Donovan and Ann McPherson.

With regard to policy, the National Service Framework (Department of Health, 2004), a landmark document, promoted the role of primary care staff in the prompt assessment and early intervention of common mental health problems. It followed 'Every Child Matters' (Department of Health, 2003), a key policy document, which set out the UK government's commitment to children and young people's welfare and has been supported by the Healthy Child Programme (Department of Health, 2009), which covers 5–19-year-olds. More recently the role of GPs and other frontline health professionals in promoting emotional resilience through early intervention was described in the policy document 'Early intervention: securing good outcomes for all children and young people' (Department of Health, 2010).

Drilling down more specifically to a primary care focus an important service development has been the government led 'You're Welcome' quality criteria for 'young people friendly health services' (Macfarlane and McPherson, 2007). Developed in conjunction with the RCGP Adolescent Task Group, the 'You're Welcome' initiative aims to support practices to make changes in their environments and systems ultimately increasing young people's access to, and use of, primary care to address early psychological problems. These have recently been revised (Department of Health, 2011). In addition, in 2006, a two-year centrally funded, locally delivered pilot project, the Teenage Health Demonstration site was launched. Conducted at four sites in Britain, the innovation generated a number of learning points, which include the importance of placing young people at the centre of service development; the need for allocating time for planning and nurturing a strong leadership who can support a multi-disciplinary core team to offer a flexible and mixed programme of both universal and targeted services; and using creativity to reach the most marginalized groups (Association of Young People's Health (AYPH), 2010).

Education and professional development has been another area of recent development in the British context with the launch of the e-learning Health Adolescent Health Project (http://www.e-lfh.org.uk/projects/ah/index.html) sponsored by the Department of Health and led by the

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Royal College of Paediatrics and Child Health with input from the RCGP. It is a 72-session self-directed learning programme available to all National Health Service staff, aiming to build capacity through individual learning and professional development.

Looking ahead

Given the current stringent economic climate creating new and innovative ways for improving services for young people who experience mental health problems is best achieved by working collaboratively. Multi-disciplinary working is a key feature of *headspace* centres and it was identified in the UK Teenage Health Demonstration sites as pivotal to the quality of care offered.

A recent development in the UK setting is the AYPH (http://www.youngpeopleshealth.org.uk), a multi-disciplinary membership organization, which aims to raise the profile of youth health needs. This umbrella organization, supported by the Department of Health, specifically intends to draw professionals from different disciplinary backgrounds to work together for common goals. The association has a broad remit including educational and professional development through the dissemination of information and research at conferences and via its website, and works closely with the RCGP Adolescent Health Group; which is now 18 years in existence and housed at the Clinical Innovation and Research Centre, RCGP.

Within the English context, improving adolescent mental health has generally been seen to be a secondary goal, best achieved by improving access to generalist primary health care. This remains the case although there is increasing recognition of youth mental health in its own right. In 2011, the RCGP Adolescent Health Group held a symposium exploring the key role of general practice in community-based adolescent mental health problems, following an earlier conference (Vallance *et al*., 2011). 2011 was also the year for the International Declaration on Youth Mental Health of which England and Ireland are signatories (Association for Child and Adolescent Mental Health, 2011)

Conclusion

This paper has drawn attention to a number of political, clinical and educational developments in both Australia and England. It has celebrated the increased focus on young people's mental health and the importance of early recognition of psychological difficulties by appropriately trained and well-prepared clinicians. This may happen in a generalist primary care setting or, resources permitting, in a youth-specific setting. In this age of economic austerity, it is to our mutual advantage to learn from each other's experiences and to look at how we can maximize our effectiveness from interventions that have proven useful elsewhere. The lessons learnt from a reflection of the Australian experience and the progress made within the last 10 years in England suggests that a multi-pronged approach is likely to prove most fruitful.

Australia has demonstrated the benefit of clinical leadership through spearheading an ambitious youth-specific mental health service and in demonstrating effective medical education programmes for 'up-skilling' GPs. They are also leading on multi-site research to generate the evidence we need to make changes in clinical practice, especially around health promotion and risk reduction. England has taken a different direction and has shown leadership through centrally supported policy-led initiatives (including a Children's Commissioner) and government-backed practice development initiatives.

Ultimately, the most successful model would include all the aforementioned elements, summarized as youth-friendly policy which supports good practice; buttressed by educational development for practitioners; informed by applied research and underpinned by adequate resources. Such would be the blueprint for a utopian model to support young people's mental health in primary care.

Currently the English economy is under greater pressure than its Australian counterpart and there are concerns in this country that the progress made through previous periods of investment cannot be guaranteed. We must be mindful of 'short-termism' when it comes to young people's health. Not only are they the next generation upon whom we will all depend, but they have the right to enjoy good mental health now and their immediate psycho-social well-being should be a high clinical and public health priority. Investment in young people's health must be a priority for us all.

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