# The primary health care response to adolescent self-harm

Project report
December 2017

NSW Department of Health Kids and Families commissioned study to identify strategies to enhance knowledge, skills and professional practice in general practice to better respond to self harm among young people – exploring support, practice and health promotional strategies.

University of Technology Sydney

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## Acknowledgements

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# Contents

# Abbreviations

| | |
|---|---|
| **ATSI** | Aboriginal and Torres Strait Islander |
| **CAMH** | Children and Adolescent Mental Health |
| **DSH** | Deliberate self-harm |
| **GP** | General Practitioners |
| **LGBTQI** | Lesbian, Gay, Bisexual, Transgender, Queer and Intersex |
| **NSSI** | Non-Suicidal self-injury |
| **PHC** | Primary Health Care |
| **PHN** | Primary Health Network |
| **SB** | Suicidal behaviour |
| **SH** | Self-harm |
| **SHWO** | Self-harm without suicidal intent |
| **SHW** | Self-harm |
| **SI** | Self-Injury |
| **YPSH** | Young people who self-harm |

**Commented [TC1]:** I'm not sure what this acronym is?

# Definition

This report uses the term self-harm (SH), although the behaviour is also known as deliberate self-harm (DSH) or non-suicidal self-injury (NSSI). SH is defined as 'a range of behaviours (including self-poisoning and self-injury) through which an individual directly causes harm to her or himself, irrespective of the type of motive or the degree of suicidal intent' [9].

SH is seen as a behavioural response to emotional or psychological distress as an alternative to ending life, that remains misunderstood and highly stigmatized. Suicide-related behaviour (attempted suicide) is therefore not the focus of this report [10], although the study did ask practitioners whether they saw a direct link between these activities.

The report uses the acronym YPSH to refer to adolescents, youth, young people and young clients aged between 10 and 24 who SH.

# Executive summary

In Australia, research has shown that about 10% of adolescents have ever attempted SH, and that 22.8% of girls aged 16–17 years had self-harmed in their lifetime [1–2]. Further, lifetime prevalence rates of SH among Australian young adults aged 20–24 years is estimated to be 20 per cent [3], while Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) young people have been found to be at an especially high risk of SH, along with Aboriginal and Torres Strait Islander (ATSI) youth [2]. Beyond physical injury, SH can have a significant emotional impact on adolescents through feelings of shame, distress, depression and mood disorders, which can extend into negative outcomes in the future, including ongoing mental health problems, substance abuse, poor economic participation and risk of suicide. SH also places pressure on families, who often respond through increased surveillance rather than emotional support and developing trusting relationships with health professionals. However, SH remains misunderstood and highly stigmatized in the community, while the extent and impact of SH amongst adolescents is relatively unstudied and there is a lack of evidence of effective prevention and early intervention approaches [2].

While publicly funded mental health care is available in Australia, with 15.8 million GP visits per year (12% of all visits) being for mental health problems [6], studies show that young people who self-harm (YPSH) seeking help find it difficult to access referral points through general practice and there is a lack of adolescent mental health resources [4–5]. A recent report stated that GPs are an important and effective point for early intervention if equipped to identify possible SH, support disclosure, connect with other services, and provide high quality integrated and evidence-based care and treatment engendering hopefulness, yet there is a paucity of research into primary health responses to YPSH to inform policy and practice in Australia [2].

In response, the NSW Department of Health Kids and Families commissioned a state-wide study to identify strategies and enhance the knowledge, skills and practices in PHC and general practice to respond to SH in young people in NSW.

There were five study objectives, as follows:

**Q1.** Map the current knowledge base relating to self-harm of practitioners in PHC and general practice;

**Q2.** Identify the range of practices and responses to self-harm current within general practice in NSW (including perceived facilitators and barriers in the provision of effective care and referral practices);

**Q3.** Explore the health promotion and information strategies provided in general practice to young people who self-harm or at risk of self-harm;

**Q4**. Identify elements/inputs to refine educational interventions/training and other workforce development initiatives e.g. good practice guide and pathway development; and

**Q5.** Examine the potential for general practice and PHC services and practitioners in providing support to young people who self-harm and their families.

## Methods

A qualitative interview study was undertaken to provide insight into how GPs across NSW make sense of and respond to SH in young people (aged between 10 and 24). Participant recruitment was guided by the development of a geographic and socioeconomic matrix categorising general practices according to their location within five remoteness areas across the ten Public Health

Networks (PHNs) in NSW. Thirty-nine semi-structured interviews were conducted with practitioners face to face and via telephone, and transcribed verbatim. Responses to open-ended questions were gathered via email and Survey Monkey from nine practitioners. Data was thematically analysed by both researchers independently using inductive coding.

## Key findings

Overall, GPs reported that SH in young people often manifests as a coping mechanism for stress, mental anguish and sometimes mental illness, social isolation or negative social situations, or in response to intense pain, distress, or overwhelming negative feelings or thoughts. Based on their experiences, SH commonly involved superficial cutting of the skin on arms or thighs, although some GPs suggested risky behaviours such as alcohol and drug abuse, and dangerous driving also constituted SH, SH was reported as being more common among adolescent girls than boys, and in cases as young as 10 years old, but primarily between the ages of 14 and 18.

The study results show that emotional distress and inability to cope with pressure are thought to be the most common catalysts of SH among young people, and that they resort to these practices as a form of relief or distraction from inner/psychological pain. GPs also reported that SH in young people is a response to negative social situations, including dysfunctional families, abuse and neglect, as well as bullying and peer pressure in school. Although SH was seen as being distributed amongst adolescents across different socio economic groups, those in rural or remote areas may be especially vulnerable to SH due to poverty, social isolation and lack of direction or opportunity in life. While the literature suggests the relationship between SH and suicidality is complex and not clear-cut, most GPs in the study reported they did not see a direct link between SH and suicide, although screening for risk of further SH and suicide ideation was central to their practices.

All participants reported having had some experience of working with YPSH. Most were brought in by others, usually by concerned parents or friends who had noticed mood changes or scarring, the latter of which was less common. In some cases, adolescents were referred to the GP by the school counsellor, or following discharge from hospital emergency departments after an episode of SH. Occasionally, older adolescents would present on their own, often for unrelated, mundane issues, such as a sore ear, or for prescription renewal, only revealing SH when questioned.

The findings show that there are a number of common practices and responses across general practices in NSW to YPSH that can be mapped onto a generic referral pathway. These involve identification and assessment, referral, support/treatment (including follow up) and discharge. After identification and initial assessment of risk of further SH, GPs refer adolescents to specialized care in the public or private sectors, such as psychologists, psychiatrists or community health mental health teams, depending on their knowledge of these services and their availability. Some GPs also reported undertaking counselling with these clients, partly to provide care until specialist appointments became available and partly because they felt confident in doing so having undertaken training in counselling or other therapeutic strategies. However, unlike a GP based in an emergency department who is able to refer clients to the hospital's mental health team, many GPs needed to consider which resources were appropriate for each client, according to affordability, accessibility and waiting times. A number of GPs reported a reluctance to prescribe anti-depressants to young people, particularly before a formal mental health assessment had been conducted. In many cases, this referral pathway is one-directional, with GPs reporting they do not always know the outcome after referring the client, until either receiving a discharge notice from a specialist service, or inadvertently hearing about them through community contacts.

GPs in very remote, remote, regional and inner regional areas reported a number of barriers to placing young people with mental health specialists, including difficulties finding and communicating with relevant practitioners through the AccessLine, age limits for the Child and Adolescent Mental Health Service (CAMHS), or clients living long distances from, or not being able to get to, services such as Headspace. There were concerns that sometimes young people got 'lost' in the mental health system, for instance, when they were discharged from CAMHS with no follow up plan or without timely notification to the GP, when they turned 25, or having had a mental health illness misdiagnosed as drug/alcohol abuse or learning difficulties. GPs reported that a major barrier to practice was the lack of time and/or financial compensation in general practice that was required for deep engagement with young people to build rapport, identify issues, assess risk of further harm, refer and follow up. Some GPs also felt they were not interested or sufficiently skilled in counselling young people, with some reporting it was mentally draining, clients were not always willing to engage, or that mental health issues were more difficult to treat in general practice than other medical conditions and there was less readily available information to support treatment.

Factors facilitating GPs' capacity to deliver effective care to self-harming adolescents were identified as having local professional networks of public or private psychologists to which to refer young people, and particularly, strong peer and family support networks around the young person.

The most common health promotion and information strategies used by GPs treating YPSH were online sites, such as those hosted by Beyond Blue and the Black Dog Institute, Kids Helpline, and mobile apps, such as Moodgym and others providing mindfulness and relaxation exercises. However, GPs reported that they were not always aware of whether young people or their families found these tools useful because they often did not report back.

All respondents saw SH as a mental health issue and mental health care as increasingly central to general practice. Yet the findings show there is a paucity of mental health training programs for GPs that specifically target adolescents, which they saw as requiring different knowledge and skills than for treating adults. Most participants had undertaken some form of mental health training through short sessions, workshops, conferences, or online programs, yet many felt these were inadequate because the information was too generalised and did not provide strategies for treating young people. Recently graduated fellows reported having completed mental health modules as part of GP training, yet many felt this addressed the 'pointy end' of mental health illness, which often omitted YPSH.

The study revealed two innovative primary health initiatives around mental health. Specifically targeting adolescent mental health, the Bega Valley Medical Practice established a self-funded, drop in clinic for teens in 2015. Teen Clinic provides free consultations with practice nurses who undertake initial screening, treat minor issues, and refer to in-house GPs as required, who then refer to in-house psychologists if needed, for which appointments are reserved. The clinic was reported as being highly successful in providing confidential primary health care to adolescents normally reluctant to see a GP, being accepted by the community and neighbouring practices, and while the clinic is free to teens, subsequent GP consultations covered its cost. The second initiative was in Cobar, where a comprehensive directory of mental health services in the area was developed through a community project funded by the LHD and auspiced through a local general practice.

## Recommendations

The findings suggest there is need for the following: -

- Develop local area-based directories of resources, services and support networks for treating YPSH, that include contact information about GPs, community mental health teams, private psychologists, NGOs, community groups, and others, such as that developed in Cobar;
- Strengthen timely communication and share knowledge and resources between GPs within practices, and between GPs, community mental health teams, private psychologists and hospital emergency departments;
- Provide continuing professional education for GPs in adolescent mental health assessment and treatment, including identification of underlying determinants, protective factors, referral pathways, services and case studies of outcomes, as well as innovative practices;
- Develop the frontline role of practice nurses in the initial contact, assessment and education of adolescent mental health, such as the Bega Valley Medical Practice's Teen Clinic model;
- Build peer and community support networks for young people to link friends and family, school, general practice and community case workers;
- Develop public campaigns to educate, raise awareness and reduce the stigma of SH, and promote the role of the GP in addressing adolescent mental health.

# Introduction

Self-harm (SH) among young people is the subject of much attention in developed countries, which research showing that 10.9% of 12 to 17 year olds (186,000 young people) and 16.8% of adolescent girls (aged 16 to 17 years) in the UK have ever self-harmed [6]. In Canada, one study found that 15% of the 424 respondents reported engaging in non-suicidal self-injuring (NSSI) behaviour, and that SH is associated with maladjustment, health behaviours indicative of negative developmental trajectories, and suicide [7]. SH is also associated with increasing anti-social behaviour, emotional distress, anger problems, health risk behaviours, and decreased self-esteem.

While non-hospital admission data is difficult to obtain, some studies have found that one in ten Australian adolescents have engaged in self-harming behaviour [11], and 22.8% women 16–17 years had self-harmed in their lifetime [12–13]. More alarmingly, Martin et al. (2010 [16] cited in Robinson et al, 2016) stated that the lifetime community prevalence rates of SH among Australian young adults aged 20–24 years is approximately 20 per cent, which is higher than the international lifetime prevalence of 16.1 to 18% for NSSI [17–18]. Although not the focus of this report, at highest risk are ATSI and LGBTQI young people, with a study showing that 27% of all completed suicides among Indigenous people in the Kimberly region between 2005 and 2014 were young people under 20 [19]. A 2014 report by the Australian Institute for Health and Welfare shows that there has been an upward trend in hospitalization for SH among adolescents in Australia, with girls aged 15–19 years comprising a significant proportion of hospitalisations [14]. Most hospitalisations are related to self-poisoning, and most of the cases reported in the community are self-cutting [15], while the majority of ambulance attended cases across NSW, Victoria, ACT, Queensland were for cutting. Besides the risk of wound-related complications, such as bleeding, infection and organ damage, SH can have a negative emotional impact on adolescents, engendering feelings of shame, distress, and depression. It can also portend future adverse outcomes, such as mental health problems, substance abuse, poor economic participation due to disruption of education and career pathways [20] and risk of suicide.

In light of this, early intervention is seen as the key to preventing serious adverse physical and emotional outcomes for young people, including increased risk of premature death [8]. Different types of interventions in Australia and their effectiveness in addressing SH in adolescents have been investigated, among them, school- and community-based interventions that seek to empower adolescents and provide them with social support for mental health wellbeing. For example, Toumbourou & Gregg (2002) investigated the impact of an intervention involving professional-led parent education groups in school communities in Melbourne, which aimed to empower parents to assist one another to improve communication skills and relationships with adolescents [21]. They found that whole-school-based parent education appears to reduce a range of short-term risk factors and behaviours and increase protective factors for SH and youth suicide, with the largest impacts associated with parents, and others, such as best friends. Stacey et al. (2007) demonstrated synergies between suicide prevention and supporting positive mental health through a social-emotional wellbeing approach rather than a diagnostic approach/clinical intervention [22]. Other interventions include training health workers to screen and support young people with mental health issues, such as improvements in emergency department nurses' knowledge and understanding of SH, their self-belief in being able to positively influence YPSH [26], and an intention to act in more person-centred and change-oriented ways towards such clients. These interventions are supplemented by a Federal government funded digital mental health gateway, *Head to Health,* that provides online health and mental health services, such as apps, online support communities and courses, as well as telephone services, to support people before they reach crisis.

**Commented [TC2]:** do you have a reference for this?

**Commented [TC3]:** what do you mean by this term? Primary health? or GPs? Or Community Health?

**Commented [TC4]:** do you have a reference to support the link to suicide? I think we have to be careful about what we say in the intro – I think the literature suggests the link is contested

**Commented [TC5]:** there needs to be some mention of which nurses, in relation to primary health, rather than hospitals

Debates around the complexity of SH and suicide-related behaviours suggest that interventions targeting SH alone may not always be appropriate and that brief interventions, such as individual therapy and group/family interventions that integrate assertive case management with individual psychotherapy, can improve the engagement of young people with suicide ideation in further therapy [9]. A US study (Deykin et al 1986) found that an intervention combining a community education program and direct service provision to high risk 13–17 year olds by community social workers facilitated early help seeking among adolescents with suicidal thoughts, and led to a slight diminishment of overall occurrence of hospital admissions for suicidal behaviours [23]. The intervention program was also effective in increasing the teens' compliance with a medical care program. A systematic review of research from Australia by Burns et al. (2005) found that group therapy (trialled in RCT) was the only specific program that lead to a significant reduction in rates of repeated SH among adolescents, and that family therapy led to significant reduction in suicide ideation [24].

**Commented [TC6]:** this study is quite old, and it deals with suicide ideation, rather than self harm

According to a recent report, youth-friendly mental health services, both online and face to face, are required in the early stages of distress at the onset of self-harming behaviour, and also on discharge from medical or psychiatric care after an instance of SH [9]. These services should have the capacity to identify possible SH, support disclosure, and provide evidence-based, high quality interventions as well as link in with other services. They should also provide care over the entire period of time it is required, rather than only immediately after incidents of SH. The development of a national set of standards of care is also urgently required, to detail appropriate ways for front-line professionals, including clinical and non-clinical staff, to respond to YPSH in ways that are understanding, empathetic, non-judgmental, optimistic (i.e., engender hopefulness) and motivating [9].

General practice is therefore an important and effective point of early intervention, as long as practitioners are equipped to identify mental health concerns among young people, and provide effective evidence-based strategies and interventions. In a recent study by Mann et al. (2005), physician education and training on depression and mental illness recognition and treatment led to a reduction in suicide attempts, which is assumed would lead to a reduction in SH incidences [25]. Robinson et al (2016) observes that although publicly funded mental health care is available in Australia, YPSH seeking help find it difficult to access such services, especially without a diagnosed mental illness [8]. Yet young people are half as likely to visit a GP for mental health related concerns because of geographic isolation, confidentiality, non youth-friendly environments, and a general reluctance to seek help, especially for males (Australian Institute of Health and Welfare 2011, cited in [9]). At the same time, the authors observe that youth mental health services are overloaded or struggle to engage with high-risk adolescent groups. Inadequate inpatient care and discharge from ED to stepdown community-based care is also a barrier to early and effective treatment (p. 6) [9].

Overall, GPs are seen to be well placed for early interventions that identify YPSH and link them with support services [9], however, there has been low participation by GPs in intervention studies. This study sought to address this by establishing a coherent map of existing practices and responses to SH among young people by GPs across NSW, to identify information and educational support and other practice development initiatives required to improve their knowledge, responses and practices.

# Methodology

The study team began by reviewing the available evidence concerning primary health responses to SH in young people aged 10–24 (WHO definition of young people) to understand and

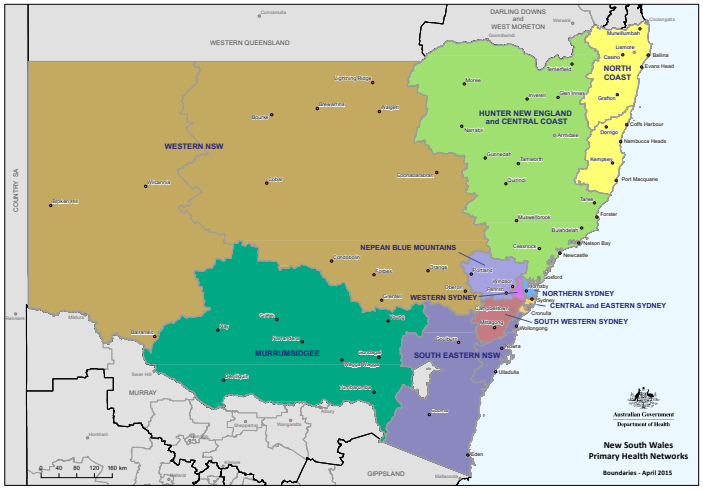
**Commented [TC7]:** is there a reference for this?

benchmark existing practice. Searches were conducted in four databases: PubMed, Web of Science, Scopus and Google Scholar. The study identified English-language, peer reviewed research articles, reporting studies involving PHC and general practice. Using qualitative content analysis, a total of 30 articles provided evidence of research into the primary health care response to adolescent SH in Australia and internationally. However, very few studies spoke directly to GPs about their responses to YPSH. This necessitated an exploratory research design for the project.

## Sampling

A qualitative research design employing semi-structured interviews was devised to collect rich data about GPs' knowledge and practices in treating YPSH, their attitudes towards SH and understanding of why adolescents engage in the practice, and what they saw as barriers and facilitators in general practice to supporting them. A stratified sampling of general practices was undertaken, with the aim of recruiting forty GPs across the ten Primary Health Networks (PHNs) in NSW, which are shown in Figure 1.

**Figure 1**. Primary Health Networks in NSW



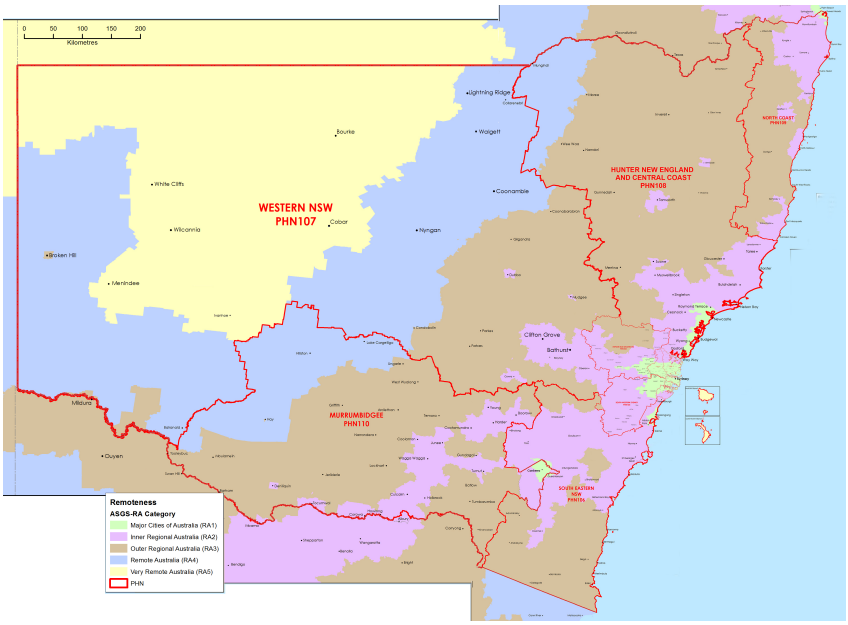

PHN Profiles:

Central and Eastern Sydney (CES)
Hunter New England and Central Coast (HNECC)
Murrumbidgee (MURRUM)
Nepean Blue Mountains (NBM)
North Coast (NC)
Northern Sydney (NSYD)
South Eastern NSW (SENSW)
South Western Sydney (SWSYD)
Western NSW (WNSW)
Western Sydney (WSYD)

To ensure a spread of participants across a range of remote, rural, regional and urban locations, the selection matrix also took into account the five remoteness areas (ASGS RA category) into

which NSW is categorised: major cities, inner regional, regional, remote to very remote, as Figure 2 shows.

**Figure 2**. Remoteness areas in NSW




Practices located in each remoteness area in the ten PHNs, where they existed, were targeted to collect responses from a range of demographics and different types of practices, with variable access to resources and practice barriers in relation to geographic location – see Table 1 for remoteness areas with practices for each PHN (X = practices found; grey = PHN does not include this category):

Table 1. Distribution of practices in ASAG Remoteness categories across PHNs

| PHN | RA-1 Major Cities | RA-2 Inner Regional | RA-3 Regional | RA-4 Remote | RA-5 Very Remote |
|---|---|---|---|---|---|
| CES | X | X | | | * |
| HNECC | X | X | X | X | |
| MURRUM | X | X | X | X | |
| NBM | X | X | X | | |
| NC | X | X | X | | |
| NS | X | X | | | |
| SENSW | X | X | X | | |
| SWS | X | X | | | |
| WNSW | | X | X | X | X |
| WS | X | X | | | |

* Comprises Lord Howe Island and Norfolk Island (no general practices identified)

Two locations from each remoteness category were chosen in each of the ten PHNs (where these categories existed), including with one a Decile 1 (Most Disadvantaged in the SEIFA Index

of Disadvantage by SA1) area. This yielded 43 recruitment locations across the PHNs, although each location varied in geographic scale, population size, and the number and range of general practice types.

Recruitment options were greater in the category of major cities, with large numbers of listed practitioners and practices to choose from. In remote and very remote areas however, recruitment was restricted for three reasons: by the lack of practices; the existence of an Aboriginal Medical Service (AMS) as the only practice, for which the project did not have ethical approval; or a clinical practice attached to the local hospital and serviced by a Visiting Medical Officer (VMO).

## Pilot interviews

A stratified sampling method was employed, based on a matrix of variables, such as, following insider leads, snowballing, recruitment through PHNs, and cold calls. The interview protocol was piloted with two GPs in December 2016 and January 2017, with minor amendments made to include questions about GPs' awareness of health promotion campaigns, and what they saw as the underlying pre-determinants for YPSH as well as protective factors for those who cease SH (see Appendix 3).

## Recruitment and data collection

To meet the target of 40 interviews with a range of GPs in NSW, two geographic locations (one being SA1) were identified in each remoteness area in each PHN. The Healthshare 'Find a professional' search engine was used to generate a database of potential participants. Between January and July 2017, practices were systematically telephoned to invite GP participation, with between two to three, and sometimes up to six, follow-up calls and emails sent with an attached information sheet and informed consent form after the initial contact (see Appendix 3). This strategy yielded only two participants however; the lack of success attributed to the difficulties in speaking directly to GPs, due to time constraints or screening by practice managers, some of whom suggested that the respondent would likely be a woman GP. This pointed to an assumption that more women GPs than men would see YPSH, possibly to align with the perceived greater occurrence of SH in girls than boys.

To increase recruitment, the study team devised two new strategies: an online survey with open-ended questions that mirrored the interview protocol, and exploratory fieldtrips in which one of the team dropped in to general practices within the targeted locations of each PHN and conducted on the spot, in-depth interviews with consenting GPs. These strategies proved highly effective. Ethical guidelines were strictly followed during the research process: participants signed informed consents (see Appendix 3) and gave permission to audio-record the interviews. All interviews were transcribed verbatim, with identifiers removed and pseudonyms assigned. The two exceptions were Dr Duncan MacKinnon of the Bega Valley Medical Practice who established the innovative Teen Clinic, and the services directory compiled by a community worker through a practice in Cobar.

In total, 48 practitioners participated: six were interviewed by telephone, and 33 face to face, while nine completed the survey. Interview duration ranged from between 16 to 50 minutes, averaging 27 minutes. Surveys were conducted electronically using SurveyMonkey, with responses averaging 12 minutes. 38 Interviews were conducted by one of the research team, while one interview was conducted by another member, who also set up and collated responses from the online survey.

## Analysis

Interview data were thematically analysed independently by two of the research team to identify patterns and themes [28]. Each researcher developed an analytical framework shaped by the research questions, and looked for themes, sub-themes and associations between them to explore practitioners' knowledge and attitudes towards SH and map the referral pathways GPs used in treating YPSH. The range of responses in each theme were summarised, and the common referral pathway mapped (see the findings section in this report).

The text analysis feature in SurveyMonkey was used to categorize open-ended responses and its built-in reader was used to produce a summary report of responses, tables, crosstabs and charts.

Subjective interpretation is necessarily involved in the analysis of qualitative data, which were contextualised within existing primary health mechanisms that facilitate and constrain GPs' responses to young people who SH, with inconsistences resolved by the chief investigators.

## Types of general practices participating in the study

- **Super clinics:** with 10 or more FTE GPs, some with specialists;
- **Medical centres or medium size practices:** with between six to nine FTE GPs;
- **Small practices:** with between two and five FTE and part-time GPs;
- **Sole provider practices:** with one full-time GP and/or one part-time GP.

# Study limitations

- The study does not claim to be representative of all general practices in NSW. This is due in part to the paucity of practices in remote and very remote areas that often hosted Aboriginal Medical Services (AMS), for which this study did not have ethics approval, and in part to the recruitment strategies of drop in fieldwork trips and self-selecting survey responses.

# Key findings

The four sections that follow report the key findings emerging from the data analysis, structured by the research objectives. Section 1 addresses objective 1 by documenting the current knowledge base of GPs and their experiences with YPSH. Section 2 addresses objective 2 by describing the range of GPs' practices and responses to YPSH, mapping a common referral pathway, and identifying the barriers to and facilitators of the effective provision of care to such clients. Section 3 addresses objectives 3 and 4 by exploring the health promotion and information strategies and resources used by GPs to support and treat YPSH, and identifying potential educational approaches to improve practice. Section addresses objective 5 by presenting two case studies of innovative models emerging from the research that have the potential to be extended to general practices across the primary health networks in NSW.

Each chapter is structured first, with a list of key findings, followed by key themes identified in the data, and exemplified by interview excerpts. Pseudonyms are used in these excerpts to maintain practitioners' anonymity, while the locations are identified by remoteness area only to de-identify the practices in which they work.

# 1. Current GP knowledge base and experiences treating YPSH

## Summary of key findings

- Self-harm in adolescents is prevalent across all PHNs and remoteness areas, with all participants reporting multiple experiences treating such clients
- Socio-economic status is not always an indicator of risk, although poverty and geographic isolation are often contributing factors in the occurrence of SH in young people
- Self-harm is more common among adolescent girls than boys, and usually occurs between the ages of 14 and early twenties, although sometimes as young as 10
- GPs see self-harm as a response to or manifestation of mental distress or mental illness in young people
- Self-harm was seen as a sub-optimal coping mechanism to distract from mental anguish, and deal with perceived and real pressures, such as family and relationship breakdowns, social isolation irrespective of geographic location, lack of self esteem, poor body image and self-esteem, frustration, bullying, lack of life direction and/or employment prospects
- Most participants see self-harm and suicide as different phenomena, although they screen clients for risk of both further self harm and suicide
- Specific adolescent mental health training for GPs was seen as lacking, but essential, because mental health more generally was considered a core issue in general practice.

This chapter addresses objective 1 of the study, by reporting on participants' current knowledge base in general practice relating to YPSH. It begins by outlining the demographic characteristics of participants in the study overall, and those that were interviewed; then describes their client base and presentation; reports participants' understandings of SH and what they saw as the role of GPs in treating YPSH; and concludes with what practitioners saw as the underlying pre-determinants for SH and the protective factors for young people who cease SH.

## Participants' demographic characteristics and practice types

48 practitioners from 42 general practices across the ten PHNs participated in the study, of which 45 were GPs, 2 were Practice Nurses and 1 was a Community worker. Practitioners in all five remoteness areas across the ten PHNs are represented in the study (see Table 2). In the very remote and remote categories, only a small number of practitioners were recruited. This is partly because of the lack of practices in these areas, or where they did exist, were closed when visited; and partly because they were alternative therapies centres, hospitals or Aboriginal Medical Services (AMS), the latter for which this study did not have ethics approval.

Table 2. Distribution of participants across Remoteness categories of the 10 PHNs (grey = either remoteness area category non-existent in PHN or no practices; white = no practices recruited)

| PHN | RA-1 Major Cities | RA-2 Inner Regional | RA-3 Regional | RA-4 Remote | RA-5 Very Remote | Per PHN |
|---|---|---|---|---|---|---|
| CES | 2 | 1 | | | | 3 |
| HNECC | 2 | 2 | 4 | | | 8 |
| MUR | | 2 | 4 | 1 | | 7 |
| NBM | 1 | 3 | | | | 4 |
| NC | | 3 | 2 | | | 5 |
| NS | 2 | 1 | | | | 3 |
| SENSW | 1 | 2 | 3 | | | 6 |
| SWS | 2 | 2 | | | | 4 |
| WNSW | | 1 | 3 | 1 | 2 | 7 |
| WS | | 1 | | | | 1 |
| **Total** | **10** | **18** | **16** | **2** | **2** | **48** |

Of the 48 study participants, 44 were permanently employed in a practice, two were locums with a broad range of experience in general practices in NSW and other states, one GP was a Visiting Medical Officer (VMO) in a regional hospital with an attached general practice clinic, one was a GP in a HealthOne centre who had also previously worked in the Royal Flying Doctors' Service. Many GPs also had had experience treating YPSH in hospital Emergency Departments.

Of the 39 practitioners interviewed face to face or by telephone, fifteen were women and 24 were men. Their ages ranged from 34 to 87 (average age 55.8), with between one and fifty years in practice (average 18.9 years). Practice types varied, with twelve interviewees working as solo practitioners who had been in the same practice for many years, sixteen working in small practices with two to five GPs, six working in multi-practitioner medical centres with six to ten GPs and two working in GP super clinics with more than ten practitioners. Many practices employed part-time GPs, registrars and locums at any given time. The majority of the GPs were Australian trained, as illustrated in Table 3.

Table 3. GP training location [n=38: community worker excluded; survey respondents not included as these data were not collected]

| Australian trained | Overseas undergraduate training, postgraduate training in Australia | Overseas trained |
|---|---|---|
| 26 | 9 | 3 |

## Client base and presentation of YPSH

All practitioners reported having treated YPSH, with a small number relaying past experiences where they had not seen such clients recently. Their responses align with the responses of practitioners currently treating these clients.

Of the YPSH participants had treated, most were girls aged between early to late teens up to the early twenties, with some clients as young as ten.

> "They tend to be 12 to 18 year-old females, high school aged females, they're the ones who seem to be the typical cutters, that's my impression" [Martin, major cities].

> "Late high school. I think that's when they are most vulnerable in what, dare I say, tends to be a bit of a jungle in the female side of the playground. I would say the majority are from about year 9 onwards, female, definitely, boys are a minority when it comes to self-harm. I think they tend to display their unhappiness in other ways, but I don't, no, I don't tend to see boys" [Richard, major cities].

Some GPs reported seeing boys, with a few seeing an equal mix of both boys and girls in the age group thirteen to eighteen.

> "We see a mix of boys and girls, there's actually not so many people with major depression, most of them are personality disorders who do self harm. If they're teenagers, they have lots of family issues, family history of depression, things like that. Yeah, boys and girls, a mix of both" [Natasha, inner regional].

Catalysts for presentation were usually a marked change in mood or behaviour, picked up by a parent, family member or school counsellor, often with the young person reluctant to see the GP, or once there, to volunteer information.

> "Dragged in by a parent, occasionally brought in by a friend, occasionally by themselves, but probably most commonly by a worried parent. Generally they won't volunteer the information that they've been self harming, generally I have to ask about it and occasionally they'll deny it but then in follow up, they'll say I have been for a while. So family don't always know, they just know that their behaviour's changed, they're withdrawing, they're not interacting as much as they were before. Sometimes they're refusing to go to school, those kinds of things" (Linda, regional, LSES).

> "Often they might have been brought in, it's not necessarily their idea to come in, so there might be a bit of resistance. They sort of sit there glumly, looking at their parent to give the responses" (Katherine, regional).

SH strategies were reported as mostly cutting for girls, often with razor blades, compasses or pencil sharpeners, and occasionally burning. Cuts were described as weak or superficial 'scratches' along the forearms, wrists or thighs, while evidence of previous SH was sometimes identified during physical examinations by scarring. Occasionally, GPs reported having to suture open wounds, but this was less common.

> "There's lots of people who come in who've self-harmed, sometimes acutely, sometimes they've just got scars all over their arms and things like that" [David, major cities].

Rather than superficial cutting, boys were seen as more likely to engage in alcohol and drug abuse, risky sexual behaviours, and dangerous driving. This suggests there are differences in how GPs define SH, which was confirmed in some of the interviews.

> "Mostly they are female. More that fourteen, fifteen, sixteen age group, that difficult age group. Boys do it for good, they go and drink alcohol and do it for good. And then one can talk about anorexia, is that the ultimate act, beside suicide, of self harm?" (Sally, inner regional, LSES).

Socio economic status was not considered to be a major factor in YPSH in city and suburban areas, although it was seen as a contributing factor when the practice was located in low socio-economic communities, particularly in regional, remote and very remote areas.

> "I think some of the things is poverty and low socio economic status and maybe social isolation, because people go to Centrelink, most of them are rejected, and I've had people come here and say I've applied for too many jobs and they can't get a job, so they really get depressed and they don't know what to do" [Arun, inner regional, LSES].

All GPs reported they saw SH as a mental health issue, although they also said the primary presentation was never for SH. Instead, adolescents presented with either relatively trivial concerns, such as a sore ear, or for a prescription renewal, or were brought in by a concerned parent or relative worried about mood changes, uncharacteristic violent behaviour or school absences, or for anxiety or depression.

> "Girls usually present feeling quite anxious or depressed, often there's a bit of school issues, school bullying in groups, all that kind of stuff, dysfunctional families and what not" [Paula, major cities, LSES].

## GPs' attitudes towards and understanding of YPSH

This section addresses two sub-themes: first, GPs' understandings of self-harm and why young people engage in the behaviour, and second, what they saw as their role in treating YPSH.

Without exception, respondents claimed they were unable to make sense of SH themselves, although they recognised the behaviour as a coping mechanism, a way for young people to deal with negative social concerns manifesting variously as: impulsive, perverse punishment; secretive behaviour; rebellion not dissimilar to getting tattoos or piercings; a response to bullying; lashing out at those that love them; an accumulation of emotion, anger or frustration turned 180 degrees onto themselves; and that it should be taken seriously.

> "I don't really understand it myself, but recognise that it is a way that they manage to continue to function and manage to keep their act together, it is a management strategy that often is successful at preventing escalation of a possible mental health crisis" (Duncan, regional, LSES).

> "Often it doesn't completely make sense and seems to be a reaction out of sync with the real problem or the severity of the problem it seems to be" (Ron, inner regional, LSES).

While SH was seen as a mental health issue, not all GPs saw it as an indication of mental illness. GPs variously described SH as a call for help, an expression of unhappiness, a feeling of being overwhelmed, isolation, loneliness, unresolved issues, being in distress, desperate, turning inward, being stuck or experiencing stress, manifesting in 'abnormal', 'maladjusted', 'maladaptive' or 'sub-optimal' behaviours. SH was seen as a suboptimal mechanism young peopled used for dealing with feelings, due to a lack of problem-solving capacity.

> "I think if they haven't been taught some other life survival skills, then that can sometimes be a place they go if they haven't got any other strategies to deal with what happens in life. And sometimes helping them to find other ways of, ok when I'm stressed, I can do these other things that are more productive and helpful, rather than going back to actually injuring myself" [Marcia, regional, LSES].

> 'A somaticisation of anxiety such as migraine or irritable bowel syndrome, it's a way that people manage to function and reduce their stress levels or anguish' (Duncan, regional, LSES).

Some GPs recounted what clients had told them about why they SH, as a way to explain their own understanding:

> "They are often struggling with all the stresses that are going on in their lives at the time, and often that feeling of helplessness and feeling overwhelmed and that's their way of managing it, because they feel that it's a release for them, and it helps with the bottling up of what's happening, that's often how they explain it" (Linda, regional, LSES).

> "Why do they do it in the first place? It's to release some built up emotion, and it just comes to a crisis, and I suppose it's better to do that than to do something more nasty. They're in such a deep dark hole, they lack the maturity and life experience to know that there is potentially life after this, that it's all here and now and how they feel and they can't seem to get themselves out of it" (David, regional).

> "It's the outlet of pain for some of them. There was a patient of mine who said that, and I will never forget, she said that no amount of physical pain would be more than the mental pain she had" [Marguni, major cities].

In some cases, GPs saw SH as a way of signalling to those around them that they needed help.

> "Well it's a signal that they want help I think and that they've got an accumulation of unexpressed emotion that arises from whatever they've been given as a prior nature and by lack of nurture. They find themselves in the soup and unable to manage it so they do things to themselves to make themselves noticed I suppose" [Malcolm, inner regional].

Some drew on their philosophical or existential understandings to make sense of the behaviour.

> "Self harm often happens in those situations where their lives have made them numb in a way and it's almost like an attempt to feel something, harming yourself is some way of saying, I'm alive, because there's just that deadening, deadness, a feeling of deadness in people, it's sort of an existential thing' (Katherine, regional).

> "Someone who's on the spectrum of no longer respecting your own body, or trying to deface your body in order to draw attention to other people who thought you were a great person and you are destroying that image of someone else. A negativity, a nihilism, it's hard to say" (Dirk, inner regional, LSES).

Yet other GPs suggested that adolescents themselves were sometimes unable to explain why they self harmed:

> "They look at you and just shake their shoulders and, I just do it, so you find that there is no rationale behind it" (Motek, inner regional, LSES).

The sense was however, that SH was not linked to socio-economic status.

> "Some of these girls are coming from what I would have considered fairly stable, happy families, and it's the last thing that parents expect and it would probably would be the last thing I would have expected to see them presenting for. It's not something you expect an otherwise intelligent, fairly well together person to do, because it does seem very maladaptive type of behaviour to someone like myself who would never think to do that' (Ron, inner regional, LSES).

Some GPs saw SH as "an expression of an organic disease" (Tarek, very remote), "poor adherence to medication" (Luke, remote, LSES), in the case of underlying mental illness, ranging from relatively minor to severe, such as: anxiety, depression, borderline personality disorder, bi-polar or acute psychosis. While one practitioner saw SH as "abnormal, dangerous and trendy: (Candice, regional), it was not always seen as a sign of mental illness.

> "I think self harm isn't normal, I think it's unhealthy, I think it's dangerous, I think it's trendy, but not everybody who's self harming, in my opinion, would have a diagnosis, so that's how I see it" (Candice, regional).

Secondly, although GPs reported not being able to understand SH per se, they recognised that mental health issues in general, not just for young people, are increasingly central to general practice.

> "I think there's quite a big recognition that mental health has been going on at a younger age, much of the focus is around the adults, but it's both, some patients have it quite a bit too late" (Luke, very remote, LSES).

Thus the role of the GP was seen as central to the identification of mental health issues, risk assessment of further self harm or suicide, hands-on treatment through counselling or

medication, referral to a private or public psychologist or acute setting, and general support for YPSH and their families. This was variously described as a first point of contact or port of call, medical home, care manager, place to go for direction, mental health 'champion', monitor [of progress or deterioration], being the 'control room' [for their care]. Most GPs described what they did as treating the whole person, by starting the process of talking to find out what was going on, reasoning, eliciting previous treatment and whether they had accepted support, and generally nurturing adolescents and their parents through particular crises, and support the young people to 'move away' from self harm activities.

Despite the lack of understanding of SH, respondents did however, without exception, describe ways they navigated their lack of understanding by talking to the client and being empathetic and non-judgemental to build rapport, for example: "helping them where they're at, be accepting"; "connecting with them at some level by talking about something they're happy to talk about"; "it's a choice in the way they've dealt with a crisis, not a 'should'"; show they are "always willing to talk/listen, and foster a belief they are 'valuable people'"; "don't be judgemental, be supportive, find alternative techniques to ally anxiety or feelings of helplessness"; and "ensure resources deployed are optimal".

> "I would just say that I understand that they're doing this for such and such a reason and that the whole aim of our treatment program will be for them to come up with a technique to find some other way of coping with those issues other than self harming, but that I'm not going to look poorly upon them because of what they do, but it's something that we would prefer them not to do and that we need to distract that into some other ability to cope' (Ron, inner regional, LSES).

GPs in rural, regional and remote towns, and sometimes urban centres, reported their role as supporting the whole family as well as the adolescent, with some referring them to family therapy, primarily because of the familiarity built up over many years, which in some cases, meant having treated three generations in a family. Such GPs saw themselves as being ideally placed as someone who knows what and where local resources are, yet locums, registrars and GPs new to a practice or area reported that finding local resources was difficult.

Many respondents also stated that treating young people in general, and those who self harmed in particular, was 'challenging' for a number of reasons, including: general practice is not very friendly for adolescents; teenagers are "difficult" because they miss appointments, don't always acknowledge there is a problem, and often exacerbate the situation through drug and alcohol abuse; and self harm is often difficult to identify because adolescents cover it up, or do not always tell the truth. In some cases, this meant having to "dig" by first establishing a rapport, then direct but gentle questioning about whether they may have wanted to hurt themselves, nor no longer want to be here (see the Practices section for more details).

Some GPs stated that they did not feel "entirely confident" or have a "specific interest" in counselling mental health clients, while others wanted to be informed of treatment and presentations – "the whole" – even if they were not counselling the client themselves, so they could use the knowledge to guide their interactions with them. This is captured in one practitioner's statement:

> "I believe that general practice should be over all things and have an awareness of all things, but I don't think they have to do all things" (Sally, inner regional, LSES).

## Underlying pre-determinants of SH

Five underlying pre-determinants or contributing factors to SH were identified: social background and relationships; education and employment opportunities; physical and emotional wellbeing and resilience; mental illness; and drug and alcohol abuse.

The first factor can be understood as primarily social, located within the home, school or peer environment, but not necessarily related to low socio economic status backgrounds. This included: childhood environment, family dysfunction, emotional and physical abuse or being witness to abuse; feeling left out of blended families; or financial issues.

> "Often they are from broken homes and [suffer] poor self-esteem and abuse in the background of emotional and physical whatever, you know" [Janini, major cities, LSES].

Absent/dismissive or helicopter parenting; traumatic experience or homelessness; lack of positive role models, supportive but strict family; parental instability; family, relationship or friendship breakdowns; social isolation, bullying and cyber bullying, feeling left out or alone.

> "Particularly with the girls, they usually present feeling quite anxious or depressed, often there's a bit of school issues, school bullying in groups, all that kind of stuff, dysfunctional families and what not" [Paula, major cities, LSES]**.**

For remote and very remote communities, geographic isolation, ostracisation, no social network, racism, parochialism in country towns, cultural difference, lost youth; and SH may be seen as a way to cope or signal a need for attention.

> **"**I think in some situations it might be more environmental and cultural in that if a child is in a community or a school group where other children are cutting, it may seem to be an appropriate thing to do, or if a child is in a situation where they may not be getting the attention and they cut, then that might get them that attention" [Peter, regional].

A second and related factor was education/employment: learning difficulties and behavioural issues, level of education, poor school performance or stress, changing schools, lack of employment opportunities and social activities, poor behavioural management in schools.

> "Some of them have other learning difficulties or behavioral problems connected up with it as well and are finding it hard to fit in" [Marcia, regional, LSES].

Third, physical wellbeing, self image and low social capacity, related to immaturity and vulnerability: low self esteem, feeling worthless or empty inside, numbness; poor body image; sexuality; high expectations or perception of family pressure; poor communication, limited problem-solving skills and lack of alternative mechanisms/strategies; poor sleep habits; pregnancy; poor coping or life skills or resilience; desperation, transition to adolescence, puberty; and unrealistic expectations about being happy all the time.

> "Most of them struggle to vocalize why they're actually self-harming. I think the majority of self-harm is that because they're in such a deep, dark hole, in terms of things like cutting as opposed to attempting suicide, cutting, pinching, scratching, all of those things, there seems to be a sense of, well I can physically feel something and that's better than feeling nothing at all" [Paula, major cities, LSES].

Fourth, mental health illness: family history, mental pain or anguish, distress, anxiety, depression, borderline personality disorder, eating disorders, bi-polar, psychosis, mood changes, PTSD.

Finally, substance abuse of alcohol and drugs, and engagement in risky behaviours such as dangerous driving, although there is some contention as to whether such behaviours can be considered accidental, SH or suicidal behaviour.

Others, there's drug and alcohol fuelling issues, or I guess adding to the issues"

## Protective factors for clients who cease self-harming

Three key factors were identified as common to young people who stop self-harming: supportive social networks; maturity and insight gained from life experience; and access to education and resources to support them.

First, social assets, which was seen as having a supportive network: family and peers/friends, stable home environment, strong relationship with mother or at least one parent, someone they can call to talk to, enough space to explore how they feel while being supported, getting a job, new relationships and positive experiences.

> "Supportive friends and family that aren't too in their face, so they're supportive but they're not too supportive, not hovering, not going every two minutes, have you hurt yourself, how you feeling now? And that have given them the space to explore how they're feeling, while feeling safe, feeling supported" (Linda, regional, LSES).

Secondly, maturity, including: life experience, they often grow out of it, gain perspective, develop insight and self awareness, recognising people love and care about them, as well as improved self esteem and self-respect.

> "It can be in a stage, a period of time they're doing self-harm, because interestingly enough, I feel the patients that come to me, they had self-harm issues in the past, like in their teen years, but they don't do it now. I think not just two or three, a lot of them say, I'm not doing that now" [Michael, inner regional, LSES].

> "I think if you've got reasonably good insight into what's happening, why it's happening, you've got a much better chance of getting on top of it. If they can improve their self esteem, I think that's one of the main things, if they think they're worthless, then hurting themselves doesn't mean very much to them, whereas if they've got better self esteem, they're less likely to do it" (Derek, inner regional).

Thirdly, access to education, external resources or support strategies: productive and helpful alternatives to SH, drug education, a safety plan (Kids' Helpline, for example), GP support, academic success, realistic goals, healthy substance use, tools to manage mental health (such as mindfulness).

> "With that girl last night, she had a lot of healed scars that weren't recent so maybe she's moved on from that" [David, major cities].

> "If a young person's previously engaged in a community mental health service such as Headspace they might have a safe environment where they can fuel some of their anger and frustration or their emotional turmoil and have a way of venting it rather than having to resort to activities such as cutting. I imagine by that same thought process that if a young person had a health practitioner within the community that they felt they could gain support from, it might prevent cutting" (Peter, regional).

However, GPs also expressed uncertainty as to which approach or strategy helped adolescents to discontinue self-harming:

> "Most of them seem to get through it. Whether that is because of the counselling or to what degree the counselling has helped them, how much of it is just maturity, how much of it is the patient learning that the self-harm is counter-productive, I don't know, that's the conundrum I suppose" (Richard, major cities).

## Perceived links between suicide ideation and SH

There were varied and sometimes somewhat contradictory responses to the idea that SH and suicide were linked. On the one hand, many GPs reported them as being separate entities, in which presentation, demographic and consultation was distinct, yet they also seemed to suggest that there were "degrees of self harm". This indicated they saw a continuum between SH and suicide, whereby the underlying risk factors and thought pattern or 'mechanism' were the same, with SH at one end and suicide at the other – "cut yourself rather than kill yourself". Some GPs who saw them as separate behaviours however, expressed concern they had not 'misjudged' and that clients would not "go to the next step". On the other hand, some GPs were adamant that the motivation for suicide and SH are unrelated: the latter was a cry for help or a way to relieve angst, while the former was an intention to 'end it all'.

> "She was saying, I don't know, I just feel sad that I don't fit in, and that she was different and she can't cope with the same things that everybody else seems to be able cope with. She still wanted to be alive and was enjoying some things in life, like her pets, she hadn't let go of life" [Marcia, regional LSES].

Regardless of how they saw the link, all participants reported that they always screened clients for risk of further SH or suicide, and some even expressed concern that they had not "misjudged and missed anything". While one GP had seen clients in hospital emergency departments who successfully suicided, the general feeling was that SH rarely signals a desire to end life, but is a mechanism young people use for coping with mental distress.

> "Self-harm, especially among young females, tends to be a way of relieving the symptoms, rather than actually wanting to kill themselves" [Derek, inner regional, LSES].

> "Self-harm is just an expression of unhappiness. Like kicking the dog, or driving a car too fast, or drinking too much, self-harm is clearly, short of suicide obviously" [Richard, major cities].

> "It doesn't look like suicide, so they're not in the self-harming situation wanting to end it all, but they're certainly wanting to make some sort of a signal, to punish themselves perversely, but certainly a cry for help" [Malcolm, inner regional].

In fact, one GP said he would be more worried by an unhappy teenager who displayed no outward anger or other symptoms, but who may nevertheless be vulnerable to suicide:

> "I get scared more with a patient who's not self-harming, but who may be scheming something else that they're not displaying, rather than a teenager who comes in with marks on their wrists. As much as it's a cry of help, I don't see it as a prelude to doing something final. I may be misjudging, or hope I haven't missed too many, but as far as I know I haven't been fooled yet by a young person who just does self-harm" [Richard, major cities].

While few participants reported having clients who successfully suicided, one GP working in a hospital emergency department described cases of SH that "escalated" to suicide attempts:

> "You have got very bad outcomes where it escalates from just simple cuts, to now somebody tries to move on to the bad things like attempted suicide by taking tablets or trying to hang themselves. It happened to me, one of my patients went on to other things, tried to kill themselves in their sleep, taking a lot of Valium, or someone comes in with very bad markings on the neck now, trying to hang themselves and I have lost some patients" [Mark, major cities, LSES].

Some respondents suggested that some successful suicides might be accidental, although not having seen the statistics on links between suicide and SH, many considered boys more likely to "be serious" than girls.

> "Usually the boys are much more definite about it, the first instance you get is that they've done the ultimate self-harm. The girls seem to spend a bit more time self-harming and I'm not as aware of the young female suiciding, so to say that ipso facto there's a direct link, but one would think the same mechanism's sort of going on, is life worth living? No, it's not 'is life worth living', but 'I can't feel anything or I feel so low, or nobody loves me and I need to feel something, so I'll feel something'" [Sally, regional, LSES].

## Summary

In summary, while GPs reported not being able to personally understand SH, they recognised it as a symptom of mental anguish, if not mental illness, in young people, which required their empathy and serious attention. GPs saw mental health as central to general practice, and the role of the GP as essential in supporting YPSH while linking them with specialist services. Five underlying pre-determinants were identified as: social background and relationships; education and employment opportunities; physical and emotional wellbeing and resilience; mental illness; and drug and alcohol abuse; while three key protective factors were identified: supportive social networks; maturity and insight gained from life experience; and access to education and resources to support them. Finally, the link between SH and suicide was somewhat contradictory; while many GPs saw them as separate entities, they screened for both, and expressed concerns that they had not "missed anything"; and while all respondents had clients who had self-harmed, only one reported having had a client who had successfully suicided.

# 2. GPs' practices and responses to YPSH

## Summary of key findings

- YPSH rarely present to GPs by themselves, and are usually brought in by family or friends
- More girls than boys SH, although some practices see an equal mix of both
- Presentation is rarely for the physical act of SH, only where suturing is required for wounds
- GPs' responses to YPSH can be categorised into four key practices:
    - Identifying, which involves screening for mental illness and risk of further harm by establishing rapport and asking direct or indirect questions
    - Treating, which involves the GP undertaking hands-on strategies, depending on their skills, time and interest, such as talking and listening, counselling, basic CBT, alternative therapies such as mindfulness exercises, and monitoring through follow up visits; prescribing medication also occurs, although GPs were divided on its efficacy
    - Referring, which involves linking to specialist psychologists, psychiatrists, family therapists in the private sector, community mental health teams, and youth-specific centres such as Headspace
    - Discharging, which involves either active release into the care of family, friends or a clinical facility; or de facto, which involves 'dropping off'
- Outcomes of SH are often unknown, yet completed suicides are rare; GPs assume the behaviour stops, attributed to 'growing out of it', or the adolescent moves to another practitioner; some GPs get indirect feedback from family or the community, and some from specialist services
- GPs face multiple barriers to practice, categorised as:
    - Limitations in their own attitudes, skills and interests;
    - Material barriers to clients, such as cost and geographic distance to services;
    - Limited client and family capacity: reluctance by young people to seek care; stigma around mental health issues;
    - Limited time and remuneration in the general practice model of care;
    - Complicated and ineffective assessment and referral processes and mechanisms;
    - Shortage of or limited access to, follow up and feedback from support services; and
    - Lack of research into YPSH.
- Factors that facilitate effective provision of care are few, but include:
    - Timely access to locally available resources and treatment services, such as specialist mental health teams;
    - Peer, family and community support networks around the young person.

This section addresses objective 2 of the study by reporting on the range of GPs' practices and responses to YPSH. It begins by outlining the range of pathways taken to the GP by YPSH, followed by a description of five common practices in which GPs engage once the client has made an appointment and a map of the referral pathway consistently used by GPs across NSW to link YPSH to specialists in their area, depending on the range and availability of services. This is followed by an outline of reported client outcomes, and concludes with what GPs see as the barriers and facilitators in general practice that respectively restrict and enable the provision of effective care for YPSH. It is important to note that this section addresses all participants, except in the case of the referral pathway for the Bega Valley Medical Practice's Teen Clinic (see section 4, case study 1).

## Presentation pathways to general practice

Pathways to care by YPSH generally began with being accompanied to the GP by a parent or relative, usually because they had noticed a change in mood, often after a relationship or friendship breakdown, or in extreme cases, because of school absenteeism or uncharacteristic engagement in violent or risky behaviours, or as a follow up once discharged from hospital for presentations involving, for example, substance abuse or as a result of a car accident.

> "They're often dragged in by a parent, or brought in by a friend, generally don't volunteer information they've been self-harming, and will deny it when asked, but will disclose in follow up consults. The family doesn't always know, but noticed they've withdrawn, or refusing to go to school" (Linda, regional, LSES).

> "They will come for relationship issues or other issues, but not because they're self-harming. What the nurses then pick up is that level of demonstrable anxiety and with that they'll pick up the self-harm stuff. Most people won't come in and declare self-harm, only if they're pushed to" [Duncan MacKinnon, Teen Clinic, regional, LSES].

GPs unanimously reported that the physical act of SH was *never* the reason for presentation.

> "Self-harm is generally part of the picture of what's going on, I can't think of anyone who's just come in and said, oh they're just self harming, there's nothing else going on, there's usually other things happening" (Linda, regional, LSES).

On the whole, GPs reported only minor differences in how boys and girls who self-harm presented, although once there, there were inconsistencies about which were considered more difficult to engage.

> "The boys, they tend to get brought in by their mum because they're just very sullen and quiet and they've been a lot more difficult to engage, and taking quite a few consultations to get to the point where I can get more information" [Paula, major cities, LSES].

> "Teenage females are probably the hardest people to get those straight answers out of" (Ron, inner regional, LSES).

In some cases, a parent will come to the GP to seek advice about something they may have noticed about the adolescent, such as changed behaviour or scarring.

> "Often the parents would ring me or come into the consultation first and say I'm worried about so and so, they're doing this or they're doing that, and usually you can then see marks up and down their forearms or, if not, they'll say, this is what I've witnessed when they've seen them undressed" [Richard, major cities].

Some adolescents were referred by their school, or presented on discharge from a hospital emergency department following an incidence of SH, or after interaction with police.

> **"**The school might send you an email saying, when you see this person, these things have been happening. So it's sort of an informal heads up" [Marcia, regional, LSES].

> "They've ended up in Accident and Emergency because of self-harm and they've been told that they've got to come and see a GP for follow up. So usually it's not self-motivated it's usually motivated either by another member of the family or something that's happened, a crisis" [Derek, inner regional, LSES].

> "In that demographic nobody really presents themselves by themselves. So there's the family alerting the police, or one of the next of kin bringing in the patient" [Luke, very remote, LSES].

Occasionally, GPs reported that older adolescents sometimes seek help on their own because they recognise a level of distress, or because they required medical documentation for school or work absences.

> **"**They often self-refer. I'm having a bad time or something like this, and I want to see somebody, and I want to see this person" [Carolyn, major cities].

> "Some of them have a little insight and realise that things are not going well, or they've been prompted because they're doing university or they've got work commitments and because of their mental health problems, they've come in to get a certificate to get an extension on their assignments or because they can't work" [Derek, inner regional, LSES].

Once there, GPs reported deploying a range of strategies to establish a rapport with the adolescent, which enabled them to respectfully investigate underlying issues manifesting in SH, while assessing risk of further harm, suicide or mental illness.

## GP practices, responses to and referral pathways for YPSH

GP responses to adolescents they suspect of self-harming have been categorised into four in-practice strategies: identifying, treating, referring and discharging.

**Identifying** involved GPs deploying a number of strategies to screen adolescents for SH, assess their immediate risk of further harm, identify any underlying mental health issues, normalise the incidence of mental anguish, and negotiate treatment, including referral to specialist services. Strategies include the deployment of professional intuition and experience built over years of practice, observation during presentation, questioning, and sometimes the use of external tools, such as such as K-10, DAS and HEADSS (http://www.bcchildrens.ca/Youth-Health-Clinic-site/Documents/headss20assessment20guide1.pdf). Initially, "reading the client" was involved.

> "Sometimes you can pick the vibe. When they come for something else, and you think no, it looks like that's not really what they came for" [Marguni, major cities].

> "I think if one is going through depression, poor performance at school, poor communication skills, someone who cannot communicate, you simply have to investigate. A kid who comes in heavily dressed on a hot day especially a girl, you want to do a really thorough examination" [Mark, major cities].

> "I have a few cases of alcohol at age 15 or 16, so once I've found out about the drugs or the alcohol, the anger as well, as I mentioned, towards the family, will start punching the walls or try to abuse the teachers, that's when I start to get worried about self harm" [Motek, inner regional, LSES].

Many GPs reported the need to build a rapport with the adolescent before being able to identify SH. This generally involved talking to them respectfully, and without judgement or pushing too hard, which often required more than one consultation before the young person opened up. In other words, 'reading patients' to test when to push and when to sit in silence and wait, to open space for the adolescent to speak.

> "You've got to kind of negotiate talking to them, confidentially, just to find out what's going on" [Carolyn, major cities].

> "I try and find something to talk about that I know they're comfortable with. So if the home situation is OK, I talk about home, if I know that school is actually a safe spot for them, I'll talk about school, if I know that they're doing something else, I'll try and find something they're comfortable with, get their confidence up. I always ask them if

someone's coming with them, do you want to see me by yourself? Often, particularly initially they'll say no, ok, so we'll just build up a bit of a rapport" (Linda, regional, LSES).

Some GPs even reported engaging in semi-covert strategies to screen for SH, such as shaking hands so the client would need to extend their arm beyond the cuff of a long sleeve, or during a routine physical examination.

> "I make them comfortable, introduce myself as Charlie so we get on well; I find out about self harm by shaking hands, looking at their hands to see evidence" (Vebna, major cities, LSES).

However, GPs reported that some adolescents were open about what was bothering them, and were keen to seek help.

> "It's interesting, all of them recognized that they were wanting help. None of them was an incidental observation on my part, because sometimes you've got to be a bit clever to identify some evidence of self-harm. But no, all of these kids were recognizing something was wrong, they wanted help, things were going wrong in their lives" [Malcolm, inner regional].

Identifying often involved a range of questioning strategies, decisions about which approach to questioning depended on GPs' previous knowledge of the client, whether they were open to being there and talking, as well as the available time. These ranged from open-ended questions such as 'how are things going', about school, home, friendships, and other interests, to direct questions, such as 'have you ever thought about harming yourself' or 'life is not worth living', or in response to scarring noticed during a physical examination, such as 'what happened there?'

> "I use plenty of open-ended questions and silence and things like that, so just don't say anything, you don't have to fill in the spaces, let them do that" [Martin, major cities].

> "I ask them what they want: what do you want from life, what do you think you will gain from self harm, if you're not happy, how can we help, what support do you want" (Vebna, major cities, LSES).

> 'I ask them, why are you doing this? Do you still want to be alive? What's actually going on?' (Marcia, regional, LSES).

While initial appointments involved the family as well as the adolescent, GPs often reported asking parents to leave so they could speak directly to the adolescent to determine their willingness to divulge information, accept help, engage in treatment, adopt alternative coping strategies, or agree to being referred to a psychologist or counsellor. Central to this strategy was the emphasis on patient confidentiality, through which GPs assured the adolescent that they would not divulge information to parents or others, except where they saw imminent risk or in response to illegal activity, such as abuse. GPs also reported using conversational strategies to normalise feelings of being down or overwhelmed, mental illness, to encourage young people to open up.

> I try and normalise it for patients so they don't feel that I'm judging them or trying to say that they've done wrong, that sometimes when there is excessive stress or there's underlying mental health strain, people don't necessarily think in their normal state of mind and that sometimes may prompt people to do things that they otherwise ordinarily would not and that may have been a primary precipitant for what they've done" [Peter, regional].

Once clients divulged either mental pain or anguish, or 'confessed' to having self-harmed, questioning extended to ascertaining what kinds of support or resources to which clients had access in their existing family, friendship or school circles. This has been categorised as **treating**,

which involved GPs engaging a range of hands-on activities after screening for and identifying SH and assessing risk. These strategies include: outlining what help was available to adolescents; explaining how they worked so they knew what to expect; 'basic counselling strategies', which were described as 'being friendly', 'talking and listening', 'saying I am here to help'; arranging further consultations, described as 'making a pact' to monitor wellbeing, need and care while adolescents waited for appointments with psychologists or programs such as Headspace.

> "Referring them on always takes a while to get someone seen, so I would probably consider giving them at least some support in the meantime and talk to them about some options, whether there's been anything that's precipitated the episode and see if there's anyone in their life that can help them and give them some support" [Derek, inner regional, LSES].

> "If I've already engaged with the patient because I've known the family for a long time, so this is a young person I know and already have a rapport, so a lot easier to engage, and if they're communicative enough and they're willing to divulge, I will try a little to see how I go and whether we can make a pact to say, alright, if you don't do this we can do this, this and this, and I'll see you again in two weeks' time and see how we go. But it is very time consuming and I'd have to feel that I had a fair chance of success for that to happen" [Richard, major cities].

> "I tell them, look these are the issues, okay, no one can take the issues away from you or me, every human being has issues, but how to deal with issues is what you need to learn. And how to deal with the issues in a way which is constructive, which is helpful. I give them simple examples, like problem-solving" [Marguni, major cities].

Treating strategies sometimes involved discharging the adolescent to some kind of care, to friends, family, or even to medical facilities, to ensure that the adolescent was safe from further SH after leaving the consultation.

> "Making sure that their situation is not getting any worse or just more a support basis and a giving them some reassurance and reassuring myself that the situation's still safe and that they're safe at home' (Ron, inner regional, LSES).

> "Some time ago this girl was brought having cut herself, slashed her wrists. The way I responded, I dressed and stitched up the wounds, called in our social mental health worker. I had to send that kid in for admission to the hospital because she had really cut herself deep and it was repeated cutting so there was no way I could send that kid home because she had done it several times" [Mark, major cities, LSES].

Some GPs reported using counselling or psycho-clinical treatment strategies themselves, to increase self-esteem, reduce anxiety or manage stress. These included modified CBT or DBT, mindfulness training, physical exercise, or strategies to raise self-esteem, depending on the GP's professional interests and experiences.

> "I would start getting them to think of their life in terms of values and, then I would say, somebody who has values is a valuable person" (Katherine, regional).

> "I use psychiatrists if they have a mental illness like psychosis, but if it is just depression and so on, I do a lot of my own counselling. I'm not trained, but hey, we are all connected as human beings, and as a human being myself, I just sit back and talk to them. So in this room, there's no judgement, no nothing, just helping another person through" [Tony, inner regional, LSES].

> "For someone with mild to moderate depression, I do the counselling, then I give him the medications, follow up after 3 weeks, if it still doesn't work, bump up the medication, or

> we leave you like that and you need to keep going in the medication for three to six months at least, don't stop it by yourself, or you stop it by yourself, come to me. If I found it's hard to be managed by myself, I need to send to psychiatrist. I'm a GP anyway, I'm the first line of treatment, but sometimes I need some help from the specialist" [Sharif, remote].

Some GPs described helping to establish a 'safety network' of friends, family and community support services, such as mental health teams, but this depended on how well they knew the adolescent.

> "We would look at the history and then we construct a plan, a safety network and mental health teams and psychiatry adolescent, the psychiatry was most of the time tele-health because we had only an adult psychiatrist visiting up there" [Tarik, very remote, LSES].

> "If it's just someone walking in off-the-street with slashed wrists then I'm less likely to want to engage and I would more likely say, alright, clearly there's some issues, I would take a history and get some sort of understanding of where it may or may not be coming from, but then I would probably refer to counselling from there if I felt it was beyond my scope" [Richard, major cities].

Prescribing medication however, seemed to be a polarizing issue, whereby some GPs refused to medicate young people, some were reluctant to do so before a diagnosis of mental illness was confirmed, and some had not seen evidence that medication was effective in young people, while others readily prescribed medication for sleeping, or for anxiety and depression. On the one hand, GPs made their anit-medication views clear.

> "I'm very reluctant to prescribe medication quickly in teenagers and in most of these situations generally because I don't think medication's really the secret" [Ron, inner regional, LSES].

> "I don't push anti-depression drugs in young people because there's not a lot of evidence that it helps. Some younger people do need an SSRI, selective serotonin, anti-depressants, and there is evidence that there are a couple of anti-depressants that can be useful in adolescents who need it, so you need to be selective about which ones you choose because while some have been shown to be useful, the majority have not" [Derek, inner regional, LSES].

> "I don't feel confident in myself for initiating anti-depressant medication in a 14 year old for example, if I thought that they're high risk because of the self-harm or the suicidal thoughts, I refer them to the Child and Young Person's Mental Health and then it's usually the psychiatrist that says, yes let's commence medication" [Paula, major cities, LSES].

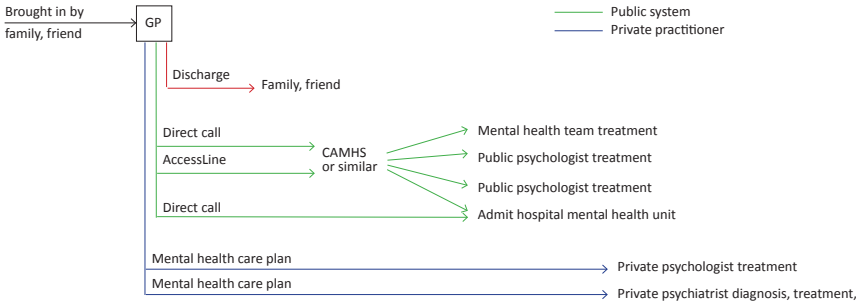
On the other hand, others were comfortable prescribing medication.

> "I talked to her about what were the problems, and they were some family issues which caused her some anxiety, but it looks like she had anxiety first and then that led to the feeling. So I spoke to her and discussed that maybe some medication for anxiety might help and be seen by a psychologist to talk through the matter and after that whether she needs anything else. I ended up putting her on medication and she's OK at the moment" [Kola, inner regional].

On the rare occasion when clients presented with open wounds, GPs reported suturing. One GP reported drug testing clients, to determine whether substance abuse might be complicating a mental health diagnosis. Only rarely did GPs confer with their in-practice colleagues for support with clients. The only practice that formally met each morning was the Bega Valley Medical Practice, which initiated the Teen Clinic (see section four, case study 1).

**Referring** occurred when GPs determined that psychological or other clinical support or resources were needed, beyond what they could provide themselves. These practices varied, depending on GPs' knowledge of and experiences with locally available services and referral pathways. However, a common referral pathway was identified from the analysis of all responses (see Figure 1).

Figure 1. Common GP referral pathway for YPSH (with the exception of The Bega Valley Medical Practice, see section 5, case study 1).




Referral usually involved the GP completing a mental health care plan for the client to see in-practice clinicians through extended primary care, or private psychologists within their local networks, some of whom bulk-billed.

> "You get to know certain psychologists, so you refer to them, just a certain number that I send them to. And if they don't like them, you just send them somewhere else, sometimes they don't click" [Carolyn, major cities].

> "Because I am in a metropolitan private practice which is not linked to the hospital proper, I need to fill in what is called the 721 Medicare item which allows at least 5 visits with a psychologist, with mental health team, and with social workers to be able to follow-up that kid. If I don't fill in a 721 which is like a care plan, then he won't be able to access cheaper, then he would have to be charged for whatever referral I'd make for him" [Mark, major cities].

Considerations of whom to refer YPSH to depended on their availability, as well as cost.

> "We've got some really good mental health workers with experience with kids. I get them going to the mental health team because I know they're going to need multiple ongoing visits, rarely would six sessions at a psychologist be that helpful in terms of that long term and there's very few families that would be able to afford private DBT here" [Linda, regional, LSES].

Depending on geographic location, some practitioners called an AccessLine for, or direct calls to CAMHS, MHEC or CHMET teams for assessment, referral for psychological or psychiatric treatment in the public or private sectors, or medication, although this was sometimes fraught (see below and in the Practice barriers section).

> "If we want to refer to mental health, it's through the AccessLine, they put them into contact with the Community Mental Health services in the nearest urban centre, they

assess them and decide to either send them back to us for us to organise a mental health plan and counselling or whether they will keep them there" [Viapoon, regional].

"If there's community *headspace* teams, I try and get them involved as well in all the adolescent cases," [Peter, regional].

"We organised for her to have an assessment through the psychology school at the university 130kms away, they actually have a psychology clinic where people can go and be assessed. It's not cheap, but often when it's complicated you do need more detailed assessments to be done. She was also connected in with a paediatrician and the paediatricians are very helpful" [Marcia, regional, LSES].

Referral practices extended to include providing helpline information and/or identifying online resources for the client (see Resources section of this report).

"Sometimes I use online resources for the patients, like the moodgym, Beyond Blue, those sorts of things where they can sit down and do things online. Probably not so much with the ten year old age bracket, but perhaps with the older ones, particularly if they're a bit reluctant to actually see someone face to face" [Marcia, regional, LSES].

"A lot of, not necessarily self-harming young people, but young people with mild to moderate mood disorders often do very well with online CBT, and Black Dog's got that, and what used to be called the Anxiety Disorders Clinic at St Vincent's, it's called This Way Up clinic now, they've got fantastic online CBT" [Martin, major cities].

Occasionally, clients or their families identified a clinician to which they requested referral through a mental health plan, responses to which by the GP varied, from either being happy not to find an appropriate clinician, to challenging whether this was the most suitable pathway for the adolescent, suggesting that agencies such as Headspace sometimes conveyed incorrect information, or that parents misinterpreted the information they provided.

"Everyone comes in demanding mental health plans. They come in demanding them. They've got the name they want to go and see, they've all talked about it" [Carolyn, major cities].

"Sometimes the parent will come in and say she's spoken to somebody at school and she wants to have a mental health care plan to Headspace, so that saves me from even having to think much about who to refer them to. It means that they've already thought about it and they've made that decision. I'm not going to disagree with that because it's a sensible decision, and all I would do is support them" [Ron, inner regional, LSES].

In one case as a sole practitioner, a GP reported being advised not to take on mental health clients because of the lack of backup and support for the GP.

"I went to a conference and the psychiatrist was talking, and advised the solo doctor, don't take them on because you don't have a cover, you don't have emergency and you don't have the backup, like if you are not there and the patient's not well, so they need to be in a bigger practice, and they have Skype too, so straight away they put him. So that's why I feel comfortable, if somebody is suicidal, you go to that place, give them the telephone number, the practice, so many doctors there" [Nadia, regional, LSES].

Sometimes, if the GP finds that self-harm is the result of family distress or dysfunction; interventions are required for the whole immediate family, who are referred for counselling.

"We try to treat them as a unit. I mean, there's always some interpersonal problems with the parents and the kid" [Martin, major cities].

Scheduling for acute presentations rarely occurred, although when GPs deemed it appropriate, they reported support as being readily available through direct admission to a local or base hospital, via ambulance, family, police, or the GP themselves if other options were not available, or to specialist centres.

> "The pointy end is the referral centre at Rivendell, where you can have an admission for long-term treatment. They even have a school there so you can actually have a long-term sort of residential treatment program" [Martin, major cities].

> "If it's acute care, it would be facing towards Orange, Bloomfield" [Luke, very remote, LSES].

However, discharge from hospitals after acute admissions was sometimes seen as problematic because the hospital tended to stabilise the client's condition, in the case of drug or alcohol abuse or non-adherence to medication (see Practice barriers section), then release them into the community with little or no support.

**Discharging** strategies ranged from actively releasing YPSH to family or hospital, to a de facto discharge, where many 'dropped off' after one or several consultations.

> "If the patient is really at risk of harm to themselves, they should be discharged into the care of a hospital facility. Or otherwise you can call their friends if they're agreeable, because while they haven't planned any self-harm procedures, they are very vulnerable and could end up having something severely wrong with them" [Janini, major cities, LSES].

> "He kind of lost touch with the practice. It was very odd, because his family had a farm in the country and they said, we're going to take him to our country estate because we feel he'll be safer there, and he sort of disappeared off to the country and I didn't hear anything after that" [Martin, major cities].

De facto discharge often depended on whether the adolescent presented alone or with a family member, and the GP's assessment of further risk of harm after a positive response to medication or counselling.

> "I saw one very young, probably in his early teens, he came back for another reason, probably an injury, and I was quite happy to see that mentally he's much more stable compared to the last time when I saw him, doesn't at all look like he's got a mental health issue at all, he's doing an apprenticeship, doing quite well" [Dobie, inner regional].

## Patient outcomes

Patient outcomes were reported as varied, ranging from good endings where the client either 'grew out of it', or were able to navigate a crisis with medication or counselling, to 'I don't know'; while others acknowledge that in the cases where negative social and environmental influences were evident, the pathway would be 'rocky' for some. However, only one GP reported having a client successfully commit suicide, although others said they had colleagues who had clients who did.

> "Most of the self harmers have stopped as far as I'm aware, it's always hard to know in terms of sometimes they'll stop coming and you don't know if that's because they're seeing somebody else, they've gotten better or they're just continuing to bumble along. But other than a few extreme cases, they've done pretty well" (Linda, regional, LSES).

Often GPs said they did not know of patient outcomes because the referral services did not update them or only did this when the client was discharged. If they did hear back, they attributed good outcomes to psychological support, although they could not be sure if this was

the reason. Mark suggested a good outcome is 'when you don't see them again', Sharif and Sally said 'they grow out of it', Candice said 'most don't come back, so I assume they bumble through', while Linda reported only remembering 'the ones you are still dealing with'. In small towns, GPs often 'ran into' families locally, so had indirect confirmation of good outcomes. Katherine suggested the act of seeking a medical opinion alone was enough to reassure some patients: 'sometimes just knowing there is a reason for their distress helps'. GPs often saw experiences of distress manifesting in self harm as resulting from short-term crises:

> 'Most seem to come out of it quite well, as fairly normal, fairly undamaged twenty year olds, I mean, some of them do go on to develop ingrained anxiety, depression, and a couple of them have even become psychotic in different ways, but that's not the norm. And the family gets back to normal and sort of wonders what it was all about' (Ron).

In some cases, self harm manifested in cycles of relapse and improvement, which required clients' commitment to long-term treatment and/or medication, which did not necessarily involve the GP, as David suggested, 'I'm just a stop along the road', while Nadia described the process as being 'passed around within the public health system' with no outcome. Motek suggested that unless clients returned and had someone in the waiting room to support them, 'by the second, third consultation they drop off. And that's where the problem is'. This supports the idea that adolescents either find it difficult to see the GP, do not acknowledge there is a problem, or refuse support.

Some GPs in remote areas suggested that those who had stable family situations or where a 'proper safety network' was established had better outcomes than those that 'moved around'.

> "Those that choose to stay here seem to have stabilised over the years. Those that went away bounce from one auntie or one mob to another, tend to have poorer outcomes" [Luke, very remote, LSES].

In some cases where GPs involved the whole family, counselling facilitated parents' support of adolescents by opening a space for talking, while some improved with medication and contact with a mental health or social worker. Younger clients often benefited from timely diagnosis and treatment of other, underlying conditions, such as ADD, autistic traits, and learning difficulties.

## Barriers to the provision of care for YPSH in general practice

The interviews explored GPs' perceptions about the barriers that inhibited their capacity to provide effective care and treatment for YPSH. These barriers are organised into seven categories: GP attitudes, skills and interest; material cost and distance in treatment options; client and family capacities; the general practice model of care; assessment and referral processes; support services; and the general lack of research around YPSH.

Firstly, GPs identified a number of barriers arising from **limitations in their own skills or practices**. Some reported not feeling comfortable working with mental health clients, or that the work is too time consuming, emotionally draining or they feel they are not qualified to deal with such clients.

> "It can be quite draining, a lot of GPs aren't trained to do that. I have no specific counselling training, I just go on intuition from what I know, being a parent, I think I relate quite well to my patients, but I know I'm no counsellor, I'm not about to do CBT on somebody, other than trusting my own judgement. I'm going to get them back every week over the next two, four, six, ten, twelve visits, I don't want to divest that much emotional energy into a patient" [Richard, major cities].

> "To be honest, I don't know if that's something I'd want to be doing all day every day, because it is quite draining and depressing in and of itself," [Paula, major cities, LSES].

Some suggested that not knowing which resources were available when GPs are new to a practice or working as a locum can be a huge barrier.

In some instances GPs reported a reluctance to refer to clinicians who medicate, while others suggested there were difficulties in identifying and assessing risk levels (superficial cutting, risk of further self harm or suicide), especially if drug or alcohol abuse was evident. Many reported that often the problems associated with YPSH are more complex than mental health.

> "Sometimes they are a little bit difficult to really engage because of their complicated background. So it takes a few times and they sometimes do have other issues and then they just don't come back" [Michael, inner regional, LSES].

GPs also commented that on the one hand, diagnostic and assessment tools are often inadequate for adolescents, for example the K-10 and DAS are 'too rigid, you can't measure feelings'.

> "I never get a decent answer from this questionnaire to be honest, when I ask them. It always go into the extreme, because you're dealing with feelings, and you're trying to shift the feelings onto a piece of paper and you got to count, 1, 2, 3, 4, 5, so 10 out of 20 you've got depression, 5 out of this you've got, so if I find them very rigid and not very friendly" [Motek, remote].

On the other hand, GPs have found ways to work around this rigidity.

> "I prefer using the DAS as much as possible, if they're relatively clued up, then I think they'll do well with the DAS and it gives me an idea of the various symptoms and how it's all spread out, rather than just giving me one score, which obviously doesn't help me nail down which is the overriding symptom" [Dorien, major cities].

Finally, a number of GPs reported being hesitant to refer adolescents to psychiatrist services because of a concern that it may cause difficulties in the future for them.

> "You are very cautious about putting people on mental health plans, because it gets into the insurance companies. So you tend to be very discreet about it all" [Carolyn, major cities].

> "I'm sometimes reluctant to label a 14 year old as having major depression, because that's something that's going to stick with them for a long time" [Linda, regional, LSES]

Secondly, GPs identified a number of **material barriers**. These include the cost of psychological and psychiatric support services, which were often too expensive for many, with subsidised visits resulting in a gap payment that was unaffordable. Distance is another material barrier. Many rural, remote and regional practices were located sometimes hundreds of kilometres from support services such as Headspace, while some practices were inaccessible by teens due to lack of transport options; while the timing of appointments were often unsuited to school schedules.

> "They're 130kms away, so it's a bit of travelling because the paediatricians don't usually do tele-health, and I think it would be very hard to a full assessment via tele-health anyway in that particular situation" [Marcia, regional, LSES].

> "In this area most of the kids need to get the school bus home, there's no other public transport, there's no other way, so a lot of them come at 2 o'clock and need to be gone by twenty past three" [Donna, Teen Clinic, regional, LSES].

Thirdly, **adolescent and family attitudes and capacities** were identified as barriers to effective care. For example, mental health is still very much stigmatized in the community.

> "There could be a lack of social acceptance around their behaviour, or fear, they might be embarrassed by it if they understand it's not a good behaviour to engage in, or maybe there's fear of, it's something they don't want their parents to know about, that their parents may find out" [Peter, regional].

> "They've got to get to a GP to get a mental health plan to get to the primary health network. They can go directly, but there's a stigma to going directly, although some still do end up there" [Sally, inner regional, LSES].

Lack of medical literacy among young people was cited as a barrier to accessing care.

> "Sometimes these poor little mites get missed in all of that, because they don't know how to make an appointment, and they've got to have a Medicare card, they don't know whether you're going to bill them or not and how are they going to pay for it? They don't want mum and dad to know" [Sally, inner regional, LSES].

> "The kids that come have no health literacy, they're not medicalised, they don't know how the health system works, often they don't have Medicare cards, and more importantly, they don't want to see their family GP" [Duncan, Teen Clinic, regional, LSES].

Adolescents were reported as often being difficult to engage, 'they don't volunteer information, often don't come back, don't always acknowledge the problem or agree to referral'; there may be a lack of understanding about what the GP can do or perceive them as being judgemental, for example, if they drink or take drugs.

> "And there are ones that drink themselves into oblivion every Saturday night. And there's a lot of that going on too. And of course they won't come to me and tell me about that, because I'm an old lady and I'll say oh dear, I don't think that's good for you, or that's not much fun, I can't see why you'd spend all that much money, it can't be that much fun" [Sally, regional, LSES].

GPs reported another barrier as the lack of awareness among young people about how a GP might be able to help them, which might contribute to their reluctance to present.

> "There may be a lack of understanding from the young person about what the GP can provide, probably they may not even have any appreciation that the GP would even care, so therefore they may not engage in health services, they think that they're not going to find someone who's going to support them through or understand what they're going through" [Peter, regional].

GPs also reported that young people may not be willing to accept support, or put in the time, effort or money.

> "Adolescents don't like coming to the doctor, they don't like being seen as being different, or having problems, or needing help, or however you want to describe that kind of thing" [Derek, inner regional, LSES].

> "It's not always easy to refer them in because sometimes they decline seeing the psychologist, so it's a bit hit and miss" [Marcia, regional, LSES].

One GP reported that in cases of diagnosed mental illness manifesting in SH, young people have a tendency to move around from practitioner to practitioner, making it difficult to build a long-term relationship or provide continuity of care.

> "I'm just a stop on the road. So they'll see me for a little while, then they'll go somewhere else" **[**David, major cities, LSES].

Another issue is that is sometimes difficult to engage parents in their child's mental health, partly because they may not acknowledge their own illnesses, or because of relationship or social circumstances that GPs are unable to change:

> "The people around them need to see that there is something amiss and then bring them forward, so it's whether the parents are clued up about that could be the first thing, and when they come in, obviously it is a vulnerable situation that they are in so it takes time to develop that trust in that sense' (Dorien, major cities).

> 'If you can't get them support, you're sending them back to the same place (Katherine, regional).

Fourth, the **model of care in general practice** was seen as not being conducive to the treatment of adolescents in general, and SH and mental health issues in particular. Some GPs reported it was difficult to find space and time in a busy practice to provide the required care for YSPH, although they would try to accommodate this as much as possible.

> "Sometimes it's the constraints of time, someone turns up with an important issue but they only make a very brief appointment, so you're trying to do the problem justice but at the same time you've got to be a little bit mindful that the waiting room might be full. Usually I just give it the time irrespective" [Ron, inner regional, LSES].

> "We've tried over the years that if an adolescent comes in and needs to be seen, tell them to wait and we'll fit them in even if we're busy, because if you don't see them, they won't come back" [Candice, regional].

A major barrier cited by many GPs is the lack of time provision in the fee for service model of 15 minutes consultations or 20 minutes for a new client for the deep engagement required with the young person. Respondents noted that it takes time, often after multiple consultations, to build confidence and trust, with some GPs reporting it takes almost a full hour before they began to open up.

> "If I took a mental history and delved into it, I'm sure I would uncover more who have or might think of self-harming, but that's generally beyond my brief. For me to do that, I would have to almost have be a mental health counsellor, to start unearthing all the different ramifications of a troubled youth. As a general practitioner, I would get so bogged down that I'd never get on with a full day of general practice" [Richard, major cities].

> "A lot of it is about time, engaging in young people, or engaging in anyone. As a general practitioner, we have fifteen minutes to see a patient or less sometimes. I see roughly about five an hour, so what I know about patients is built up over a long time. So in twelve minutes, or even if we booked a long consultation, twenty five minutes, that's a lot of time to go through the details of the particular mental health client, which a lot of GPs are not comfortable in doing, I don't think" [Paula, major cities, LSES].

Related to the lack of time was the poor rate of reimbursement by Medicare.

> "People don't like to do mental health plans because they are poorly remunerated, they take very long for a very set amount of money so if it is a front-line practice, time with the patient counts and if you going to take a very long time with a patient you have to be paid for it, so I think it is poorly remunerated" [Mark, major cities].

Some GPs said they felt isolated because they generally do not speak with their colleagues about clients, as there is an expectation that they have the same level of knowledge; while some noted the difficulty in attracting and retaining GPs in remote, rural and regional areas.

> 'The Rural Doctors' Network, the College, the state government, the federal government are all onto it, nobody's come up with the solution. Giving them money won't work, you give them a motza of money, they stay for three years and then they go. What I'm trying to say is that in the old days the GP was kind of a family therapist, because they saw mum and dad and kids and would see them down the street, etc. and it was like a therapeutic relationship, even though you might talk about confidential stuff. Now it's a little bit scattered and a little bit more broken, disconnected' [Sally, inner regional, LSES].

Acute presentations to mental health units in hospitals were reported as being unsuitable for young people, partly because some GPs feel they 'don't get treated well' there, or they are confronted by serious adult mental health illness.

> "Sending the patient off to a hospital or a mental health outpatient sometimes can be a little bit bothersome for the patients and the families. It could be confronting because it's unknown, you go in the great big hospital and you poke around all over the place and then you find a place where there are people with all different kinds of mental illness, it's confronting to a young girl" [Charles, inner regional].

The fifth barrier was the **assessment and referral process.** Centralised referral processes were seen as poor, often referring adolescents to places that were geographically inaccessible.

> "I linked a young chappie up with CAMHs, who said, no they wouldn't see him even though he was quite depressed and hadn't been to school for weeks on end. They said, oh, send him to Headspace, it's good for that age group. But it was 250ks south! I was like, how the heck is he going to get there? To get people linked in with the mental health team, you've got to ring a centralised number in a regional city, and they have no clue where we are or that where this guy lives in is well over 200ks from the closest large town. I don't think they realise that he's not going to be able to get there – he can't drive! You're just cutting him off from any possibility of having any help" [Marcia, regional, LSES].

The risk classification and assessment process was also seen as overly complicated, making it difficult for GPs to know to whom to refer adolescents, particularly with the shortage of services and waiting times to see specialists in some areas.

> "Our only way of linking up with a child psychiatrist is the CAMHs team and if the CAMHs team knocks them back, then we have no way of getting them in, so we've just got to do it ourselves" [Marcia, regional, LSES].

> "That's a really good service in they have a GP liaison that I can call and say, look, this is the person I've got and if they think the person is not at a level of risk that would warrant their intervention, they down step them to Headspace, but from what I can understand Headspace is pretty flat chat at the moment, so most of them are doing an initial assessment and then saying, look go back to your GP, get a mental health plan and then see a psychologist or just privately" [Paula, multi-practice, Major cities, LSES].

While some GPs felt the national AccessLine was helpful, others found the response mechanism both frustrating and 'hit and miss'.

> 'I call that number and they tell me I've got to call another number and then another number, your heart sinks when you know you've got to call one of these numbers. The last time I called them, eventually they said you need to talk to the psychiatrist on call, so I

ring up the psychiatrist on call who says oh no, you need to call up the psychiatrist on call and you say, no, you're the psychiatrist on call, and you're just tearing your hair out and you think, here I am trying to see patients throughout the day and you just get this complete run around that's so inefficient. It's almost like they just want you to go away. You can be on a line for an hour and a half, waiting for somebody to answer the phone! The mechanisms for responses are really poor" [Ron, inner regional, LSES].

"It can take six phone calls to get some sort of a response from anybody. They've got these numbers that you're supposed to call, so you call up that number and they say oh no, you've got to call this number and you call this number, and the last time I did that with someone, I wound up speaking to the first person I'd spoken to after about four other phone calls. And you get back to where you're starting from, plus you're often put on hold. I think there's a fair amount of disarray in the mental health services so you can't actually get a rapid response from anyone" [Katherine, regional].

Some GPs reported that unless they were willing to 'fight' with some service providers, particularly in the community health sector and hospitals, so they resorted instead to advising adolescents to present themselves at emergency departments.

"You've really got to stand on your ear and say, this person's got the knife out ready to cut their throat to get their interest, because they see that a lot of the funding's going into the primary health network" [Sally, inner regional, LSES].

"Mental health, it needs somebody young, strong, and assertive and a team with them. So if a man called that person at the hospital saying, I have somebody suicidal, with strong accent, not like my accent, he would be admitted. But me…" [Nadia, regional, LSES].

The sixth, and biggest barrier was seen as the **support services** themselves, because of the 'siloed' nature of Australian health, the difficulties in navigating the private and public systems, the paucity of good adolescent psychologists in remote and regional areas, and because of the lack of coordination between services and with general practice.

"All the community healths have a CAMHs, but it's not always easy to refer them in because sometimes they decline seeing them, so it's a bit more hit and miss than sending them to a private psychologist where they do actually see them" [Marcia, regional, LSES].

"The number that see the younger spectrum is somewhat limited, so there can be a wait and it can be difficult" [Derek, inner regional, LSES].

'There's lots of organisations doing the same thing, and no one really knows who's doing what and there's no coordination. So when we see guest speakers coming about suicide prevention, there will be a number of bodies that will support that, and all those bodies actually do have a role and do have a clientele which are sometimes different, sometimes the same as those which we see' [Duncan, Teen Clinic, regional, LSES].

Further, there is some ambiguity around the quality and authority of some services in terms of psychologists and psychiatrists in the public health system, the lack of local availability, with often 'fly in, fly out' or only tele-health services for regional and remote areas, which was seen respectively as discontinuity of care and an inadequate response for mental health issues.

"We don't really have resident psychiatrists and it's quite difficult to get people in to psychiatrists here in general, adults or kids, but particularly kids and particularly face to face. We've got some access to tele-psychiatry via Skype, but it's not the same. I've had one teenager that was self-harming that I felt was major depression and she's still waiting three months later to see a psychiatrist, so I'm managing it" [Linda, regional, LSES].

Some GPs said that pathways to care were not 'visible and adequately signposted', while others complained that other services, such as Headspace and psychologists working in CAMHS teams, do not report back to the GP in a timely way, or the clinicians are often 'transient', which disrupted clients' continuity of care.

Diagnostic complexities that limit early intervention for YPSH were identified as a barrier by some GPs. This made it difficult to assess whether there was underlying mental health disease, an intellectual disability, anxiety or depression, or drug and alcohol abuse, with unclear or contested diagnosis of core issue, which could lead to difficulties and delays in accessing specialist help.

> 'Sometimes there's a diagnostic dilemma and you feel that for medication purposes, you really need to get a clear diagnosis and you want to send them in to see the psychiatrist, and sometimes they get blocked by the mental health team, they look at it and say, oh no, they've got an intellectual disability, they're not ours. So they're really, really left out on a limb, because they're out in an area where there aren't a lot of neuro-psychiatrists, and they can't get in to the child psychiatrist because our only way of linking up with a child psychiatrist is the CAMHs team and if the CAMHs team knocks them back, then we have no way of getting them in, so we've just got to do it ourselves' [Marcia, regional, LSES).

While it was acknowledged there are services for acute presentations, this is not the case for 'grey area patients' (Charles). Further, hospital emergency services discharge clients when their condition is stablised, but they are often released without a mental health assessment. Further, the end of service 'cliff' was mentioned as a big barrier for clients with ongoing needs, who are discharged from youth services when they reach 16, 18 or 25.

> "Child and Young Person's Mental Health (CYPMH), they're great when you're in the service, discharged, not so helpful. And it concerns me a little, particularly if they've been commenced on anti-depressant medication at the age of 14, we're now 16, and they've had that relationship with the psychiatrist and the psychologist, they've been discharged because they're now stable, I find it quite difficult, because in an ordinary circumstance I would think the psychiatrist, every six months a review, but they just stop, because they don't have that facility to provide an outpatient service" [Paula, major cities, LSES].

This is particularly the case when GPs seek to involve families in the young person's care, due to the lack of available family therapy services, with some services providing incorrect or incomplete information to families who then go back and challenge the GP.

In some locations, schools actively supported adolescents through the provision of in-school counsellors, yet accessing them can be socially problematic.

> "Most kids won't see them because they get pulled out of school and everyone knows" [Neranda, regional].

Perhaps most importantly, almost all GPs criticised specialist support services for not providing timely feedback on the client's progress, to keep them informed of the support they were receiving and to indicate emerging issues.

> "Recently I had a girl, she's now 16, on anti-depressant medication, discharged from Child and Young Person's Mental Health, so she's been with them for 18 months. It took me 18 months to get a letter, and it was the discharge letter! So the only time that I would know what is happening is when she came in and saw me for something else, and I'd say, well how's it going, what's happening? Oh, we're doing this, haven't you heard? No" [Paula, major cities, LSES].

> "My experience with sending people with, not necessarily self-harming, but younger people with mood disorders for instance to Headspace, they tend to disappear into the system a bit, we don't get a lot of feedback. It's very sporadic, but I think that's the same with all mental health services, they're really hopeless at keeping the referring doctor in touch" [Martin, major cities]

To conclude this section, the final barrier was identified by one GP, noting that adolescent **SH is not widely researched** or written about in general practice or primary health journals.

## Facilitators in general practice

Only a small number of facilitators for general practice were identified. These were the local availability of good adolescent psychologists who reported back to GPs in a timely manner; promotional strategies delivered by the Black Dog Institute and other organisations; familiarity with the client through a long-term relationship; AccessLine for sourcing clinicians; increased community awareness and acceptance of mental illness; inter-practice cooperation in regional areas; free support services provided by volunteer community members; practice nurses; and a range of readily accessible services that do not involve a long waiting time.

## Summary

This section illuminates the experiences GPs have had and the difficulties they face in treating YPSH. First, adolescents rarely seek help on their own and are often 'dragged in' by family, never present with SH, find it difficult to open up, are sometimes reluctant to follow up referrals, and often 'drop off' before outcomes are known. Second, GPs respond to SH in consistent ways across remoteness areas, practice types and range of clients, which can be depicted in a common referral pathway. Third, there are multiple, complex barriers in general practice that intervene in the effective care provision by GPs to YPSH, and few facilitators. Despite this, the GPs in this study navigate systemic constraints to find the time to treat and refer YPSH as best they can, to the point where successful completed suicides are almost non-existent.

The respondents did have some suggestions for addressing the identified barriers. These include: formally collate and promote locally available, public and private resources; increase the number of locally available and affordable psychologists and psychiatrists; develop team-based approaches in general practice to share information, knowledge, strategies and resources to improve the provision of support; and establish local specialist multidisciplinary teams to jointly treat YPSH.

> 'We need team work. You can't tell me that the GP's going to solve the problem. You can't tell me that the psychologist or the mental health worker is going to solve the problem' (Motek, regional, LSES).

> 'This is not something that one doctor can actually look after, you need a whole team of people' [Charles, inner regional].

These suggestions are realised, to some extent, in each of the two case studies of innovative practice in section 4 of the key findings.

# 3. Health promotion, information and resources used by GPs in response to YPSH, and potential educational strategies to improve practice

## Summary of key findings

- GPs often used online resources to diagnose and source information in treating YPSH, and some referred young people to use them;
- Resources most commonly used were HEADSS and DAS for diagnosis and mental health assessment; and moodgym, Beyond Blue, and Black Dog for information for GPs and client support. Some refer to mobile apps that teach mindfulness and mental relaxation;
- Some GPs engaged in volunteer health promotion strategies around adolescent SH and mental health, while some expressed a desire to do so;
- Few GPs were aware of any community campaigns targeting adolescent SH and mental health, although some were aware of broader mental health campaigns, such as RUOK day;
- All GPs saw training in adolescent mental health as essential in general practice, with varied content and case studies showing, for example, how to assess and approach young people, referral pathways, and access to resources to support treatment;
- Only one established GP reported having specific adolescent mental health training, while a newly graduated fellow suggested the focus on adolescents in GP training was inadequate;
- Many GPs have completed professional development training in mental health through a range of short seminars, workshops, conferences, or webinars, although most noted the lack of focus on adolescents;
- Delivery modes for CPD need to be flexible, local and timely, to accommodate busy GPs;
- Some GPs thought adolescent mental health training training should also be offered to practice nurses and other staff who deal with YPSH, such as receptionists;
- Some GPs wanted training in team-based approaches in general practice; to share information and resources, and regularly audit client progress.

This section addresses study objective 3 by reporting on the health promotion information strategies and resources GPs in the study used to support YPSH or those they suspect are at risk of self-harming due to mental health issues. It also addresses study objective 4 by identifying what respondents saw was needed in professional educational opportunities for GPs that have the potential to enhance practice. It begins by describing the health promotion resources and networks GPs used to access information to support their work in treating YPSH, as well as resources to which they referred young people to access on their own. This is followed by a description of GPs' educational and training experiences in relation to mental health in general, and adolescent mental health in particular. The section concludes by identifying the educational opportunities GPs saw as having the potential to improve practice in supporting YPSH.

## Health promotion resources and networks used by GPs to support YSPH

Many, but not all GPs reported using a wide range of health promotion resources and networks that provided useful information to support them in the effective provision of care to YPSH. The ones most commonly mentioned are listed alphabetically below, according to specific organisations and networks that produce multiple resources, as well as individual telephone or online resources or apps. They are:

- AccessLine
- AFP therapeutic guidelines
- Beyond Blue – website
- e-Couch
- e-Mental Health
- Headspace – centres and website
- Lifeline and Kids' Helpline
- Mood gym
- Royal Australian College of General Practitioners (RACGP)
- Smiling Mind
- Tele-counseling
- The Black Dog Institute – seminars, webinars and website.

While participants' enthusiasm for most of the resources mentioned was consistent, there contrasting responses to Headspace, with some GPs suggesting there is often a long waiting time, or that they do not always contact the client or follow up with the GP, or instances where they appear to mislead parents by inappropriately suggesting care pathways.

> "I've had parents who've contacted Headspace by phone and have pretty much got the impression, oh you just need to go to your GP and get a mental health care plan. Well, the mental health care plan is a bit of paper and it's an item number, what we're actually doing is the stuff that's in there, I just haven't put it on a bit of paper and billed it. And your child is going to be better served by going to the mental health team here than having six sessions with a psychologist. So I feel that they're advising people in towns that they really don't know, stuff that's not particularly helpful for our setting" [Linda, regional, LSES].

Some GPs reported using the listed resources themselves, to inform their own practice responding to YPSH, while others referred the resources to young people to use. These were primarily activity-based resources, that both provide information, interactive games or questionnaires and links to other useful information or organisations, as well as mobile apps that teach mindfulness and relaxation.

> "Sometimes I use online resources for the patients, like the Mood gym, Beyond blue, those sorts of things where they can sit down and do things online. Probably not so much with the ten years old age bracket, but perhaps with the older ones, particularly if they're a bit reluctant to actually see someone face to face" [Marcia, regional, LSES].

> "A lot of, not necessarily self-harming young people, but young people with sort of mild to moderate mood disorders often do very well with online CBT, and Black Dog's got that and the Anxiety Disorders, what used to be called the Anxiety Disorders Clinic at St Vincent's has a fantastic, it's called This way up clinic now, they've got fantastic online CBT" [Martin, major cities].

> "They've been doing Smiling mind, the Headspace apps are really helpful, so they're mindfulness meditation type apps. I've had lots of people doing that, but there's a few that I've gone, that's fantastic, they're free apps, give it a go. And particularly the Smiling

> Mind's got ones that are aimed at different age groups. So often I find that people, particularly with adolescents, that if they've got something that they feel is aimed at their age group, they're more likely to engage with it" [Linda, regional, LSES].

While some GPs said they knew online resources existed, but said that they did not use them because of lack of time, being 'old generation', or a feeling that they were not 'digitally savvy', some reported that they would need to carefully screen the resources before referring them to clients.

> "They need to know where to look because there's a lot of rubbish, but there are some good resources as well, so if you can point them in the right direction" [Derek, inner regional, LSES].

GPs reported referring young people to a number of treatment programs, although they also reported that they often did not receive feedback so were unable to confirm their helpfulness or otherwise to adolescents and families. These included:

- Child and Young Person's Mental Health program (http://www.ycentral.com.au/cymph-at-ycentral/);
- Reconnecting Adolescents and Parents (RAPT: http://coastkids.com.au/directory/support-services-community-groups/support-services/reconnecting-adolescents-parents-team-rapt-187/),.

A number of GPs reported using online assessment tools to screen young people and identify SH or risk of further SH, although the latter two were reported as being either not specific enough or inadequate for assessing adolescents:

- HEADSS (Home, Education and employment, Activities, Drugs, Sexuality, Suicide/depression) assessment guide (https://depts.washington.edu/dbpeds/Screening%20Tools/HEADSS.pdf),
- DAS (Depression, Anxiety, Stress Scales http://www2.psy.unsw.edu.au/dass/)
- K-10 (Kessler Psychological Distress Scale https://depts.washington.edu/dbpeds/Screening%20Tools/HEADSS.pdf)

Most GPs had a local network of private psychologists to whom they referred, but those new to the practice and locums reported not knowing which local resources and clinicians were available. Referrals were also commonly made to Child and Adolescent Mental Health Service (CAMHS: see referral pathway diagrams), but these services were often seen as limited because of the small number of available free sessions with a public psychologist or psychiatrist (6 annually); recent changes to provision mode (1 face-to-face, 5 tele-health); gap payments; and changes in provision/governance (ATAPS no longer available, tendering process).

For acute presentations, GPs in city or inner regional areas advised clients to present to the local hospital, or the base hospital in regional areas, although some reported they were not able to refer clients directly but instead had to call an AccessLine and speak to a mental health team, often based in Sydney, who then referred. Practices in Western NSW PHN referred to the acute mental health unit at Bloomfield hospital in Orange.

On a more personal note, some GPs reported having family members or close friends in law, policing or mental health professions to whom they could turn for support, information and professional advice. Rarely did GPs report that they regularly consulted with colleagues about their clients, with the exception of the team-based integrated-care approach adopted by the Bega Valley Medical Practice (see section 4, case study 1).

## GPs' training experiences

Most GPs reported having completed level-one CME/CPD[1] training, which they said enabled them to claim certain Medicare items, although it did not appear that remuneration was the main reason for having done this. Most said this training was beneficial, because it made them aware of the resources available to GPs.

> "I know a lot of the doctors here have done extra mental health training, I mean that's linked to Medicare item numbers" [Martin, major cities].

A few had completed, while others aimed to complete, the level-two training in the future, enabling them to provide focused psychological strategies under a Medicare counselling team.

> "I did the level 2 mental health in-training, which allows you to get certain counselling item numbers and provide some focused psychological strategies and that kind of stuff. I wanted to be a bit more knowledgeable on what the latest therapies are so I could better describe to them why they're seeing the psychologist, rather than, go see the psychologist and have a chat" [Paula, major cities, LSES].

The Sphere program, previously run at Macquarie University, was mentioned a number of times, although some GPs were critical of what they perceived as a push to treat mental health clients quickly.

> "Teaching young doctors how to get rid of them in 12 minutes or less. I thought it was a disgrace, it takes people a huge amount of courage to come and talk to a GP about these sorts of issues, and unfortunate though it may be for the patients in the waiting room, you have to spend the time that you have to spend, because it's important you know" [Katherine, regional].

Short mental health and suicide prevention seminars presented by Black Dog, Beyond Blue, PHNs, and RACGP, both face to face and online, were popular, although most of these programs targeted adults and were often only available to GPs, excluding practice nurses. Responses to these seminars ranged from agreeing they were very beneficial in 'stimulating thinking', to criticism of their being aimed at 'entry level' or not being specific enough.

> "I've done a few meetings and things, not recently, but in the past run by psychologists and psychiatrists and people like that, especially if they're doing it for adolescents, because it is a different group from the rest of the population" [Derek, inner regional, LSES].

> "I did one of those courses that the Primary Health Network ran a few years ago, there was something from Beyond Blue or Black Dog that was specific for adolescents, I think it was adolescents, but I found it was too general, it was covering mental health and there was a little bit about adolescents in it, but it wasn't specifically about adolescents" **[**David, major cities**].**

One GP reported having completed mental health training when he worked in psychiatry overseas, yet only one GP had completed specific adolescent mental health training, and another had previously worked at Headspace. Some GPs however, reported engaging in semi-regular Mental Health Network meetings comprising local GPs, psychologists and mental health nurses.

The practice nurse in Teen Clinic reported having completed mental health first aid and Applied Suicide Intervention Skills Training (ASIST: http://suicidefirstaid.org.au/asist/), while Dr MacKinnon completed the Black Dog training on teenage depression, anxiety and mental health

[1] Undertaken as a module in general mental health as part of GP training

early in 2017. One GP completed a program targeting the management of borderline personality disorder, enabling him to 'scratch a little bit there', he did not consider himself to be an expert. In contrast, a number of GPs suggested that clinical experience 'sitting with people' (Charles) was what was required: 'medical training and experience is a great teacher of psychology' (Dirk).

Two GPs were training or trained in child care, with one previously working overseas as a paediatrician, with another enrolled in an online university Diploma of Child Care, although he commented it was 'not practical enough'. Interestingly, several GPs had trained along spiritual lines to learn how to bolster young people's self-esteem.

While all participants acknowledged that mental health knowledge was crucial for GPs, many actively chose not to pursue specific mental health training because of, for example, an interest in working with range of health issues in general practice, a clientele comprising chronic and complex patients, or professed a lack of interest and/or time in working with mental health clients:

> "I have no specific counselling training, I just go on intuition from what I know, being a parent, I think I relate quite well to my patients, but I know I'm no counsellor, I'm not about to do CBT on somebody, other than trusting my own judgement and if I've got a good patient who understands where I'm coming from then it works well, but for me to just embark on, right, I'm going to counsel this patient, I'm going to get them back every week over the next two, four, six, ten, twelve visits, I don't want to divest that much emotional energy into a patient' [Richard, major cities].

## GPs' health promotion awareness

All participants agreed there was a need for community adolescent mental health awareness campaigns, if not campaigns targeting SH, yet none were aware of any specific ones, apart from those for adults, such as RUOK day and suicide prevention programs.

> "…helping to identify there's a problem to start with, helping to educate the younger people that it's not something freaky, it doesn't make them weird or different or anything, and it's common and they should seek help and they will get better. And coordinating their care through psychologists and possibly psychiatrists if you think they're completely crazy, and offering continuing support, as I've said, I'm a lot more accessible than an appointment with a psychologist, you probably have to wait at least weeks" [Derek, inner regional, LSES].

While most GPs knew schools were involved in a variety of adolescent health education, such as sexual health, and that referrals sometimes came from school counsellors, their awareness of what was available and what was missing in terms of educational health promotion campaigns for young people was varied. In contrast, some GPs suggested that schools should not be expected to be responsible for adolescents' mental health. Only one GP expressed hesitancy in campaigns focusing on self-harm because of the fear that it might promote the behaviour.

Quite a few GPs were involved in volunteer adjunct practices speaking to schools and the community, or were actively involved with charities, for example, those in the Teen Clinic (see section 4, case study 1). Others reported they were keen to become involved in health promotion by collaborating with schools to educate young people on life skills and coping strategies to deal with difficult situations. One respondent stated that GP involvement in such campaigns was necessary, to change perceptions among young people about the role of the GP in adolescent mental health.

> "Well, being a place that you can go to and where some direction can be given for further management. But I don't think most people would perceive a GP to be the source of the remedy they're looking for" [Malcolm, inner region].

A number of strategies were suggested for health promotional campaigns targeting young people in general, as well as those who self-harm.

> "It might be a good idea to have a card, like a laminated sheet to say, I know it's simplifying very much, but this is the scope of mental health problems, within reason. I don't think we can tabulate everything, but a lot of young people don't know where to approach, what to do, and the GPs by the same token, may be equally amiss about where to turn. So a laminated sheet to say, these are the signs of real distress, this is the scheduling thing" [Janini, major cities, LSES].

> "If the person is ok, these are the flag signs that you can do this, you can call this number for a hotline on what to do next, and somebody should be available, and not put the GP and the patient, say oh well, we'll get back to you in a the next twenty four hours, because that's not what we want to hear, and not talk to a machine" [Janini, major cities, LSES].

To summarise, suggestions included:

- A one-line public slogan of 'you don't have to live with pain and isolation, there is something that can be done' with a phone number;
- Radio and social media advertising to normalize mental health issues;
- Laminated cards for GPs signaling the scope and signs of mental illness and/or self harm and suggestions as to whom to contact and what to do; and
- Campaigns promoting stress management and relaxation techniques. Some were aware of campaigns promoting Lifeline or Kids' Helpline, although they did not know whether these programs addressed SH.

One GP felt that there may be a bigger role for their early involvement in the medical and non-medical management of YPSH by providing support and education to the family, as well as championing the young client's welfare,

> "For the GP role, one thing would be early involvement with mental health support services within the local area and trying to work out how the patient may be best served from a pharmacological but also from a non-pharmacological point of view, so whether or not there's underlying anxiety and do they need mindfulness meditation and grounding techniques, CBT and other support. Then also I guess, the GP can be involved in getting collateral history and getting a sense of what the home environment might be like and then engaging the parents as support persons for the children and maybe some parental education as to what some of the underlying issues may be and how they can best support the young person" [Peter, regional].

## Educational opportunities to improve GP practices and responses to YPSH

Suggestions for training and educational opportunities varied among respondents. This included the provision of programs with a range of content, forms and delivery modes, as well as the development of case studies and other resources, such as the services directory developed in Cobar (see section 4, case study 2).

> "A directory of what services are available locally, how things should work locally, who would be able to provide help on an urgent basis if needed, would be really useful,

because as a GP you will be working with all sorts of different people, so you need this sort of information at your fingertips to be able to make these decisions" [Dorien, major cities, LSES].

Many GPs commented on the Federal and state political context of constantly shifting policy and training requirements, such as around Medicare items, and for example, the shift from *Better Outcomes in Mental Health* to *Better Access to Mental Health*, as well as shifts in services funding. These shifts required GPs in busy practice settings to maintain currency on what to claim and how to claim Medicare items, which health services and sectors were funded and suitable for young clients based on government health priorities at any given time.

Some older GPs also recognised that contemporary general practice training had changed since they had graduated. One GP expressed concern that training needed to improve.

> "I'm from the old school and I've sort of learnt on my feet, but I don't know in the medical training these days how exhaustive the mental health training is compared to what we did when we went through. I would hope and I would think it is better than it used to be. Our days in medical school was basically learning all the nuts and bolts, and mental health tended to be sort of added on, not added on at the end, but we tend to classify it as, well the really bad ones like schitzophrenia and bipolar and so on, suicide and so on, but in my recollection, self-harm didn't feature highly in that as an entity. Now whether that is different now, I don't know. I'd like to think maybe it is since it appears that mental health is a much larger part of our general practitioners' day-to-day work than it ever used to be" [Richard, major cities].

Yet another older GP was impressed at how much it had changed by observing the younger GPs in his practice.

> "I think people would be surprised at how the young GPs coming through their training program, how well these things are covered for them, as part of their training. It's covered extremely well, not necessarily in a lot of depth, but they know this sort of stuff. I'm always amazed at how well they handle that stuff like that" [Martin, major cities].

Yet some younger GPs who had had this training reported a lack of confidence in being able to treat mental health issues, because of the lack of depth in the training on adolescents.

> "As part of the GP training program that I went through, we did the level one mental health training and as part of that a small focus was around adolescent mental health, but in regard to my confidence level and where I would rate my ability, I certainly wouldn't say that I am entirely one hundred per cent confident in dealing with adolescent mental health presentations" [Peter, newly graduated fellow regional].

The need to focus training on adolescent mental health was recognised by GPs with a range of experience in different practice types.

> "You can't just take adult mental health and transplant it into adolescents because it just doesn't work. There's good evidence that adolescents' brains work in a different way, so if you take a paradigm that works with people who have mature brains and try and impose it on adolescents, they just don't accept it, they don't deal well" [Derek, inner regional, LSES].

> "I was trying to look for more programs that I could do, or upskill more on the psychotherapy side of things, because some patients are reluctant to see a psychologist, for whatever reason, they feel more comfortable speaking to a GP, but I haven't been able to find something at that level" [Paula, major cities**,** LSES].

Despite not having a specific interest in mental health, GPs went as far to say that such training was necessary for GPs, to enable them to support adolescents while waiting for specialist appointments, particularly in remote and regional areas, where GPs have traditionally taken on broader responsibilities because of the lack of specialists.

> "We deal with an awful lot more mental health issues than say people do in Sydney because there's two psychiatrists in town, one's very picky about who he'll see and the other one's booked out for months and months and months in advance. So it's difficult to get someone seen by a psychiatrist, so by default, we end up doing a lot of the mental health things" [Derek, inner regional, LSES].

> "Some of the good ones, they're very busy, it takes one month or one and a half months, I feel this is too late" [Michael, inner regional, LSES].

> "Mental health is not one of my areas of interest, but obviously it's a crucial part of GP training, so it's something we have quite a lot of dealings with, particularly with this kind of work where I do all the rural ED work." [Peter, regional].

General barriers to training faced by GPs were identified as financial cost, loss of practice time spent on training, having to travel to the city, and mental health training being restricted to GPs while practice nurses and staff who deal with clients were often excluded.

> "If you are going to have everybody attend seminars, you want to pay for people's time. If you going to have a seminar on mental health on a Monday or Tuesday, are you going to pay my time for me to leave the practice and go attend that seminar" [Mark, major cities].

In terms of content, some younger GPs requested training in how to approach, assess and diagnose clients to identify SH, develop an appropriate treatment plan, and identify relevant resources and locally available and affordable services. However the need varied, depended on the GP's position as registrar, recently graduated fellow, locum or being new to the practice and/or area.

> "I think there is a need to make the GPs or young registrars like us to be aware because I have a lack of information about this" [Michael, registrar, inner regional, LSES].

Some GPs requested case studies exemplifying how to identify populations of young people in at risk of SH or mental health issues, how to interact with them in a 'non-discriminatory way', localised referral pathways, treatment and information outcomes.

Many GPs acknowledged the lack of collaboration and information sharing within practices, and suggested regular multi-disciplinary practice meetings taking a team-based approach to primary health care provision would improve individual GPs' knowledge and capacity to respond to YPSH.

> "Maybe once a month, have a conference or whatever, bring in the patient list, how they follow up, what happened to this patient, or the social worker or if it's an Aboriginal patient, the Aboriginal health worker involved and then we know the outcome of what happened to that patient, is he living ok, is he well off? So that would help the patient, but it's not happening" [Arun, inner regional, LSES].

In fact, only one practice, the Bega Valley Medical Centre) (see section 4, case study 1, reported having such regular meetings.

> "We've probably got about 7 GPs and there's three practice nurses, there's always two practices nurses working each day. It's a very team orientated practice, there's a meeting every morning including all the GPs and the nurses that day and everyone discusses any patients they might be needing some help with or what's going on for that day, so

everyone leaves that meeting with a bit of an idea of what's going on for the day for everyone, so that's a really good part of the day and it sets the scene for a team approach" [Donna, practice nurse].

In terms of delivery mode, suggestions include: mobile teams of trainers conducting on-site training in practices after hours or on weekends, regional seminars, and local after-hours discussion sessions with other practitioners in a format other than lectures.

Some respondents felt that if the government made it mandatory for all GPs to be trained in adolescent mental health as part of the license requirement, this might improve skills and expand the pool of those able to provide quality service.

## Summary

In addressing the study objectives 3 and 4, this section reported on the health promotion information strategies and resources GPs used, and their training experiences, as well as educational opportunities to improve GPs' practices and responses to YPSH. The key findings are that GPs often used online resources to source information on how to support YPSH as well as referring young people to them. The purpose was for diagnosis, assessment, and apps with exercises teaching, for example, mindfulness and relaxation. Some GPs collaborated with schools and community groups in health promotion strategies around adolescent SH and mental health, while others expressed a desire to do so, yet GPs knew about specific community mental health campaigns targeting young people.

Training experiences varied, with all respondents reported having undertaken some form of mental health training, either in GP training program or short seminars or webinars. Yet it is clear that all GPs saw a need for programs that specifically target adolescent mental health screening and identification, assessment and treatment, and local referral pathways. Case studies exemplifying the process from presentation to outcome were seen as useful, while delivery modes needed to be flexible, local and timely, to accommodate busy GPs, while covering time lost in the practice. There was also a good argument for extending such training to practice nurses and other staff who deal with YPSH, while training in team-based approaches to general practice would ameliorate the lack of knowledge sharing within practices and improve the effective provision of care to YPSH.

# 4. Innovative case studies in general practice that support YPSH

This section reports on two innovations in general practice that provide different kinds of support to YPSH and have the potential to be extended to general practices across primary health networks in NSW. The first is the Teen Clinic, established by the Bega Valley Medical Practice in 2015 in response to youth suicides in the region. It represents a primary health model that provides free medical services to adolescents, including those who SH, while generating subsequent GP and specialist appointments to fully fund the clinic. The second case study is a mental health initiative facilitated by the Western NSW LHD and Outback Division of General Practice (ODGP) that is co-located with a general practice in Cobar. The initiative has produced an up-to-date, local area-based directory of mental health professionals, clinicians, specialists, schools, community workers, NGOs and community-led groups to resource and link GPs and other health professionals in the region.

## Case study 1: The Bega Valley Medical Practice's Teen Clinic

> "Teen Clinic is that first access point. So the nurses aren't trying to be experts in any particular area, we're just trying to be a welcoming soft entry point into accessing care, and we've found that to be a nice way for them to enter into health care if they need it. And sometimes they come not really knowing why they're here, just getting here was scary enough, and we can just chat with them, work out what's going on for them, because we've got the time to sit with them. The pros and cons – when we started we were aware that being within a general practice setting was potentially a big barrier as far as them having to come into the waiting room where their neighbour might be sitting, so we made sure that the receptionists were on board as far as not making things any more difficult for them when they present, making them feel really welcome, you're here, that's fine, have a seat. We knew that was a potential barrier, but we have also found that it's actually a really efficient and safe way to provide health care to this age group. So the access is through the nurses, we can introduce them to whatever they might need on the day, but if someone's acutely unwell, we're able to access the GPs straight away, and we've got psychologists that work from these rooms and we save psychologists appointments that are specifically for Teen Clinic patients so that we can get people in quickly if needed".
>
> [Donna, practice nurse]

For over five years, the Bega Valley Medical Practice has employed a team-based model of care in which GPs, psychologists and nurses work together. Teen Clinic is an initiative of the practice, established in 2015 in response to youth suicides and the deficit of adolescent-specific medical services in the region. The policy background for the initiative is the Commonwealth Government's trial of health homes, which seeks to change the fee for service model to a team-based, patient-centred payment system. This model means practice nurses can be involved in the care of chronic and complex patients, such as blood pressure monitoring, which frees up the GP for other patients, and reduces hospital admissions for such patients.

The nurse-led Teen Clinic runs between 2pm and 5pm every Tuesday and Thursday. This leaves space for teens to be referred to complementary clinics in other general practices along the

NSW south coast. The clinic's catchment area covers high schools in Merimbula and Pambula, so adolescents can use the school bus to access care, ameliorating the lack of public transport in the area.

***Model of care.*** The clinic functions as a free drop in centre, a non-threatening initial point of contact with primary health care where teenagers can discuss any health concern, beyond sexual health alone. Confidentiality is emphasised from initial contact with receptionists to nurse consultations, with the latter versed in the legalities of age of consent, and trained in youth mental health first aid and suicide prevention. Teens access the clinic individually or in groups, or are brought in by a school counsellor. The nurse listens to their concerns, asks questions to assess need, and if required, expedites appointments with GPs or psychologists in the practice, or facilitates appointments with their family GP. The purpose is to provide space for teens to talk about anything, beyond sexual health alone, with the nurse acting as a frontline access and referral point to multiple health services and other social services, such as housing.

> "We wanted to let the kids know that they're welcome here and no judgements, it's that first access point, where the nurses are a soft entry point into accessing care" [Dr Duncan MacKinnon, GP and practice principal).

Psychologist appointments are routinely held open to accommodate the needs of Teen Clinic clients. The consultation process involves the nurse risk assessing the client by asking direct questions about thoughts of SH, without focusing on the actual harm. This opens space for exploring alternative coping strategies, such as mindfulness, or other mechanisms or support systems to which they can be referred. The process was reported to have changed practitioner beliefs that SH is directly related to suicide intention:

> "We ask, have you ever harmed yourself, and some of them will go, oh no, no, no, and some of them will go, oh you know, only this or only that, they talk it down. I think probably years ago, a lot of us thought, oh, self-harm is almost suicide, but that's not how we see it now. It's a stress release for them, their coping mechanism" [Donna, Teen Clinic practice nurse].

***Team-based, community-oriented coordinated care*.** The practice uses a team-based care approach, in which GPs, nurses and psychologists meet every morning to discuss Teen Clinic and other patients, supplemented by engagement in 'corridor conversations' throughout the day to 'hot hand people in crisis over to each other at the time'. The aim is to 'build a relationship' between individual teens and the practice, and to understand their social circumstances to better formulate an early intervention management strategy so 'they're not falling off the radar'.

> "We say, don't wait til it's a crisis, just come. Oh, I'm a bit anxious and a bit stressed, ok, great, that's normal, let's have a chat about how you can cope with some of that stuff, and let them know it's hard sometimes and that's normal, and these are some of the things you can do' [Donna, Teen Clinic practice nurse].

This coordinated approach builds trust within the practice team, involves families in their children's health, and breaks down barriers with the community, from initial suspicion that the Teen Clinic would 'make them all sexually active' to where people now say that 'it's good that they have somewhere to go', to reduce any stigma associated with SH, mental health or other socially embarrassing conditions or issues.

> 'They're sitting in the waiting room with all the other community, but we make sure that the community knows it can be anything' [Donna, Teen Clinic practice nurse].

The groundwork for the clinic's success has been and continues to be built through hands-on promotion by the GPs to create awareness around health literacy for teens via the clnic. GPs

visit the schools, speak at assemblies, attend suicide prevention training for parents, sit on panels, present at Apex and Rotary meetings, support sporting clubs, and do radio interviews.

***Financial model*.** Teenagers do not require a Medicare card to consult with practice nurses. instead, they complete an information form on their first visit, and any subsequent GP or in-practice psychologist appointments are bulk billed. Clinic costs are absorbed by the practice and in fact, produce income. According to Dr MacKinnon at the time of the interview, of the 92 teens the clinic has seen since its inception, 290 Medicare item numbers have been generated for issues ranging from mental health consultations and care plans or referrals to a psychologist, to scripts for acne medication. This means that Teen Clinic is both cost-free for teens, *and* also generates income for the practice:

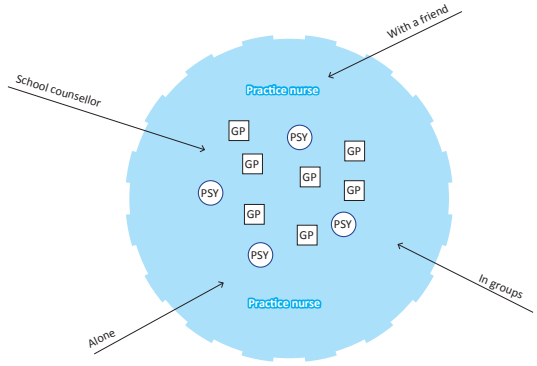
> "I look at it as a loss-leader in some ways, it's like bread and milk in the supermarket, they sell them cheaply to get you in the door, and then they'll sell you something else. We're not selling anything, but at the end of the day, it does generate work, that's the thing, and that does help it get across the line in some of these other practices" [Dr Duncan MacKinnon, GP and practice principal).

Client outcomes suggest the clinic is a safe and efficient way to provide primary health care for adolescents. Practice data show that teens will come to Teen Clinic rather than the general drop in clinic in the morning or booking online appointments. This is in contrast to most practices, where GPs report parents having to 'drag them in'. Instead, teens attend willingly, with the nurse reporting that girls often come in pairs, while boys either come in big groups, or on their own for mental health issues. As Dr MacKinnon said:

> "They come to see the nurses, and that's great because the kids that come have no health literacy, they're not medicalised, they don't know how the health system works, often they don't have Medicare cards, and more importantly, they don't want to see their family GP. And we know this from the research, we know from our own statistics, that 70% say they don't have a GP and I know they've seen a GP in town, but they just don't want to acknowledge that or be identified by their family GP when they come to see us".

The referral pathway for young people visiting Teen Clinic contrasts significantly to the generic referral pathway generated through analysis of the study data. First, present to the clinic of their own volition without an appointment or Medicare card, and consult with a practice nurse, rather than having to book an appointment to see the GP or be brought in by parents. The nurse conducts an initial assessment to uncover the issues, has time to provide emotional support by listening, and can offer advice, information or treatment, such as for minor injuries. If an appointment with the GP is deemed necessary, the nurse can refer the client immediately, rather than them having to wait or come back later. Additionally, if the situation is acute, the GP can refer immediately to the practice psychologists, through appointments reserved for Teen Clinic clients, rather than having to wait weeks, and sometimes months for appointments, without having to travel long distances or find ways to get to services or fit into business hours. Clients can be treated within the practice without parents' knowledge, unless the situation dictates or mandatory reporting is required. Finally, because of the morning team meetings, all practitioners are cognisant of the client's treatment and progress, rather than having to chase up external practitioners for updates.

Figure 2 Referral pathway for Bega Valley Medical Practice's Teen Clinic




The Teen Clinic referral pathway diagram is dramatically different to the generic referral pathway. Similarly to a moth being attracted to a flame, teens are drawn into the practice through Teen Clinic, and can be held and treated at multiple service levels by the practice nurse, GP and psychologist, sometimes simultaneously. This is in stark contrast to the linear, uni-directional generic model, where GPs are a 'stop along the road' for YPSH.

## Case Study 2: Cobar Community Services Directory

> "What is needed is working on what's out there and how things should work locally, what local services are there, even a directory of what's available locally, who would be able to provide help on an urgent basis if needed, these sort of information collected in a directory of services would be really useful, because as a GP you will be working with all sorts of different people, so you need this sort of information at your fingertips to be able to make these decisions. I walk home from work, so because there's a lot of psychologists and doctors around that locally based, I just keep looking at the boards and if it says they're children and adolescents, I keep it in mind"
>
> [Dorien, major cities].

This case has been included as an innovative practice because it represents a successful primary health initiative that links services and people, which is what GPs identified as missing, but essential, for each local area, as the quote above illustrates.

The interview was conducted with Bella, a social and community coordinator who works in two positions in Cobar: four days a week funded by NSW Health on an integrated care initiative between Western NSW Local Health District (LHD) and the NSW Outback Division of General Practice (ODGP); and one day a week funded by the Western NSW PHN to work on a suicide prevention strategy for ODGP. This strategy is based on the Lifespan model [http://www.lifespan.org.au/], with each area in the WNSW PHN generating a different model adapted to suit local circumstances, for example, Cobar has a generic model, while an Indigenous model has been developed in Bourke and Walgett.

Bella reported that the integrated care initiative was initially established for chronic disease management in Western NSW, but it was discovered that social issues, such as lack of transportation, rather than medical issues were impacting patients' ability to access care. Her role in this initiative is:

> "…to know what the services are and to refer into the services and coordinating those services to work better together, trying to figure out where they start, where they stop, where they complement each other, you know, because everyone's a clinician rowing their own boats and given their own briefs, and then suddenly it's hard for them to do community engagement and have time to ring everyone and play phone tag when they've got their own case load, so that's where this position is complementary, where we pick up and go, ok, well let's do a pathways to care. So that's the project, is to do a proper pathways to care, so then the clinicians have a nice document that they go, oh, beautiful. This is what I do" (Bella).

Bella has been working on two documents: one that with contact lists and details that will be distributed to GPs as well as services, showing them how to link across services. The other is a child and adolescent pathways to care, which Bella describes as a community services directory, which is:

> "…a good example of what most people don't have. When I started in integrated care, it's more about communication than the fact that people don't exist, so everyone said, oh, this isn't here, we don't have that, we've got trouble with transport. But it's not that, it's people don't communicate services, people change in small communities, and particularly here in mining communities, people come and go all the time. So a service will come into

> town, wave their flag, tell everyone they exist, and out they go because they've tendered for this ginormous area, yet they only have a small bucket of funds to actually do it. And I'll ring them and go, oh no one actually knew you existed, and then they'll go, oh well I've been out there, and yes, who'd you tell, because they've all gone. So now we're back to no one knowing about you again" (Bella).

The initiative has been popular, sparking new connections that would previously not been possible, such as Bella describes:

> 'I think what happens is that everyone talks about working together and no one ever does, it's so annoying. And I started running a meeting for family and carers of mental health and one day someone said to me, I'd go to that meeting, and I said, I work for Health, I've got money, you've got money, let's work together. So we started all these partnerships and it worked, I run a carer's group here, I don't pay for it, I just write her a nice little, you know, I'll staff it, you pay for it, it's a win-win for both of us'.

Bella also reported that the counsellor from the school contacted her to put her in the system, so when families visit the GP she can be their first referral base. This points to the problem of identification in schools:

> 'They can't support them in the schools if they're not identified, so if the GPs send them somewhere else, then they don't know, so they may be getting word that the teachers are identifying there's sort of an issue but we're not sure what that looks like' (Bella).

By collating this directory, Bella reports that unlike other regional and remote locations, Cobar has adequate service provision for mental health issues, with a mental health nurse visiting fortnightly for four days; two private psychologists in the town; Marathon Health managing the former ATAPS funding; two Community Health clinicians employed by the LHD two days a week each: a visiting mental health worker, and a local child and adolescent mental health worker; a fulltime counsellor at the local high school; a family mental health support service run by Interrelate who work with families with children at risk;

> 'People sort of yell and scream for services, but there's enough services, there's school counsellors, there's the family referral service, there's lots of things in town' (Bella).

This is confirmed by the GP, who reported that he had not seen a patient with mental health issues in 9 months he has been at the practice, which is in stark contrast to the very remote area where he previously worked.

As a result of the integrated care initiative, Bella reports:

> "Cobar's got a really strong community services forum here now thanks to integrated care, we have a really good community services directory, and we're working together, people are getting more referrals, there's plenty of people at Flourish Australia, they went from probably two workers, and when we started to figure out who's who and started referring appropriately, suddenly they've got three workers, they're building a workforce because people are being utilised".

Interestingly, Bella raised the problem of how SH might be missed in a presentation where drug and/or alcohol is involved:

> "Self-harm, that's a hard one to capture. When we're talking to people around data collection, it depends on what happens, they may have self-harmed, but they might have ODd, so how do they report it? No one picks the self-harm up because they're intoxicated, so that's the secondary not the primary, so was it a suicide attempt or self-harm, you know? All the reporting systems report differently, so to get accurate, clean data, I think, is a really hard thing. That's what the ambulance would say – we might get a call out over

> triple 0 saying my friend's overdosed, so that's how we pick them up, we'll take them up to ED and they'll evaluate it because that's what the next step is, so then it turns very clinical and it's about the presentation and what to do with it".

The GP in the local practice positively affirmed the effect of the integrated care initiative, in contrast to another NSW very remote practice where he had previously worked.

> "This place is much better and the people are more intimate, which surprises me because we've got psychologists, counsellors, we've got a mental health team coming in, we've got school counsellors, we've got GPs, we've got adolescent psychiatrists on tele-health, once a week there is a tele-health psychiatrist, so that's more resources, and that's less issues being shared on. So our job as a GP is more a screening job, ok, we've screened you, this is a problem, follow this, you've got this team to work with on and we'll see how we go, how the progress and then follow up. But the other practice is a bit different, we have to put the shoes on and have run on the field as well, because there is no resources there" [Tarek, very remote].

The services directory compiled by Bella was due to be completed and distributed to services in the Cobar region in late 2017.

## Summary

While different in scale, form, scope and function, each of these case studies are innovations located in general practice that provide different kinds of support to YPSH and their families and has the potential to be extended in some way to general practices across NSW. The Teen Clinic model provides free medical services to adolescents, while generating subsequent GP and specialist appointments that enable the clinic to be fully self-funding. It is important to acknowledge that not all general practices have the client base, funds, resources, interest, or capacity to attract specialist practitioners such as adolescent psychologists that would facilitate a Teen Clinic, especially those in remote and very remote areas, and even in major city areas where practices compete for clients. It is possible however, to see the potential for the model to function across cooperating practices, whereby drop in facilities for teens can be distributed across the week, as with GP appointments, while practices may collaborate to appoint a shared psychologist with regular appointments reserved for teens.

The second case study can more readily be applied to regions and cities across all five of the remoteness category areas in NSW. As already implemented in Cobar, the pathways to integrated care model and services directory could be facilitated by other LHDs working collaboratively with the local PHN, and co-located with and auspiced by one general practice, to link and resource GPs, mental health professionals, clinicians, specialists, schools, community workers, NGOs and community-led groups. This initiative represents the less resource-intensive model of the two presented here, which can be readily adapted to the needs of each area to encourage integrated care across services in the primary health sector. Preliminary outcomes also suggest such an initiative, combined with adequate resources, has the potential to change the role of the GP from treatment to screening, referral and follow up.

# Discussion of findings

# Conclusions

## Implications and recommendations

## Further research

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# Appendices

## Appendix 1. Insights from the field trip interviews

In early June 2017, the decision was made to conduct fieldtrips to increase the possibility of recruitment, a strategy that proved to be effective. Overall, eleven field trips were conducted in June, July, August and September, covering almost 9,000 km.

On each trip, the aim was to travel from Sydney to the furthest location in one or more PHNs, visiting the listed practices and towns, as well as others if they were on route. If there was more than one practice in each town, the nearest on arrival was visited first, and on until the last. Once the goal of two interviews in each remoteness area, including LSES areas was reached, the trip continued to the next area, bypassing those remaining on the list.

In some cases, practices were telephoned ahead of arrival, if it was late in the day and the visit would have constituted a few hours' drive. Visits more successfully resulted in interviews when the researcher arrived either during lunch time, when the practice was quiet, when a GP was at reception, or later in the day immediately prior to closing. Solo practitioners were far more open to being interviewed, particularly if direct contact was made with the researcher on arrival. In many instances, particularly for the large medical centres, the Practice managers required prior notice or bookings and in some cases, were quite resistant to passing on information about the study to the GPs.

Incentives were offered to participants, constituting payment of a consultation fee. Overall, only two practitioners were remunerated, to the value of $60 and $80.

39 interviews were conducted, of which six were by telephone, while thirty three were face to face. 38 interviews were conducted by one member of the research team, while another member conducted one interview. Each transcribed their own interviews.

Table 4. Distribution of participants across PHNs and remoteness areas, and survey or interviews

| PHN | RA-1 Major Cities | RA-2 Inner Regional | RA-3 Regional | RA-4 Remote | RA-5 Very Remote | Per PHN |
|---|---|---|---|---|---|---|
| CES | 2 | 1 survey | | | No practices | 3 (1 survey) |
| HNECC | 2 | 1 + 1 survey | 2 + 2 surveys | | | 8 (3 surveys) |
| MUR | | 1 + 1 survey | 3 + 1 survey | 1 | | 7 (2 surveys) |
| NBM | 1 | 2 + 1 survey | No practices | | | 4 (1 surveys) |
| NC | | 3 | 2 surveys | | | 5 (2 surveys) |
| NS | 2 | 1 | | | | 3 |
| SENSW | 1 | 2 | 3 | | | 6 |
| SWS | 2 | 2 | | | | 4 |
| WNSW | | 1 | 3 | 1 | 2 | 7 |
| WS | | 1 | | | | 1 |
| **Total** | **10** | **18 (4 surveys)** | **16 (5 surveys)** | **2** | **2** | **48 (9 surveys)** |

## Appendix 2. Interviewee demographics

Table 3.1. Gender [n=39]

| | |
|---|---|
| Women | 15 |
| Men | 24 |

Table X. Age group of participants – average age 55.8 years [n=38: community worker excluded]

| 30–39 | 40–49 | 50–59 | 60–69 | 70–79 | 80–89 |
|---|---|---|---|---|---|
| 5 | 12 | 9 | 8 | 4 | 1 |

Table 3.2. Years in practice – average 18.9 years [n=38: community worker excluded]

| 1–5 | 6–10 | 11–20 | 21–30 | 31–40 | 41–50 |
|---|---|---|---|---|---|
| 12 | 3 | 9 | 9 | 2 | 3 |

Practice types ranged from solo practitioners who had been located in the same practice for many years, to multi-practitioner medical centres and GP Supercentres (note, registrars not included in this count). Many practices had part-time GPs, and two of the interviewees were locums.

Table 3.3. Practice type (registrars not included) [n=36]

| Solo practice: 1 practitioner | Small practice: 1.5–5 GPs | Large practice 6–10 GPs | Medical Centre or GP Supercentre |
|---|---|---|---|
| 12 | 16 | 6 | 2 |

Table 3.4. GP training location [n=38: social worker excluded]

| Australian trained | Overseas UG training, PG training in Australia | Overseas trained |
|---|---|---|
| 26 | 9 | 3 |

Table 3. Interviewees' pseudonyms

| PHN | Major cities | LSES | Inner regional | LSES | Regional | LSES | Remote | LSES | Very remote | LSES |
|---|---|---|---|---|---|---|---|---|---|---|
| **CES** | Martin Groves | Jannini Arim | | | | | | | No practices | No practices |
| **HNECC** | David Lomas | Paula Tan | | Ron Golden | Katherine Raite | Marcia Burdekin | | | | |
| **MUR** | | | | Motek Barak | Nadia Verot | Viapool Ghan Neranda Mitza | | No practices | | |
| **NBM** | Richard Tang | | Malcolm Burns | Arun Marchanda | No practices | | | | | |
| **NC** | | | Tony Soo | Derek Molden | | No practices | | | | |
| **NSYD** | Carolyn Stokes Marguni Herra | | Kola Meldo | | | | | | | |
| **SWNSW** | | Vebna Mahun | Terrence Ballen | Sally Lancer | Candice Thompson | Donna Terle Duncan MacKinnon | | | | |
| **SWSYD** | Dorien Serandi | Mark Lapogo | Lewis Jerde Charles Sin | | | | | | | |
| **WNSW** | | | | Michael Cho | Peter Burke Dobie Mbele | Linda Bell | Sharif Bye | AMS only | Bella King, Tarik Merga | |
| **WSYD** | | | Natasha Savic | No practices | | | | | | |

## Appendix 3. Interview guide

**ETH16-0795 The primary health care response to adolescent self-harm: interview guide**

1. Demographic information
   - Name, age and location of practice
   - Years in practice, number of years in current location
   - Number of GPs in practice
   - General patient demographics (young people, ethnic diversity, age, socioeconomic factors)
2. GP practices (what do you do?)
   - Can you tell me about your recent experiences treating young people aged 10–24 who have self-harmed or whom you suspect are at risk of self-harming?
   - How would you describe these patients? (gender, age, socioeconomic, geographic, ethnicity/cultural and linguistic diversity, Indigenous, immigrant)
   - Can you tell me about a particular example? What did they come to you for? What kind of help do you think they were they seeking?
   - If you were to advise a colleague on how to identify a young person who is at risk of self-harm, what would you say to look out for?
   - What strategies would you recommend the colleague use to treat or manage young people suspected of self-harming? Can you talk me through the process? (Prompt: age-related strategies? male/female different strategies? mental illness or substance misuse? family?)
   - Do you make use of mental health care plans?
   - Is there a particular allocation of GPs in your practice to treat YPSH? If not, do you think there should be?
   - What are some of the outcomes for the young people you have treated?
3. Resources and support networks or training used
   - What kinds of resources would you suggest your colleague use to help them support young people who self-harm?
   - How helpful are these resources?
   - What would you say is missing from the resources you currently use?
   - What kinds of support organisations do you refer these patients to?
   - To whom do you talk to help you manage the treatment of young people who self-harm?
   - What are some of the perceived facilitators and/or barriers in the provision of support in PH for young people who SH?
   - Have you engaged in any health care promotion training?
   - Do you know of any school programs addressing self-harm?
4. Resources and/or training needed
   - Are you aware of any work in schools about SH?
   - What kinds of training/education have you engaged in to help you manage young people who self-harm or you suspect are at risk of self-harm?
   - What did you like about this training/education?
   - What kinds of additional support or training do you think might help?
5. Attitudes (what do they think about self-harm?)
   - How do you make sense of self-harm in young people?
   - What are some of the underlying determinants for SH in young people?
   - What are some of the protective factors, such as resources or assets young people draw on when engaging in primary health for help with SH?
   - What do you see as the best way to work with these young people?
   - How do you think parents/families of young people who self-harm might best be supported?
   - In what ways do you think this issue could be addressed more broadly in the community?

GP interview protocol Page 1

## Appendix 4. Information sheet and consent form

**INFORMATION SHEET**
**The Primary Health Care Response to Adolescent Self Harm**
(UTS HREC REF NO. ETH16-0345)

WHO IS DOING THE RESEARCH?
**Dr Teena Clerke**. I am an academic at UTS. I can be contacted on **0414 502 648.**

WHAT IS THIS RESEARCH ABOUT?
This research is to find out how primary care staff and General Practitioners in particular identify and respond to self-harm in young people, and what knowledge and resources they draw on to do so. For the purposes of this study, young people means between 10 and 24.

IF I SAY YES, WHAT WILL IT INVOLVE?
I will invite you to participate in a 15–20 minute audio-recorded interview at a place and time convenient to you, or over the phone. We will share the findings of this research with other researchers and practitioners through reports and papers in journals. However your name or any identifying features will not be present. We will also provide a leaflet outlining the findings of the research to you and other participants. The data may also be used for further studies to inform research about interventions to reduce self-harm.

ARE THERE ANY RISKS/INCONVENIENCE?
Yes, there are some risks related to your involvement in this research but these are minimal because the research only involves seeking your opinions and experiences. You will experience minor inconvenience as we will require you to attend an interview (either by phone or face to face) at a time and place suitable to you. It is possible that you may feel some discomfort, embarrassment, or sense of vulnerability during the discussion but the process can be terminated at any time and counselling is available to address any issues that come up if you need.

WHY HAVE I BEEN ASKED?
You are able to give us information about your views and/or needs regarding self-harm strategies.

DO I HAVE TO SAY YES?
You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?
Nothing. I will thank you for your time and won't contact you about this research again.

IF I SAY YES, CAN I CHANGE MY MIND LATER?
You can change your mind at any time and you don't have to say why. I will thank you for your time so far and won't contact you about this research again.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?
If you have concerns about the research that you think I, Teena Clerke can help you with, please feel free to contact me on (teena.clerke@uts.edu.au). You can also contact Professor Fiona Brooks (fiona.brooks@uts.edu.au Tel: 9514 4577) or Associate Professor Angela Dawson (angela.dawson@uts.edu.au Tel 9514 4892).

If you would like to talk to someone who is not connected with the research, you may contact the Research Ethics Officer via Research.Ethics@uts.edu.au, and quote this number: UTS HREC REF NO. ETH16-0345.

**The Primary Health Care Response to Adolescent Self Harm**

***INFORMED CONSENT FORM***

I _____ *(participant's name)* of

_____(location) agree to participate in the research project: *The Primary Health Care Response to Adolescent Self Harm* (UTS HREC REF NO. ETH16-0345) being conducted by Prof Fiona Brooks (fiona.brooks@uts.edu.au Tel: 9514 4577) and Drs Teena Clerke (teena.clerke@uts.edu.au Tel **0414 502 648**) and Angela Dawson (angela.dawson@uts.edu.au Tel 9514 4892).

I understand that the purpose of this study is to find out how primary care staff and General Practitioners in particular identify and respond to self-harm in young people, and what knowledge and resources they draw on to do so.

I understand that I have been asked to participate in this research because of my role in primary health care and/or general practice identifying and responding to adolescents who self-harm. I understand that my participation in this research will involve participation in a 15–20 minute face to face/telephone audio recorded interview at a place and time of convenience to me. I am aware that there is a risk that I may feel some discomfort, embarrassment, or sense of vulnerability during the interview but that the process can be terminated at any time. I am aware that counselling is on hand to address this if required.

1. I agree to participate in the study described in the participant information statement.
2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.
3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any inconvenience and discomfort I might suffer as a result of my participation and I have received satisfactory answers.
4. I understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason**.** I understand whom to contact if I wish to withdraw, and that I do not have to give any reason.
5. I agree that research data (interviews) gathered from this project may be published in a form that does not identify me in any way.
6. I also agree that non-identifiable data collected from this study may be used to inform a future study on preventing self-harm and my confidentiality will be maintained.
7. I understand that if I have any concerns or questions relating to my participation in this research, I may contact Prof Fiona Brooks who will be happy to answer them.
8. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.
9. I agree that Teena Clerke has answered all my questions fully and clearly.

_____ ____/____/____

Signature (participant)

_____ ____/____/____

Signature (researcher or delegate)

**NOTE:** This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer (ph: +61 2 9514 9772 Research.Ethics@uts.edu.au), and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome.