HeadStart

Young people working with GPs to get
Back-on-Track

Child and Adolescent Mental Health Training for General Practitioners.

This project is funded by:
the Children, Youth and Women's Health Service (CYWHS) and
the Department of Health (Mental Health Unit) through
the South Australia Division of General Practice Inc (SADI)

OVERVIEW – July 2006

Government of South Australia
Children, Youth and Women's Health Service

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PROJECT OVERVIEW:

Program Scope:

The Scope of this program is to deliver training and education to GPs in South Australia who are managing children and adolescents with mental health issues and to provide them with increased access to mental health clinicians (not necessarily psychiatrists) for advice on appropriate psychological consultation and management of the child or young person in the care of the GP.

The project will:

- Ensure that consumers and carers are involved in the planning, development, delivery and review of training, wherever possible.
- Ensure that all training is registered and recognised under the 'Better Outcomes in Mental Health Care Initiative through the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine so that GP's can gain access to any Service Incentive Payments and relevant Continuing Professional Development points.
- Provide a child and adolescent mental health "hot line" phone number for GP's to access once they have completed Level 1 training, which will give them direct access to a Mental Health Clinician. They will also be informed about using existing Emergency Mental Health Services at the Women's and Children's Paediatric Emergency Department (CYWHS).
- Establish referral pathways between GP's and CAMHS clinicians and identify processes to provide support and advice to GPs whilst their patients are on the CAMHS waiting list.
- Ensure that the Chief, Division of Mental Health has the program on the agenda at appropriate Commonwealth funding meetings and that funding applications are submitted as appropriate.

Project Development Membership:

During 2005, a project group was assembled to oversee the development of a pilot training program. The project groups involved the following members:

Reference Group:
Mr Phil Robinson, Chief, Division of Mental Health (CAMHS), CYWHS.
Dr Jon Jureidini, Medical Unit Head, Department of Psychological Medicine, CYWHS
Mrs Sandy Terry, Senior Project Officer, CAMHS, CYWHS
Ms Barbara Magin, Mental Health Programs Manager, ANDGP
Dr Sue Evans, General Practitioner
Ms Kathy Crossing, Director, CAMHS Northern Region, CYWHS
Dr Tori Wade, Medical Director, SADI
Dr Anne Sved Williams, Medical Unit Head, Helen Mayo House, CYWHS

Working Party:
Dr Jon Jureidini
Mrs Sandy Terry
Ms Barbara Magin
Dr Sue Evans

INTRODUCTION:

The purpose of this report is to provide an overview of the HeadStart Program. It also contains information from the pilot training, which was conducted in 2005.

Dr Jon Jureidini (Head, Department of Psychological Medicine) and Mrs Sandy Terry (Program Manager) both from the Division of Mental Health (CAMHS) at the Children, Youth and Women's Health Service (CYWHS) manage the program.

Young consumers from the YouTHink and Headroom Projects have also been involved in the project namely in the development and review of training material, the review of scope and project documentation and the design of various graphics and handouts. Consumer and carer involvement will continue throughout the project but may utilise consumers and carers from local areas where the project is being delivered, so that local community issues are discussed and are more relevant to GPs from the surrounding areas.

Currently, the South Australian Department of Health (Mental Health Unit) has provided funding to continue the project for the next 12 months (until April 2007). The funding has been allocated to SADI who have contracted the Children, Youth and Women's Health Service's (CYWHS) Division of Mental Health (CAMHS) to develop and deliver the training.

The program is being delivered in 4 locations over the 12 months. The sessions have been booked for the Limestone Coast, Western metropolitan, Southern metropolitan and the Flinders and Far North areas.

The Statewide Mental Health Evaluators (Fresbout Consulting Pty Ltd) will evaluate the project and the results will be included in the Statewide Mental Health Shared Care report. The GPMHSC are also auditing the program on the 29th July in Mt Gambier.

The HeadStart program has been approved by the RACGP, GPMHSC as Level 1 training and ACRRM. The project team will fulfil reporting requirements to all three groups in relation to the ongoing progress of the training.

It is the intent that GPs in both Southern and Northern areas of the state are given the opportunity to attend this training, with the long-term focus being that it could be implemented as a Statewide and National initiative.

OVERVIEW OF TRAINING PROGRAM:

"HeadStart" is a 6-hour workshop (Level 1 – 30 points) preceded by a 1 hr introductory module aimed at GPs to supplement their existing skills in managing children and young people who present with mental health issues, and to capitalise on their existing knowledge about their patients and families in planning rehabilitation interventions.

The training and education will be in line with the provisions of the Better Outcomes in Mental Health Care Initiative (BOiMHC). It will focus on the 3 step mental health process ie assessment, planning and review but will also provide access to allied mental health services and access to psychiatric mental health services, relevant to this client group (ie children under the age of 18 years).

The focus is on how GPs can learn;

- to make their practice more youth friendly,
- to enhance their interview skills with this client population,
- to further develop current assessment skills,
- about planning, applying and reviewing new intervention techniques other than prescribing medication,
- about recognising cultural issues in young people,
- about improving collaboration and shared care options with child and adolescent mental health clinicians,
- about improving management, transfer and discharge pathways for rural and remote GPs.
- to negotiate a rehabilitation plan in consultation with the young person, with clear goals that can be measured on review.

Young consumers will also be involved in the delivery of the training, which will provide GPs with an understanding of the barriers young people face when presenting to their GP with mental health issues.

Once they have completed the training and relevant assessment questionnaires, GPs will receive a regular e-bulletin, and access to a website. The regular Headstart bulletin aims at keeping GPs up to date with the latest child and adolescent mental health information and provides GPs with quick single page refresher on information and topics discussed at their training. The website will also provide them with quick links to various information such as guidelines for transporting country patients to the CYWHS, how to use the various tools such as the Alert Form when liaising with CAMHS staff etc as well as providing relevant journal articles which may be of interest. (www.headstart-gp.com.au)

They will also be given access to the "HeadStart Hotline", which provides GPs with immediate support and assistance from a child and adolescent mental health clinician. The long-term goal of these measures is to enhance collaborative relationships between CAMHS clinicians and GPs, with the effect of improving the speed of referrals and the ability to provide a shared care arrangement in the management of patients. The benefits will therefore not only be to the GPs and CAMHS staff, but their patients as well.

This program was piloted between January and August 2005. A summary of the feedback from GPs is attached, which highlights the desire from GPs for further training in this area. This was conducted as part of a package of projects by the Division of Mental Health (CAMHS) at the Children's, Youth and Women's Health Service including the National Youth Participation Strategy (NYPS), the Children of Parents with Mental Illness (COPMI) and the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) under the guidelines of the BOiMHC. The pilot training was delivered in collaboration with the Adelaide Northern Division of General Practice (ANDGP).

The program is delivered as 1 x 1hr introduction and then 3 x 2 hr sessions either on a single day or, ideally, over 3 days up to a month apart, according to the needs of the GPs. Face-to-face delivery is anticipated to consist of 1/3 didactic and 2/3 interaction, some of it in small groups and some in role-plays.

Our experience of teaching child and adolescent MH to psychiatry trainees is that the skills learned are readily applicable to their adult patients. Similarly we would expect the family centred rehab approach taught here to enhance GP work with adults.

The evidence that supports this program is as follows:
It is well established that the burden of mental health problems and mental illness is high. Depression is predicted to be one of the major health problems worldwide by 2020 (Murray & Lopez, 1996)[1]. The majority of people with a mental health problem do not seek any professional help. Of those who do, three quarters visit a General Practitioner (GP) as a first point of contact (Australian Bureau of Statistics, 1997)[2]. GP's and other primary care services therefore deliver the bulk of initial mental health care by direct treatment, shared care, or referral to other health professionals. In 2000-01, almost 11 million visits to GPs were for mental health conditions (Australian Divisions of General Practice, 2003)[3]

Recent evidence compiled by the World Health Organisation (WHO) indicates that by the year 2020, childhood neuropsychiatric disorders will rise by over 50 percent internationally to become one of the five most common causes of morbidity, mortality and disability among children. (National Institute of Medicine, 2002)[4]

In Australia, surveys indicate that between 14-18% of children and young people aged 4-16 years, experience mental health problems of clinical significance. This equates to in excess of 500,000 individuals nationally. These findings are comparable with findings internationally. (Sawyer et al 2000)[5]

The prevalence of mental health problems and disorders in children and young people in Australia is significant and represents a large public health problem. Infants, children and young people need to be treated within a developmental framework, which addresses their unique needs. The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) believes that service arrangements for this population should be consistent with mainstream health service provision that broadly provides medical, hospital and community services around the age 0-18 years as evidenced by age criteria for child and youth services around the country and the world. (AICAFMHA Position Paper 2004)[6]

"It is important to underscore the often heard admonition that 'children are not little adults'. Even more than is true for adults, children must be seen in the context of their social environments, that is, family, peer group, and their larger physical and cultural surroundings. Childhood mental health is expressed in this context as children proceed through development" (Surgeon General's Report on Mental Health, 1999, page 123)[7]

Sawyer et al (2000)[5] in the Mental Health of Young People in Australia noted:
"Adolescents with mental health problems do not have problems that are limited to a single aspect of their lives. Rather, their problems are wide-ranging and include suicidal ideation, smoking, alcohol use and drug abuse. There is consequently a need to develop joint policies and strategies across the different services that provide help to young people with mental health and related problems (eg, school-based services, paediatricians, family doctors, mental health services, and drug and alcohol services)." (Sawyer et al, 2000, page xii).

O'Hanlon et al (2004)[8] in the Partners in Prevention: Mental Health and General Practice recommends:
"Referral pathways that take multidisciplinary approaches, and promote shared care and joint action across sectors, are required. General practitioners need improved access to appropriate psychological consultation, treatment and advice in order to better understand and support people at risk, within a preventative frame. Equally, at the systemic level, there needs to be improved communication and collaboration between general practice, government and non-government

organisations and specialist providers (in particular, child and adolescent mental health services)". (O'Hanlon et al, 2004, page xiv).

Jureidini et al (2004)[9] and Whittington et al (2004)[10] illustrate the dangers of responding to young people as though they were adults in treating depression in children and adolescents. A combination of the relative unavailability of CAMHS services, lack of access to skilled providers of psychological interventions, aggressive promotion by the pharmaceutical industry, and a belief that Selective Serotonin Reuptake Inhibitors (SSRI's) were safe, led to a striking increase in SSRI prescribing in under 18's in the decade leading to 2004, especially by general practitioners. However, recent reviews of the published and unpublished literature have established that a number of SSRI's have been insufficiently researched to demonstrate their effectiveness or otherwise in young people under 18. For those SSRI's with adequate research data available, the cost/benefit ratio, (when patient safety is taken into account) is at best marginal or in some cases ineffective in the treatment of mild and moderately severe adolescent depression. This outcome illustrates some of the dangers of adopting standards that represent best practice in research, clinical practice and disclosure by pharmaceutical companies to address the specific mental health needs of infants, children and adolescents.

A summary of the findings to date:

- Psychological therapy (such as cognitive behaviour therapy and interpersonal therapy) is the recommended first-line treatment for child and adolescent depression.
- On current evidence, the ratio of potential harm to potential benefit is unfavourable for the SSRIs (and venlafaxine) for child and adolescent depression.
- There is consistent evidence of increased risk of suicidal ideation and behaviour, which increases from 2% with placebo treatment to 4% with an SSRI.[11]
- The evidence for increased suicidality has emerged in trials of approximately 8 weeks duration. Risks of longer treatment are unknown.
- Fluoxetine is associated with adverse effects including increased suicidality. It has some evidence of efficacy, and hence a slightly better benefit: harm ratio than other SSRIs. However fluoxetine's evidence of efficacy is not overwhelming; around two-thirds the numbers who respond to fluoxetine show a similar response with placebo.
- No antidepressant is licensed in Australia for use in children or adolescents with depression. The Therapeutic Goods Administration (TGA) has instigated changes to product information to include warnings about the known risks in this context.[12]
- Adverse effects such as hyperkinesia, agitation, mania and hostility can occur with the SSRIs including fluoxetine. Although not common, these effects are consistently noted in trials.
- Although not first-line treatment for depression in children and adolescents, in some individual cases the use of an SSRI might be considered appropriate by a child psychiatrist or other mental health expert. In this case, response to treatment must be monitored closely with regular review. The potential for harmful adverse effects must be discussed with both patients and parents/carers, and explain the need for home and clinic monitoring.
- Tricyclic antidepressants have previously been shown to be no more effective than placebo. As the risks with non-SSRI antidepressants could not be ruled out, the precautions apply to all antidepressants.[13]

In summary, GPs are at the frontline in managing high prevalence mental illnesses such as depression and anxiety in the community. This is because GPs are often the first point of call and are expected to have the knowledge and skills to assess both the physical and psychological symptoms of people with a possible mental illness. GPs are also often perceived as a low stigma option for people seeking out professional assistance. It is therefore critical that GPs are trained and supported by child and adolescent mental health specialists. These specialists don't have a vested interest in prescribing medication and therefore offer an unbiased and holistic approach to the mental health problems that children, young people and their carers face.

Experience demonstrates that the consumer perspective and carer perspective are frequently different, therefore as part of the commitment to consumer and carer involvement and as part of the National Mental Health Plan, wherever possible, a carer and consumer will be involved in the planning, development, delivery and review of the training modules.

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OVERALL OBJECTIVES:

- To provide GPs with techniques for engagement with young people who present with physical and mental health issues.
- To enlighten GP's about young people's barriers to presenting with mental health issues and steps to reducing these barriers.
- To build on GPs existing skills in conducting a child and adolescent mental health base line history and assessment.
- To provide GPs with the tools for accessing immediate support and advice from a child and adolescent mental health clinician.
- To provide GP's with the intervention techniques for mild to moderate cases of distress, depression and anxiety.

LEARNING OBJECTIVES (knowledge (K), skills (S), attitude (A), behaviour (B))

By the end of the seminar participants will have increased their knowledge in the following areas:

- Increased clinical knowledge in assessing mental illness in children and adolescents using the 3 step process as per the BOiMHC (K)
- Increased knowledge in the support systems available for GPs treating young people with mental illness (K)
- Increased clinical knowledge in the use of other treatment options other than medication. (K)
- Increased clinical knowledge in the use and side effects of psychiatric medications. (K)
- The role of harm minimization particularly in relation to drug and alcohol misuse and sexually dangerous behaviour (K)
- Confidentiality and the legal implications and duty of care in relation to assessment; the need to warn others of dangerousness; and detention under the Mental Health Act (K)

Participants will have acquired the following skills:

- Feel more confident in their ability to engage children and young people. (S)
- Be able to conduct a base line history for a child or young person presenting with mental health issues (S)
- Recognise signs and symptoms of common paediatric mental health problems, particularly psychosis, anxiety and depression (S)
- Be able to undertake a mental health assessment on a child or young person presenting with mental health issues (S)
- Be able to identify, assess, treat and make appropriate referrals for children and young people who present with mental health issues (S)
- Be able to confidently liaise with other agencies, including CYFS and CAMHS, in advocating for their patient's needs (S).

Participants will have increased confidence in the following areas:

- In the assessment of suicidal risk and confident when to refer on (A)
- In addressing the barriers young people have when presenting to a GP (A)
- In treating children and young people who suffer from mental health problems (A)
- In the interface between medical illness and psychological difficulties in young people (A).

Participants will be provided with:

- The opportunity to practice new behaviours and techniques that will enhance their work when dealing with young people through role-plays and contributing to both small and larger group discussions (B)
- The tools to make their practice more youth friendly (B)
- The encouragement and support to actively seek out information about patients that have been referred on, if this information has not come to them (B)
- Increased comfort when liaising with CAMHS and other Child Psychiatry Services (B).

TRAINING MODELS:

The Training models are as follows:

Work by Iliffe et al (2004) shows that work with GPs needs to be adaptable to the different working style of different General Practitioners.

> 'The introduction of new interviewing and therapy skills in General Practice cannot rely upon a single form of training, education or professional development, as practitioner's respond in different ways according to their experience and training, sensitivity to psycho-social issues and own emotional state'. (Iliffe S, Gledhill J, da Cunha F, et al(2004). *The recognition of adolescent depression in general practice: issues in the acquisition of new skills.* Primary Care Psychiatry. Vol 9, No. 2, 2004, 1-6.)

Time constraints need to be respected and are 'the biggest obstacle' to applying new diagnostic and intervention packages. Although timely recognition and management of mental health problems will save time and money for the whole medical system in the medium to long term, the individual GP dealing more comprehensively with mental health issues will have extra costs. Therefore, incentives are required to engage most GPs in this kind of practice. Capacity exists within the HIC system to better renumerate this work and continuing medical education points can also be gained. Neither of these strategies however has so far been completely successful.

In our consultation with GPs, another barrier to GP involvement in this area is that they do not feel their opinion and expertise is adequately valued by mental health services staff when they refer or consult. Conversely mental health staff have complained that GPs do not understand the pressures on the mental health system and do not refer in a helpful way.

Thus we have plausible and acceptable diagnostic and intervention packages but low uptake by GPs and poor relationships between GPs and mental health staff. GPs are grateful for training but value more highly the availability of colleagues to assist them with specific dilemmas. They often desire immediate access to a mental health consultant (not necessarily a psychiatrist) to help with difficult cases.

To summarise, we need an intervention that addresses the two critical barriers to GP engagement in working confidently with patients who have a mental health issue

- The lack of incentive to put in the extra effort required.
- Scepticism about the quality of support that will come from the mental health system.

This leads us to propose a further incentive to GP engagement – the availability of an appealing high quality immediate consultation service contingent on the GP undergoing sufficient training to be able to make appropriate use of that service.

Part of the function of the Introductory training would be to promote the Level 1 package as leading to the availability of the 'hotline' service. The Level 1 package has been approved for Continuing Professional Development (CPD) and Service Incentive Payments (SIP).

The training package may consist of the following modules and will be delivered by lectures, handouts, videos, role plays and if possible at some later date, through online training:

THEME	MODULE 1	MODULE 2	MODULE 3
SKILLS:	**INTERVIEWING**	**ASSESSMENT**	**MANAGEMENT**
ANXIETY	'What's wrong' vs 'What's bugging	The anxiety cycle, hyper-ventilation	Desensitisation, breathing, etc
DEPRESSION	Sadness, grief vs illness	Diagnosing depression	Neuro-vegetative rehabilitation
DRUGS	Good drugs/bad drugs	Interface with MH	Harm-minimisation
BEHAVIOUR PROBLEMS	Behaviour has meaning	Self-regulation vs ADHD	Teaching Mind Magic
BOiMHC steps	History taking	Assessment/ treatment planning	Treatment planning/ reviewing

Tier 1 – Introduction to HeadStart

(1 hour - This is a pre-requisite to continuing to Tier 2)

Introduction to the project

1 What challenges do you as GPs face with children and adolescents?
2 Guide to available services:
   - Information about CAMHS and waiting lists etc
   - How to refer to CAMHS
   - How to utilise CAMHS allied health staff not just psychiatrists.
   - Expectations of CAMHS service
   - Providing support and advice whilst waiting on the CAMHS waiting list
3 Benefits of doing the training:
   - "HeadStart Hotline" and shared care options
   - CPD and SIP points (Continuing Professional Development & Service Incentive Payments)
   - What professional benefits will be obtained
4 Overview of the 3-Step BOiMHC process and how this will be incorporated into the training.
5 Identify what other issues GPs would like addressed through the training.

Tier 2 – HeadStart: history taking, assessment and models for intervention

Level One training (30 points - total of 6 hours training)

1 **Techniques of engagement and questioning strategies for use with children and adolescents** (BOiMHC step 1).
   - Who to interview; interviewing with and without parents
   - What can be done in a 10 minute assessment
   - Questioning skills:
     - ❑ Closed versus open multiple choice questions
     - ❑ Speculating about the adolescent's experience
     - ❑ Third person perspective
   - Talking about feelings: the "feelings triangle"
   - Optimal treatment versus harm-minimization

2 **What constitutes a baseline history for children and adolescents with mental health issues? (BOiMHC step 1)**
   - Why Now?
   - Genogram
   - Sequence
     - ❑ Antecedents
     - ❑ Behaviour
     - ❑ Consequences
   - Family as well as Individual Perspective
   - Functional profile

3 How to make your practice youth friendly (BOiMHC all steps)

This segment will involve trained young people and carers, both on DVD and face-to-face, in talking to and role-playing with GPs.

- Physical changes
- Reception staff
- GP attitudes and practice
- Discussion on how to use best practice methods in providing a youth friendly service to clients. This will include how to encourage young people to approach the service in a confidential manner, appropriate information in a youth-friendly manner and providing feedback from young consumers on their perceptions and needs of a GP service.
- Cultural diversity in adolescent health care is also an area that will be discussed as young people are not only dealing with the developmental tasks of adolescence but possibly also the experience of growing up between two cultures.

4 "Back-on-Track" (BOiMHC steps 2 &3)

It is a feature of research into depression that the 'placebo' response is very high in adolescents, even with moderately severe depression. Sometimes placebo is equated to doing nothing but remember that placebo patients in trials receive regular monitoring and support. Thus one way of interpreting the literature on child and adolescent depression is that such monitoring and support constitutes a powerful treatment methodology and it should not be equated with 'doing nothing'.

Work by Gledhill et al (2003) shows that it is feasible to teach GPs to develop non-drug based interventions for depression that can be used within the constraints of general practice consulting. Added to this, NICE advocate 'Watchful Waiting' as an intervention for mild depression. This merely consists of reviewing the patient within 2 weeks. (The National Collaborating Centre for Mental Health. Depression in Children and Young People. Identification and management in primary, community and secondary care. British Psychological Society, 2005. http://www.nice.org.uk/pdf/cg028fullguideline.pdf. Accessed October, 2005.)

Bringing together these two approaches leads us to a somewhat more active version of Watchful Waiting (ie "Back-on-Track") that will be suitable for mild and moderate cases of depression and anxiety. Having excluded the risk of acute danger (from suicide or other activities) the GP will learn to offer some or all of the following:-

- Psycho-education – explain what depression/anxiety is and communicate the expectation for recovery.
- Advise seeking out a confidante and or keep a journal (evidence for positive effects of talking about or writing about feelings).
- Encourage good eating patterns
- Advocate a regular exercise program or some other activity (evidence for supervised exercise in treatment of depression).
- Sleep hygiene.
- Avoid drugs including caffeine and nicotine.
- The patient should be reviewed in 2 weeks and encouraged to call back before then if worried or if there is any deterioration.

5 Family Engagement (BOiMHC steps 2 & 3)

- The importance of engaging families in this process will be discussed with an emphasis on the provision of family therapy or other systemic approaches should a need be identified.

6 CAMHS Referral Process (BOiMHC step 3)

- Although GPs have identified a frustration at accessing CAMHS, the referral process will be discussed and how best to access CAMHS to meet the needs of the patient and their family or carers.
- Information about access to services, including emergency responses, will be provided on the Headstart website, which will be available to GPs who complete the training. See further information below.

- For country GPs who undertake this training, a special component will be added to discuss the issues of transferring patients to the CYWHS, how this process can be improved and what measures need to be implemented to ensure discharge planning is co-ordinated with the primary health care provider and family, in line with risk assessment and follow up principles. GPs will also be advised about the use of telehealth for such options as case conferences, ward rounds, discharge planning, follow-up after discharge etc.

7 CAMHS Hotline & Shared Care (BOiMHC steps 2 & 3)

- Discussion about the use of the "Headstart hotline", Emergency Mental Health Service and Shared Care arrangements and how these can provide support for GP's when dealing with children and young people with mental health issues.

Tier 3 – Shared Care - Level Two

GPs completing the Level 1 Training would be given a special phone number ("HeadStart Hot Line") that gives them access to a Mental Health Clinician during normal working hours. This service would be in addition to, and would work collaboratively with, the already existing 'Emergency Mental Health Service' provided by the Division of Mental Health at the CYWHS. Part of Level 1 Training would be on how to make the best use of such a consultation eg what information to impart in a brief conversation over the phone to allow the consultant to give the best advice.

Qualified GPs could also book longer telephone consultations (perhaps face-to-face if it were convenient for either the Mental Health clinician or the GP to travel) where difficult patients could be discussed outside the emergency situation. After such a consultation, a face-to-face interview with the Mental Health clinician and the GP in the GP's surgery could be arranged in selected cases.

SUMMARY OF RESULTS FROM 2005 PILOT TRAINING:

The program was piloted in 2005.

The feedback from the 42 GPs who undertook the training was outstanding. Evaluation of the program was through GPs completing pre-questionnaires (4 weeks prior to training), on-the-day session questionnaires and post-questionnaires (4 weeks after training has completed). A summary of the on-the-day session questionnaires is attached (see Table 1), which demonstrates that the outcome of the training was very positive and that GPs were requesting that it continue and the next stage be developed.

Comments such as "excellent to see a child psychiatrist providing support & education on the ground" and "a really valuable session and liked the interaction, spontaneity, flexibility of the format – there is a lot of information passed informally". These types of comments have been the motivator for the continuation of this program. There is also evidence that GPs confidence, skills, knowledge and attitudes have increased considerably since attending the training program.

The inclusion of consumers has also been very positive as both participating GPs and consumers have indicated a benefit from this experience. The consumers are highly motivated to now become actively involved in the delivery of training modules, which can be seen as a leading and progressive outcome from this program.

TABLE 1 - OVERALL SUMMARY OF SESSION QUESTIONNAIRES FROM THE PILOT TRAINING CONDUCTED IN 2005.

Satisfaction with Process & Presenters/Facilitators					
	Strongly Agree	**Agree**	**Neutral**	Disagree	**Strongly Disagree**
MODULE 1 - 12 participants – 9 completed survey (2 not required to complete)					
The **format** of the session was satisfactory	11%	89%	▫	▫	▫
The session was **relevant** to my patient care	11%	89%	▫	▫	▫
The **general facilitation of the session** by Jon Jureidini was satisfactory	22%	78%	▫	▫	▫
The **presentation by** Jon Jureidini was satisfactory	33%	67%	▫	▫	▫

Please make any comments you have on the above questions here
Clearly identified learning/presentation

MODULE 2 - 16 participants - 16 completed survey.	**Strongly Agree**	**Agree**	**Neutral**	Disagree	**Strongly Disagree**
The **format** of the session was satisfactory	31%	69%	▫	▫	▫
The session was **relevant** to my patient care	69%	31%	▫	▫	▫
The **general facilitation of the session** by Jon Jureidini was satisfactory	69%	31%	▫	▫	▫
The **presentation by** Jon Jureidini was satisfactory	63%	37%	▫	▫	▫

Please make any comments you have on the above questions here

- Really valuable session.
- Excellent to see a child psychiatrist providing support & education on the ground.
- Liked the interaction, spontaneity, flexibility of the format – there is a lot of information passed informally.

MODULE 3 - 14 participants - 13 completed survey (1 not required to complete)	**Strongly Agree**	**Agree**	**Neutral**	Disagree	**Strongly Disagree**
The **format** of the session was satisfactory	46%	54%	▫	▫	▫
The session was **relevant** to my patient care	69%	31%	▫	▫	▫
The **general facilitation of the session** by Jon Jureidini was satisfactory	77%	23%	▫	▫	▫
The **presentation by** Jon Jureidini was satisfactory	85%	15%	▫	▫	▫

Please make any comments you have on the above questions here

- Very relevant. Would have liked more time and depth.
- Although not a fan of role-play, it may be helpful to include it, bearing in mind it can be several weeks in-between seeing patients who could benefit from our new talents.

Satisfaction with Impact of the Session.					
This session met the following desired objectives:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
MODULE 1					
To identify my needs from child & adolescent mental health services, not necessarily CAMHS.	▫	89%	▫	11%	▫
To provide me with a better understanding of the priority levels for the CAMHS waiting list and the information I can provide to assist this process.	33%	67%	▫	▫	▫
To begin the process of altering my current perspectives about child & adolescent mental health services.	▫	100%	▫	▫	▫
To identify some of the barriers faced by young people when presenting to a GP.	11%	89%	▫	▫	▫
To provide me with some basic knowledge about techniques for engaging with young people in the therapeutic setting.	▫	100%	▫	▫	▫
To provide me with some basic interview skills in conducting a child and adolescent mental health history and assessment.	11%	89%	▫	▫	▫
To increase my knowledge about support systems available for GPs treating young people with mental illness.	11%	89%	▫	▫	▫
To have the opportunity to discuss what challenges GPs face when dealing with this client group.	11%	89%	▫	▫	▫
To provide me with enough interest to attend the next training session on this topic to further my skills and knowledge in this area.	11%	89%	▫	▫	▫

MODULE 2	*Strongly Agree*	*Agree*	*Neutral*	*Disagree*	*Strongly Disagree*
To improve my knowledge about techniques for engaging with young people in the therapeutic setting.	50%	44%	6%	▫	▫
To improve my understanding of the barriers faced by young people in relation to presenting to a GP.	25%	75%	▫	▫	▫
To improve my skills in conducting a child & adolescent mental health history & assessment.	31%	69%	▫	▫	▫
To improve my intervention techniques for dealing with mild to moderate distress, depression & anxiety.	19%	44%	31%	6%	▫

List any changes you intend to make to they way you practice because of this session?

- Use more open-ended questions, family tree, look at ways to make practice more youth friendly.
- Intervention skills and techniques for relating and exploring issues.
- More genograms. Will look at ways of making practice youth friendly.
- Practice more formal assessment technique.
- 4 x Using genograms,
- Use 3rd person statements more.
- Widen the interview techniques of adolescent.
- Better history taking.
- Apply the HEADSS approach to assessment.
- Undertake future sessions in adolescent mental health.
- Attitude and interview style.
- Do more reading and research in the topic.
- Ask direct questions more when dealing with youths.
- Adapt history taking as have learned; review the age/fear/sadness triangle.
- Implement workshop outlines.

Would you like to make any other comments on the session or module in general?

- Doesn't like meetings on Monday.
- Very interesting, a little daunting for GPs to manage some of these issues.
- Good subject area.
- Appreciates being able to do this locally.
- Treatment session would be good.
- Good introduction.
- Drug use and its effect on behaviour/mental illness.
- It was interactive and of good value.
- Examples and role-play might be good.
- Need more of the same.
- Excellent.

Please list any other child and adolescent mental health topics you would like to incorporate into future training.

- Social phobias and dealing with problem parents.
- 4 x ADHD and Aspergers.
- 2 x more on treatment.
- Drug use eg. THC and counselling about risky behaviour.
- Eating disorders, anxiety, depression and relationship problems, PTSD.
- OCD in the above group.
- Management and treatment.

MODULE 3	*Strongly Agree*	*Agree*	*Neutral*	*Disagree*	*Strongly Disagree*
To increase clinical knowledge in the use of other treatment options other than medication.	62%	38%	▫	▫	▫
To define the role of harm minimization particularly in relation to drug and alcohol misuse and sexually dangerous behaviour.	30%	62%	8%	▫	▫
To recognise signs and symptoms of common paediatric mental health problems, particularly psychosis, anxiety and depression.	15%	77%	8%	▫	▫
To have an increased confidence in the interface between medical illness and psychological difficulties in young people.	23%	77%	▫	▫	▫
To have the opportunity to practice new behaviours and techniques that will enhance your work when dealing with young people.	15%	70%	15%	▫	▫
To increase confidence in assessing suicidal risk and when to refer the client on.	8%	62%	30%	▫	▫

List any changes you intend to make to they way you practice because of this session?

- I am going to try some "mind magic" education and 2 minute breathing exercise intervention.
- Will take more time with my adolescent patients.
- Use more modern terminology in approach.
- I thought the approach to behavioural problems was simple and easily convertible to use in general practice.
- Relaxation techniques and breathing exercises. Genogram. Sleep hygiene info.
- Using the checklist to help delve behind difficult behaviours. To review previous beneficial interview techniques I haven't implemented.
- To organise follow-up earlier and more frequently.
- Non-pharmaceutical strategies in management of depression and anxiety.
- To think from the children's perspective.
- Really think about "what is worrying" this patient.
- Suggestions/approaches to treatment and help.
- Many
- To determine what is this patient worried about and to take a lot more history re behavioural problems.

Would you like to make any other comments on the session or module in general?

- Tonight in particular very valuable. Last session was interesting but this has more practice take-home new tools.
- 3 x this module on treatment and actions was very interesting and useful.
- It was a breath of fresh air.
- I appreciated the clarity of presentation, small group and offer of practical support if needed.
- Refresher course would be helpful.
- This is very beneficial assistance. The age-old problem is time to produce and implement them.
- Excellent
- Very directive. No opportunity to practice skills.