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Towards early intervention for youth mental health in primary care: a mixed methods investigation

Dorothy Leahy

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UNIVERSITY of LIMERICK

OLLSCOIL LUIMNIGH

Towards early intervention for youth mental health in primary care: A mixed methods investigation

Dorothy Leahy, BA, BA, PgDip, MSc.

For receipt of PhD

University of Limerick

Supervisor: Professor Walter Cullen

Co-supervisors: Professor David Meagher and Dr Patrick Ryan

External Examiner: Professor Mary Cannon

Internal Examiner: Dr Patricia Mannix McNamara

January 2015

Abstract

Author: Dorothy Leahy

Student number: 0406708

Title: Towards early intervention for youth mental health in primary care: A mixed methods investigation

In Ireland, psychological morbidity has been reported in 21-27% of young people and recent data has indicated that the youth suicide rate in Ireland is now the second highest (of 26 countries) in the European Union, for 0-19 year olds. Early intervention in youth mental health is increasingly viewed as easier, cheaper and more effective than traditional approaches to care. GPs, as the health care professional most often consulted by young people, have a central role in early detection of youth mental health and substance use problems. However, there is a dearth of evidence regarding the experiences and attitudes of young people and health care workers towards screening and treatment for mental and substance use disorders in primary care in Ireland.

The overarching aim of this thesis was to examine the role of primary care (with a particular focus on the role of the GP) in providing early intervention and treatment for mental health and substance use problems in young people. It was a mixed methods study that involved qualitative interviews with health care workers (n=37) and young people (n=20) from primary care, secondary care and community agencies in two of Ireland's most socio-economically disadvantaged areas, Limerick City and Dublin South Inner City and a national cross-sectional survey of GPs (n=175).

The research found that while addressing youth mental health problems was a priority for most participants, a number of barriers to the identification and management of such issues were identified: access to services, flaws in traditional mental health services for young people under eighteen years, fragmentation between services and limited resources. The research outlined potential implications for clinical practice, research and education such as promoting awareness of mental health and the role of the GP in helping these issues, education of practitioners and improving access to psychological treatments for young people.

Declaration

I the undersigned submit this thesis to the University of Limerick for examination for the degree of Doctor of Philosophy (PhD). The work herein is my own work except where acknowledged and has not been previously submitted for any other degree at this, or any other university. This thesis may be made available from the library for consultation of copying.

_____

Dorothy Leahy

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I wish to express my sincere gratitude to the study participants for taking the time to participate in the research and particularly to the young study participants for sharing their personal experiences with us. I hope that our study findings will guide the way for improvements across mental health and addiction services for both health care workers and young people. I would also like to thank the Health Research Board for funding this PhD.

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Appendix I Ethical approval (study two)

List of abbreviations

ADHD – Attention Deficit Hyperactivity Disorder

CAMHS – Child and Adolescent Mental Health Services

CBT – Cognitive Behaviour Therapy

CME – Continuing Medical Education

CMHTs – Community Mental Health Teams

CPI – College of Psychiatrists of Ireland

DSH – Deliberate Self-harm

ED – Emergency Department

GMS – General Medical Services

GP – General Practitioner

HSE – Health Service Executive

ICGP – Irish College of General Practitioners

RCT – Randomised Controlled Trial

UCD – University College Dublin

UL – University of Limerick

WHO – World Health Organisation

"It was like spaghetti junction inside in my head and I just didn't even know where to start anymore." (Young Female Participant aged 23 attending General Practice)

Study overview

Introduction

In Ireland, mental health problems among young people are increasing in prevalence. Their delayed treatment is associated with adverse clinical outcomes which are improved by early intervention. Primary care, particularly GPs (with appropriate training and resources) has a crucial role in the identification and management of young people experiencing these problems, including facilitating more timely intervention.

This thesis was conducted as part of a Health Research Board (HRB) funded programme of research, "Towards early intervention for youth mental health in primary care", the aim of which was to develop an intervention that would address barriers to 'early intervention' for mental health and substance use problems that is evidence based, feasible and acceptable to young people and health care workers in primary care. There is a dearth of evidence regarding the experiences of and attitudes towards screening and treatment of mental health and substance use problems among health care workers and young people in Ireland. To create future interventions for this population, it is important to understand how current practice for youth mental health and substance use problems in socio-economically disadvantaged areas (where young people are particularly vulnerable to developing such issues), is experienced by health care workers who work within the field and the young people who utilise those services. This knowledge ensures interventions will be tailored to meet the needs of the population served and will address the relevant domains for improved services and outcomes.

Research aims and objectives

The overarching aim of this thesis was to examine the role of primary care (with a particular focus on the role of the GP) in providing early intervention and treatment for mental health and substance use problems in young people. Specific objectives were:

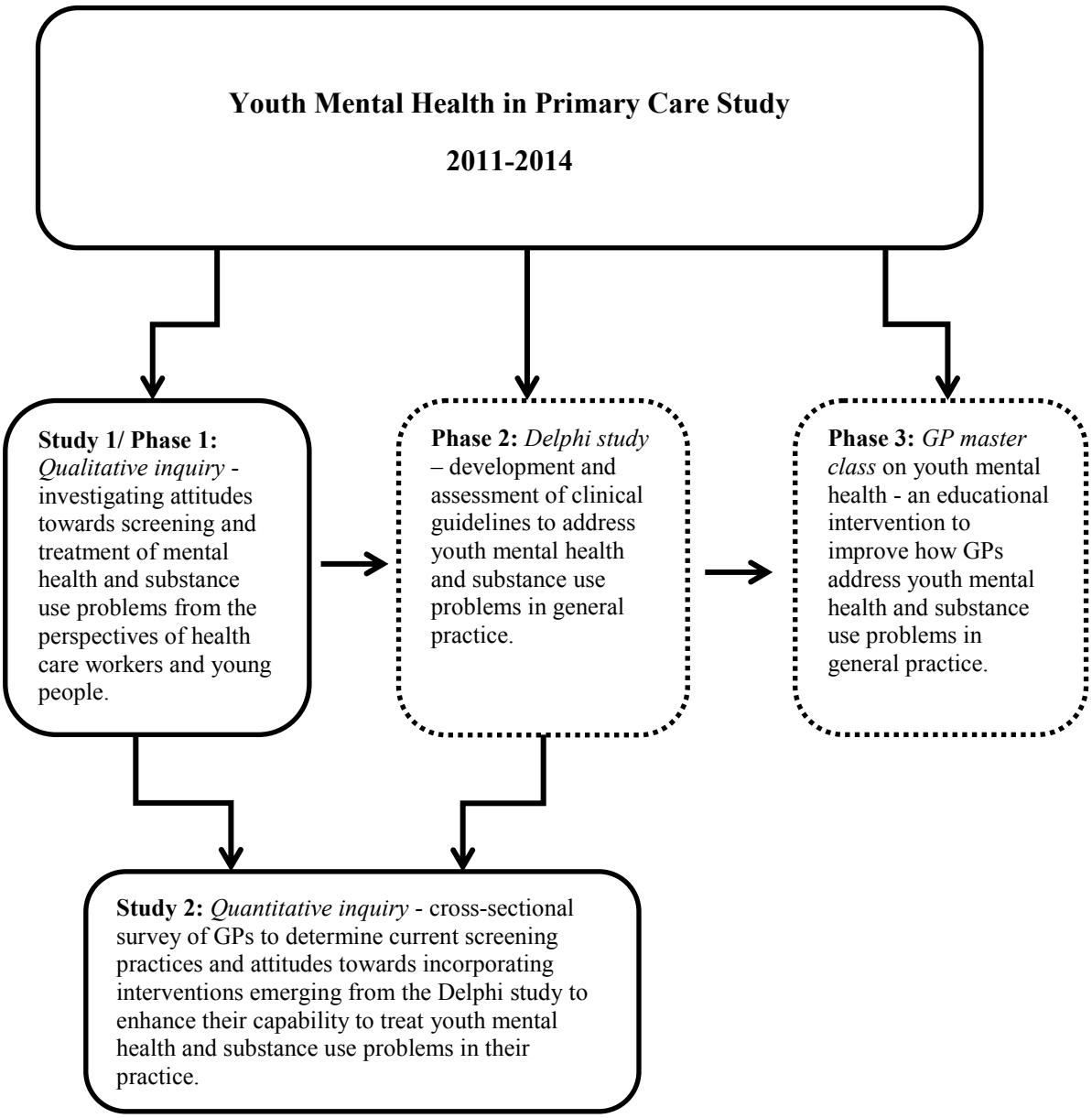
- To increase understanding of the psychological and social needs of young people experiencing mental health and substance use problems.

- To investigate the subjective accounts of both young peoples' experiences of screening and early intervention and explore the topic from the perspective of health care workers who work in the field of mental health / substance use.
- To determine the current practice of GPs in addressing youth mental health and substance use problems.
- To assess the current status of training and professional development of GPs in regards to treating youth mental health and substance use problems.
- To explore the feasibility of training GPs to deliver brief consultative interventions to young people with mental health and substance use problems and to assess GP attitudes towards potential interventions for addressing such issues in primary care.

Youth Mental Health in Primary Care Research Group

This thesis is based on data gathered to inform a larger project which aimed to develop an intervention that would address barriers to early intervention for youth mental and substance use disorders. The qualitative inquiry (study one) and the quantitative inquiry (study two) are included in this thesis. While all named collaborators contributed to various phases of the research DL (thesis author) has been the lead researcher on study one. This involved leading on study design, reviewing the literature, recruitment in the Limerick study sites, data collection for 23/29(79%) of interviews conducted in Limerick, analysis, write up and dissemination of findings and DL was the sole researcher for study two (see figure 1 for an overview of the research conducted by the Youth Mental Health in Primary Care Research Group).

Figure 1: Youth Mental Health in Primary Care Research Group – work completed 2011 – 2014.



Thesis structure

- *Chapter one* provides a narrative literature review on youth mental health in primary care including population based studies of psychological morbidity among young people in Ireland; studies of psychological morbidity among young people attending general practice / primary care and primary care based intervention studies for addressing youth mental / substance use disorders. The literature review also incorporated studies based on the experiences of young people with mental / substance use disorders and their interactions with services, particularly primary care. Finally the rationale for the current study is outlined.

- *Chapter two* describes the methodology, specifically a mixed methods design combining qualitative and quantitative approaches. The chapter includes: an overview of qualitative and quantitative methods, the rationale for and methodological considerations behind such an approach and an outline of the specific type of mixed method approach that was used - a sequential qualitatively-led design. The methods adopted for the qualitative inquiry (study 1) and the quantitative inquiry (study 2) are also outlined in this chapter.

- *Chapter three* presents a qualitative inquiry which aimed to improve understanding of the experiences of and attitudes towards screening and treatment of mental / substance use disorders from the perspectives of both health care workers and young people.

- *Chapter four* presents a cross-sectional study with GPs which aimed to assess current GP practices in regards to addressing youth mental health and substance use problems and also to assess GP attitudes towards managing and utilising interventions that could enhance their capability to treat these issues in their practice. This chapter also triangulates and synthesises the key findings from both quantitative and qualitative studies and examines convergence / divergence in findings.

- *Chapter five* discusses the empirical findings and how they relate to other literature, methodological considerations and considers implications of the thesis for future research and development.

Publications and conference presentations

Peer-reviewed journal articles (see Appendix A for full copies of manuscripts)

Leahy, D., Schaffalitzky, E., Armstrong, C., Bury, G., Cussen-Murphy, P., Davis, R., Dooley, B., Gavin, B., Keane, R., Keenan, E., Latham, L., Meagher, D., McGorry, P., McNicholas, F., O'Connor, R., O'Dea, E., O'Keane, V., O'Toole, T., Reilly, E., Ryan, P., Sanci, L., Smyth, B.P. & Cullen, W. (2013) 'Primary care and youth mental health in Ireland: Qualitative study in deprived urban areas', *BMC Family Practice,* 14:194.

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Chapter 1 - Literature Review

1.1 Introduction

1.1.1 Objective of the literature review

The main objective of the literature review was to assess the current state of knowledge on screening and treating youth mental health problems in primary care. A secondary aim was to provide an appropriate rationale for the current study.

1.1.2 Literature search

A comprehensive review of the literature was conducted using the search terms outlined in table 1.1 from both manual and electronic resources to address the key research aims:

- Further understanding of the experiences of young people with mental and / or substance use problems / disorders.
- Investigate attitudes towards screening and treating mental and / or substance use problems / disorders from the perspectives of both health care workers and young people.
- Assess the current status of training of GPs to address youth mental health problems.
- Examine the effectiveness of offering brief interventions for screening and treating mental health and substance use problems in primary care.

Multiple databases and individual journals (Psych Info, Psych ARTICLES, Medline, Science Direct, Academic Search Premier, BMJ, BJGP, Cinahl Plus with full text, Springer Link, SAGE journals online, and Google Scholar) were searched to identify relevant publications for inclusion in the review. Full texts for relevant citations were obtained and appropriate sections integrated into the final review. The search was limited to articles published in English and papers not specific to primary care / general practice settings were excluded from the review. 'Grey literature' (i.e., conference proceedings, policy documents and reports) was also included in the search. Qualitative and quantitative studies were consulted for all sections of the literature review.

- In regards to population based studies of psychological morbidity among young people in Ireland, papers and reports specific to young people in Ireland which was defined in line with previous work on youth mental health, where the terms 'youth' or 'young people' are often used to describe people within the 11 to 25 age range were included (McGorry et al. 2007a, Tylee et al. 2007, Cannon et al. 2013). However, two reports including young people over the age of 25 years were consulted for this section of the literature review, a longitudinal study which involved a ten year follow up of the young people and their mothers (Cleary et al. 2004) and the 'HRB National Psychological Wellbeing and Distress Survey' defined young people as those in the 18-29 year age range (Tedstone Doherty et al. 2007). The Clonmel Project included children in addition to young people ranging from 0-18 years (Martin et al. 2006).

- Studies of psychological morbidity among young people attending general practice and / or primary care, included young people in the 12-25 year age group.

- Papers included older adult samples in regards to GP attitudes towards screening and treating mental health problems, where instruments / studies specific to youth mental health were lacking.

- Primary care based intervention studies for screening and treating youth mental health and substance use problems were refined to young people in the 12-25 year age group. Training initiatives for GPs / primary care physicians and other staff members in the clinic e.g., practice nurse, GP registrars were included in this section of the review.

- Policy documents and reports were also consulted in regards to mental health policy and epidemiological studies based on youth mental health research in Ireland.

Table 1.1 Key words used for literature search

Key words	*Combinations with key words*
mental health mental disorders substance use disorders GPs / mental health GPs / substance use	youth general practice primary care early interventions screening brief / psychotherapeutic interventions socio-economically disadvantaged areas

In total, 201 papers were identified for the review, (four of which were systematic reviews) and these examined the following topics:

- Prevalence of youth mental and substance use disorders (49 papers)
- Studies of psychological morbidity among young people attending primary care (23 papers)
- Mental health initiatives / services in Ireland (24 papers)
- Primary care based studies:
    - GP role (43 papers)
    - Youth experiences of primary care services (21)
    - Screening (23 papers)
    - Treatment (18 papers)

Table 1.2 Glossary of terms

Term	Definition
Alcohol dependence	A cluster of cognitive, behavioural and physiological characteristics indicating that the patient uses alcohol despite significant alcohol related harms (American Psychiatric Association 2013).
Harmful drinking	A pattern of drinking which causes harm to the health (physical or mental) of the individual without the presence of alcohol dependence (Babor and Higgins-Biddle 2001). 'Binge drinking is a type of harmful drinking' (Anderson 2007).
Mental health problems	In accordance with the definition of mental ill-health suggested on a recent report documenting the psychiatric epidemiology of young people in Ireland, defined as *"being similar to that of a mental disorder but is not based on someone meeting the diagnostic criteria for a mental disorder"* (Cannon et al. 2013), mental health problems refer to young people who have experienced moderate to severe mental health difficulties and who require support from the health care services.
Mental disorder	The Diagnostic Statistical Manual (American Psychiatric Association 2013) defined a mental disorder as: *"a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning."*
Substance use problems	Substance use problems refer to an on-going pattern of substance abuse that results in repeated negative psychosocial consequences in a person's life. Substance use problems can involve the abuse of alcohol and / or drugs (Cannon et al. 2013).
Substance use disorder	Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. Each specific substance is addressed as a separate use disorder (e.g., alcohol use disorder, stimulant use disorder, etc.), but nearly all substances are diagnosed based on the same overarching criteria. In this overarching disorder, the criteria have not only been combined, but strengthened. Whereas a diagnosis of substance abuse previously required only one symptom, mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11 (American Psychiatric Association 2013).
Youth	Definitions of youth in the current study are in line with previous work on youth mental health where the terms 'youth' or 'young people' are often used to describe people within the 11 to 25 age range (McGorry 2007, Tylee et al. 2007, Cannon et al. 2013).

1.2 Overview of mental and substance use disorders 'a global concern'

By 2030, mental health problems will be the main cause of morbidity in the industrialised world (Mathers and Loncar 2006). Substance use problems (tobacco, alcohol and illicit drugs) also contribute to the global health burden, causing 20% of illnesses and premature death in Europe (World Health Organisation 2002). Despite the economic and psychosocial consequences of mental health problems (Lim et al. 2008); Irish statistics reported that €308,218,053 was spent across all government departments relating to youth mental health in 2011 (Clayton and Illback 2013); evidence suggests that rates of suicide risk assessment and screening for young people are limited in practice (Klein et al. 2001, Ozer et al. 2009). With most health-compromising behaviours emerging in adolescence (Catalano et al. 2012), early intervention for youth mental health problems are likely to result in long-term health and societal gains (Sawyer et al. 2012).

McGorry and colleagues (2007a) suggested that treating youth mental health was a 'best buy', in terms of being more cost-effective and efficient than treating adults with mental disorders. Not only are adult mental disorders a major threat to economic productivity worldwide (Bloom et al. 2012), but it costs ten times more to treat a person who develops a mental health problem in childhood than if this develops in adulthood (Suhrcke et al. 2008). Additionally, young people often struggle with the challenges that coincide with adolescence and early adulthood (e.g., puberty, career choices, new and changing relationships), therefore mental health problems may be far more salient in the lives of young people compared to adults (Wisdom et al. 2006). However, the time delay before diagnosis of mental health disorders among young people is 5-15 years (Kessler et al. 2005). The World Health Organization (2003a), in 'Caring for Children and Adolescents with Mental Disorders', stated that:

> *"The lack of attention to the mental health of children and adolescents may lead to mental disorders with lifelong consequences, undermines compliance with health regimens and reduces the capacity of societies to be safe and productive."*

1.3 Prevalence of mental and substance use disorders in young people

Mental disorders contribute the largest disease burden in young people globally (Patel et al. 2007); 70% of health problems and mortality among young people are a result of mental and substance use disorders (McGorry 2005) and depression is the primary cause of illness and disability among adolescents (World Health Organisation 2014). According to Kessler and colleagues (2005), 50 per cent of mental disorders start by 14 years of age and 75 percent by the age of 24, with the most common disorders including: depression, anxiety and substance use (Rickwood et al. 2007). Harmful drinking is the leading cause of death and disability among young people aged 10-24 years (Gore et al. 2011). Previous research has reported prevalence rates of 30-50% for binge drinking and 10% for cannabis use among adolescents and young adults in Europe and the US (Andersson et al. 2007, US Centers for Disease Control and Prevention 2012, Currie et al. 2012). With a high prevalence of psychiatric morbidity in youth aged 15–24 years (Kessler et al. 1994) mental and substance use disorders impact on the most productive (in regards to education and employment) of the population (Knapp et al. 2007).

In Ireland, psychological morbidity has been reported in 21-27% of young people (Sullivan et al. 2004, Martin et al. 2006, Lawlor and James 2000, Cleary et al. 2007, National Youth Council of Ireland 2009, Casey et al. 2011, Dooley and Fitzgerald 2012a, Cleary et al. 2004). Research studies based on the psychological morbidity of young people in Ireland are mainly focused on large scale cross-sectional studies with adolescents in the 12-18 year age range (Sullivan et al. 2004, Lynch et al. 2004, Martin et al. 2006, O'Farrell et al. 2005). Findings across studies suggest that about one in five young people are experiencing serious emotional distress at any one time. Cannon and colleagues (2013) suggested that up to one third of young Irish adolescents and over half of young Irish adults are at risk of developing mental health problems in adulthood. Comparative rates with international epidemiological studies indicated that young Irish adolescents in the 11-13 year age range had higher current rates of disorder compared to similarly-aged young adolescents in the USA and the UK (15% compared to11% and 10%) and young people in the 19-24 year age group had similar rates of disorders among 18-29 years olds in the USA and higher than similarly aged young people in both Northern Ireland and Germany (55% compared to 52%, 43% and 39%) (Cannon et

al. 2013). Cannon and colleagues (2013) also noted that one in five young people aged 19-24 years meet the criteria for a substance use disorder over the course of their lives.

Reports from Dooley and Fitzgerald (2012b) and Cannon and colleagues (2013) were based on a broad age range of young people, 12-25 years and 11-24 years respectively. Additionally, both reports provided strong evidence for early intervention for youth mental health problems. Emerging patterns across both studies indicated an increase in symptom severity / prevalence of mental health problems with age (late teens / early twenties) and similar to the aforementioned cross-sectional studies (Martin et al. 2006, Sullivan et al. 2004, Lynch et al. 2004) low rates of help-seeking were apparent (6-39%). In the 'Health Research Board National Wellbeing and Psychological Distress Survey, Tedstone-Doherty et al. (2007) noted that 18-29 year olds had the lowest rate of self-reported mental health, with the highest proportion of respondents reporting less than good mental health among those aged between 50 and 64 (9% compared to 38%). Additionally, people in the 18-29 year age group were the least likely to have discussed their mental health problems with a GP in the past year. The proportion of young people who met the criteria for depression ranged from 16-21% (Cleary et al. 2004, Sullivan et al. 2004, Martin et al. 2006, O'Farrell et al. 2005).

Martin and colleagues (2006) also reported extremely high rates of anxiety disorder (43%) among a subset of participants with both positive and negative scores on the 'Child Behaviour Checklist' and 'Youth Self Report Form', however, it should be noted that young children (0-18 years) were included in this sample and classification of anxiety included phobias and separation anxiety. However, anxiety and depression were the most common disorders identified in other Irish studies with prevalence rates ranging from 27-40% for anxiety disorders (Cannon et al. 2013, Dooley and Fitzgerald 2012b, Cleary et al. 2007). Moreover, a retrospective study of young people attending general practice, documented stress, anxiety and depression among 35% of cases (Connolly et al. 2012). Gender differences were also noted across studies, with females having higher scores on the clinical range for psychological distress, depression and anxiety disorders (23% compared to 19%; 39% compared to 9% and 57% compared to 34%) respectively (Lawlor and James 2000, O'Farrell et al. 2005, Martin et al. 2006). Female participants were also more likely to disclose their mental health problems with a distress disclosure index (DDI) score of 40 compared to 36 for males (Tedstone Doherty et al. 2007) and have more internalising psychiatric problems e.g., poor self-

concept (73% compared to 32%) and externalising psychiatric problems e.g., disruptive behaviour (64% compared to 36%) (Edokpolo et al. 2010).

While the prevalence rates of mental health problems seem to be consistent across studies, it is worth noting the following methodological implications: studies were mainly self-report measures with only two studies incorporating parental perspectives (Cleary et al. 2004, Cleary et al. 2007, Martin et al. 2006), however, previous research has noted that the most reliable source of information in regards to their mental health is the young person themselves (Rowley et al. 2001). School based studies were conducted in mainstream schools (Lawlor and James 2000, Lynch et al. 2004, O'Farrell et al. 2005, Dooley and Fitzgerald 2012b), therefore, schools for young people with learning disabilities, physical disabilities or severe emotional and behavioural problems were not included. Additionally, school based samples need to allow for early school leavers mainly comprising of a vulnerable population of young people who are often most at risk (Lynch et al. 2004) and students absent on the day of assessment, which would suggest that the aforementioned prevalence rates are an underestimate of the mental health problems experienced among young Irish people.

1.4 Mental and substance use disorders – comorbidity

Irish and international studies have demonstrated that mental health problems very frequently co-exist with drug and alcohol problems; with problems in one domain perpetuating those in the other (Kessler et al. 1996, Degenhardt et al. 2013, James et al. 2013, Lubman et al. 2007). Previous research has indicated an association between early onset regular cannabis use during adolescence and depressive symptoms in early adulthood (Hayatbakhsh et al. 2007, Wittchen et al. 2007). Degenhardt and colleagues (2013) identified an association between daily adolescent cannabis users, (even among those who ceased cannabis use in early adulthood) and the onset of anxiety disorders in adulthood. Evidence in the UK indicated that co-morbid conditions of problem drug and alcohol use and mental health problems is widespread, with 44% of mental health service users having had previous problem drug use or harmful alcohol use. Furthermore, the study also indicated that 75% of drug service users and 85% of alcohol service users had a psychiatric disorder in the previous year (Weaver et al. 2003).

While systematic evidence in Ireland on the prevalence of co-occurring problematic substance use and mental health problems is lacking, previous research reported that one in two Irish adolescents with a substance use disorder will experience a psychiatric disorder across their lifetime (James et al. 2013). Teenage alcohol and drug use have been associated with depression, anxiety disorders, such as post-traumatic stress disorder and increased use of marijuana and other illicit drugs (Smith et al. 2008, Dooley and Fitzgerald 2012b, Edokpolo et al. 2010). The 'My World Survey' reported problem drinking in 4434 (31%) of the overall sample of 12-25 year olds; the survey also noted that rates of depression and anxiety were significantly higher when a young person engaged in harmful drinking or was classified as alcohol-dependent (Dooley and Fitzgerald 2012b). Additionally, when a young person engages in harmful drinking, their anxiety levels tend to increase and if they are classified as alcohol-dependent, their anxiety levels are often in the severe range (Dooley and Fitzgerald 2012b).

1.5 Suicide and deliberate self-harm in young people

Global rates of youth suicide and suicidal ideation among young people are increasing at an alarming rate, with over one million suicide attempts among children and adolescents in the United States (Horowitz and Ballard 2009, Bridge et al. 2006). Increasing rates of suicide and self-harm in young people are a major concern across health care services in Ireland (Lynch et al. 2004, Cleary et al. 2007, McMahon et al. 2010). Recent data relating to suicide has indicated that the youth suicide rate in Ireland is now the second highest (of 26 countries) in the European Union, for 0-19 year olds, at 5.12 (males) and 2.09 (females) per 100,000 of the population (European Child Safety Alliance 2014). Increasing suicide rates were noted among young Irish males in the 20-24 year age group and 42% (31.9 per 100,000 of the population) of those who died by suicide in 2010 were males under 40 years of age (National Office for Suicide Prevention 2012). The rate of suicidal ideation ranged from 6% to 46% among youth based studies in Ireland (Lawlor and James 2000, Lynch et al. 2004, Dooley and Fitzgerald 2012b).

Rates of deliberate self-harm (DSH) in Ireland are higher than they have ever been particularly among young females in the 15-19 year age group with 617 / 100,000 of the

population (one in every 162 females in the 15-19 year age group presented to hospital in 2012 as a consequence of DSH. In males, the rate was 533 / 100,000 among 20-24 year olds / one in every 188 men). However, the incidence of DSH gradually decreased with increasing age in men (National Office for Suicide Prevention 2012). Cannon and colleagues (2013) noted that over one in fifteen young people ranging in age from 11-24 years had engaged in DSH and Sullivan et al. (2004) reported repeated attempts of DSH among 46% of participants.

Suicidal behaviour in young people may not be detected by parents, teachers or health care workers, despite high prevalence rates and well known risk factors (Horowitz and Ballard 2009). While previous research has documented the benefits of targeted suicide screening in schools and universal suicide screening in primary care clinics and emergency departments (EDs) to detect and prevent self-harm (Horowitz and Ballard 2009), most primary care clinicians and ED clinicians do not routinely screen for suicide risk (Olson et al. 2009, Habis et al. 2007, Frankenfield et al. 2000). Studies have revealed that as many as 83% of people attempting suicide are not identified as a danger to themselves by health care workers, even when examined by primary care clinicians in the months before their attempt (Frankenfield et al. 2000, Clark 1993, Pfaff et al. 2001). Furthermore, nearly 60% of youth in need of mental health services do not receive the care they need, even after suicide attempt (Horowitz and Ballard 2009, Eaton et al. 2008). (Table 1.3 summarises population based studies of psychological morbidity among young people in Ireland).

Table 1.3 Population based studies of psychological morbidity among young people in Ireland.

Author, date	Study population	Study instrument	How cases defined	Findings
Lawlor and James (2000) **Research aim:** To establish the prevalence of psychological problems in older adolescents.	Second level students (n=779)	Survey involving: • The Achenbach Youth Self Report scale (YSR) (Achenbach 1991)	Percentages scoring above 'clinical threshold' for a clinical level disorder were calculated.	• Of the girls 23% reported problems in the clinical range on total problem score compared with 19% of boys. • 6% reported thinking of suicide frequently (almost twice as many girls as boys) and this rose to 25% of girls who scored in the clinical range of total problem score and 15% of boys.
Cleary et al. (2004, 2007) **Research aim:** A longitudinal study of Irish children and their families to assess social, psychological and educational dimensions.	Urban children (n=2029) with follow up at ten years of young people (n=97) and mothers (n=80)	Survey involving: • Structured Clinical Interview for DSM-IVAxis Diagnosis (First et al. 1995) • The Beck Scale for Suicide Ideation (Beck and Steer 1991) • Rosenberg Self-Esteem Scale (RSE) (Rosenberg 1965) • The Arizona Social Support Interview Schedule (Barrera et al. 1981) • Locus of Control was measured using a scale devised by (Pearlin et al. 1981) • Study specific instruments	Psychometric assessments to assess social, psychological and educational dimensions at baseline and follow up.	Phase 1 data: • 16% of the children showed evidence of formal psychiatric disorder. • Childhood diagnosis was related to maternal mental health and to the economic circumstances of the family. Phase 2 data: • 21% of respondents had a probable psychiatric condition (most commonly depression or anxiety). • 18% received treatment. • 55% had a likely diagnosis of substance –related disorder. • 25% had contact with the law which was related to deficits in educational attainment and childhood socio-economic disadvantage.

Sullivan, Arensman, Keeley, Corcoran and Perry (2004) 'The Lifestyle and Coping Survey'. (CASE Study) **Research aim:** To investigate the extent of problems experienced by adolescents in regards to drug use, DSH and associated psychosocial factors and to determine the coping skills and help seeking behaviour amongst adolescents who are experiencing difficulties.	15-17 year olds (n=3,830) from 39 schools in the Southern Health Board Region	Survey involving: 'Lifestyle and Coping Questionnaire'. (Internationally accepted anonymous scale)	Data were collected from a random sample of teenagers, using the 'Lifestyle and Coping Questionnaire' that included questions about: lifestyle, coping problems, alcohol and drug use, DSH, depression, anxiety, impulsivity and self-esteem.	• 27% had serious personal, emotional, behavioural or mental health problems. • 20% showed signs of depression. • 18% sought help from a professional. • More females showed signs of depression (8%) and emotional disorders (13%) than males (5% and 6%). • 12 % had long-term DSH and 46% had engaged in DSH more than once.
Lynch, Mills, Daly and Fitzpatrick (2005) **Research aim:** To determine prevalence rates of psychiatric disorders, suicidal ideation and intent and para-suicide in young Irish adolescents.	12-15 year olds (n=723) from eight main-stream secondary schools in Dublin were eligible for inclusion	A two-stage procedure was used involving a screening and interview phase. Screening instruments: • The Children's Depression Inventory (CDI) (Kovacs 1984) • The Strengths and Difficulties Questionnaire (SDQ) (Goodman et al. 2000) Interview instruments: • The Schedule for Affective Disorders and Schizophrenia for School-aged Children (Kaufman et al. 1997) • The Beck Scale for Suicide Ideation • The Suicidal Intent Scale (Beck et al. 1974)	In the first stage, 51% (n=723) of the eligible population completed screening questionnaires in a classroom setting. Those scoring in the clinical range on the screening measures 72% (n=101) attended for interview in addition to a comparison group 54% (n=94) matched for gender, school and school year.	• 16% met the criteria for a psychiatric disorder. • 5% had possible presence of a depressive disorder. • 32% from the 'at risk' group had come to the attention of the mental health services. • 12% expressed suicidal intent and 46% expressed suicidal ideation from participants in the 'at risk' group.

O'Farrell, Flanagan, Bedford, James et al. (2005) **Research aim:** To measure the prevalence of and risk factors associated with, depression and low self-esteem among Irish post-primary students.	Young people (n=992) aged 13-17 years from schools (n=24) in counties Cavan, Monaghan, Louth and Meath	Survey involving: • Centre for Epidemiological Studies Depression Scale (CES-D) (Radloff 1977) • Rosenberg Self-Esteem Scale	Questionnaires incorporating two standardised scales for measuring depressive symptomatology and self-esteem were distributed to students.	• 21% had a high depression score. • Being from a single parent family; having low self-esteem; being female and having a low fitness level were independently associated with a high depression score.
Martin, Carr, Burke, Carroll and Byrne (2006) – 'The Clonmel Project'. **Research aim:** To determine the prevalence of mental health problems among children and adolescents in the South East of Ireland and make recommendations for service development.	Children and adolescents 0-18 years (n=3374) in the Clonmel area	A two-stage procedure was used involving a screening and interview phase. Screening instruments: • Child Behaviour Checklist (Achenbach 1991) • The Achenbach Youth Self Report Scale Interview instrument: • The Diagnostic Interview Schedule for Children (DISC) (Shaffer et al. 2004)	Cases that screened positive and a random sample of those that screened negative for mental health problems were interviewed. The response rate (39%) / prevalence of psychological disorders included (cases that screened positive and got a diagnosis when interviewed), and (those that screened negative, but nevertheless got a diagnosis when interviewed).	From the 99 cases (55 screened positive; 44 screened negative): • 21% of 12-18 year olds met the criteria for at least one psychological disorder. • 43% had an anxiety disorder • 25% had oppositional defiant disorder • Over one fifth had ADHD • 13% had conduct disorder • 10% had either a mood disorder or an intellectual disability, or were abusing alcohol. • Compared with age and gender matched normal controls, the 99 cases with psychological disorders were: from more socio-economically disadvantaged backgrounds, had more behavioural difficulties and adaptive behaviour problems, physical health problems, family problems, life stress and poorer coping skills.

Tedstone Doherty, Moran, Kartalova-O'Doherty and Walsh (2007) HRB National Psychological Wellbeing and Distress Survey: Baseline Results	A national representative random sample of (n=2,711) adults aged 18 years and over; age groups were divided into the following categories: (18-29; 30-39; 40-49; 50-65 and 65+)	A telephone survey involving: • General Health Questionnaire (GHQ-12) (Goldberg and Williams 2000) • Distress Disclosure Index (Kahn and Hessling 2001) • Study specific instruments	Items in the survey included: demography; health status and quality of life; self-reported mental health problems; self-reported limitations in physical and social activities; willingness to disclose distressing information to others and use of health care and treatment services.	Respondents in the 18-29 age group: • Had the lowest percentage of self-reported mental health (9%). • Younger females seemed to be most willing to disclose their emotional distress. • 6% reported having discussed mental health problems with a GP in the last year. • Use of prescribed psychotropic medication was the lowest among this age group, particularly among young males. • Were more likely to consult the internet for health problems (71% compared to 15% for the 65+ age group).
Edokpolo, James, Kearns, Campbell and Smyth (2010) **Research aim:** To determine if mental health symptoms differ by gender in a cohort of adolescents with substance use disorders.	Young people (n=88) aged 13 to 18 years attending a multidisciplinary drug and alcohol service for young people under 18 years in Dublin	An audit of patient scores involving: Beck Youth Inventories (Beck 2005)	Scores obtained from clients upon initial assessment were compared for age and gender.	• Substances most frequently abused were alcohol (87%) and cannabis (72%). • (68%) of the participants had a psychological problem which was moderate or severe in at least one of the five domains (e.g., self-concept, anxiety, depression, anger and disruptive behaviour). • Females differed from their male counterparts in having more internalising and externalising psychiatric problems.

Dooley and Fitzgerald (2012) 'My World Survey' (MWS) – National Study of Youth Mental Health in Ireland **Research aim:** To provide a baseline of youth mental health risk and protective factors for young people in Ireland.	12–25 year olds (n=14306), attending second and third level education schools and colleges in the Republic of Ireland	Survey involving: • Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al. 1993) • Behavioural Adjustment Scale (BAS) (Brown et al. 1986) • Coping Strategy Indicator (CSI) (Amirkhan 1990) • CRAFFT Substance Use Screening Scale (Knight et al. 2002) • Depression Anxiety and Stress Scale (DASS-21) (Henry and Crawford 2005) • Eating Attitude Test – Eat-10 (Garner and Garfinkel 1979) • Formal and Informal Help-Seeking Behaviour (HSB) (Saunders et al. 1994) • Gambling Attitude Scale (GAS) (Kassinove 1998) • GHQ-12 • Life Orientation Test Revised (LOT-R) (Scheier et al. 1994) • Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al. 1988) • Resilience Scale for Adolescents (READ) (Hjemdal et al. 2006) • Rosenberg Self-Esteem Scale • Satisfaction with Life Scale (SWLS) (Diener et al. 1985)	Data were collected from: over 7,000 students in second level and 8,000 students in third level. A further 1,000 young people who were employed, unemployed, or enrolled on FAS training schemes participated.	• 21% of young adults had engaged in self-harm and 7% reported a suicide attempt. • Mental health difficulties emerged in early adolescence and peaked in the late teens and early 20s. • The peak in mental health difficulties was associated with a decrease in protective factors such as self-esteem, optimism and positive coping strategies.

Cannon, Coughlan, Clarke, Harley and Kelleher (2013) The Mental Health of Young People in Ireland. A report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group based on two studies. **Research aim:** To report the psychiatric epidemiology among young Irish adolescents and young people.	Study 1: The Adolescent Brain Development Study (On-going study – findings at time of report) 11-13 year olds (n=212) based in primary schools (n=39) in North County Dublin and Kildare	Clinical diagnostic interviews with young adolescents involving: Survey • SDQ Clinical interview • The Schedule for Affective Disorders and Schizophrenia for School-Aged Children, Present and Life-time Version (K-SADS-PL) (Kaufman et al. 1997)	Interviews were conducted with (n=212) young adolescents who were randomly selected to attend for clinical assessment interviews following an initial survey of (n=1,100) young people based in North County Dublin and County Kildare.	• At the time of interview 1 in 6 young people aged 11-13 years (15%) were experiencing a mental disorder. • The most prevalent types included: anxiety, behavioural / mood disorders.
	Study 2: The Challenging Times Two Study young people aged 19-24 years (n=169)	A follow-up study based on a cohort of participants who had taken part in The Challenging Times Study when they were aged 12-15 years, that focused on the experience of mental health problems, alcohol and substance use, DSH and suicidality among young people involving: Clinical interview • Structured Clinical Interview for DSM-IV Psychiatric Diagnoses 1 (SCID-1) (First et al. 2002) • Stressful Life Events Schedule for Children and Adolescents (Williamson et al. 2003)	Interviews were conducted with young people aged 19-24 years who had previously taken part in the first Challenging Times study.	• 20% young people aged 19-24 were experiencing a mental disorder. • Anxiety was the most prevalent type of disorder followed by mood disorders.

1.6 Risk factors for the onset of youth mental / substance use disorders

Risk factors associated with mental health disorders in young people include: stressful life events in relation to health, work and interpersonal relationships (Cleary et al. 2004, Cannon et al. 2013), poor maternal mental health (Cleary et al. 2007), single parent families, low self-esteem and fitness levels (O'Farrell et al. 2005) and having a bisexual or homosexual orientation (Cannon et al. 2013). Dooley and Fitzgerald (2012b) identified links between a peak in mental health problems during later adolescent years / early twenties and a decrease in protective factors such as self-esteem, optimism and positive coping strategies. Previous studies identified the following risk factors for the onset of developmentally harmful substance use during adolescence: level of community drug use (Hawkins et al. 1992); genetic vulnerability (Lachman 2006); maternal smoking and alcohol use, family breakdown (Fergusson et al. 1994) and extreme socio-economic disadvantage (Lynskey and Fergusson 1995).

1.6.1 Risk factors in socio-economically disadvantaged areas

Risk factors for mental health and substance use disorders tend to be greater in socio-economically disadvantaged areas, especially inner cities (Rutter 1981, Kelly et al. 2010, Martino et al. 2008). Consistent links have been identified between low socio-economic status and suicidal behaviour, particularly among young people (Baudelot and Establet 2008, Middleton et al. 2006). Living in socio-economically disadvantaged neighbourhoods is associated with various psychosocial problems including: negative effects on mental health (Kalff et al. 2001, Stirling et al. 2001), lower employment expectation (Quane and Rankin 1998), chronic exposure to community violence (Mendelson et al. 2010), problematic interpersonal relationships and classroom behavioural problems (Patterson et al. 1990).

Similar psychosocial issues in socio-economically disadvantaged urban areas have been reported in Ireland where substance abuse, criminal activity, poor housing conditions and anti-social behaviour were key concerns among residents (O'Kelly et al. 2010, Stevenson et al. 2014). In 'The Clonmel Project' which assessed mental health needs in a random sample of 0-18 year olds, Martin and colleagues (2006) noted that young people identified with clinical risk compared to matched controls were from more socio-

economically disadvantaged backgrounds, had more behavioural difficulties, physical health problems, family problems, life stress and poorer coping skills than those who did not meet the criteria for diagnosis. In Ireland's Mid-West region, GPs working in 'Regeneration Areas' were more likely to report dealing with stress / anxiety among young adults than GPs in rural areas (80% compared to 28%) (Healy, Naqvi et al. 2013).

Given the multiple psychosocial issues that young people (particularly from socio-economically disadvantaged areas) experience, health care workers are faced with additional challenges in addressing the needs of this population (Roberts et al. 2013). Evidence has shown that akin to Hart's 'Inverse Care Law' (Tudor Hart 1971), as social deprivation in an area increases, so too does the prevalence of psychological distress, yet average consultation times in family practice decrease (Stirling et al. 2001). The WHO Regional Committee for Europe noted that poverty and mental health form a vicious cycle where poverty can be both a contributory factor to poor mental health, while also being a potential consequence of it (WHO Regional Committee for Europe 2003). Socio-economically disadvantaged areas tend to be less well-served by GPs than more affluent areas both internationally and in Ireland, due to limited financial incentives e.g., insufficient pay for General Medical Services (GMS) workload, inadequate staffing levels, poor service availability for referral and lack of time to deliver quality care (Crowley 2005).

Previous research has reported that primary and secondary care services are configured to give advantage to those with the least health need, where GMS eligibility "is concentrated on sickness rather than on achieving health gains for people who are poor." (Sinclair et al. 1997).This has resulted in the provision of limited services which are mainly focussed on GPs as opposed to the range of health care needs for patients who are eligible for free GMS e.g., limited or non-existent service provision outside the scope of the GMS, including psychotherapy, counselling and other mental health interventions (Sinclair et al. 1997). Furthermore, previous Irish research has found that, people with low incomes and who are not eligible for free GMS or a GP-visit card are less likely to visit a GP (Nolan and Nolan 2004). In essence, those who are most in need of longer consultation time and improved care, are less likely to receive it. Therefore, a cycle exists where burden and poverty are reinforced by the failure to receive necessary

services (Knapp et al. 2006). Tudor Hart's 'Inverse Care Law' is in line with one of the key recommendations proposed by Ireland's mental health policy document 'A Vision for Change', where the provision of mental health services should be prioritised and developed in areas of high need (Expert Group on Mental Health Policy 2006). The need to incentivise GPs in addition to other health care workers within the primary care setting to work in areas of socio-economic disadvantage is particularly relevant for treating young people with mental health and substance use problems, where prevalence rates tend to be higher (Martin et al. 2006, Cleary et al. 2007, Healy et al. 2013).

1.7 Psychosocial consequences of experiencing mental health problems

For young people, the psychosocial consequences of experiencing mental health problems include: school failure (Needham et al. 2004, Burnett-Zeigler et al. 2012), unstable employment (particularly in the early adult years if mental health problems are experienced in childhood / adolescent years) (Cannon et al. 2013) and poor family and social functioning (Dey et al. 2012, Fergusson et al. 2005). Previous qualitative studies based on young peoples' experiences have reported: fear of being stigmatised (Wisdom et al. 2006, Biddle et al. 2006b); poorer grades (Burnett-Zeigler et al. 2012); social withdrawal, loss of control, struggling to make sense of their experiences and self-harm (McCann et al. 2012).

1.8 Initiatives to support youth mental health

Service models have aimed to address the following initiatives considered to be of central importance to improving service developments for young people: 1) youth participation at all levels; 2) holistic, preventive stance with stepwise care and shared decision making; 3) early intervention and social inclusion; 4) consideration of both epidemiological factors of mental health problems in young people and cultural changes of emerging adulthood in the 21st century; 5) continuity of care and 6) seamless transition between services (McGorry et al. 2013). The dramatic decline in youth suicides in Australia, particularly for young males aged 20-34 years, declining from approximately 40 per 100,000 in 1997–1998 to approximately 20 per 100,000 in 2003

(Morrell et al. 2007) has been attributed to a National Youth Suicide Prevention Strategy which commenced in 1999 (Parker 2008). The primary aims of Australia's 'Suicide Prevention Strategy' involved public health campaigns and initiatives to increase help-seeking among young people and abolish the stigma associated with mental illness (Hickie et al. 2007).

1.8.1 International initiatives

McGorry and colleagues (2007b) proposed a 'Clinical Staging Model' whereby young people experiencing mild emotional problems are provided with non-pharmacological interventions. The Primary Care 'Behavioural Health Model' suggests that behavioural health providers deliver brief consultative interventions in primary care (Robinson 2005, Robinson and Reiter 2007, Strosahl 1996, Strosahl 1997, Strosahl 2000). Brief consultative interventions also more commonly described as brief interventions, refers to the potential of primary health care workers to co-manage behavioural health conditions in a primary care clinic as part of a primary health care team (Robinson 2005, Alexander et al. 2010). In the UK, a new initiative in 2009 established the development of the Primary Mental Health Worker which aimed to bridge the gap between primary care and specialist Child and Adolescent Mental Health Services (CAMHS) (Macdonald et al. 2004). One of their key duties is to work with local GP practices to improve access to CAMHS clinicians (Roberts and Bernard 2012). However, a more cost effective approach might be the 'Consultation-Liaison Model' where the provision of ongoing training is made available to primary care staff from specialist services (Vallance et al. 2011). A survey of CAMHS services in the UK demonstrated positive enhancements resulting from such collaborative approaches with primary care (Bradley et al. 2003).

'Headspace', funded mainly by the Australian government under the 'Youth Mental Health Initiative Program' (Muir et al. 2009), was established as an enhanced primary care service to provide mental health support, information and services to young people (aged 12–25 years) and their families. At present, there are 30 'Headspace' services across Australia (McCann et al. 2012). The benefits of having medical and counselling services co-located has proved to be beneficial in terms of increasing help-seeking in

young people; additionally service users also noted that they would be more likely to take advice from 'Headspace' clinicians because they were working in collaboration with health care workers from psychology and mental health (McGorry et al. 2013).

'Orygen Youth Health' was established in 2002 to address the needs of young people with complex presentations and more severe conditions. This organisation provides specialised treatment to over 700 young people (aged 15-25) annually living in Melbourne (McGorry et al. 2013). With a specific focus on early intervention, 'Orygen Youth Health' treats young people with psychosis, mood disorders and borderline personality disorders. The service also has a youth access team that provide 24-hour care seven days a week, offering a crisis response service in addition to community and home-based services (McGorry et al. 2013).

1.8.2 Irish initiatives

In Ireland, great efforts have been made to address youth mental health problems and abolish the stigma associated with experiencing such issues.

'Headstrong' – The National Centre for Youth Mental Health is a charitable organisation that initiated the design and delivery of community based programmes in 2007 to support young people aged 12-25 years (Bates et al. 2009). This nationwide initiative with ten service hubs across the country known as 'Jigsaw', aimed to incorporate young people in the design and development of the programmes that were non-stigmatising, accessible and that would facilitate early intervention for young people at risk of mental health problems as well as facilitating interagency collaboration across services (Bates et al. 2009). Additional objectives included: mapping clear pathways of care for an array of psychosocial problems (including specialised mental health care), increasing mental health awareness, reducing the stigma associated with help-seeking and encouraging communities to embrace young people as important figures in their local area (Bates et al. 2009). The report also highlighted the important role of the GP for young people who experienced barriers to accessing non-specialist support services, particularly in terms of providing appropriate and efficient referral links to external agencies (Bates et al. 2009).

Other initiatives that have been developed to address the psychosocial needs of young people in Ireland have included: 'Shine', 'Barnardos', 'Spun Out', 'Aware', 'Reach Out', 'Foróige', 'Mental Health Ireland', 'GROW', 'Bodywhys' 'Pieta House' and 'Teen Counselling' (Buckley et al. 2013).

1.8.3 Evaluation of services

Preliminary findings have highlighted the benefits of such services. An evaluation of 'Headspace' indicated that 93% of young people were satisfied with the care they received, with equal engagement from males and females and over 50000 young people provided with access across 30 sites in operation (Muir et al. 2009). According to Patulny (2013) when 'Headspace' service use demographics were compared to population data from the Australian Survey of Mental Health and Wellbeing from 2007, Australia witnessed substantial growth in the number of 12–25 year olds accessing mental health services between 2006 and 2008, coinciding with the establishment of the 'Headspace' youth mental health initiative. Furthermore, 'Headspace' has been successful in increasing service access among males and socially and economically excluded young people. 'Headspace' has been less successful in increasing service access among 18–25 year olds, some perceived services to be too 'youthy', older males, those from low socio-economic backgrounds, youth lacking social support and young people from non-English speaking backgrounds (Muir et al. 2009). Data from qualitative interviews with young people attending 'Headspace' suggests that the service helped them to overcome barriers associated with traditional mental health services such as: being youth-friendly, low cost, accessibility, provision of information about service processes, positive rapport with staff and effective mechanisms for encouraging appointment attendance (for example, SMS appointment reminders) (Patulny et al. 2013).

A recent evaluation of 'Jigsaw' services reported that 4771 young people had been helped by services across the country from 2008 to 2013 (Illback 2014). Anger, depression and low self-esteem were the most common problems among the young people attending the services. Interventions offered included: brief interventions (42%), brief contact (20%) and collaboration with parents and external services for referral

(37%) (Illback 2014). In a recent study which aimed to evaluate 'Jigsaw' service use for one calendar year, similar to the evaluation of 'Headspace services', a gender balance was almost observed in terms of service engagement, (57% females and 44% males) (O'Keeffe et al. 2015). The most common presenting issues among females included: anxiety, family problems and isolation from others and for males the most common issues were anxiety, anger and family problems. Results from an assessment using Clinical Outcome Routine Evaluation (CORE) questionnaires (Connell and Barkham 2007) indicated that the majority of participants had healthy (47%) or low (29%) levels of psychological distress (O'Keeffe et al. 2015) after engaging with 'Jigsaw' services. However, a lack of a control group, limits the interpretation of the findings from O'Keeffe and colleagues.

1.9 Mental health policy in Ireland

The Mental Health Act 2001 introduced important changes to Ireland's rules about admission to psychiatric hospitals, regulation of hospitals, reforming processes of involuntary detention of persons with mental disorders and strengthening quality assessment procedures for assuring standards of mental health care (Kelly 2007). Additionally, the Mental Health Act 2001 was also responsible for the establishment of the Mental Health Commission as a statutory agency, which was responsible for the provision of quality mental health services and regulation of inpatient services (Mental Health Reform 2012). Furthermore, the Mental Health Act 2001, stipulated that the provision of training and familiarisation with mental health legislation, including the Mental Health Act 2001, should be made available for all professionals, administrators and others by the HSE in collaboration with the Mental Health Commission (Expert Group on Mental Health Policy 2006).

The Expert Group on Mental Health, established in 2003, created 'a blueprint for a modern, comprehensive, world-class service' to meet the challenges of society, particularly the increasing suicide rate among young people. 'A Vision for Change' (AVfC) placed a strong emphasis on the need for a recovery oriented approach where individuals can reclaim their lives to the best extent and become involved in society

(Expert Group on Mental Health Policy 2006). Some of the key recommendations included:

- Involvement of service users and their carers in all aspects of service developments and delivery.
- The availability of mental health promotion for all age groups.
- Highly skilled community mental health teams (CMHTs), specific training for GPs in the area of mental health which should involve service users in the provision of education for mental health.
- Collaborative links between primary care and specialist mental health services.
- Educational intervention services that are focused on enabling a "non-stigmatising and seamless transition" for young people with mental health problems into the community.
- Two additional adolescent multidisciplinary teams established outside Dublin to provide expertise care for adolescents with co-morbid addiction and mental health problems.
- Collaboration between the GP training body, the Irish College of General Practitioners (ICGP) and the psychiatry training body, College of Psychiatrists of Ireland (CPI) to review all issues in relation to mental health training for GPs.
- Training in mental health legislation should be provided for all professionals by the Mental Health Commission in consultation with the HSE.

In the model proposed by the 'Primary Care Team Strategy', it was suggested that a group of primary health care providers (e.g., GPs, health care assistants, nurses, social workers and administrative support) would work as part of an inter-disciplinary team, referred to as a primary care team to serve small population groups of approximately 3000 to 7000 people (Department of Health and Children 2001). Furthermore, the strategy proposed that the primary care team would liaise with specialist teams in the community e.g., mental health teams to facilitate integrated care. One of the key recommendations outlined in 'AVfC' was the availability of appropriately trained staff

at the primary care level to address mental health problems (Expert Group on Mental Health Policy 2006). The policy document advocated the benefits of a model for shared mental health care i.e., the consultation-liaison model, which is a model of shared care between primary care and other levels of care with a particular emphasis on developing close links between the primary care team and the mental health team with a view to reducing referrals of milder mental health problems to specialist care (Expert Group on Mental Health Policy 2006).

1.9.1 Implementation of mental health policy

Reactions to the implementation of mental health policy in Ireland have been mixed, however, progress has been made in certain domains. At the time of the policy 'Planning for the Future' was adopted in 1984, there were only 18 Child Guidance Teams and three in-patient units for children and adolescents, based in Dublin, Galway and Cork. However, following implementation of the policy CAMHS have been established in every HSE area (Expert Group on Mental Health Policy 2006). Furthermore, the number of social work posts increased with social workers contributing to 18% of the clinical staff on CAMHS teams nationally (Health Services Executive 2011a). In a report from the Irish Association of Social Workers (IASW), which reviewed progress of AVfC, an increase of in-patient child and adolescent beds, the establishment of youth initiatives such as ten 'Jigsaw' mental health projects around the country and continued funding for community responses to suicide such as 'Teen Line', 'Pieta House' and 'LGBT Lives' were received favourably (McKenna et al. 2012).

However in 2012 a manifesto (Mental Health Reform 2012) reporting on the implementation of AVfC stated that:

> *"In the six years since publication…implementation of 'A Vision for Change' has been disappointingly slow…the challenge of implementing 'A Vision for Change' …has been hindered by lack of resources available to mental health, the imposition of the public service moratorium and a lack of dedicated corporate leadership."*

Delayed progress with policy implementation has resulted in 'service gaps', especially in the care of adolescents / young people (Coughlan et al. 2013). AVfC recommended that there should be 22 clinical staff on community CAMH teams per 100,000 of the population. The Fifth Report of the AVfC Implementation Group noted that, the majority of CMHTs were incomplete, with over 30% of CAMH teams not fully staffed and 1000 vacant posts since 2010 (Department of Health 2011). Furthermore, staffing levels were at 42.1% of the level recommended per 100,000 population in AVfC (McKenna et al. 2012). Limited staffing levels have had an impact on waiting lists, CAMH teams were providing services to 1.5% of young people under the age of eighteen years as opposed to the 2% recommended in AVfC (Lynch et al. 2010) and 288 (15%) of young people were on waiting list for more than a year (Health Services Executive 2011b). Therefore mental health care systems are struggling to meet the needs of the population who are most at risk, in regards to youth service provision (McGorry et al. 2007a, Coughlan et al. 2013).

The Mental Health Act 2001, had a positive impact in terms of improving the rights of people involuntarily detained, whereby every involuntary detention is reviewed by an independent tribunal and the act also promoted the closure of old psychiatric hospitals (Mental Health Reform 2012). However, Jabbar and colleagues (2011) conducted a survey of Irish GPs (n=820) to examine the implications of the Mental Health Act 2001 for their work environment to identify lessons of relevance to primary care in England and Wales. Almost two-thirds of the sample felt the new legislation was not user friendly, decreased time with patients and increased work load, with GPs who had received training about the legislation more likely to find it user friendly (43% versus 31%). Furthermore, a report from the Mental Health Reform Group, highlighted gaps in the current legislation for protecting the rights for users of inpatient services in regards to: protection of voluntary but incapacitated patients; a direct complaints procedure for both inpatient and outpatient users; reduction of seclusion, physical and mechanical restraint; regulation of chemical restraint, service user input in their care plans and legal recognition of family members accompanied by the provision of information and support (Mental Health Reform 2012).

1.9.2 International Declaration in Youth Mental Health

More recent policy developments since the publication of AVfC have seen the launch of the 'International Declaration in Youth Mental Health'. In 2010, the National Special Interest Group in Youth Mental Health hosted an International Summit in Youth Mental Health in Ireland, which provided a forum for 80 leading international researchers and professionals, young people and their family members to discuss the future of youth mental health in Ireland (Coughlan and Doyle 2015). At the Summit it was agreed that a new Declaration was necessary to support youth mental health service developments internationally. Coughlan and colleagues (2013) stated that their key aim was to:

> *"Change the way the global community thinks about young people and their mental health by ensuring that services are developmentally age appropriate and that young people have an active voice in determining what is best for them."*

To transform mental health service provision the Declaration outlined five core areas:

1) *Public health target to reduce preventable mortality* – reduce mortality rates correlated with mental ill-health and reduce suicides rates for youth (12-25 years) by over 50% in ten years.

2) *Mental health literacy* – promote young people to stay mentally healthy, education in regards to symptom recognition and information about accessing services.

3) *Recognition* – training for all health care workers in primary care services and across all health, youth and social care training programmes.

4) *Access to specialist support* – early access to specialist mental health services and community settings for young people and their families.

5) *Youth and family participation in service development* – youth participation in the planning of future services, a minimum of 80% of young people will report satisfaction with their experience of service provision and a minimum of 80% of families will report satisfaction that they felt respected and included as partners in care.

1.9.3 Mental health promotion

Previous literature found that mental health promotion programmes are beneficial in terms of improving mental health and quality of life while also reducing the risk of mental disorder (Hosman and Lopis 2002). The report also indicated that mental health promotion contributed to a reduction across an array of social problems including delinquency, child abuse, early school leaving, lost days from work and social inequity. According to AVfC, mental health promotion is outlined as working on three levels which have the potential to enhance protective factors (e.g., social support) and decrease risk factors (e.g., unemployment) for developing mental health problems (Expert Group on Mental Health Policy 2006):

1) *Strengthening individuals* – increasing self-esteem, coping skills, interpersonal relationships.

2) *Strengthening communities* – increasing social inclusion, improving social environments, developing anti-bullying campaigns at school and in the workplace and provision of community social support networks.

3) *Reducing structural barriers to mental health* – using initiatives to reduce discrimination and inequalities, promote access to education and employment and services to those in need.

Additionally, the WHO has advocated the importance of promoting positive mental health, not just among people with mental health problems but among the entire population. To enhance the importance and visibility of mental health the WHO (1986) stated that:

> *"National mental health policies should not be solely concerned with mental illness but recognise the broader issues affecting the mental health of all sectors of society…including the social integration of severely marginalised groups."*

According to AVfC mental health promotion programmes should be tailored to meet the needs of specific groups e.g., building resilience and promoting health for health populations might involve taking mental health promotion programmes into schools whereas programmes aimed at promoting early intervention and identification of high-

risk groups might be delivered in primary care. For children aged between 5-12 years, AVfC advocated the school setting as an ideal environment for the promotion of positive mental health (Expert Group on Mental Health Policy 2006). The benefits of the Social Personal and Health Education (SPHE) curriculum have been documented previously, where the main aim of SPHE is to provide second level students with a more holistic and "broad balanced education" by incorporating communication skills, problem solving techniques, developing self-esteem and group work within a forum that would enable the development of student health literacy (Mannix McNamara 2012, Mannix McNamara et al. 2012). SPHE may also have a crucial role in regards to incorporating bullying prevention as a key element of mental health promotion (Expert Group on Mental Health Policy 2006). The 'Mental Health Matters' programme promoted the extension of SPHE to the senior cycle given that adolescence can be a time for increased risk of mental health problem (Expert Group on Mental Health Policy 2006).

For mental health promotion programmes to have a wider impact, socio-economic factors should be considered due to the fact that low socio-economic status is one of the biggest factors that influences overall health. In the 'Strategy Statement on Health and Well-being' close and inter-sectoral co-operation was advocated as many factors which contribute to health inequalities are outside the direct remit of the health services (e.g., poverty and unemployment), therefore close co-operation between the Departments of Health and Children, Education and Science and Environment and Local Government are necessary (Department of Health and Children 1998, Chief Medical Officer 1999).

However, recent HSE survey results have indicated that mental health promotion and suicide prevention programmes are lacking, despite recommendations from AVfC. Additionally only one of the thirteen Expanded Catchment Areas (ECA) was involved in setting and evaluating targets for mental health promotion programmes, while only two ECAs had a designated mental health promotion officer (Health Services Executive 2011a). Furthermore, extension of SPHE to senior cycle as a compulsory subject has not been implemented and as SPHE is a non-examination subject, it tends to be "avoided or over-looked" by teachers due to pressures associated with meeting the demands of other examination subjects (Mannix McNamara et al. 2012). Moreover, the current level of training, consisting of 40 hours teacher in-service is insufficient to support teachers or

the role that SPHE could have in developing effective health promotion programmes among Irish post primary school students (Mannix McNamara et al. 2012).

1.10 Mental health and addiction services in Ireland

1.10.1 Mental health services

In Ireland, treatment of mental health and substance use problems is delivered by specialist services (James et al. 2013), general practice / primary care and at a range of community or voluntary agencies. While mental health care in Ireland has historically been structured around large psychiatric hospitals, there has been a progressive shift towards a more community based model of treatment and now community mental health teams are the norm (MacGabhann et al. 2004); with supported accommodation / employment, day centres, day hospitals, inpatient admission facilities and multidisciplinary teams (that include doctors, nurses, social workers, psychologists, occupational therapists and counsellors / therapists) as key features of mental health services (MacGabhann et al. 2004). Previous qualitative research with former residents (aged 20 to 66 years) who had spent time (1 to 13 years) in various psychiatric institutions in Ireland reported significant improvements in relation to their psychological, physical and social health and well-being when they made the transition to community service provision (Mannix-McNamara et al. 2012).

1.10.2 Addiction services

Since the late sixties, health care services have tried to meet the demands of the ever changing drug culture in Ireland from the Working Party on Drug Abuse in 1968, to centralised treatment facilities, to the first voluntary addiction treatment service established in Coolmine in 1973 (Butler 1997, MacGabhann et al. 2004). The prevalence of problem substance use has increased in Ireland since 1978 (O'Kelly 2000). Ireland's integration with the European Economic Community (EEC), now referred to as the European Union (EU), with rising prosperity and rapid social change had negative social consequences in terms of illicit drug use (O'Kelly 2000). Initial

cases of heroin abuse were noted by two GPs working in socio-economically disadvantaged areas in Dublin (O'Kelly et al. 1988). The large quantity of heroin in the late seventies resulted in major psychosocial problems for the residents of Dublin's inner city local authority housing complexes particularly among the 15-24 year age group (O'Kelly and O'Kelly 2012, Dean et al. 1983).

The issue of problem drug use in Dublin changed and intravenous heroin use became prevalent in the eighties (MacGabhann et al. 2004) and by mid-eighties intravenous drug use was recognised as a significant risk factor for transmission of HIV. In response to the HIV / AIDS pandemic, Irish health care policy on drugs saw the introduction of needle substitution programmes (NSPs) and opioid substitution programmes (OSPs), with the inclusion of both fixed and mobile NSPs and OSPs for sex-workers and homeless people (O'Kelly and O'Kelly 2012). Over the past three decades, illicit drug use has been a problem in areas of socio-economic disadvantage, where levels of educational attainment are low and drug related criminal activity and families with a longstanding history of drug use are common (O'Kelly et al. 1988, Dean 1984, Smyth et al. 2000). Growth in drug-related problems throughout the country has resulted in the need for health services nationally to formulate a specific drug strategy to meet the needs of their population, thus the provision of service developments that are relevant to local area needs and available resources (Department of Tourism Sport and Recreation 2001, MacGabhann et al. 2004).

1.11 Screening for mental and substance use disorders

National Institute for Health and Clinical Excellence (NICE) guidelines on depression in children and young people have indicated that GPs should be familiar with screening for mood disorders in addition to receiving further training in communication skills including active listening and conversational techniques, to treat patients with acute sadness and distress in community settings (National Institute for Health and Clinical Excellence 2005). The 'HEADSS' assessment is a useful guide to explore the various psychosocial factors associated with a young person's life (Goldenring and Cohen 1988). 'HEADSS' is an acronym for the topics that the GP might want to cover during the consultation: home, education, activities / employment, drugs, suicidality and sex.

Recently the 'HEADSS' assessment was expanded to 'HEEADSSS' (Goldenring and Rosen 2004) to include questions about eating and safety (see table 1.4). The US Preventative Task Force (2009) updated recommendations on screening for child and adolescent major depressive disorder in primary care based on findings presented in a systematic review which outlined the existence of accurate instruments for the identification of depression in adolescents and the benefits of early intervention (Williams et al. 2009).

In Ireland, services for the screening and treatment of mental and substance use disorders are provided by independent agencies privately, specialist mental health services, community agencies / NGOs and in some primary care centres. With so many agencies involved in service delivery, inter-agency communication is likely to be a challenge. The increase in suicides among young problem drug users (particularly young males) suggests the complex needs of this group are not being met (Lynn et al. 2009). Given the fragmentation and multiplicity of services geared towards young people with mental health and / or substance use problems, general practice is likely to have a key role in providing continuity of care (Smith et al. 2008). Previous research suggested the feasibility of identifying younger patients from socio-economically disadvantaged areas through their GP records as a first step towards planning a clinical intervention to improve outcomes for such patients in primary care (NSW Health Department 2000, Smith et al. 2008).

Table 1.4 HEEADSSS

HEEADSSS Psychosocial Assessment Explain reasons for delving into sensitive areas and asking permission to proceed	
H	**Home** (Consider living arrangements, transience, relationships with carers / significant others, supervision, childhood experiences, cultural identity)
E	**Education, Employment, Eating, Exercise** (Consider – school / work retention and relationships, bullying, belonging, study / career progress and goals)
E	**Eating, Exercise** (Consider – nutrition, vegetarianism, eating patterns, weight gain / loss, exercise, fitness energy)
A	**Activities / Hobbies & Peer Relationships** (Consider - free time, hobbies, culture, belonging to peer group, peer activities & venues, lifestyle factors, risk-taking, injury, avoidance, sun protection)
D	**Drug Use** (Consider – alcohol, cigarettes, caffeine, prescription / illicit drugs and type, quantity, frequency, administration, interactions, access, increases / decreases – treatments, education, motivational interviewing)
S	**Sexual Activity & Sexuality** (Consider – knowledge, sexual activity, age onset, safe sex practices, same sex attraction, history pap smears / STI screening / abuse, pregnancy / children)
S	**Suicide, Depression & Mental Health** (Consider - normal vs clinical, suicidal ideation / intent / method / past attempts / treatment, anxiety, reaction to stress, sleep – depression score & mental state exam)
S	**Safety, Spirituality** (Consider – sun screen protection, immunisation, bullying, abuse, traumatic experiences, risky behaviour, belief, religion; What helps them relax, escape? What gives them a sense of meaning?)

1.11.1 Gaps in services for young people

In Ireland, young people at risk or meeting the criteria for a psychiatric disorder do not always come to the attention of CAMHS (Lynch et al. 2004, Sullivan et al. 2004). Variable access to CAMHS has been problematic for young people in Ireland, where some CAMHS only offer services to young people under 16 years, while others serve those under 18 years, thus resulting in less clear pathways to care for this age group (O'Keeffe et al. 2015). Services for the screening and treatment of mental and substance use disorders are provided by independent agencies privately, specialist mental health services, community agencies / NGOs and in some primary care centres. With so many agencies involved in service delivery, inter-agency communication is likely to be a challenge. The increase in suicides among young problem drug users (particularly

young males) suggests the complex needs of this group are not being met (Lynn et al. 2009). Given the fragmentation and multiplicity of services geared towards young people with mental health and / or substance use problems, general practice is likely to have a key role in providing continuity of care (Smith et al. 2008). Previous research suggested the feasibility of identifying younger patients from socio-economically disadvantaged areas through their GP records as a first step towards planning a clinical intervention to improve outcomes for such patients in primary care (NSW Health Department 2000, Smith et al. 2008).

Community-based services and supports for young people with mental health problems are challenged by limited staffing, lengthy waiting lists and lack of inpatient services for young people with more severe mental illnesses (Headstrong 2008, Expert Group on Mental Health Policy 2006, HSE 2009, Mental Health Comission 2008, College of Psychiatrists of Ireland 2006). Gaps in service provision are particularly applicable to young people in the 14-17 year age group with only three adolescent day programmes nationally (College of Psychiatrists of Ireland 2006). According to data from the Health Services Executive (2009), 66% of the 398 young people in the 12-18 year age group with mental health issues who were hospitalised were admitted to adult psychiatric units due to the lack of child and adolescent beds (10 % of these were under the age of 16) (HSE 2009).

A report from the College of Psychiatrists of Ireland assessed service provision for young people with mental and substance use disorders in Ireland, identified the following gaps in service delivery: no existing teams for the 14 to 17 year age group, gaps in specialist alcohol and substance abuse services (no services available outside the Dublin area), inadequate services for children at risk of suicide and DSH and limited services for children with ADHD, autism spectrum disorders, conduct disorders and eating disorders (College of Psychiatrists of Ireland 2006). In a review of psychiatric presentations to the ED of a large children's hospital in Dublin, Byrne and colleagues (2011) noted that two-thirds of children and adolescents up to the age of 16 presented outside of working hours and 80% required referral to CAMHS, highlighting the need for a 24-hour CAMHS. Furthermore, in a report outlining the management of mental health and addiction services in Ireland, MacGabhann and colleagues (2004) noted gaps in services for those with dual diagnosis:

> *"National policy and service reviews need to address dual diagnosis and develop clinically effective service and treatment models applicable to the Irish context. Clarity and practice guidelines to provide frameworks for managing dual diagnosis are essential. Without such developments there may be little drive or support for practitioners trying to improve the care for people with dual diagnosis."*

Limited spending on CAMHS was also highlighted in the report from the College of Psychiatrists of Ireland (2006), with CAMHS accounting for 5-10% of spending on mental health services, while covering 23% of the population. The Mental Health Commission (2004) stated that:

> *'This under funding is reflective of the low priority given to mental health services, the lack of public awareness of the prevalence of mental disorder and the generally negative and stigmatised attitudes toward mental illness."*

1.12 Primary care and early intervention

1.12.1 Why youth mental health is an important issue for primary care?

Previous research indicated that 70–90% of young people contact primary care services at least once annually (Elliott and Larson 2004, Booth et al. 2004, Irwin and Charles 2003, Klein et al. 1998, Zimmer-Gembeck et al. 1997, Haavet et al. 2005, Chinet et al. 2003). GP based studies reported annual attendance rates between 50-70% among registered adolescents (Gledhill et al. 2003, Fallucco et al. 2012, Healy et al. 2013, Kramer et al. 1997). One third of young people attending primary care have a high probability of mental disorder (Haller et al. 2009). Sanci et al. (2010) referred to Goldberg and Huxley's model of pathways from community to inpatient psychiatric care in terms of an individual's journey from the community to their initial consultation in primary care, where clinical factors determine detection of distress and referral (Goldberg and Huxley 2001). However, despite the high prevalence of mental disorders in young people and the valuable opportunities for primary care settings to engage with this population, detection and treatment for such issues are low (Kramer and Garralda 1998, Roberts et al. 2014b). Previous research reported routine screening rates for

adolescent depression between 14-22% (Fallucco et al. 2012, Richardson et al. 2010b, US Preventive Services Task Force 2009).

1.12.2 Benefits of early intervention for young people

Delayed treatment for mental disorders is associated with adverse clinical outcomes such as poor functional outcome, increased risk of suicide, unnecessary treatment regimen, poorer social adjustment and more hospitalisations (Matza et al. 2005, Goldberg and Ernst 2002, Conus and McGorry 2002). Sanci and colleagues (2010) argued that early intervention is easier, cheaper and more effective than later treatment. Based on a large epidemiological survey, Korczak and Goldstein (2009) found that childhood-onset major depressive disorder resulted in longer depressive episodes, higher recurrence, more frequent hospitalisations and more suicidality compared to adult-onset major depressive disorder. Primary care interventions, including education and awareness, have been an important component of services that led to earlier treatment of young people with first episode psychosis (Power et al. 2007) and timely interventions in primary care can reduce the number of referrals to secondary care (Roberts and Bernard 2012).

The physical and psychosocial benefits of early intervention for young people have been documented across a range of mental disorders including psychosis (McGorry et al. 2007a, McGorry et al. 2008), depression (Allen et al. 2007), bipolar disorder (Berk et al. 2007), personality disorder (Chanen et al. 2007) and problem drug use (Lubman et al. 2007). Preventive screening, brief motivational interventions and school based interventions promoting alcohol and drug awareness have resulted in promising outcomes for young people with substance use problems (Lubman et al. 2007). Chanen and colleagues (2007) emphasised the importance of early intervention for bipolar disorder symptoms which are often risk factors for substance use disorders and violent behaviour in early adulthood (Cohen et al. 2007). A randomised controlled trial demonstrated modest benefits of cognitive analytic therapy for early intervention for bipolar disorder, however larger sample sizes in follow-up studies are required to determine the specific value of such treatments (Chanen et al. 2008).

Cognitive behaviour therapy (CBT) was considered an effective treatment for early intervention for depression in young people, while antidepressants were not recommended as first-line of treatment for initial episodes of depression (Allen et al. 2007). Interestingly, while there was no overall improvement for bipolar disorder with the use of CBT, Scott and colleagues (2006) reported the benefits of using CBT for those who had experienced fewer than ten illness episodes, which provides further evidence for the importance of early intervention (Berk et al. 2007). Despite the importance of early identification and intervention for mental disorders among young people, particularly in terms of pharmacological treatments being more efficacious early in the illness and mitigating the collateral damage associated with long-term illness (Baldessarini et al. 1999), there are clear risks associated with inappropriate therapy particularly for bipolar disorder (Berk et al. 2007). Post and colleagues (2001) found adverse effects (manic switching and increased cycle frequency) as a result of antidepressant monotherapy in a sample of patients with bipolar disorder.

1.12.3 Barriers between primary care and secondary care

Stigma and poor accessibility are key barriers to specialist mental health services (Buckley et al. 2013), therefore primary care (particularly general practice) is well placed to address the mental health needs of young people (Vallance et al. 2011). The co-occurrence of physical symptoms, psychosocial problems and psychiatric disorders in young people, in addition to some GPs' long-term knowledge of families are key factors contributing to the case for the provision of mental health promotion, prevention and early intervention in primary care (Vallance et al. 2011). However, limited capacity and absence of relevant skills are a global challenge for primary care (Vallance et al. 2011). Additionally, links between primary care and secondary care, particularly the mental health services are lacking. In a Canadian study, over 50% of GPs reported that they had no contact with resources in mental health (e.g., psychiatrists, psychologists, community agencies etc.) (Fleury et al. 2012). GPs indicated their dissatisfaction with mental health services and stated that they were: "of poor quality, particularly with respect to accessibility and continuity of care" (Fleury et al. 2012).

According to Mathers and Loncar (2006) countries with an effective primary care system are superior in terms of population health (Mathers and Loncar 2006). The WHO identified the need for investment in primary care to address the ever increasing rates of youth mental health disorders (World Health Organization 2005). It has also been suggested that new systems of primary care for young people should be based on collaborative care models, which increase detection, promote access to information and e-health services, with improved access to psychological treatments, where indicated (Hickie et al. 2007).

1.13 The role of the GP in youth mental health

1.13.1 Barriers to treating youth mental / substance use disorders

Young people attend primary care regularly and as they often present with co-existing risk behaviour / psychosocial problems, primary care, particularly GPs are ideally placed to address these issues opportunistically (Sayal 2006, Brown et al. 2007, Tylee et al. 2007, Bates et al. 2009). Previous research has noted that mental health problems often go undetected in general practice (Stensrud et al. 2014), even when the doctor feels that these are present and the adolescent is similarly aware (Martinez et al. 2006, Frankenfield et al. 2000). GPs tend to respond only when young people present with severe emotional distress (Kramer and Garralda 1998). Studies in the US and Australia have reported low rates of screening for emotional disorders, with detection rates ranging from 7 to 40% (Sayal 2006, Ozer et al. 2009, Klein et al. 2001, Pfaff et al. 2001, Hickie et al. 2007) and GP screening for such disorders were often initiated as a result of parental concerns (Sayal 2006). Fleury and colleagues (2012) suggested that GPs rarely used clinical screening tools or collaborated with other health care workers and tended to limit treatment options to monitoring medication or providing support therapy (Fleury et al. 2012).

Many health care workers, including GPs, may not be confident identifying / treating young people with mental health and / or substance use problems. Previous research identified the barriers experienced by GPs when treating mental health problems in young people as: fear of ‘over-medicalising’ young lives (Iliffe et al. 2004), reluctance to diagnose mental health conditions in younger people (Iliffe et al. 2008), limited

treatment options (Iliffe et al. 2009) and misinterpreting depression as a normal response to the wider psychosocial context of a young person's life (Biddle et al. 2006a, Patel et al. 2007).

GPs are also confronted with many structural and systemic barriers when trying to identify and treat youth mental and substance use disorders. Factors that limit the management of mental health problems included: limited resources (e.g., lengthy waiting lists, lack of information, limited number of psychotherapy sessions), communication barriers with mental health care services, lack of available GPs, inappropriate referral procedures, inadequate training (Cockburn and Bernard 2004) and the increased work load treating patients with mental health problems (Fleury et al. 2012).

Other barriers include lack of financial reimbursement for uncompensated time spent on mental health screening (Schmitt et al. 2010), limited knowledge about suicide risk, poor availability of mental health services for referral (Diamond et al. 2012, Healy et al. 2013), insufficient time to discuss mental health problems during consultations, restricted resources for screening (e.g., space, computers and staff) (Olson et al. 2009), patient confidentiality issues (Frankenfield et al. 2000), lack of clearly defined guidelines, ineffective communication skills and reluctance to discuss sensitive issues (Igra and Millstein 1993) and health care workers' own stigmatising attitudes towards mental illness (Wahl 1999). Similar barriers relating to time, resources and poor service availability were evident across studies both locally and internationally (Healy et al. 2013, Diamond et al. 2012, Igra and Millstein 1993).

Fleury and colleagues (2012) identified the factors that could facilitate the management of mental health problems and liaison with mental health resources: multidisciplinary practice teams, more patients with less complex mental health problems, further / specified training in mental health care, limited access to psychiatric services (forcing them to be involved), GP interest in mental health problems, good interpersonal skills and patient registration. Inter-professional collaboration was supported when GPs worked primarily in health and social service centres, practised in hospitals and had contacts in the field of mental health (Fleury et al. 2012).

1.13.2 The importance of training for GPs in youth mental health

Lack of time and training are often mentioned by GPs as major barriers to a comprehensive psychosocial diagnosis (Kushner 1995, Wright 1997, Cockburn and Bernard 2004). In a survey of 1000 Australian GPs in 1995, Veit and colleagues found that 80% were dissatisfied with their undergraduate training in consultation skills and psychosocial diseases in adolescents and 87% wanted continuing medical education (CME) in these domains (Veit et al. 1995, Veit et al. 1996). Fleury and colleagues (2012) reported that 75% of the sample felt competent to address common mental health problems, whereas only 17% shared similar beliefs in regards to serious mental health problems. GPs who did feel competent to treat serious mental health problems had specified training in mental health (Fleury et al. 2012).

The lack of training opportunities for Irish GPs in the detection and referral of mental health problems has been well documented in the literature (Copty and Whitford 2005, Bates et al. 2009, College of Psychiatrists of Ireland 2006, Cullen et al. 2012, Gavin et al. 2005). A study commissioned by the Irish College of General Practitioners (ICGP) reported that 68% of the GPs surveyed indicated that they had no specific training in mental health. Of the remaining 32%, who had received some training on the job and / or during hospital rotation, the training was only between three and nine months in duration (Copty and Whitford 2005). The study noted the paradoxical structure of the Irish mental health system where the responsibility of detection clearly lies within primary care, yet sufficient training on assessment and detection of mental ill health is virtually non-existent for GPs (Copty and Whitford 2005). Previous research noted the importance of providing further education, clinical guidelines and promoting awareness to support GPs in their endeavor to address youth mental health (Cullen et al. 2012).

1.13.3 Benefits of training GPs

The benefits of providing training have been highlighted in several studies (Sanci et al. 2000b, Sanci et al. 2000a, Rutman et al. 2008, Mauerhofer 2009, Stensrud et al. 2014, Stensrud et al. 2012). A cross-sectional study with 212 adolescents aged 12-17 years presenting at an ED showed that asking only two questions was an effective way to detect depressive symptoms (Rutman et al. 2008). The two-question screen were:

"During the past month, have you often been bothered by feeling down, depressed, or hopeless?" and *"During the past month, have you often been bothered by little interest or pleasure in doing things?"* Answering *"yes"* to one or both of these questions was considered a positive two-question screen. Participants also completed the 20-question Centre for Epidemiologic Studies Depression Scale (CES-D) (Radloff 1977), 37% screened positive on the CES-D and the two-question screen correctly identified 78% of participants with a positive score on the CES-D. Mauerhofer (2009) noted the potential for GPs to adopt a similar approach. However, the author noted a high refusal rate (34%) which may have skewed the data (Rutman et al. 2008).

Richardson et al. (2010a) demonstrated the usefulness of a two question screening instrument, the Patient Health Questionnaire-2 (PHQ-2) which asked respondents to rate the frequency they had (1) a depressed mood and / or (2) lack of pleasure in usual activities in the past two weeks on a Likert scale of 0 (not at all) to 3 (nearly every day). The PHQ-2 had a sensitivity of 74% and a specificity of 75% for detecting youth who met DSM-IV criteria for major depression on the Diagnostic Interview Schedule for Children (DISC) and a sensitivity of 96% and specificity of 82% for detecting youth who met criteria for probable major depression on the Patient Health Questionnaire 9-item (PHQ-9) depression screen. However, the study was conducted among an insured US adolescent population, thus the generalisability of the findings warrants further research. According to Sanci and colleagues (2000b) training GPs in adolescent health can contribute to more efficient consultations, while also increasing self-perceived and improved personal knowledge and skills.

1.14 Young people and access to mental health services

An increase in the range of youth health problems (e.g., depression, eating disorders, drug and alcohol use, unplanned pregnancy, chronic illness and suicide) emphasises the level of urgency required in the provision of health care services for young people (Ginsburg and Slap 1996, Bearinger and Gephart 1993, Veit et al. 1996). Although mental health and substance use problems can hamper everyday functioning and wellbeing, only a minority of these young people receive professional help, with rates of unmet needs varying between 65% and 95% (Kataoka et al. 2002, Sturm et al. 2003,

Gasquet et al. 1999, Sourander et al. 2001, Zachrisson et al. 2006, Biddle et al. 2004, Biddle et al. 2006a). The link between limited financial status and barriers to help-seeking has been well documented in the United States (Kataoka et al. 2002, Sturm et al. 2003) and in European countries where health insurance is compulsory (Gasquet et al. 1999, Sourander et al. 2001, Biddle et al. 2004, Gasquet et al. 1997).

In Ireland youth based studies have highlighted the following barriers to accessing services: fear of being stigmatised, complex referral pathways, lengthy waiting lists, staff shortages, concerns about consent and confidentiality (Buckley et al. 2013) and limited or non-existent out of hours services (Bates et al. 2009). Young people who do not meet the referral criteria for accessing services such as a young person with: a mild intellectual disability, a history of substance abuse, a diagnosis of a personality disorder, or a young person who is homeless or in the 16-18 year age group are prone to "falling between the cracks" (Headstrong 2009).

1.14.1 Solutions

International studies that incorporated the views of young people highlighted the key strategies to addressing perceived barriers to accessing mental health services for young people: provision of flexible appointments, evening drop-in services, easing problematic transitions between CAMHS and adult services, skilled staff in mental health care, protecting young peoples' ability to consent (National Children's Bureau 2004, Sayal 2006, Sayal et al. 2010, Biddle et al. 2006a) and improving the consultation process (Teggart and Linden 2006). Other models (e.g., 'The Zone' in Plymouth, UK and the 'Orygen Youth Project' in Melbourne, Australia) have highlighted the importance of making services more responsive and accessible (Buckley et al. 2013).

1.14.2 Young people and help-seeking

Young people most commonly attend primary care for respiratory or dermatological reasons (Ozer et al. 2002, Tylee et al. 2007, Potts et al. 2001). Previous research reported low rates of help-seeking (18-34%) among young people in the 4-17 year age group (Essau 2005, Zachrisson et al. 2006). A school-based Norwegian study with

teenagers in the 15-16 year age group reported very low rates of help-seeking (less than one-third of the study population) despite severe level symptoms of anxiety and depression (Zachrisson et al. 2006). Additionally, a cross-sectional study with young people from Switzerland reported that 87% did not seek help for depression even though 78% had seen their GP in the previous 12 months (Mauerhofer 2009). Haller and colleagues (2009) found that 10% of 16-24 year olds attending general practice in Australia presented with psychological complaints despite 24% believing they had a mental illness. Previous cross-sectional studies in Australia noted a link between suicidal ideation and unwillingness to seek help among adolescents (Wilson et al. 2005, Deane et al. 2001).

Several reasons have been noted for limited help-seeking in young people with mental health problems: Zachrisson and colleagues (2006) reported recognition of mental health problems and intention to seek help as major barriers; other studies have reported that young people prefer to seek help from friends and family for more sensitive matters (e.g., sexual advice, family conflict issues) as opposed to health care workers (WHO 1999, Barker et al. 2005, Rickwood 2005). Adults in the young person's life may assume the lead role in terms of how and when help-seeking should occur (WHO 1999, Sayal 2006). However, lay diagnosis, while a key strategy in the help-seeking process can often hinder help-seeking in terms of normalising symptoms, denial and delay (Biddle et al. 2007). In a series of focus groups with parents of young people, Sayal et al. (2010) reported similar barriers to help-seeking in terms of embarrassment and stigma associated with mental illness; some parents were reluctant to access services for their children due to fear of their child 'being labelled' or being judged as 'a poor parent'.

According to Klineberg and colleagues (2011), young males from socio-economically disadvantaged backgrounds were less likely to recognise symptoms associated with depression, recommend seeing a doctor for mild depressive symptoms and were at greatest risk of suicide. Klineberg et al. (2011) noted the importance of such gender specific differences in help-seeking, given the higher rates of suicide among young males (Cleary 2012). In the 'My World Survey', 77% reported that they would obtain information / support from the internet for mental health problems (Dooley and Fitzgerald 2012b). However, in a UK survey of adolescents' preferred modes of service

delivery for mental health problems, Bradford and Rickwood (2014) reported that most participants indicated a preference for face-to-face services, with 16% preferring online treatments, the majority of whom were male.

In a review of both qualitative and quantitative studies based on perceived barriers and facilitators to help seeking for youth mental health problems, Gulliver and colleagues (2010) found that stigma, embarrassment about seeking help, limited mental health literacy and a preference for self-reliance were the most prominent barriers. Facilitators to help-seeking were not as widely reported in the literature, however positive past experiences with health care workers, social support and encouragement from others were identified as key strategies to reduce the stigma associated with help-seeking (Gulliver et al. 2010). Additionally, Mauerhofer (2009) noted that being older or a student, having higher depression scores, a history of suicide attempt and positive experiences confiding in adults was also associated with higher rates of help-seeking among young people.

However, despite resistance among young people to discuss their mental health concerns with health care workers, previous studies that involved focus groups with young people and their carers reported the willingness of young people to work collaboratively with providers in developing care and treatment plans (Roose and John 2003, Teggart and Linden 2006). Bates and colleagues (2009) noted the increase in young people in Ireland who were willing to voice their opinions in regards to the need for reforming mental health service delivery.

1.15 Young people and their relationship with the GP

Young people attending primary care are more likely to present with physical symptoms despite having mental health problems, resulting in barriers to their recognition and referral (Sayal et al. 2010). While young people may engage regularly with general practice, psychosocial issues are the presenting complaint in only 2-12% of young people's consultations (Cleary et al. 2007, McKelvey et al. 1998, Zwaanswijk et al. 2005). Indeed, GPs are not consulted by young people with psychosocial issues, even in dire circumstances (Rickwood et al. 2007, Biddle et al. 2006a). However, recent Irish studies in socio-economically disadvantaged areas in Dublin noted the common

occurrence of mental and substance problems amongst young adults aged 15-25 attending primary care with 35% having a psychosocial issue documented in their clinical record (Connolly et al. 2012), thus highlighting the potential benefits of training GPs, having direct access to psychological services and closer links with specialist mental health services (Connolly et al. 2012, Healy et al. 2013, Leahy et al. 2013).

Previous research has documented various reasons why young people are reluctant to attend a GP when experiencing a psychological issue and these include: cost (National Youth Council of Ireland 2009, McCann and Lubman 2012a), geographical distance (Tylee et al. 2007), lack of awareness that a GP can help with emotional difficulties (Biddle et al. 2006a), misconceptions about the level of support offered by GPs, perceived lack of youth friendly services, concerns about confidentiality (Martinez et al. 2006, Churchill et al. 2000, Biddle et al. 2006a), being viewed as weak or abnormal (Wisdom et al. 2006), insufficient time in the consultation (Jacobson et al. 1994), a belief that GPs are not interested in mental health problems (Biddle et al. 2006a, Tait 2009) and the belief that treatment will not help (Copty and Whitford 2005, Biddle et al. 2006a, Rickwood et al. 2007).

1.15.1 Young people and their experiences of primary care services

Primary care based studies with young people have noted the following facilitators associated with engaging with primary care: positive rapport with health care workers (Wisdom et al. 2006, McCann et al. 2012, Haller et al. 2007); autonomy (Wisdom et al. 2006, Byczkowski et al. 2010) and continuity of care (Sayal et al. 2010, McCann and Lubman 2012b). Additional factors associated with attendance at general practice for mental health problems were lower socio-economic status, non-White ethnicity (mainly young black women), non-intact families and not believing that GPs only address physical problems (Ferrin et al. 2009). Reasons for the association between certain demographic variables and higher rates of attendance have included: the variation in somatisation with ethnicity which may be more common in young people of non-White ethnicity and as physical symptomatology is a likely factor for GP consultation, young people with non-White ethnicity may be amongst the high number of attenders at GP practices compared with White adolescents. Additionally, adolescents from socio-

economically disadvantaged families may have a greater need for external support and help with depressive symptoms where support structures within their family unit are lacking (Ferrin et al. 2009). Similar links were reported between young people from more socio-economically disadvantaged backgrounds and higher rates of attendance among Irish based samples (Connolly et al. 2012, Healy et al. 2013). The inclusion of family members and carers where appropriate was also an important strategy in facilitating youth engagement with primary care services (McCann and Lubman 2012b, Mauerhofer 2009).

Barriers to engaging with primary care services for youth mental health problems included fear of stigmatisation and perceived judgement from the GP (Meredith et al. 2009, Wisdom et al. 2006). Additional barriers included: transport, appointment delays, unfamiliarity with the service and cost (McCann and Lubman 2012a). Medication as a form of treatment also deterred young people from engaging with services (Meredith et al. 2009, Tanielian et al. 2009). In a study looking at young peoples' treatment preferences for depression, Jaycox and colleagues (2006) noted that 72% of those studied preferred active treatment over watchful waiting (28%). Of those who wanted active treatment, over twice as many expressed a preference for counselling over medication. Factors which predisposed young people to prefer pharmacological treatments, related to having current anxiety symptoms, a generally positive attitude towards medication and a negative attitude toward depression treatment (Jaycox, Rosenbaum, Asarnow et al, 2006). It has also been shown that symptom severity is related to 'readiness' for treatment and readiness for treatment before treatment commences predicts adherence to treatment (Tanielian et al. 2009). Interestingly, young people believed that having depression was more stigmatising than 'being in a wheelchair' or having HIV/AIDS, which may partly explain the low rates of adherence to pharmacological treatments and the high drop-out rates from psychological treatments (Jaycox et al. 2006).

Limitations of the aforementioned studies were that the majority are based on young people with depression or experiencing depressive symptoms (Wisdom et al. 2006, Jaycox et al. 2006, Ferrin et al. 2009, McCann and Lubman 2012b, McCann and Lubman 2012a), therefore findings may not be generalisable to young people with other types of mental health problems. Cross-sectional studies are problematic as they often

only collected data at one time point and are limited in causality (Mauerhofer 2009). Self-report data may be subject to inaccurate responses, however the literature suggests that self-administered anonymous questionnaires encourage reporting the truth, especially concerning sensitive topics (Brener et al. 2003, Kann et al. 2002). Qualitative accounts of young people in Ireland with mental health problems are lacking particularly in terms of their attitudes towards screening and treatment for such issues and their interaction with primary care services. (Table 1.5 summarises studies based on psychological morbidity in young people attending general practice and other primary care sites).

Table 1.5 Studies of psychological morbidity among young people attending general practice, primary care, family medicine.

Author, date	Setting / Study population	Methodology	How cases defined	Findings
Wisdom, Clarke and Green (2006) **Research aim:** To explore the experiences of teenagers seeking and receiving treatment for depression from primary care providers.	**Setting:** Northwest division of Kaiser Permanente (NGO health maintenance organisation) serving Northwest Oregon and Southwest Washington (KPNW). **Population:** Young people aged 14-19 years (n=7) from local high school for focus group and current KPNW members (n=15) with a diagnosis of major depression or dysthymia, participated in individual interviews.	Focus group and semi-structured interviews involving study specific instruments.	Focus group and interview participants were asked about their understanding / experiences of depression in regards to diagnosis / treatment / relationships with primary care providers.	Themes from the focus group and interviews which facilitated / limited decisions to engage with primary care services included: • Fear of being stigmatised by health care workers. • Being connected (with health care workers, being listened to etc.) • Being autonomous – not having a voice in their treatment, receiving limited information.
Jaycox, Rosenbaum and Asarnow (2006) **Research aim:** To examine adolescents treatment preferences as a potential reason for low levels of adherence to care (part of the Youth Partners in Care YPIC study)	**Setting:** Primary care sites (n=6) **Population:** Young people (n=444) aged 13-21 years	Screening and interviews involving: 10 minute screener: • Composite International Diagnostic Interview Version 2.1 (CIDI-12, 2.1) (World Health Organisation 1997) • CES-D Baseline interview (face to face questionnaire on treatment preferences) • CIDI 2.0 • MHI-5 (Ware and Sherbourne 1992) • Life Stressors and Social Resources Inventory (Derogatis and Melisaratos	Young people who screened positive for depression completed a treatment preference assessment.	• Prefer active treatment (72%) rather than watchful waiting (28%) • 50% prefer counselling • 22% prefer medication • Youth preference for counselling over medication may contribute to low adherence to medication treatment

		1983) • Brief Symptom Inventory (Moos and Moos 1994) • Study specific instruments		
Haller, Sanci, Patton and Sawyer (2007) **Research aim:** To describe the perspectives of young people presenting to GPs to inform the development of youth friendly services.	**Setting:** 26 randomly selected practices in Australia **Population:** Young people (n=450) aged 16-24 years and Practitioners (n=106)	Cross-sectional study involving: • Short Explanatory Model Interview (SEMI) (Lloyd et al. 1998) • Scale of Emotional Distress (K-10) (Kessler et al. 2002) • Study specific instruments	Patients attending were asked to describe their reason for the consultation, complete a scale of emotional distress and self-rate the severity of their physical and mental health problems. GPs completed a short questionnaire summarising consultation outcomes for each patient.	• 10% presented with psychological complaints but 24% perceived they currently had a mental illness. • The most common expectations were treatment (50%) and good communication (42%). • Gap identified between young people's view of illness and their presentations to GPs.
Ferrin, Gledhill, Kramer and Garralda (2009) **Research aim:** To identify contributory factors to GP attendance in young people with high depressive symptoms.	**Setting:** Central London general practice **Population:** Young people aged 13-17 years (n=156) attending general practice and controls (n=120) not attending the practice GPs (n=7) Registrar (n=1)	Case control study involving: • Mood and Feelings Questionnaire (MFQ) (Angold and Costello 1987) • Children's Somatisation Inventory (CSI) (Meesters et al. 2003) • Study specific instruments	All young people attending the practice over a 6 month period were asked to complete questionnaires by reception staff; 63 (34%) scored above or equal to the MFQ cut-point of 17 for high level depressive symptoms, of whom 61 completed the CSI.	Attendance was significantly linked to: • Lower socio-economic status • Non-White ethnicity • Non-intact families • Not believing that doctors are only interested in physical symptoms.
Tanielien, Jaycox, Paddock et al. (2009) **Research aim:** To examine readiness for treatment among adolescents with depression in primary care.	**Setting:** Young people and their parents who were involved in the 'Teen Depression Awareness Project', from 7 health care organisations. **Population:** Young people (n=184) aged 13-17 years and parents (n=170)	Telephone questionnaire involving: • Diagnostic Interview Schedule for Children (DISC) • MHI-5 • PHQ for Adolescents • Sheehan Disability Scale (Sheehan 1983) • Study specific instruments	The readiness for treatment measure was constructed by compiling responses from the baseline teen and parent interviews where eligibility for depression was defined using the DISC.	• 78% of depressed teens acknowledged problem • 25% getting treatment • 41% ready to receive treatment • Depressive symptoms predicted readiness • Readiness predicted treatment adherence

Meredith, Stein, Paddock, Jaycox, Quinn, Chandra and Burnam (2009) **Research aim:** To understand perceived barriers and their impact on service use among adolescent patients attending primary care.	**Setting:** Primary care practices (n=7) **Population:** Adolescent patients aged 13 to 17 years (n=368; n=184 depressed and n=184 non-depressed) and n=338 parents.	Telephone interview involving: • Study specific instrument	After completing an eligibility and diagnostic telephone interview, all depressed teens and a matched sample of non-depressed teens recruited from 7 primary care practices were enrolled and completed telephone interviews at baseline and 6 months.	• Teens with depression were more likely to perceive barriers to care compared with non-depressed teens. • Perceived stigma and concern about family response were significant teen barriers. • Teen perceived barriers scores were negatively associated with any use of antidepressants at the 6 month follow-up.
Mauerhofer, Berchtold, Michaud and Suris (2009) **Research aim:** To assess differences among youth who seek help and those who do not for psychological issues	Young people (n=7429) aged 16–20 years.	Survey involving: • The Inventory of Parent and Peer Attachment (Armsden and Greenberg 1987) • Short version of CES-D • Study specific instrument	Among a Swiss sample of students and apprentices cases were divided into those who sought help (n=256) and those who did not (n=1675), differences between them were assessed.	• 1931 participants (46% females) reported needing help for depression / sadness. • Only 13% needing help for psychological problems consulted for that reason. • 80% who did not consult for psychological problems visited the GP at least once during the previous year.
Sayal, Tischler, Coope, Robotham et al. (2010) **Research aim:** To explore the factors which influence parental help-seeking for children with emotional / behavioural difficulties.	**Setting:** Community based organisations working with families across London boroughs of Lambeth and Southwark **Population:** Parents (n=34) of children with clinically significant mental health problems / associated impairment in function ranging in age from (2-15 years)	Focus groups (n=8) and validation interviews involving: • SDQ • Study specific instrument	Additional measures included parent and child demographic details and parent questionnaires providing descriptive data about the children represented in the groups.	Facilitators to help-seeking included: • Trusting relationship with GP • GP validation of parental concerns • GP interest in child / family • Continuity of care Barriers to help-seeking included: • Embarrassment • Fear of stigma or child being labelled with a diagnosis • Being judged as a 'poor parent' • Short appointments

Burnett-Zeigler, Walton, Ilgen, Barry et al. (2012) **Research aim:** To describe the characteristics of adolescents with mental health problems presenting to primary care clinics.	**Setting:** US community health clinics (n=7) based in urban areas in the Midwest. **Population:** Young people (n=1076) aged 12-18yrs.	Ten minute computerised questionnaire followed by a 25 minute screening instrument that included: baseline mental health problems, health service usage and demographic characteristics involving: • Brief Symptom Inventory • AUDIT • Study specific instruments	A consecutive sample of adolescents who presented to community health clinics were approached to participate in a randomised controlled trial of a prevention intervention for marijuana use.	• 14 % screened positive for a mental health problem. • 43% had received care for a mental health problem in the past 3 months. • Mental health problems related to: being female, having poorer grades, poorer self-reported health, drug use and lower parental monitoring.
Connolly, Leahy, Bury, Gavin, McNicholas, Meagher, O'Kelly, Wiehe and Cullen (2012) **Research aim:** To determine the prevalence of psychological problems and general practice utilisation among young people.	**Setting:** General practices in Dublin city (n=3) **Population:** An audit was conducted in practices to identify young patients (n=180) aged 15-25 years	A retrospective cross-sectional study involving: • Study specific instrument	Clinical records were retrospectively reviewed for a two year time period from the date of data collection and the data collected were anonymised.	• Considerable contact was observed for 44% of female patients (who were also GMS-eligible). • The most common psychosocial issues were stress / anxiety and depression in 35% of cases. • Identification of psychosocial issues was associated with GMS-eligibility, three or more consultations and documentation of smoking / drinking on patient files.
Healy, Naqvi, Meagher, Cullen et al. (2012) **Research aim:** To describe strategies adopted by GPs in dealing with youth mental health problems and collate GP proposals for improved care of this cohort.	**Setting:** Ireland's Mid-west region **Population:** GPs (n=39)	Cross-sectional study involving: • Study specific instrument	Self-administered questionnaire on physician and practice demographics, case management and barriers to care in youth mental health based on young patients aged (16-25 years).	• Depression, anxiety, family conflict, suicidal thoughts, ADHD and substance use were the most common issues. • GP referral practices varied due to insufficient access to services and training. • GPs stated the need for improved access to psychiatry, counselling / psychology / educational interventions).

McCann, Lubman and Clark (2012) **Research aim:** To explore the experience of young people with depression accessing 'Headspace' primary care services.	**Setting:** 'Headspace' primary care site, Melbourne. **Population:** Young patients (n=26) aged 16-22 years	Qualitative study – semi-structured interviews involving: • Study specific instrument	A purposive sample of young people recruited through a primary care service, were asked about their experiences of accessing the service.	• School counsellors facilitated youth engagement with 'Headspace'. • Barriers included: transport, unfamiliarity with the service, appointment delays and limited free consultations. • Three themes were identified in relation to satisfaction with care received from clinicians: o Youth-friendly clinicians o Holistic approach o Care facilitating recovery

1.16 Effectiveness of interventions in primary care.

1.16.1 Screening / identification

Common screening instruments used in primary care for mental health and substance use problems include:

- *Alcohol Use Disorders Identification Test (AUDIT)* consists of ten items designed to measure three domains: 1) alcohol consumption, 2) signs of alcohol dependence and 3) alcohol-related harm (Saunders et al. 1993).
- *Beck Youth Inventories - Second Edition (BYI-II)* is an assessment tool which comprises five scales that can be used individually or in combination, the scales cover self-concept, anxiety, depression, anger and disruptive behaviours (Beck 2005).
- *Centre for Epidemiological Studies Depression Scale (CES-D)* - a short self-report scale designed to measure depressive symptomatology in the general population. Scores on the 20-item scale range from 0 to 60, with higher scores reflecting greater severity of depression (Radloff 1977).
- *Children's Somatisation Inventory (CSI)* - includes 35 symptoms that were taken from the DSM-III–R criteria for somatisation disorder and the somatisation factor of the Hopkins Symptom Checklist (Meesters et al. 2003).
- *Depression Anxiety Stress Scale (DASS)* – a 21-item response form where a higher score indicates greater depression, anxiety or stress (Lovibond and Lovibond 1995).
- *Depressive Symptom Inventory Suicidality Subscale (DSI-SS)* - a four-item self-report questionnaire designed to identify the frequency and intensity of suicidal ideation and impulses in the previous 2 weeks. Scores on each item range from 0 to 3 and for the inventory, from 0 to 12, with higher scores reflecting greater severity of suicidal ideation (Metalsky and Joiner Jr 1997).
- *General Health Questionnaire-12 (GHQ-12)* – The 12-Item scale is the most extensively used screening instrument for common mental disorders, in addition to being a more general measure of psychiatric well-being (Goldberg and Williams 2000).
- *Mood and Feelings Questionnaire (MFQ)* – a 33-item scale where the child or parent rate depressive symptoms on a Likert scale (Angold and Costello 1987).

- *The Primary Care Evaluation of Mental Disorders (PRIME-MD) / PHQ* - a 26-item self-administered questionnaire that screens for five of the most common groups of disorders in primary care: depressive, anxiety, alcohol, somatoform and eating disorders (Spitzer et al. 1999).
- *The Children's Depression Inventory (CDI)* – a 27-item self-rated symptom-oriented scale to screen depressive disorders in children and adolescents (Kovacs 1984).

In a systematic review of studies to determine the use of psychometric data collected in primary care for the identification of adolescent depression, Zuckerbrot and colleagues (2006) found that few health care workers used systematic depression identification methods despite growing evidence for their validity, feasibility and possible efficacy. While most studies using self-reported tools had recommended clinical cut-offs to identify depression, Zuckerbrot et al. (2006) reported the problematic nature of using liberal screening criteria which may result in over identification and increase the burden of false positives. The use of HEEADSSS is often discussed in adolescent health care literature, however, no studies reported its use for identification of adolescent depression in primary care (Zuckerbrot and Jensen 2006). In later work, Zuckerbrot et al. (2007) found that primary care practitioners were positive about using questionnaires to systematically screen their patients and young study participants and their parents were equally as receptive.

Intervention studies in primary care to enhance screening for youth mental health problems reported significant increases in the detection of psychological distress and inquiry about suicidal ideation (Pfaff et al. 2001) as a result of educational workshops. Pre and post-test design studies (Gledhill et al. 2003, Fallucco et al. 2012) noted significant increases in screening adolescents for depression post training which included educational programmes / seminars based on the use of screening tools and psychotherapeutic interventions delivered by experts in the field of youth mental health. Significant gains were also noted in GP knowledge and confidence to address youth mental health problems as a result of the training (Sanci et al. 2000a) and GPs were also more likely to use screening tools (Fallucco et al. 2012). However, in an intervention to increase screening and counselling for adolescents presenting with risky behaviour,

Ozer et al. (2005) found that GPs attributed the provider training to the significant increases in screening as opposed to the use of screening tools.

The 'Therapeutic Identification of Depression in Young People' (TIDY Study) involved an intervention developed by GPs and child psychiatrists to combine diagnosis of depression with a CBT based psychological intervention to facilitate GPs in systematically screening adolescent attenders for depression during a single consultation (Kramer et al. 2013). Screening rates increased from 0.7% to 20% and depression identification rates increased from 0.5% to 2%. In a follow-up qualitative study, with GPs and nurses who participated in the TIDY study, participants noted the benefits of undergoing training in terms of enhancing awareness of depression in young people, building self-perceived skills and confidence, however, GPs were still anxious about the medicalisation of psychological distress in young people and time constraints associated with a busy practice were barriers for some (Iliffe et al. 2012). However, the study highlights the potential of training GPs in the assessment and management of mental health problems in young people and an additional strength of the study is that it can be administered to young people during one consultation which is sometimes the only opportunity to intervene with this age group (Iliffe et al. 2012).

Aarseth and colleagues (2014) reported increases in utilisation of GP services (from 59% to 69%) by sending an informative letter to patients where the protection of adolescent privacy and information about health rights had been outlined. Advances in information technology have also proved to contribute to increases in the detection of behavioural problems for young people. In a randomised controlled trial, Stevens et al. (2008) examined the use of an *e*Touch tablet to deliver a questionnaire screen which was based on several validated screening tools. The study showed positive results in terms of increased detection of behavioural concerns, however organisational issues in practices (i.e., busy receptionists frequently failed to administer the *e*Touch), often hindered the possibility for routine screening (Stevens et al. 2008).

Roberts and Bernard (2012) reported a reduction in referrals to secondary care with only eighteen referrals made for fifty young people seen, as a result of extended GP involvement in the assessment and management of youth emotional and behavioural problems. Management of problems included both 'behaviour interventions' defined as structured discussions which addressed smoking behaviour, patterns of alcohol and

illicit drug consumption, peer networks etc. and 'psychological interventions' involved sustained engagement with the young person including three or more thirty minute sessions of active listening, non-directive counselling, narrative therapy and elements of CBT.

The main limitations of the screening intervention studies include: low response rates and GP self-report as opposed to patient report (Gledhill et al. 2003, Kramer et al. 2013, Fallucco et al. 2012). The majority of studies were conducted in controlled test settings; therefore the transferability of such interventions into real world clinical settings remains unknown. In the TIDY study, practitioner knowledge at baseline was high with 16 (69%) of the sample having received training / worked in youth mental health. Therefore, a larger sample using a randomised controlled trial is required to establish the impact of the TIDY intervention. Additionally, screening was selective rather than systematic, therefore many adolescents with depression may not have been identified. While some interventions may have resulted in significant increases for screening young people with mental health problems, Pfaff and colleagues (2001) noted that training did not lead to any changes in GPs' patient management strategies, with the majority of cases continuing to be referred to secondary care (Zwaanswijk et al. 2011).

1.16.2 Treatment

In a review of intervention based studies for child and adolescent mental health problems in primary care, Bower and colleagues (2001) noted the potential benefits of having specialist staff in primary to address mental health problems and also the importance of incorporating educational interventions in practice for increasing skills and confidence. However, data regarding the cost effectiveness of interventions, changes in professional behaviour and patient health outcomes were lacking (Bower et al. 2001). In a CME based training course for GPs on adolescent health, which incorporated modules relating to adolescent development, consultation and communication skills, health risk screening, health promotion, risk assessment of depression and suicide, Sanci et al. (2000b) reported gains in knowledge, clinical skills and self-perceived competency compared to controls. A follow-up postal survey five years after the intervention indicated that 45⁄46(98%) of GPs maintained their clinical

approach to youth and 22⁄46(46%) reported maintaining practices to address systemic barriers to adolescent health care access (Sanci et al. 2005a). However, the self-selection bias cannot be ignored with those who were intrinsically motivated to acquire such skills and the intervention was delivered in a controlled test setting, therefore its transferability into clinical practice warrants further research.

The 'Youth Partners in Care' study, is a collaborative care model which demonstrated positive effects for young people between 13 and 21 years with depression. Youth who screened positive for depression were randomised to either a quality improvement intervention (which was designed by an expert team leader and included links with mental health support) or usual care. At six months, patients in the intervention group reported significantly fewer depressive symptoms, higher mental health-related quality of life and satisfaction with mental health care compared to controls (Asarnow et al. 2005). However, no significant differences in depressive symptoms were noted at 18-month follow-up assessment (Asarnow et al. 2009) and there was no significant effect on use of medication. Unlike a traditional clinical trial, the patients and providers were encouraged but not required to consider evidence-based treatments and given training and materials to support their use. In a subsequent study, Wells et al. (2012) conducted a randomised controlled trial to determine the effectiveness of depression treatment compared to usual care where patients and providers actually chose the type of treatment. The study results complimented the modest findings from Asarnow et al. (2005), in terms of reinforcing the importance of implementing interventions in primary care to increase rates of appropriate care as well further improving the effectiveness of quality improvement interventions (Wells et al. 2012).

Additionally, GP intervention studies have indicated a decrease in youth mental health problems due to CBT and internet based interventions (Van Voorhees et al. 2008) and mobile phone-based interventions (Reid et al. 2011). In a randomised controlled trial which compared two forms of a primary care / internet-based behavioural intervention utilising brief advice or motivational intervention, Van Voorhees et al. (2008) found both approaches resulted in declines in depressed mood and depression related impairment in school and increases in peer support. The results of this study demonstrated promising potential for GPs to engage with youth at risk of progressing to major depression with internet-based programmes. Additionally, Mason and colleagues

(2011) reported a decrease in substance use and social stress as a result of a motivational interviewing (MI) / social network intervention and a readiness to start counselling within their primary care setting. Reid et al (2011) found that actively monitoring one's mental health symptoms using a mobile phone application led to increased emotional self-awareness through the provision of frequent GP reminders and clinical resources.

Conversely, in a GP intervention study incorporating MI techniques and strategies for behaviour change to reduce excessive substance use in adolescents, Haller and colleagues (2014) reported no significant reductions in patient substance use compared to patients whose GPs were not trained to use the intervention although a 28% reduction was identified in the proportion of patients reporting excessive substance use at 12 months. The absence of a validated instrument for primary care in French in addition to the possibility that young people may have minimised the level of substance use depending on their wish for further consultation may have contributed to problems identifying excessive substance use (Haller et al. 2014). (Tables 1.6 to 1.8 provide an overview of GP based intervention studies for screening and treating youth mental / substance use disorders and the types of therapeutic approaches which are commonly used in primary care).

Table 1.6 Primary care based intervention studies in screening and identification of youth mental health and substance use problems

Author, Date / Study type	Setting / study population	Intervention	Description	Outcome measure	Key findings	Limitations
Pfaff, Acres and McKelvey (2001) *Pre / post-test design*	Australian general practices (n=23; 17 urban and 6 rural) in 1996 and 1997. GPs (n=23) Patients aged 15-24 years who presented to GPs pre-workshop (n=203); post-workshop (n= 220).	One day youth suicide prevention workshop to enhance GPs' ability to recognise, assess and manage young patients at risk of suicide.	Adolescents were screened pre / post intervention using GHQ-12; CES-D, DSI-SS and a GP-completed form.	Recognition of psychological distress and suicidal ideation in young people.	Better identification of people with high CES-D scores (63% vs. 45%), psychological distress (48%). Increased inquiry about suicidal ideation (33%). Increased identification of suicidal patients (130%).	Training did not lead to any significant change in GPs' patient management strategies. No definitive diagnostic assessment used.
Sanci, Coffey, Veit, Carr-Gregg et al. (2000) *RCT*	General practices in Melbourne. GPs (n=108)	Workshops for 2.5 hours weekly for 6 weeks.	The intervention included: evidence based educational strategies, role play, modelling practice with opinion leaders and use of checklists to cover risk assessment for depression and suicide and a broader educational intervention for GPs in adolescent health care.	Knowledge, skill and self-perceived competency (including clinical approach to adolescents with issues of depression, suicide risk assessment, alcohol and drug issues etc.), satisfaction with the programme and self-reported change in practice.	The intervention group showed greater improvements in all outcomes than the control group. 96% found the programme relevant. 98% reported a change in practice attributable to the intervention.	Self-selection bias. Controlled test setting.

Gledhill, Kramer, Iliffe and Garralda (2003) *Pre / post-test design*	A large Central London practice GPs (n=10); adolescent patients aged 13-16 years (n=130 pre-training and n=184 post-training).	Two 1 hour group sessions by two child psychiatrists. Training included: (1) Changing consultation focus from physical to psychological enquiry. (2) Screening for depression. (3) Treatment interventions: CBT and inter-personal therapy techniques.	Phase 1: Adolescents over 10 months were screened for a disorder and offered the K-SADS interview. Phase 2: Post-training, adolescents completed the MFQ and CSI those above the cut off were offered the K-SADS interview.	Recognition of adolescent depression.	Identification rates of depression increased from 26% to 48%. Sensitivity of GP identification improved from (20% to 43%). 91% of adolescents interviewed found it helpful.	Self-selection bias. Small sample size.
Ozer, Adams, Lustig, Gee et al. (2005) *Pre / post-test design*	Two outpatient paediatric clinics; two other paediatric clinics in the same health maintenance organisation (HMO) served as comparison sites in Northern California. Primary care providers (n=37) / Comparison group (n=39) Adolescents 13-17 years (n=2628)	An 8 hour training workshop to increase screening and counselling of adolescents for: tobacco, alcohol, drugs, sexual behaviour and safety (seatbelt / helmet use). Training was provided by an expert panel of adolescent medicine specialists.	Clinicians were trained to deliver preventive services and use screening tools. The control group provided usual care. Adolescents completed surveys on whether their providers screened and counselled them for risky behaviour.	To test an intervention to increase screening and counselling for adolescents presenting with risky behaviour.	Screening and counselling rates increased in the intervention sites, compared with usual care: • Screening rates (58% to 83%) • Counselling (52% to 78%). Provider training had more impact compared to screening tools.	Intervention conducted in a group model HMO may not be transferable to other settings.

Stevens, Kelleher, Gardner, Chisolm, McGeehan, Pajer and Buchanan (2008) *RCT*	Urban clinics (n=9) in Ohio serving predominantly low-income patients. Primary care patients (n=878) 11 to 20 years of age.	Patients participated in computerised behavioural screening (the Health eTouch system) in clinic waiting rooms.	The clinics were randomly assigned to have paediatricians receive screening results either just before face-to-face encounters with patients (immediate-results condition) or 2 to 3 business days later (delayed-results condition).	To determine whether computerised screening with real-time printing of results for paediatricians increased the identification of adolescent behavioural concerns.	59% of Health eTouch respondents had positive results for ≥1 of the following: injury risk behaviours, significant depressive symptoms or substance use. 68% of youths in the immediate-results condition who screened positive were identified as having a problem compared to 52% in the delayed-results condition.	[Abstract only]
Haavet, Kaur Sirpal, Haugen et al. (2010) *Pre / post-test design*	Multicentre study conducted in Norway and Denmark. Adolescents 14-16 years (n=2374) recruited from GP (n=43) patient lists.	Adolescents responded to the Hopkins Symptom Checklist-10 test (HSCL-10) questionnaire (n=380) and participated in a Composite International Diagnostic Interview (CIDI) via telephone (n=294).	Youden index scores used to calculate optimal cut-off point for depression, pre and post-test scores were compared.	To validate the (HSCL-10) for identifying adolescent depression.	Thirty (9%) young people who participated in the CIDI interview met the ICD-10 criteria for major depression. Participation was higher in Denmark than Norway (21% vs. 12%) may be due to parental consent requirement in Norway.	Low response rate 16% returned the HSCL-10. Language selection bias (Norwegian and Danish). Self-report Telephone interviews as opposed to face-to-face interaction.

Falluco, Conlon, Gale, Constantino and Glowinski (2012) *Pre / post-test design*	Primary Care Practitioners (PCPs) in the greater St. Louis area. PCPs (n=44 paediatricians and n=2 family practitioners) participated in the intervention and (n=58) PCPs served as an untrained comparison sample.	60-minute seminar followed by a 60-minute standardised patient (SP) session to practice assessment for adolescent depression and suicide risk assessment (ADSRA) skills in simulated clinical situations delivered by expert child and adolescent psychiatrists / medical educators.	Teaching adolescent depression and suicide risk assessment using evidence based screening tools at six different time points over five months. PCPs completed pre- and post-intervention assessments. Assessments evaluated ADSRA and self-reported confidence.	To examine the effect of an intervention using standardised patients (SPs) on PCPs assessment for ADSRA confidence, knowledge, and practices.	Compared with untrained PCPs, PCPs 5–10 months post-intervention were more likely to: Screen adolescents for depression (40% vs. 22%). Use a depression screening tool (50% vs. 19%). Diagnose at least one adolescent with depression in the past 3 months (96% vs. 78%).	Physician self-report as opposed to patient report. Motivated cohort
Kramer, Iliffe, Bye, Miller, Gledhill & Garralda (2013) Therapeutic Identification of Depression in Young People - (TIDY Study) *Pre / post-test design*	Four general practices in socio-economically disadvantaged urban areas in Northwest London. GPs (n=23) and GP registrars (n=2); practice nurses (n=6) and young people ranging in age from 13-17 years (n=426) pre-training and (n=449) post training.	Two 1 hour training sessions 3 weeks apart conducted by a GP and a child and adolescent psychiatrist	PCPs received training in a CBT technique for TIDY (clinical screening questions informed by ICD-10 and DSM-IV). Changes in depression screening rates were assessed from electronic medical records. PCPs also completed questionnaires pre and post training.	Knowledge of depression prevalence and treatment guidelines. Confidence regarding identification and management of depression. Screening rates, identification of depression.	Screening rates increased from 0.7% to 20%. Depression identification rates increased from 0.5% to 2.2%. Identification was associated with PCP knowledge of prior mental health problems.	Only 4/70 practices agreed to participate. Selective screening of adolescent attenders as opposed to systematic screening.

Iliffe, Gallant, Kramer, Gledhill et al. (2012) *Qualitative interviews*	Four general practices in North West London. GPs (n=25) and nurses (n=6)	Two 1 hour training sessions 3 weeks apart conducted by a GP and child and adolescent psychiatrist.	PCPs were trained in the TIDY intervention. Face-to-face semi-structured interviews were conducted with practitioners post training.	The perceived utility and usability of the TIDY technique.	The TIDY technique is usable in routine practice but only if practitioners are allowed to use it selectively due to time constraints and fear of over medicating psychological distress.	Additional components need to be incorporated in the TIDY intervention that are often linked with youth depression (e.g., drug / alcohol / sexual risk taking etc.)
Aarseth, Dalen and Haavet (2014) *A community based trial using a retrospective control group*	GP surgeries in Oslo (n=12) GPs (n=34); young 16 year olds (the age when young people can choose their own GP and have complete doctor / patient confidentiality in Norway), intervention group (n=975) and control group (n=978).	Initiative to increase service utilisation among young people in primary care.	GPs sent a personal, informative letter at the beginning of 2008 and 2009 to individuals in their practice population who were turning 16 years of age that year.	To determine whether an informative personal letter could enhance the accessibility and utilisation of health care facilities and services.	Adolescent contact with a GP increased 59% in the control group vs. 69% in the intervention group. For males, the increase in contact was from 54% to 72% there was no significant increase for females.	Data for sex of participants were not collected for the population. Control group included historical / retrospective data (patient files dated 1990/1991).

Table 1.7 Evidence based psychosocial interventions for mental health problems in primary care

Brief Intervention (BI)	Brief interventions are particularly suited to primary care as they are time limited and suitable for non-specialist facilities. The time length associated with BIs can vary depending on the extent of the mental health or substance use problem from a couple of minutes to several sessions (Babor and Higgins-Biddle 2001).
Cognitive Behavioural Therapy (CBT)	The core elements of CBT include the recipient establishing links between their thoughts, feelings and actions and target symptoms; correcting misperceptions, irrational beliefs and reasoning biases related to these target symptoms, involving monitoring of one's own thoughts, feelings and behaviours with respect to the symptom and / or the promotion of alternative ways of coping with target symptoms (Lynch et al. 2010). CBT has demonstrated positive outcomes in the treatment of adolescent depression (Brent et al. 1997, Asarnow et al. 2005, Wells et al. 2012).
Motivational Interviewing (MI)	Motivational interviewing is a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Rollnick and Miller 1995). Previous research has shown promising effects based on the use of motivational interviewing for young people with substance use problems in primary care settings (D'Amico et al. 2008, Knight et al. 2005).
5 As Framework	1) **ASSESS** (Frequency / circumstance of youth, related psychosocial problems, impact on health) 2) **ADVISE** (Address patient questions about possible effects on health / provide personalised information taking the patient's medico-psycho-social problems into account) 3) **AGREE** (Intention to change 0-10? / type of changes / realistic objectives and timeframe) 4) **ASSIST** (Strategies for reaching objectives / agree on action plan 5) **ARRANGE** (Provide information sources / further communication with patient / follow-up) (Haller et al. 2014).

Table 1.8 Primary care based intervention studies for treating youth mental health and substance use problems

Author, Date / Study type	Setting / study population	Intervention	Description	Outcome measure	Key findings	Limitations
Tonge and Rowe (2003) *Pre / post-test design*	'Clockwork Young People's Health Service', Victoria, Australia. GPs (n=68)	Training of GPs and other practitioners in CBT skills.	Ten GPs opted to undergo training in CBT skills.	Training GPs and other practitioners in CBT skills.	GPs reported significant changes in their confidence to detect, assess and treat adolescent depression.	Small sample size.
Asarnow, Jaycox, Duan, LaBorde et al. (2005) Youth Partners-in-Care (YPIC) Study *RCT*	Primary care sites (n=5). Young patients (n=418) aged 13-21 years with current depressive symptoms.	Control group: Usual care (n=207) Intervention group: 6-month quality improvement intervention (n=211) in evaluating and managing patients' depression and training for care managers in CBT for depression.	Care managers supported PCPs in evaluating and managing patients' depression, training for care managers in manualised CBT for depression and patient and clinician choice regarding treatment modality. PCPs also received education regarding depression evaluation, management, pharmacology and psychosocial treatment.	Depressive symptoms assessed by (CES-D) score. Secondary outcomes were mental health–related quality of life (MCS-12) and satisfaction with mental health care.	Intervention group had: Fewer depressive symptoms, including those with severe depression (31% vs. 42%) and greater satisfaction with mental health care after 6 months. Decline in suicide attempts from baseline to post intervention (14% to 6%). The difference between groups at 6 month follow-up was non-significant.	Despite significant intervention effects almost a third of the quality improvement participants continued to have severe depressive symptoms. No requirement to consider evidence based treatments.

Van Voorhees, Vanderplough-Booth, Fogel, Gladstone et al. (2008) *RCT*	US primary care practices (n=13) within five different health systems in four states (US Midwest and South). Young people (n=84) aged 14-21 years who were at risk of developing major depression.	To compare two versions of an internet based behavioural primary care intervention to prevent the onset of major depression.	Study participants were randomly assigned to two groups: Group 1: brief advice (BA) (1-2 minutes) and internet programme. Group 2: motivational interview (MI) (5-15 minutes) and internet program. Internet intervention: Four internet-based modules incl. CBT, behavioural activation and interpersonal psychotherapy techniques.	Researchers compared pre / post changes and between group differences for protective and vulnerability factors (individual, family, school and peers).	Compared with pre-study values both groups demonstrated: Declines in depressed mood. Increases in peer support. Reductions in depression related impairment in school. Symptoms of panic disorders, anxiety disorder and moodiness declined significantly in the BA group but not in the MI group.	Young people with major or minor depression, expressing frequent suicidal ideation, bipolar, substance abuse, generalised anxiety disorder and eating disorders were excluded from the study.
Mason, Pate, Drapkin et al. (2011) *RCT*	US urban primary care health clinic African American female adolescents considered to be an 'at risk' group (n=28) aged 14-18 years; 32% of the participants lived below the poverty line.	Participants were randomly assigned to a treatment / non-treatment group. The treatment group (n=14) received a 20 minute social network intervention delivered in an MI consistent style.	Post-test scores were compared with the following outcome variables: Substance use, trouble due to alcohol use, substance use before sex, social network quality, offers to use marijuana, social stress, and readiness to start counselling.	To test the efficacy of a brief preventative intervention for substance use and associated risk behaviours in primary care.	One month post-treatment reductions were reported in the following domains: trouble due to alcohol use, substance use before engaging in sexual activity, social stress, offers of marijuana and increased readiness to start counselling.	Small sample size Short-term follow up (i.e., 1 month post baseline assessment). Purposeful sampling (African American females) limits generalizability.

Reid, Kauer, Hearps, Crooke, Khor, Sanci and Patton (2011) *RCT*	General practices (n=26) in Melbourne, Goulbum Valley Region and Albury / Wodonga. Young patients aged 14-24 years attending general practices. Of the (n=163) participants assessed for eligibility (n=114) were included in analyses: intervention group (n=68), comparison group (n=46).	GPs referred eligible participants (those with mild or more mental health concerns) were randomly assigned to either the intervention group (mood, stress, and daily activities were monitored) or the attention comparison group (only daily activities were monitored). Both groups self-monitored for 2 to 4 weeks and reviewed the monitoring data with their GP.	At pre-test, the GPs completed a questionnaire assessing the participants presenting concern, their current diagnostic information and pathways to care. GPs' confidence was measured with the SHO Appraisal Form. At post-test the above measures were repeated and specific feedback on the usefulness of *mobiletype* in clinical practice was sought.	To examine the mental health benefits of the *mobiletype* phone application which monitors mood, stress, coping strategies, alcohol and cannabis use etc. at least daily, and transmits information to GPs via website in summary format.	The *mobiletype* program significantly increased emotional self-awareness compared to an attention comparison. Post-hoc analyses suggested that participation in the RCT led to enhanced GP mental health care at pre-test and improved mental health outcomes.	Small sample size Uneven distribution between groups at baseline.
Roberts and Bernard (2012) *Clinical pilot study*	Three UK practices. Children (n=20) (10 years and under) and young people (n=30) aged 11-19 years presenting with varying psychosocial concerns (e.g., mood variability, self-laceration, etc.)	Internal referral process where children and young people presenting to any GP or nurse practitioner were referred to the main author (who is a GP), for a 30 minute appointment / bio-psychosocial assessment.	GP based interventions were offered where appropriate (e.g., watchful waiting, brief interventions, non-directive counselling, brief CBT and liaison with colleagues in education, CAMHS and voluntary services).	A GP-led initiative to explore the potential of GPs to respond to common mental health problems in children and adolescents.	18 / 50 referrals were made to CAMHS. With adequate time, supervision and support young people with common mental health problems can be helped in primary care.	Applicable to GPs who are highly motivated in the field. Time constraints Resources

Wells, Tang, Carlson & Asarnow (2012) Youth Partners in Care (YPIC) trial. *RCT*	Primary care practices (n=6) in five different healthcare organisations. PCPs (n=52) Young people aged 13-21 years (n=344) who screened positive for depression.	Participants were randomly assigned to: 1) Usual care plus provider education on depression evaluation and management . Or 2) A quality improvement intervention designed to improve access to antidepressant medication and / or CBT for depression.	At baseline and 6-month follow-up, youth completed the CIDI and Mental Health Inventory 5 and reported service use during the previous 6 months by using the adapted Service Assessment for Children and Adolescents. CES-D was collected at 6-month follow-up.	To estimate the effect of providing practitioners with extra CBT and / or medication resources but otherwise allowing usual practice conditions to continue.	Use of a quality intervention resulted in study participants being four times less likely to have severe depression at six months compared to those receiving usual care (11% vs. 45%). Better outcomes were noted at 12 months and 18 month follow-up studies.	Purposive sampling across specific sites limits generalizability. Broad categorisation of appropriate treatment strategies
Haller, Meynard, Lefebvre, Obioha et al. (2014) *Clustered RCT*	Family practices in Switzerland. Physicians: Intervention group (n=17); control group (n=16) and all eligible young patients aged 15-24 years attending the practice for any health problem (n=594); Intervention group (n=287); Control group (n=307)	Physician training by (two family physicians trained in adolescent health) in a brief intervention (incorporating MI style and 5 As for behaviour change: Assess, Advise, Agree, Assist and Arrange).	Physicians were assigned to: 1) Intervention group – training received in delivering a brief intervention plus usual care. 2) Control group: delivered usual care.	The primary outcome measure was self-reported excessive substance use (≥ 1 episode of binge drinking, or ≥ 1 joint of cannabis per week, or both) in the past 30 days. Outcome measures noted at 3, 6, 12 months after the consultation.	Excessive substance use did not differ significantly between patients whose physicians were in the intervention group compared to the control group at any of the follow-up points. 28% patients had reduced substance use at 12 month follow-up.	No formal screening tools were used. Motivated physicians

1.17 Literature review conclusion and rationale for the current study

A responsive youth mental health system can serve to reduce the financial burden of chronic adult mental illnesses with origins in adolescence and young adulthood (Asarnow et al. 2005). Mental health care in primary care has been defined as "the provision of basic preventive and curative mental health care at the first point of contact of entry into the health care system" (WHO 2001). Efficient primary care systems can improve health indicators (Lee et al. 2007). With improved adolescent mental health considered a key global health target (Sawyer et al. 2012), supporting primary care is a priority.

In contrast to adult mental health, research relating to youth mental health in primary care is still at an early stage, particularly in regards to the GP's perspective when addressing young people experiencing emotional distress (Roberts 2012a, Roberts et al. 2014a, McCann et al. 2012). The need for patient reported outcomes has also been highlighted, as mental health problems and the related treatments affect many aspects of a young person's life (Lundstrøm 2014). There is a dearth of evidence regarding the experiences and attitudes of young people and health care workers towards screening and treatment for mental and substance use disorders in primary care in Ireland. Research is required to establish effective ways of making GPs and primary care more approachable and relevant to young people. Improved understanding of the barriers faced by both health care workers and young people in an Irish context, in terms of addressing youth mental health problems and accessing services in the current study would aid such developments. In their report, Buckley and colleagues (2013) highlighted the importance of service user inclusion in the design and delivery of mental health services and aptly noted that to exclude service user perspectives would be 'ethically unsound'. Therefore the predominant aim of this study is to determine the role of the GP in addressing mental health and substance use problems among young people in primary care in socio-economically disadvantaged urban settings from the perspectives of both health care workers and young people (Table 1.9 outlines a synthesis of the literature review).

Table 1.9 Synthesis of the literature review

Finding	Evidence
Prevalence rates of psychological morbidity	• 21-27% (Lynch et al. 2004, Sullivan et al. 2004, Dooley and Fitzgerald 2012b). • Emerging patterns across Irish studies indicated an increase in symptom severity / prevalence of mental health problems with age (late teens / early twenties) (Dooley and Fitzgerald 2012b, Cannon et al. 2013). • Increasing rates of suicide and DSH are a major concern in Ireland (Lynch et al. 2006, Cleary 2012) the youth suicide rate in Ireland is now the second highest in the EU (European Child Safety Alliance 2014).
Most common disorders identified	• Anxiety and depression (Cannon et al. 2013, Dooley and Fitzgerald 2012b, Cleary et al. 2007). • Gender differences were also noted with females having higher depression and anxiety scores and females were also more likely to disclose their mental health problems (Lawlor and James 2000, Martin et al. 2006, Tedstone Doherty et al. 2007).
Youth mental health initiatives	• 'Headspace' (McGorry et al. 2013); 'Jigsaw' (Bates et al. 2009); 'Orygen Youth Health' (McGorry et al. 2013) / Irish charitable organisations • Over 50000 young people provided with mental health support across 30 'Headspace' sites (Muir et al. 2009) and 4771 young people attending 'Jigsaw' services received help from 2008-13 (Illback 2014).
Gaps in services for young people	• No existing teams for the 14 to 17 year age group and limited services for children with ADHD, autism spectrum disorders, conduct disorders and eating disorders (College of Psychiatrists of Ireland 2006). • Gaps in specialist alcohol and substance abuse services and inadequate services for children at risk of suicide, DSH etc. (HSE 2009)
Importance of early intervention for youth mental health problems	• Delayed treatment for youth mental health problems is associated with poor functional outcome, increased risk of suicide and poorer social adjustment (Matza et al. 2005, Goldberg and Ernst 2002). • The benefits of early intervention for young people were reported across a range of mental disorders e.g., psychosis (McGorry et al. 2007a), depression (Allen et al. 2007) and bipolar disorder (Berk et al. 2007).
Primary care and early intervention for mental and substance use disorders	• Young people attend primary care at least once annually, attendance rates ranging from 50-70% among registered adolescents (Gledhill et al. 2003, Fallucco et al. 2012, Healy et al. 2013, Kramer et al. 1997). • Low rates of routine screening 14-22% have been reported in previous studies (Fallucco et al. 2012, Richardson et al. 2010b, US Preventive Services Task Force 2009).

	• Barriers experienced by GPs when treating mental health problems: fear of 'over-medicalising' young lives (Iliffe et al. 2004), reluctance to diagnose mental health conditions in youth (Iliffe et al. 2008), time and resource issues (Healy et al. 2013, Diamond et al. 2012, Igra and Millstein 1993), inadequate training (Cockburn and Bernard 2004) and patient confidentiality issues (Frankenfield et al. 2000). • Facilitators to youth engagement: positive rapport with health care workers (Wisdom et al. 2006, McCann et al. 2012, Haller et al. 2007), autonomy (Wisdom et al. 2006), continuity of care (Sayal et al. 2010, McCann and Lubman 2012b), not believing GPs only address physical problems (Ferrin et al. 2009). • Barriers to youth engagement: fear of stigmatisation and judgement (Meredith et al. 2009, Wisdom et al. 2006), transport, appointment delays, unfamiliarity with the service and cost (McCann and Lubman 2012a), concerns about consent and confidentiality (Buckley et al. 2013), medication perceived to be the only form of treatment (Meredith et al. 2009), lack of awareness that a GP can help with emotional difficulties (Biddle et al. 2006a) and a belief that GPs are not interested in mental health (Tait 2009).
Interventions for screening and treating mental health and substance use disorders in primary care	• Educational interventions have shown significant increases in rates of screening for psychological distress, suicidal risk and depression (Pfaff et al. 2001, Gledhill et al. 2003, Kramer et al. 2013). • GPs attributed provider training to increases in screening as opposed to screening tools (Ozer et al. 2005). • Treatment based studies reported increased GP knowledge and confidence, fewer depressive symptoms, mental health problems and risk behaviours (Sanci et al. 2000b, Asarnow et al. 2005, Reid et al. 2011). • Intervention studies mainly conducted in controlled test settings, using GP self-report. While significant increases noted in screening, training did not lead to any changes in GPs' patient management strategies (Pfaff et al. 2001, Zwaanswijk et al. 2011).

Chapter 2 – Methodology & Methods

2.1 Overview of study design

This thesis involved a sequential mixed methods design as outlined by Creswell and colleagues (2003), which investigated the experiences of and attitudes towards screening and treatment of mental and substance use disorders from the perspectives of both health care workers and young people. Two studies were included:

- Qualitative inquiry (study one) involved semi structured in-depth interviews with health care workers and young people on their experience of screening and treatment for mental and substance use disorders and how this could be improved.
- Quantitative inquiry (study two) involved a cross sectional survey of GPs to determine current screening practices and attitudes towards training and future interventions for addressing youth mental and substance use disorders in primary care in Ireland. The questionnaire which was mailed to a national random sample of GPs was strongly influenced by data from study one (see section 2.15 for more detail on questionnaire design).

2.2 Research design

2.2.1 Qualitative and quantitative studies – a review

Qualitative methods of data collection are sensitive to the unique personal experiences, perceptions, beliefs and meanings of individuals (Meatherall 2005) and as such can be invaluable when trying to capture the essence of the experience of health service users. They give the opportunity to understand a phenomenon in a holistic way by getting to the genuine experiences of those involved, be it through self-report, interviews, or observations. The data generated is context-driven and offers richer and more novel insights into human experiences that are not always possible with quantitative methods where findings may be too abstract and general to apply to specific contexts (Bhati et al. 2014, Kidd 2002, Johnson and Onwuegbuzie 2004). Research incorporating qualitative

methods can build theory (Yang 2007), facilitate the inclusion of user perspectives in the design and delivery of health services (Pollitt 1988) and compile a rich account of the participant's subjective experience, culture and context (Yardley 2000). Previous authors have suggested that qualitative research continues to be viewed with scepticism in the medical field (Lincoln 1995, Pope et al. 2000) particularly with regards to a perceived lack of scientific rigour that is evident in quantitative research (Hamberg et al. 1994, Povee and Roberts 2014). However, Mays and Pope (2000) suggested that qualitative studies can be assessed with the same scientific criteria as quantitative studies by using procedures to improve validity (e.g., triangulation, participant inclusion, thorough overview of the process involved in data collection and analysis and reflexivity). Qualitative methods have also been criticised for being arbitrary, unscientific, susceptible to researcher bias (Rabinowitz and Weseen 1997), inferior to quantitative methods, too subjective, lacking in generalisability (Povee and Roberts 2014, Schofield 2002), time consuming and therefore having less influence on policy makers (Johnson and Onwuegbuzie 2004).

Quantitative methods have been commended for their accuracy, facilitating the collection of large data sets for numerical analyses (Stenius et al. 2008), data collection and analysis for quantitative methods is considered to be less time consuming and results are relatively independent of researcher bias (Johnson and Onwuegbuzie 2004). However, quantitative findings are often limited to the pre-existing concepts on which the measurement tool for data collection was based (Stenius et al. 2008). While quantitative researchers might criticise qualitative research for the lack of a representative sample, Yardley (2000) noted the inability to conduct an in-depth analysis on such a large sample size, thus opportunities for rich interpretation of participant accounts would be lost. Therefore, qualitative research is often used for the study of social processes, human behaviour / experiences on a broader and more nuanced level (e.g., the why and how of social matters), whereas quantitative research focuses more on specific details (e.g., the what, where, and when) (Stenius et al. 2008).

2.3 A mixed methods approach

Mixed methods approaches are widely deployed in health services research (O'Cathain 2009) and are defined as "the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, given a priority and involve the integration of data at one or more stages in the process of the research" (Creswell et al. 2003). When combined, the strengths of both qualitative and quantitative methods facilitate a better understanding (Ivankova et al. 2006) and greater insight into the phenomenon under investigation (Creswell 2009). Therefore, mixed methods approaches can deliver more rigorous and methodologically sound research which leads to a more comprehensive analysis of the topic (Creswell and Plano Clark 2007). Researchers can also use the strengths of a second method to compromise for the weaknesses of the other method and vice versa (Johnson and Onwuegbuzie 2004).

2.3.1 Philosophy behind a mixed methods approach

2.3.1.1 Epistemology and selecting a research paradigm

In order to understand the foundations on which a research project is based and its underlying assumptions, it is important to be aware of its epistemological position. Knowledge of the philosophical and methodological assumptions of a study provides a clear rationale for the chosen methods of data collection and analysis and justifies the interpretation and findings reported (Grix 2004). Epistemology is concerned with the nature and scope of knowledge and is referred to as the "theory of knowledge". It questions what knowledge is and how it can be acquired in addition to how knowledge from any discipline or entity can be acquired (Hammersley and Atkinson 1995). Traditional epistemological assumptions in health care research have involved a choice between realism and constructivism, however, previous authors have noted that neither of these approaches has convincingly provided the right answer to health psychology's epistemological questions (Marks 2002).

Previous research has indicated the importance of locating research in accordance with a specific paradigm which has been defined as "the set of beliefs and practices that guide a field" (Morgan 2007). Hanson and colleagues (2005) described a paradigm as a world view that incorporates distinct elements including epistemology (how we know what we know), ontology (nature of reality), axiology (values) and methodology (the process of research). Therefore a paradigm may influence the questions a researcher will ask and the methods used to answer them (Doyle et al. 2009). Researchers may follow a number of different paradigms. As Guba and Lincoln (1994) stated: "questions of method are secondary to questions of paradigm, which we define as the basic belief system or worldview that guides a researcher, not only in choices of methods but in epistemologically and ontologically fundamental ways." Quantitative research is based in the positivistic paradigm, that ontologically speaking believes that there is a 'real' reality that can be apprehended and epistemologically believes that knowledge is objective and that there is a universal truth to findings in empirical studies (Lincoln and Guba 1985). Qualitative research is based in a new paradigm of science, sometimes referred to as the 'metaphysical paradigm' as it combines a number of different ontologies and epistemologies (Morgan 2007), which tends to be constructivist in nature, believing reality is relativistic that is, individuals create reality from different ideological, social and personal positions (Lincoln and Guba 1985), and that knowledge is subjective and transactional and co-created by both participants and researchers in qualitative inquiries.

2.3.1.2 Qualitative research paradigms

Historically, the predominant approach in health care was focused almost exclusively on the positivist (quantitative) tradition, where the researcher remains objective and independent of the research process, employing larger samples to test hypothesis (Doyle et al. 2009). Constructivist (qualitative) research emerged as an alternative approach, as researchers aimed to investigate "the context of human experience" (Schwandt 2000). According to Appleton and King (2002) constructivism offers multiple realities and different interpretations, researchers who work in the constructivist paradigm aim to describe the experiences of smaller samples by providing detailed interpretations of their

experiences. Constructivists reject positivism in favour of idealism, relativism, humanism, hermeneutics and sometimes postmodernism (Lincoln and Guba 1985, Schwandt 2000). Constructivists are characterised by a dislike of detached and passive writing styles, and therefore provide rich interpretive accounts of the research data (Johnson and Onwuegbuzie 2004).

During the 19th century qualitative methods were considered to be a more valid way of understanding human behaviour particularly by Wilhelm Wundt and other introspectionists among this era (Hayes 1997). However, the behaviourist revolution saw the devaluation of qualitative methods where claims that introspection was unreliable and scientific psychology should be conducted in an objective and measurable way. Over the last thirty years there has been a further paradigm shift, where qualitative methods have been viewed as an important asset to the research process in terms of viewing the meaning of human experience and behaviour in its social context, as opposed to reducing complex social phenomena to oversimplified variables (Hayes 1997).

Within qualitative research paradigms there are a specific set of underlying assumptions. Guba and Lincoln (1994) described paradigms as having three aspects: 1) Ontology (assumption about the nature of reality); 2) epistemology (a set of assumptions about the relationship between the knower and the known and 3) each paradigm contains some assumptions about methods, though none are restricted to simply one way of gathering and analysing data. Three paradigm assumptions: post-positivism, constructivism and the critical perspective have emerged in accordance with different historical time points associated with the evolution of qualitative inquiry (Creswell and Miller 2000). Post-positivism assumes that qualitative research consists of rigorous methods and systematic forms of inquiry; constructivism involves a pluralistic, interpretive, open-ended, and contextualised (e.g., sensitive to place and situation) perspectives towards reality and the critical perspective stipulates that the researcher's role is to uncover the hidden assumptions about how narrative accounts are constructed, read, and interpreted, where the researcher's perspective about narratives is influenced by 'historical situatedness' of inquiry in terms of the social, political, cultural, economic, ethnic, and gender antecedents of the studied

situations. Table 2.1 is based on the work of Creswell (2009) and Guba and Lincoln (1994) which provides an overview of the types of paradigms that exist in qualitative research.

The importance of understanding the human experience in relation to social context was particularly relevant to the current research as the aim was to increase understanding of young people and health care workers based in socioeconomically disadvantaged areas, in relation to their views on screening and treatment of mental health and substance use problems. A secondary aim was to determine the attitudes and experiences of a larger sample of GPs towards screening and treating youth mental health problems. Previous research in this domain has focused predominantly on survey and experimental methods, therefore the use of qualitative techniques allowed the researcher to explore the lived experiences of participants in addition to how their broader social contexts can impact on their attitudes and experiences towards screening and treatment for mental health and substance use problems, while the quantitative element facilitated the testing of selected variables from the qualitative study among a larger sample of GPs. Therefore, the epistemological position taken in this thesis adopted a pragmatic approach, where participant views were incorporated through both qualitative and quantitative methods (pluralistic means) to address the research questions among a diverse range of participants in a variety of social settings.

Table 2.1 Research paradigms in qualitative research

Positivism (very rare in qualitative research)	Ontology: Realism. There is a "real" objective reality that is knowable. Epistemology: Objectivist. The researcher can and should avoid any bias or influence on the outcome. Results, if done well, are true. Methods: Tends toward quantification and controlled experiments.
Post-positivism	Ontology: Critical Realism. There is a "real" objective reality, but humans cannot know it for sure. Epistemology: Modified Objectivist. The goal is objectivity, but pure objectivity is impossible. Results are "probably" true. Methods: Includes both qualitative and quantitative methods. Seeks reduction of bias through qualitative validity techniques (e.g. triangulation)
Critical Theory	Ontology: Historical Realism. Reality can be understood, but only as constructed historically. Epistemology: Knowledge is mediated reflectively through the perspective of the researcher. Methods: Focused on investigator / participant dialogue, uncovering subjugated knowledge and linking it to social critique.
Constructivism	Ontology: Relativist. All truth is "constructed" by humans and situated within a historical moment and social context. Multiple meanings exist of perhaps the same data. Epistemology: Researcher and participants are linked, constructing knowledge together. Methods: Generally qualitative, research through dialogue.
Pragmatism	Ontology: Varied. Pragmatists may be less interested in what "truth" is and more interested in "what works." Epistemology: Accepts many different viewpoints and works to reconcile perspectives through pluralistic means. Methods: Focuses on a real world problem, by whatever methods are most appropriate and tends toward changes in practice.

2.3.1.3 Pragmatism – 'a third paradigm'

Epistemologically speaking, there has been a long debate on whether the mixed methods approach can exist as both quantitative and qualitative research are rooted in different paradigms and they are thus incompatible (Tashakkori and Teddlie 2003). Both of these viewpoints have been criticised. Positivism for prioritising a single form of knowledge as 'true' and therefore ignoring other alternative forms of knowledge (Cornish and Gillespie 2009) and constructivism for refusing to accept that knowledge that is constructed from ideological, social and personal position can be simply wrong or even oppressive (Prior 2003) and as such is not morally defensible when considering the responsibilities of science and research to provide the best solutions to problems. Recently, however, the concept of pragmatism has been proposed to bridge the gap between the two methods and their paradigms (Bryman 2006). Previous researchers have advocated varied feelings for the potential of mixing paradigms, Guba (1994) (a leading qualitative purist), stated that "accommodation between paradigms is impossible…we are led to vastly diverse, disparate and totally antithetical ends." However, Johnson and colleagues (2004) highlighted the need to move beyond the "paradigm wars" where the focus has been predominantly on the differences between the two orientations and recognise that both qualitative and quantitative research are "important and useful." Furthermore, despite the paradigmatic differences between qualitative and quantitative research, all research in the social sciences aims to provide accounts of human experiences and the environments in which they live and evolve (Biesta and Burbules 2003).

Mixed methods research as the "third paradigm" has the potential to meet the demands of today's research environment which has become increasingly interdisciplinary, where researchers are required to understand multiple methods to facilitate collaboration and communication with colleagues from various disciplines. As Johnson and colleagues (2004) stated: "epistemological and paradigmatic ecumenicalism is within reach in the research paradigm of mixed methods research." Pragmatism as a "third paradigm", "middle ground" between the "paradigm wars" can provide a workable solution between philosophical dogmatisms therefore rejecting traditional dualisms e.g., rationalism versus empiricism, subjectivism versus objectivism. As a "third paradigm" pragmatism promotes

eclecticism and pluralism where conflicting theories, observation, experience and experiments are all deemed valuable in terms of understanding human experiences and their broader social context (Johnson and Onwuegbuzie 2004). The current study was guided and driven by adopting a pragmatic approach where obtaining a comprehensive understanding of the strengths and weaknesses of both quantitative and qualitative research provided the researcher to collect multiple data using different strategies and approaches which results in a product that is superior to a mono-method study (Johnson and Onwuegbuzie 2004). Pragmatists believe that the research question is more important than the chosen method, or the paradigm underlying that method; thus, appropriate techniques can be selected and applied from both the quantitative and qualitative domains without question (Tashakkori and Teddlie 2003). This overall stance provided the researcher with a freedom of choice with respect to methods of data collection and analysis, while still claiming epistemological coherence.

2.3.2 Why a mixed methods approach was chosen

A mixed methods approach was chosen for this study as integrating qualitative and quantitative methods would answer the research questions more effectively than either method in isolation. Creswell (2009) noted that the underlying logic of mixed methods research was that combining the strengths of both quantitative and qualitative methods facilitates a better understanding of research problems than either approach independently. This approach is ideal when "one phase can contribute to the second phase and enhance the entire study" (Creswell et al. 2004). The latter statement is applicable to the current study, as qualitative data from study one informed the development of the questionnaire in study two. Originally used mostly for triangulation purposes, combining quantitative and qualitative methods are now used to: develop the method of one study by using the results of the other; to complement one another; to recast results from one method as questions or results in another; or to expand the range of inquiry by using different methods for different routes of inquiry (Kortte et al. 2007).

Other studies have suggested that mixed methods can be used to:

- Develop a study instrument by utilising qualitative data to identify relevant questions (Kutner et al. 1999).
- Understand quantitative research data (e.g., outliers / extreme results via qualitative data collection) (Creswell et al. 2004).
- Quantitative data might also facilitate researchers in determining suitable participants for the qualitative recruitment process, thus allowing for a more in-depth analysis of the results (Creswell et al. 2003).
- Mixed methods has been commended for its usefulness in health care research particularly to ensure the perspectives of stakeholders inform policy in health care services (Doyle et al. 2009, Creswell and Plano Clark 2007); which is particularly relevant to this study where data from a relatively small but diverse sample of health care workers and young people can be applied to a much larger population to identify the most appropriate strategies for future service development.

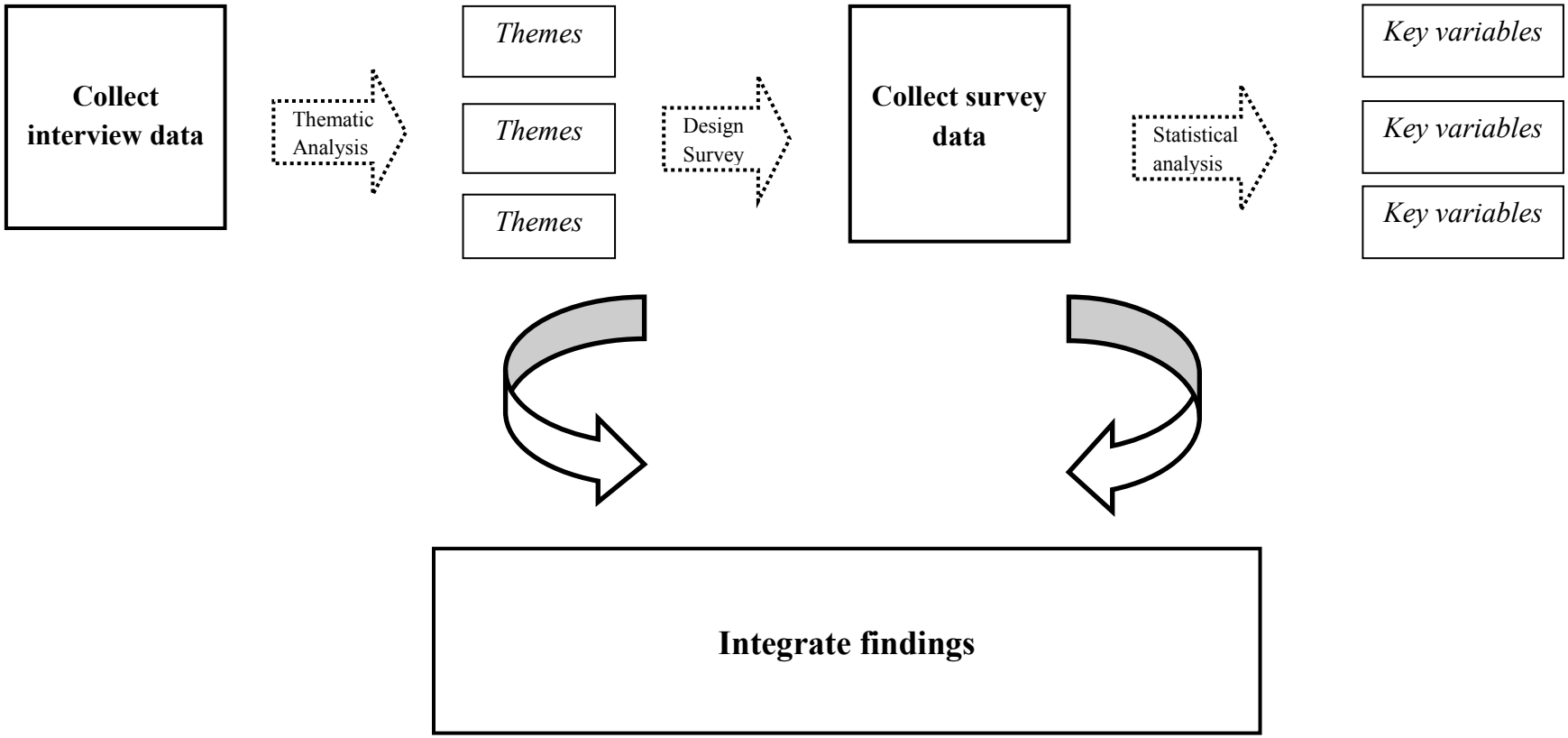
2.3.3 Sequential qualitatively-led design

The research design chosen for the current study was a qualitatively-led sequential design as outlined by Creswell and colleagues (2004), which consisted of a qualitative study followed by a quantitative study, from two perspectives (health care workers and young people), using the research participants as expert witnesses on the subject of *mental and substance use disorders in primary care* in Ireland. Sequential qualitatively-led designs have been used to explore relationships, test emerging theories, develop study instruments to be used in follow-up quantitative studies and generalise qualitative findings to larger populations (Hanson et al. 2005). This mixed methods study was qualitatively driven and took place over two phases. Similar to previous studies (Kutner et al. 1999, Nutting et al. 2002), qualitative interview data was collected initially to explore participant information needs and attitudes, the analysis from the qualitative study then informed a semi-structured instrument that was used in the quantitative study and thus administered to a larger population of GPs.

A sequential qualitatively-led design was considered the most suitable approach to address the research questions which were both qualitative and quantitative in nature. Qualitative research questions aimed to explore the experiences of health care workers and young people in regards to screening and treatment and highlight recommendations for future service provision. Quantitative questions were based on the current practice methods employed by GPs, their attitudes towards further training and incorporating brief interventions in general practice. Combining both studies facilitated the researcher to assess the views of young people and a diverse range of health care workers and assess selected variables from study one via a questionnaire in study two among a larger sample of GPs to determine convergence / divergence between the three groups. Therefore, the initial qualitative study would provide a detailed picture of psychosocial experiences and attitudes towards screening and treatment and selected variables from the qualitative study could be applied to a larger group of GPs to inform future developments for addressing youth mental and substance use disorders in general practice.

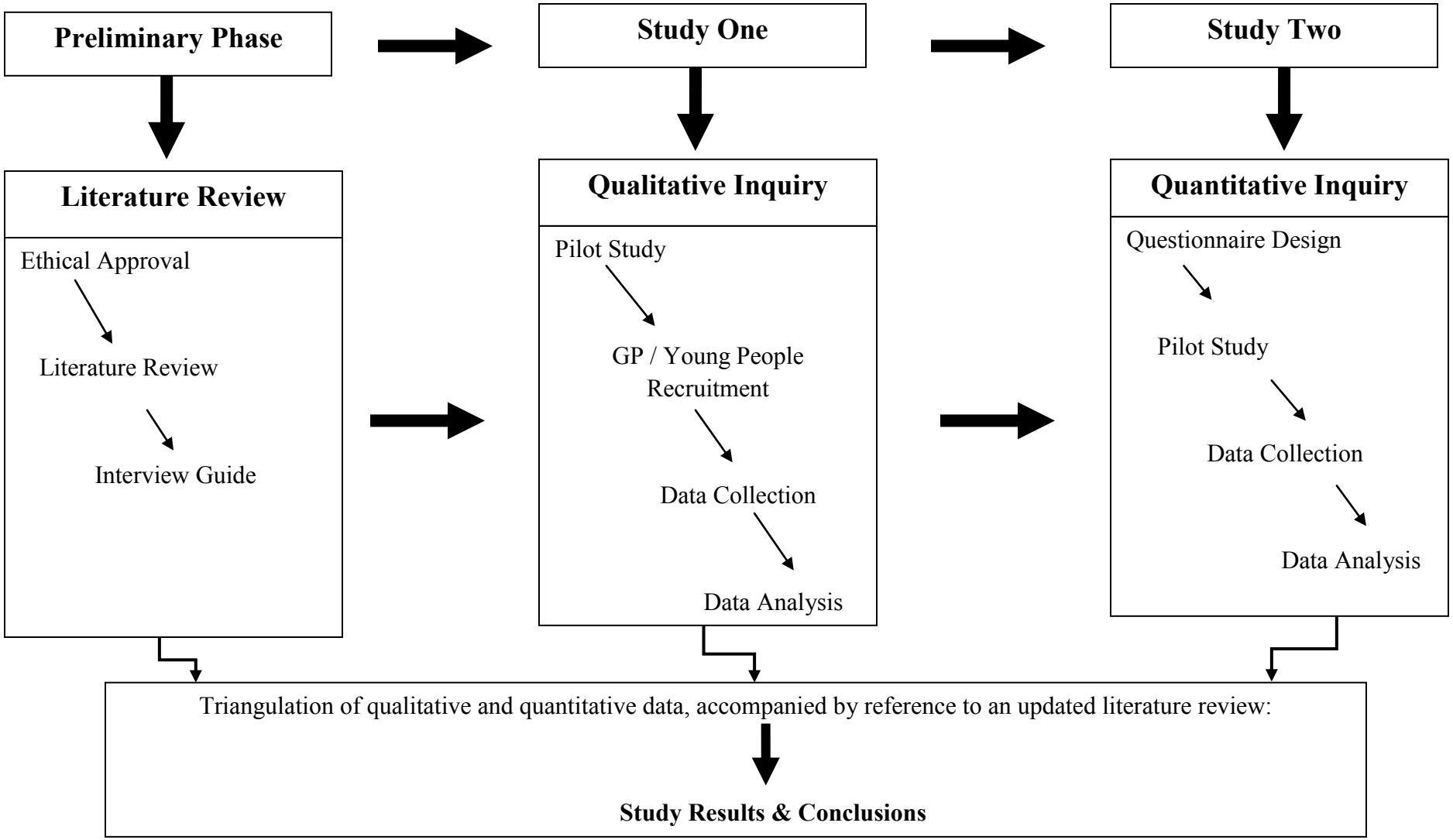
According to Morgan (1998), the sequential qualitatively-led design is useful for generalising qualitative findings to different samples, in the current research, study one data from health care workers and young people from a range of clinical sites and community agencies were administered to a random sample of GPs that participated in study two. The sequential qualitatively-led design has also been highlighted as a useful strategy for developing an instrument, particularly where existing instruments are lacking or unavailable which was applicable to the current study (Creswell 2009). As outlined by Creswell and Plano Clark (2007), the following procedures were adopted in this study: 1) qualitative data from health care workers and young people were collected and analysed; 2) analysis was used to develop the questionnaire / instrument and 3) the questionnaire was administered to a larger population of GPs (see figure 2.1 for an overview of the qualitatively-led mixed methods process and figure 2.2 for an outline of the research design and procedures).

Figure 2.1: An over-view of the qualitatively-led mixed methods process



Adapted from Dures et al. (2011)

Figure 2.2: Research design and procedure



2.4 Methodological considerations of adopting a mixed methods approach

2.4.1 Challenges of a mixed methods approach

Incorporating a mixed methods approach presented certain challenges in terms of: 1) the need for extensive data collection; 2) the time required to analyse both quantitative and qualitative data; 3) researcher knowledge of statistical packages (e.g. NVivo and SPSS) required to analyse data (Creswell 2009). Mixed methods research can also be more costly and there are aspects of the approach that are still in their infancy in terms of interpreting conflicting results, "paradigm mixing" and analysing alternative methods (e.g. "how to qualitatively analyse quantitative data)" (Johnson and Onwuegbuzie 2004).

2.4.2 Additional factors to be considered when using a mixed methods approach

Timing – the timing of the data collection needs to be considered in regards to whether data will be collected in phases (sequentially) or at the same time (concurrently) (Creswell 2009). In this study, data were collected sequentially, qualitative data were collected at participant sites and findings were then incorporated into a questionnaire for the second quantitative study which was administered to a larger population of GPs.

Weighting – This refers to the level of priority given to each method, whether there will be equal emphasis given to both the qualitative and quantitative studies (Creswell 2009). The sequential qualitatively-led design meant that the qualitative study which included interviews with health care workers and young people was given research priority. The decision to prioritise the qualitative study was based on a number of factors:

- The knowledge gaps in relation to experiences of and attitudes towards screening and treatment of mental and substance use disorders among young people and health care workers in primary care in Ireland.
- Qualitative methods provided the researcher with an in-depth account of the key issues relative to socio-economically disadvantaged areas in an Irish context.

- Data emerging from the qualitative study informed the key variables to be included in the questionnaire.

Mixing / integrating data – key questions to be considered when integrating both approaches are when and how mixing should occur? (Creswell 2009). Yin (2006) noted the importance of integrating studies across the following domains (a) research questions (b) units of analysis (c) sampling (d) data collection and (e) analysis. In this study data integration took place when findings from the qualitative study were utilised to inform the development of the questionnaire, which subsequently assessed attitudes towards certain aspects emerging from the qualitative study across a larger population. The second phase of integration between the qualitative and quantitative studies occurred in the write up of the results section. Results for each study were written up separately, followed by a section which aimed to integrate findings from both studies to determine if there were areas of convergence or divergence between the themes from study one (qualitative inquiry) and the descriptive and inferential statistics from study two (quantitative inquiry). Qualitative and quantitative findings were combined in a table which facilitated the researcher to 1) organise the research into more compact units and 2) assist the linking process within these units (Woolley 2009).

Theorising / transforming perspectives – Creswell (2009) noted the importance of considering the influence of larger theoretical perspectives that might lead the overall study design. We adopted two models in this study: 1) *Social Determinants of Health* (Wilkinson and Marmot 2003) and 2) *The Chronic Care Model* (Bodenheimer et al. 2002). Further details regarding the models are outlined in section 2.6. These models informed the interview schedule used in the qualitative study (a detailed outline of this process has been provided in table 2.4) and therefore key domains from both models also guided the structure of the questionnaire in study two.

Data triangulation – triangulation which has been defined as: "the combination of two or more theories, data sources, methods, or investigators in the study of a single phenomenon" (Denzin 1970); aims to achieve a rounded multi-layered understanding of the research topic (Yardley 2000). Denzin (1970) identified four forms of triangulation; this study incorporated each form of triangulation.

1. *Data triangulation*, which entails gathering data through several sampling

strategies, so that slices of data at different times and social situations, as well as on a variety of people, are gathered – Data for study one involved semi-structured interviews with health care workers and young people from a diverse range of health and social care settings in Limerick City and Dublin South Inner City and data for study two involved a cross-sectional survey with a national random sample of GPs.

2. *Investigator triangulation*, which refers to the use of more than one researcher in the field to gather and interpret data – Interviews were collected by the thesis author DL and two research assistants, ES and CA. Interview data were analysed by DL and one of the research assistants, ES, in collaboration with the principal investigator, WC.

3. *Theoretical triangulation*, which refers to the use of more than one theoretical position in interpreting data – Data were analysed using both an inductive and deductive approach to coding, where deductive coding was influenced by two theoretical frameworks, the Social Determinants of Health and the Chronic Care Model.

4. *Methodological triangulation*, which refers to the use of more than one method for gathering data – qualitative (semi-structured interviews) and quantitative (questionnaires) methods were employed for the collection of data.

Furthermore, utilising a mixed methods approach contributed to triangulation of the findings in terms of validity, where corroboration was sought between qualitative and quantitative data (Doyle et al. 2009).

2.5 Research context / Study setting

The study was conducted in two socio-economically disadvantaged centres, Limerick City and Dublin South Inner City during 2011-12. Both centres contain some of Ireland's most socio-economically disadvantaged local areas (O'Connor et al. 2010), with 24 (65%) of Limerick City's local areas among Ireland's 10% most socio-economically disadvantaged district electoral divisions (DEDs) (Long et al. 2005). In both Dublin South Inner City and Limerick City, youth mental health (Fitzgerald 2007, Health and Well-being Sub Group 2009, Healy et al. 2013, Leahy et al. 2013) and problem drug use are challenges for population health (Long et al. 2005, Cullen et al. 2009) with 20,709 (74%) of injecting drug users living in Dublin (Kelly et al. 2009).

2.6 Theoretical framework

The theoretical framework for the study was based on two well established models: (1) *'Social Determinants of Health'* (Wilkinson and Marmot 2003) and (2) *'The Chronic Care Model'* (Bodenheimer et al. 2002).

2.6.1 The Social Determinants of Health (SDH)

The WHO defines the SDH as:

> *"the conditions in which people are born, grow, live work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The SDH are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."* (Report of the National Expert Panel on Social Determinants of Health Equity 2009, World Health Organisation 2008).

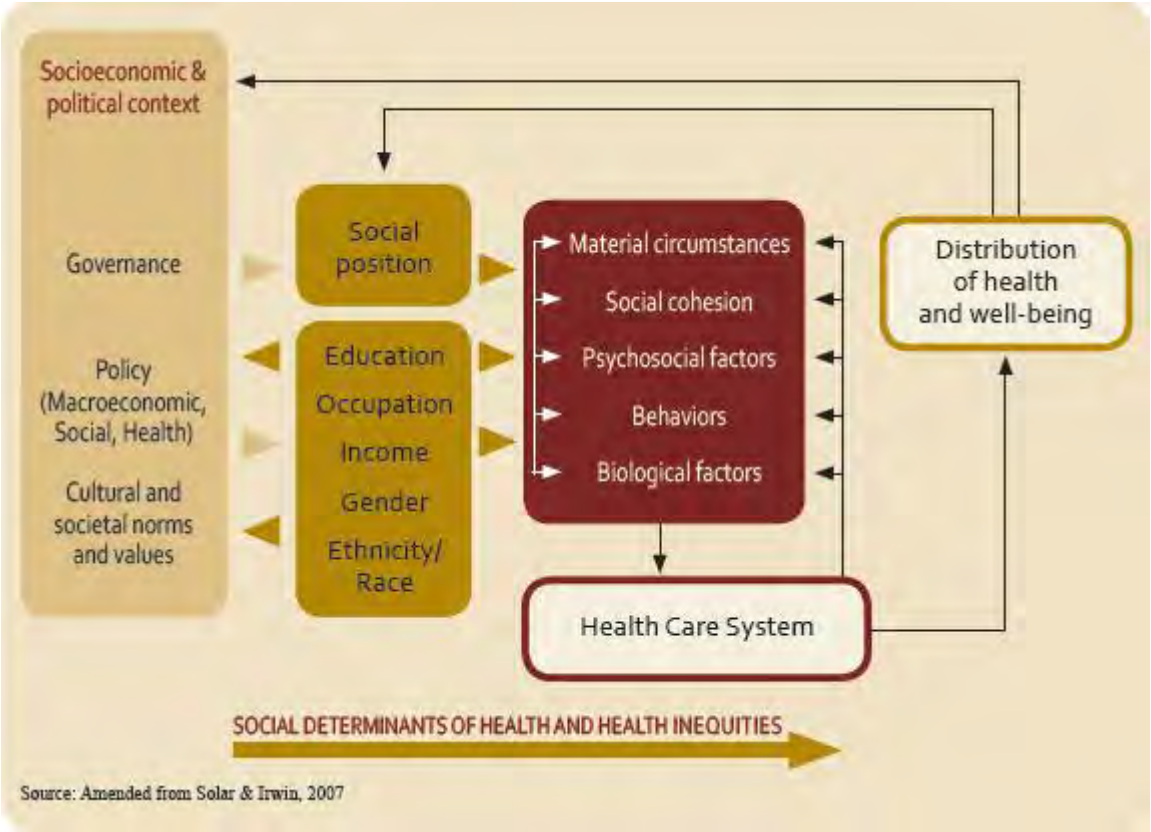
Previous research has reported 'gross health inequalities', with life expectancies ranging from 34 years in Sierra Leone to 81.9 years in Japan (Marmot 2005) and life expectancy are reported to be 16 years shorter for adolescents in the poorest regions compared to the most affluent regions in the US (Geronimus et al. 2001). Despite two decades of work dedicated towards abolishing health inequity, gaps in morbidity, mortality and life expectancy between advantaged and disadvantaged communities still remain (Report of the National Expert Panel on Social Determinants of Health Equity 2009). Wilkinson (2006) suggested that more equal societies had superior health systems and noted in a review of studies based on inequalities in health, that 78% indicated statistically significant evidence to support better health in more equal societies. Factors that contribute to health inequalities include: inequitable distribution of education, housing, employment, access to health care, green spaces, occupational safety and freedom from classism, sexism and any other form of marginalisation / discrimination (Report of the National Expert Panel on Social Determinants of Health Equity 2009).

Marmot and colleagues (2008) noted that health and illness are determined by a social gradient regarding a person's social position; lower socioeconomic positions were

normally associated with poor health. The SDH model is applicable to the young participants in this study in terms of the greater levels of inequality that tend to exist in socioeconomically disadvantaged areas, specifically the role of social deprivation and social cohesion in both the manifestations and effective treatment of mental illnesses. The association between mental health and socioeconomic status is both well established and longstanding (Wilkinson and Marmot 2003). This study's placement in areas of low income / high socio-economic disadvantage in Dublin and Limerick reflect this relationship. However, social cohesion and the capacity of a low income community to serve as an internal resource to its members can ameliorate the effects of individual socio-economic disadvantage (Fone et al. 2007). The GP and primary care sites, which are embedded in the community and have much greater contact and collaboration with community resources, were viewed as effective vehicles for optimising mental health care to at-risk young people.

Policies designed to improve mental health and substance use services for young people could certainly adopt some of the factors associated with SDH such as participation in society, (particularly in socio-economically disadvantaged areas where members of these communities are very often excluded from decisions and potential strategies to improve their health / social status), economic and social security, conditions in childhood and adolescence, healthier working life and environment and products. In 2008, the Commission on the SDH suggested that health systems should be based on primary health care (World Health Organisation 2008). Previous qualitative research, based across six primary health care services in Australia, noted the potential of primary health care services to address the SDH with more support and interagency collaboration from political and social resources in regards to delivering services in a way that takes account of the limitations individuals face from their life circumstances (Baum et al. 2013). SDH education is also lacking in young people, previous research found that participants linked their health to physical determinants as opposed to SDH and there was also an association between students from low socio-economic backgrounds and less knowledge of SDH (Kenney and Moore 2013). Figure 2.3 illustrates the relationship between the structural and individual factors that may contribute to health equity / inequity (World Health Organisation 2008).

Figure 2.3: WHO, Social Determinants of Health Conceptual Framework.



2.6.2 The Chronic Care Model (CCM)

Wagner and colleagues developed the CCM in the mid-nineties to enable better care for patients with chronic conditions (Wagner et al. 1996). The underlying framework of the CCM is based on the need for specified care for patients with long-term illness; particularly in primary care where GPs very often apply the same level of treatment to patients with chronic conditions that they would normally adopt for patients with acute conditions (Wagner et al. 1996). As Kotte, Brekke and Solberg cited in (Wagner et al. 1996): "the health care system prioritises urgency over sensitivity and encourages physicians in clinical settings to be respondents not initiators." The CCM comprises six key elements to promote high quality care for individuals with chronic conditions, which can be applied to a variety of chronic illnesses (including mental and substance use disorders), health care settings and target populations. The primary goal of the CCM is healthier patients, more satisfied health care workers and cost savings (Wagner et al. 2001).

Six key aspects of the CCM include:

1) *Self-management support* – promoting patient autonomy in their care plan, linking patients to appropriate community resources, use of evidence based programs to provide emotional support in addition to strategies for living with chronic conditions.

2) *Clinical information systems* – effective data management of patient files can improve patient care (e.g., providing timely reminders for appointments and tests or other services that may be required). Data management can also facilitate performance monitoring and quality improvement strategies.

3) *Delivery system redesign* – incorporating a multidisciplinary approach, where tasks could be delegated / shared with other members of the team (e.g., pharmacists, practice nurses, external agencies) in terms of patient follow-up, support for self-management and behavior change.

4) *Decision support* – Utilisation of evidence based guidelines in practice, information sharing and patient participation in the use of evidence-based guidelines in addition to liaison with specialists in the field.

5) *Health care organisation* – Effective leadership, leadership support where changes have been implemented within an organisation for quality improvement purposes. Communication and interagency collaboration between health care workers across services may break down barriers that patients often encounter during their trajectory of care.

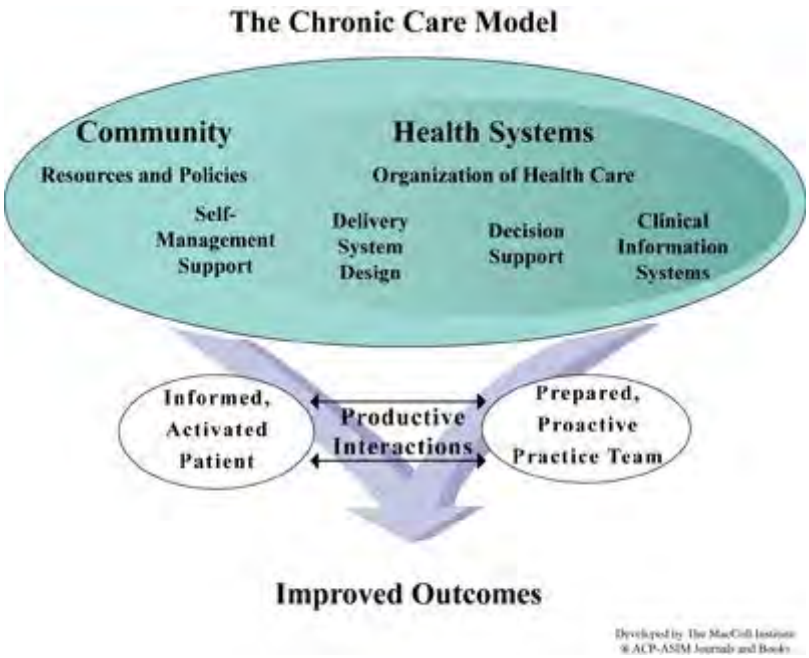
6) *Community resources* – Collaboration between clinicians and external agencies, encouraging patients to utilise appropriate community-based resources. Increasing links with other agencies in the community (e.g., counselling services, peer support groups can be cost effective in terms of obtaining important services and can also facilitate continued care for patients with chronic conditions).

In a systematic review of studies that assessed the impact of the CCM on the management of chronic conditions, Bodenheimer and colleagues (2002) noted improvements in terms of reduced health care costs and less use of health care services for patients with congestive heart failure, asthma and diabetes. Aspects of the CCM are certainly applicable to how GPs might better address youth mental and substance use

disorders, particularly in regards to self-management support (promoting patient autonomy and facilitating links to appropriate community resources) decision support (utilisation of evidence based guidelines for addressing youth mental health problems in general practice) and delivery system redesign (multidisciplinary approaches to care across the health services which are focused on addressing youth mental health problems). As Bodenheimer et al. (2002) noted where physicians are under pressure to meet the multiple demands associated with running a busy practice, delegation of care for young people with long and enduring mental health problems would certainly be of benefit.

O'Toole and colleagues examined the CCM in relation to patients with substance use and suggested that patient consultations involving general health concerns should be utilised by health care workers as a 'treatable moment' to engage individuals in substance abuse treatment (O'Toole et al. 2008). In a cohort of medically ill polysubstance-using adults admitted to a day-hospital program, physical health concerns were the most frequently cited reason for wanting to engage in substance abuse treatment at baseline (28%), yet individuals who cited this as their primary motivator were significantly less likely to complete the treatment program. However, 43% of respondents also reported a transition in their motivation during treatment; 100% of those transitioning from an extrinsic motivator (e.g., physical health concerns) to an intrinsic motivator (e.g., wanting to do / achieve more in life) completed treatment, compared with only 38% of those whose extrinsic motivating factors were static (O'Toole et al. 2006). This suggests that medical illness represents a "treatable moment" to engage individuals in substance abuse treatment, a similar approach could be utilised by GPs during consultations with young people presenting with physical complaints but who may also have underlying mental health concerns. However, while general health concerns may provide a 'treatable moment', treatment engagement must include intrinsic motivation and personal desire for change from young people which provides further challenges for health care workers (see figure 2.4 for an overview of the CCM).

Figure 2.4: The Chronic Care Model



2.7 Method – Study one

2.8 Aims

To explore the experiences of and attitudes towards screening and early intervention for youth mental and substance disorders from the perspectives of young people and health care workers who have a direct link with primary care in two of Ireland's most socio-economically disadvantaged areas, Limerick City and Dublin South Inner City (Haase and Pratschke 2008).

2.9 Participant recruitment and sampling procedure

2.9.1 Purposive sampling

We adopted a purposive sampling framework to achieve a diverse range of knowledge and experience across the health care spectrum. Purposive sampling facilitates the qualitative researcher with "information rich" cases to best address the phenomena under study (Miles and Huberman 1994). Sampling parameters included; 1) geographical region: two socio-economically disadvantaged areas, Limerick City and Dublin South Inner City where youth mental health and substance use problems have been identified as priority issues (Fitzgerald 2007, Long et al. 2005). 2) Health / social care agency: the study sample included health care workers (n=37) and young people (n=20) attending clinical sites and agencies reflective of the range of settings where young people seek help for mental health and substance use problems and which have a direct link with primary care, specifically:

- Primary care itself (general practices and community-based health services
- Secondary care (adult mental health services, child and adolescent mental health services and specialist addiction services)
- Community agencies / NGOs involved in mental health awareness / care

By recruiting 1-2 young people and 1-2 health care workers at each site, we estimated two general practices, 1 adult and 1 child and adolescent mental health service, 1-2 community agencies and local HSE Primary Care / addiction services in each centre would provide a sample with a sufficiently wide perspective from young people with no

(young people who are engaging with services / experiencing problems but may not have received a diagnosis), or mild, mental or substance use disorders to young people with more severe disorders. Tables 2.2 and 2.3 outline the purposive sampling framework used in recruitment and the actual number of participants sampled.

Table 2.2 Purposive sampling framework used in recruitment

Agency	*Dublin*	*Limerick*
Community / NGO	2-4	2-4
Primary care: general practice	2-4	2-4
Primary care: HSE primary care services	2-4	2-4
Secondary Care	2-4	2-4
Total sample size	*16-32*	

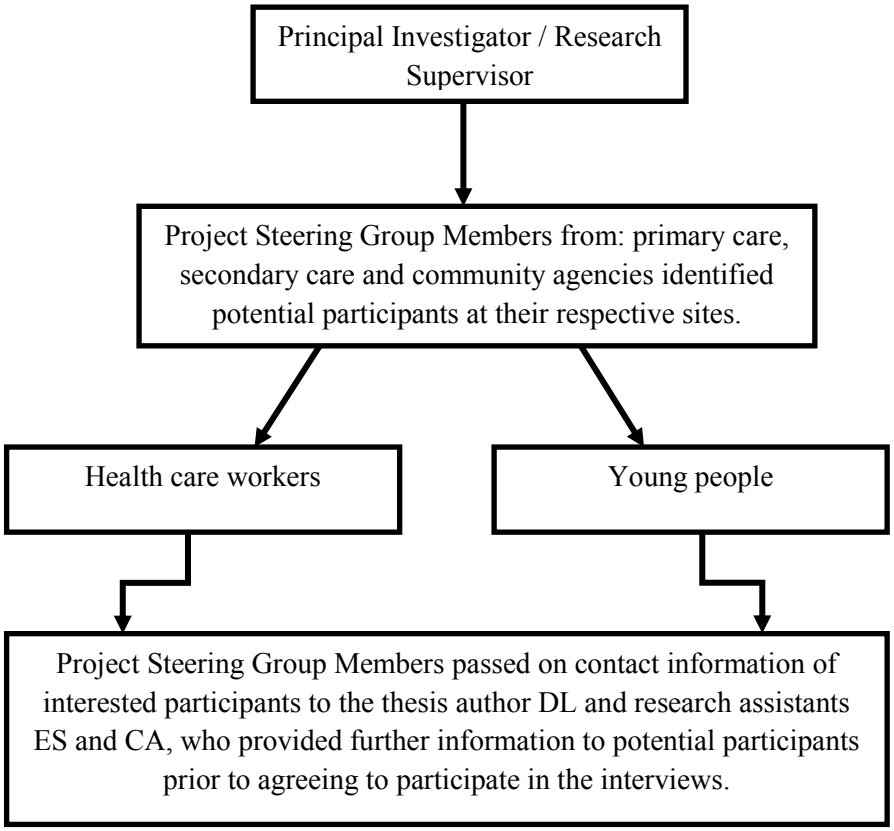
Table 2.3 Number of participants actually recruited

Agency	*Health care workers*		*Young people*	
	Dublin	*Limerick*	*Dublin*	*Limerick*
Community / NGO: • Community addiction service • Youth cafe • Regeneration project • Garda diversion project •	5	7	1	2
Primary care: • General practice •	3	2	1	1
Primary care teams: • Specialist community based addiction services • Primary care teams •	3	5	2	1
Secondary Care (Mental Health): • Child and adolescent psychiatric services • Adult psychiatric services •	5	3	3	4
Secondary Care (Addiction) • Drug and alcohol services • Hospital offering counselling services for addiction •	2	2	3	2
Total sample size	*18*	*19*	*10*	*10*

2.9.2 Participant recruitment

The sampling practice employed in this study adopted a similar approach to previous work conducted by members of the project group where studies were based on similar populations working in and attending primary care, which demonstrated the feasibility of recruiting across a similarly diverse range of settings (Cullen et al. 2003, Swan et al. 2010, Field et al. 2013). Previous pilot studies conducted in the study sites included in this study facilitated a collaborative relationship between the study team and participants at each site where continued commitment to further research has been expressed. The applicant team / project steering group for this study included individuals who co-ordinated recruitment at participating agencies. The role of each coordinator consisted of identifying potential participants, inviting potential participants to participate and identifying those who would like to participate (see figure 2.5 for an outline of the study recruitment strategy).

Figure 2.5: Study recruitment strategy



At each site, 1-2 health care workers and 1-2 young people were identified by a member of the project steering group and invited to participate. Members of the group facilitated participant recruitment in terms of identifying colleagues (health care workers) who were engaged in the area of youth mental health and arguably young people were more likely to participate when approached by familiar and trusted health care workers (Emmel et al. 2007). If young people and health care workers expressed initial interest in participating, potential participants received a telephone call from one of the researchers who explained the study, outlined the interview purpose and the use of the findings. Prior to participation, information sheets and consent forms (appendix B and C) were mailed to participants who had the opportunity to contact the researchers with any concerns or further queries before the interview. A record of how many participants were approached by the members of the steering group could not be determined as participant contact names were not known to the researchers (the thesis author and the two research assistants) until they had expressed an interest to participate. However, all of the health care workers that the thesis author and the two research assistants made contact with agreed to participate (n=37). Three young participants withdrew from the study after being contacted by the researchers, the first young person changed her mind and did not provide a reason for non-participation, the second young person was slightly intoxicated before the interview and both the thesis author and health care worker at the study site agreed that it was not appropriate to proceed and the third young person did not attend the interview (no reason provided).

2.9.2.1 Potential bias implications

While a purposive sample was recruited where health care workers who may have been more engaged in the area of youth mental health participated, all participants were asked about the barriers / negative aspects of their experiences in regards to screening and treatment for mental health and substance use problems in addition to the enablers / positive aspects. Furthermore, bias was controlled for by having the data independently coded by the thesis author and a research assistant. Research with vulnerable populations invariably presents particular challenges including: estimating the size of hidden populations, securing access to these populations, asking sensitive questions in a survey or interview format and handling sensitive data (Lee 1993). Consequently, the

young study participants were approached by a member of their clinical team; most had contact with formal support services (mental health, addiction, primary care services). Therefore it is possible that this may have led to some degree of sampling bias, although access to young people with mental health and / or substance use problems by any other means, tends to be ethically and practically problematic. Nonetheless, the findings from health care workers and young people converged in a logical and meaningful way, whilst the results for the sample as a whole, are consistent with previous findings from a similar field of research.

2.9.3 Inclusion criteria

We considered the following eligible for the study:

- Health care workers working in and young people attending each study site who volunteered to participate in the study and were willing to be interviewed.
- Young people (aged 16-25 years) with none / mild / moderate mental or substance use disorder diagnoses.
- Young people (aged 16-25 years) with more severe disorders (who yet could provide informed consent).

2.9.4 Exclusion criteria

- People aged less than 16 years.
- People with language difficulties (e.g., dysphasia, people who did not speak English).
- People with severe mental health or addiction problems which impaired their capacity to provide informed consent.

2.9.5 Data saturation

A clear definition of data saturation is currently lacking in the literature (Guest et al. 2006, Francis et al. 2010). To achieve data / theoretical saturation, it was estimated that16-32 health / social care workers and 16-32 young people would be invited to take part in semi-structured interviews, similar to previous qualitative research based on

comparable populations in primary care (Swan et al. 2010, Field et al. 2013, McCann et al. 2012). Interviews were transcribed, reviewed and checked prior to data analysis. Upon initial coding, interview transcripts were reviewed and initial codes generated. The collection and analysis of data was a parallel process. During the data analysis phase, a list of codes generated with accompanying descriptions for each code were updated and circulated to other members of the group (see appendix D for a copy of the code books for health care workers and young people), upon review of the coding list and discussion with ES and WC, it was agreed that no new codes were evident in the interview transcripts. Data saturation was defined in this study as "the point in data collection and analysis when new information produces little or no change to the codebook" (Guest et al. 2006).

Key principles outlined by Francis and colleagues (2010) were also consulted:

1) *Specify a priori* – at what sample size the first round of analysis will be completed. In the current study after initial coding of the pilot transcripts, interview transcripts were coded in batches of four and the codebook was updated accordingly.

2) *Stopping criterion* – how many interviews need to be conducted before data saturation has been reached, e.g., after 10 interviews, when three further interviews have been conducted with no new themes emerging, it would be defined as the point of data saturation. However, in the current study, interviews were based on a diverse range of participants from different health care settings, thus, for health care workers (n=37) new codes were identified across the majority of transcripts. While efforts were made to recruit more young people, the final sample (n=20) did not impact negatively on data saturation (more detail provided in Chapter 3, section: 3.1.2).

3) *Analysis conducted by at least two independent coders* – DL and ES coded transcripts independently, prior to reviewing codes in collaboration with WC.

Data saturation was achieved as similar themes emerged from each transcript and it was agreed by all members of the research team that no new themes would emerge from further analysis. When data saturation became apparent, data collection ceased (see section 2.11.3 for more detail on data analysis).

2.10 Data Collection

2.10.1 Study instruments / topic guides

The interview topic guides (see appendix E) were informed by:
1) A literature review on the role of general practice in addressing youth mental health (Cullen et al. 2012).

2) Theoretical frameworks for the study:

- Social Determinants of Health (SDH) which explored young peoples' engagement with services in terms of: *need identification, treatment engagement, treatment sustainment and community resource engagement / partnership*. The SDH model emphasises the role of socio-economic disadvantage and social cohesion in the effective treatment of mental illnesses (Wilkinson and Marmot 2003). Thus, the current study's placement in socio-economically disadvantaged areas (Dublin South Inner City and Limerick City) where GP and primary care sites have the potential to liaise with community resources to address youth mental health, reflect this relationship.

- The 'Chronic Care Model (CCM) (Bodenheimer et al. 2002) describes how six interdependent facets of primary care delivery: *self-management support, clinical information systems, delivery system redesign, decision support, health care organisation and community resources*, can effectively improve patient satisfaction and chronic disease outcome measures in a variety of health care settings including low income communities (Bodenheimer et al. 2002). Mental illness is applicable to the Chronic Care Model in terms of its chronicity, need for monitoring, care adjustments and multifaceted interventions.

Thus, semi-structured interviews examined:

- Demography
- Young people's experiences of mental health and substance use problems.
- Health care workers' professional background, experience and training in youth mental health and substance use disorders and current screening practices.
- Young people's experiences with services, information received in regards to treatment options and their views on how services could be improved to address participant needs.
- Health care workers were asked about the identification of service user needs, the challenges of meeting the needs of young people in regards to treatment engagement / sustainment, need identification and the availability of community resources.
- Attitudes / views on the barriers and enablers of screening and early intervention for youth mental and substance use disorders which was informed by a discussion paper on the role of general practicing in addressing youth mental health (Cullen et al. 2012). (See table 2.4 for an overview of questions informed by the theoretical models and the literature review).

Table 2.4 Interview questions related to theoretical models and literature review

Theoretical model / literature review	Interview questions - health care workers
Social Determinants of Health • *Need identification* • *Treatment engagement* • *Treatment sustainment* • *Community resource engagement*	➢ How are service user needs identified? ➢ What are the main challenges in regards to meeting the needs of young people with respect to: treatment engagement / treatment sustainment / need identification / resources available?
Chronic Care Model • *Self-management support* • *Community resources*	➢ Are there additional supports / community resources available outside of this service? ➢ How would you improve your service with respect to: access to services for young people?
Literature review *What is the role of general practice in addressing youth mental health? A discussion paper (Cullen et al. 2012)*	➢ Do you think it would be feasible to have screening in your service? ➢ What are the main factors that facilitate screening for mental / substance use disorders in young people? ➢ What are the main barriers that prevent screening for mental / substance use disorders in young people?
Theoretical model / literature review	**Interview questions – young people**
Social Determinants of Health • *Need identification* • *Treatment engagement* • *Treatment sustainment* • *Community resource engagement*	➢ When did you first seek help? / How did you know something was wrong? ➢ What services have you had contact with since then? / How did you find out about this service? ➢ Can you tell me about what they have been able to do for you / the help you received? ➢ What kind of information did you receive about your treatment options? ➢ Are you happy with the help / support / treatment you have received from this service? ➢ Do you think the service could be improved in any way? If yes...how?
Chronic Care Model • *Community resources*	➢ Is there anything you could have been told in a school or community centre which might have helped you?
Literature review *What is the role of general practice in addressing youth mental health? A discussion paper (Cullen et al. 2012)*	➢ If you were attending your GP for a physical ailment, how would you feel if they were to screen you for a mental illness / substance abuse? ▪ Would you find it off putting or useful? ▪ Would you want to talk about these things with your GP? If not, why not? ▪ What would make you want to discuss these issues with him / her? (Choice / Time / Personality)

2.10.2 Pilot study

Two young people and two health care workers (two based in Limerick and two based in Dublin) were interviewed as part of the pilot study. The pilot study facilitated the researchers to test recruitment procedures and determine the suitability of the interview schedules for both health care workers and young people. During the interview process, the researchers noted any difficulties with specific questions, wording etc. Audio recordings were reviewed in addition to the interview transcripts, any questions which posed difficulty for participants (i.e., in terms of clarification, sequence of questioning etc.) were reviewed and altered accordingly.

2.10.3 Interview procedure

After the pilot interviews were completed and subsequent changes made, fieldwork commenced at the sites. Interviews were conducted in collaboration with two research assistants (ES) and (CA). Each interview took place face-to-face in a location and at a time convenient for participants. In most cases, this was at the service which they attended / worked in. Interviews took place in a quiet room with only the interviewer and participant present.

The topic guide served as a guiding framework for the interview rather than a prescriptive line of questioning, thus, every effort was made to allow participants elaborate on aspects of importance to them (Pope et al. 2002). Interviews ranged in length from 16 to 120 minutes, however, most ranged from 30 to 90 minutes. The 16 minute interview was one of the pilot interviews which took place in a busy GP practice and while relatively short, it was included in the study as the interview contributed rich data. All health care workers were interviewed in their work place, therefore in some cases, the interview duration was dependent on external factors related to the participant's work environment (e.g., time constraints associated with a busy practice environment resulted in shorter interviews). However, varying interview length did not impact negatively on data analysis. Interviews were audio recorded using a digital voice recorder. Interview material was reviewed after every 2-3 interviews to allow researchers identify new issues to explore in subsequent interviews and to note emerging / diverging consensus. Each interview was then transcribed verbatim using a

transcription service and participants were given the opportunity to check their transcript if they wished; some health care workers requested a copy of their transcript, however, no edits or omissions were requested. None of the young participants requested a copy of their interview data.

2.11 Data Analysis

2.11.1 Thematic analysis

Thematic analysis was used to analyse respondents' experiences of and attitudes towards screening and early intervention for mental and substance use disorders among young people. Boyatzis (1998) described thematic analysis as a process rather than a method to be used with qualitative information which facilitates the identification, analysis and reporting of patterns (themes) within data (Braun and Clarke 2006). According to Boyatzis (1998) thematic analysis can facilitate researcher "insight" in terms of systematically observing interview data and its versatility as a methodological approach can be communicated across a wide and varied cohort for the dissemination of findings. The process of thematic analysis involves basic to advanced encoding of data to develop themes which are patterns found in the information that "at a minimum describes and organises the possible observations and at a maximum interprets aspects of the phenomenon" (Boyatzis 1998). Themes can be developed in an inductive manner from raw information but also deductively from prior / existing research and knowledge (Boyatzis 1998). This flexible approach can also be seen in how themes identified at one level can help the researcher describe their observations and at a more advanced level allowing the researcher to interpret aspects of the phenomenon under study (Boyatzis 1998).

2.11.2 Rationale for using thematic analysis

There are various qualitative methods for analysing data, originating from an epistemological or theoretical position. There is grounded theory which aims to generate theory as it emerges from the data using a ground (data) up approach (McLeod

2001). For a Grounded Theory approach, the study would have been conducted in a Grounded Theory framework from the outset, which would have been inappropriate given that the primary aim was to answer specific research questions as opposed to developing theory. Grounded theory is normally used when researchers wish to set aside theoretical ideas from the field of inquiry in order to allow a substantive theory to emerge (Lingard et al. 2008). With Interpretive Phenomenological Analysis (IPA), the research needs to be again applied within a specific framework and the analysis is connected to phenomenological and hermeneutic backgrounds which focus on the science of interpreting human meaning and lived experience. This approach would have been inappropriate for the current study which included a broad range of young people with various mental health and substance use problems and / or disorders and health care workers from a wide variety of settings. While one of the key research questions was to investigate the experiences of young people with mental health and / or substance use problems, additional research questions included examining young participants' and health care workers' experiences and attitudes to screening and treatment across a broad range of services. Therefore, thematic analysis was considered the most appropriate as it facilitates individuals making meaning of their experience in addition to how the broader context affects this meaning.

Furthermore, because the overall study adopted a mixed methods approach which was based on a pragmatic epistemological position; thematic analysis is flexible because it is not locked into a realist approach. It is "an essentialist or realistic method, that reports experiences, meaning and the reality of participants, or it can be a constructionist method, which examines the ways in which events, realities, meaning experiences and so on are the effects of a wide range of discourses operating within society" (Braun and Clarke 2006). Thematic analysis has been commended for its flexibility as it is not tied to a particular epistemological position as opposed to other qualitative methods such as conversation analysis (CA), discourse analysis (DA) and IPA where there is limited variability in the applicability of the methods (Braun and Clarke 2006). Thematic analysis can be applied across a range of theoretical and epistemological approaches and is compatible with both positivist and constructivist paradigms. Previous authors in the field of mixed methods have highlighted the tendency of some researchers who engage in the qualitative versus quantitative paradigm debate to treat epistemology and methods as being "synonymous" (Onwuegbuzie and Teddlie 2003, Bryman 2008). However, as

Johnson and colleagues (2004) suggested, a researcher's logic of justification (a key facet of epistemology) should not dictate the type of data collection or the data analytical methods used. In contrast to IPA, DA, CA, thematic analysis is not tied to any pre-existing theoretical framework and can be applied to different theoretical frameworks which was applicable to the current study given the influence of the SDH and Chronic Care model on certain aspects of the data collection and analysis.

Thematic analysis moves away from language as a social construction (as per DA) and accepts that it can be a representation of psychological values, identities and ideology. For example if a grounded theory approach was employed, the researcher would allow themes to emerge from the data, rather than identifying them in relation to a priori theoretical position as with the analysis in this thesis. If DA was used as an alternative approach, the focus would have been on social construction of talk and language that is used rhetorically and how psychological phenomena are constructed in speech. Thematic analysis facilitated the researcher to engage and be informed by both participants' accounts and existing theoretical frameworks. In keeping with a mixed methods approach, a key element of thematic analysis is that the theoretical framework and methods used best answer the key research questions (Braun and Clarke 2006).

Thematic analysis also allows for social as well as psychological interpretations of data and has been commended for its utility as a methodological approach for informing policy development (Braun and Clarke 2006). Additionally, thematic analysis provides results that are generally accessible to the general public such as a large group of stakeholders from different occupational backgrounds which was applicable to the steering group members in this study (Braun and Clarke 2006). Our sample size for study one included a relatively large number of participants for a qualitative study; 37 health care workers and 20 young people, thematic analysis is useful in terms of summarising key features of a large body of data, while also providing a rich description of the data set (Braun and Clarke 2006). Thematic analysis has been used across various studies in primary health care research (Biddle et al. 2006a, Saba et al. 2006, Iliffe et al. 2008).

2.11.3 Procedure for data analysis

Data were analysed using a thematic approach to analysis in accordance with Braun and Clarke's (2006) five-step process:

1) *Familiarisation with the data* – DL reviewed audio files against the transcripts for accuracy, read and re-read the data, annotated interview transcripts and noted down initial thoughts and ideas.

2) *Generating initial codes* – Using NVivo software, initial codes (relating to the interview questions and topic guide as well as "free codes" developed by the researcher were generated and data relevant to those codes were collated.

3) *Searching for themes* – after collating all of the codes, the researchers tried to establish relationships between them to identify major themes and sub-themes.

4) *Reviewing themes* – themes were checked against coded extracts as well as across the entire data set.

5) *Defining and naming themes* - the names of the themes were reviewed and some were amended to ensure accurate reflection of the data they represented.

DL reviewed all of the interview transcripts against the audio files to check for accuracy. DL printed all of the interview transcripts. DL and ES read and re-read the first interview transcript (pilot practice nurse interview) and noted initial ideas. DL and ES both coded the entire transcript of the (pilot practice nurse interview) separately. DL and ES coded two further interview transcripts separately by hand. DL and ES met to review the initial coding process and agree on initial code names. DL and ES met up with WC to discuss the coding process after the first four interviews had been coded, interviews were also made available to WC who checked the coding for accuracy. DL compiled a list of codes with accompanying descriptions and circulated it to ES and WC.

DL set up a 'Dropbox' account for a qualitative research package – Nvivo 9.2 which was used to store, code and analyse the data. NVivo facilitated quick-automated coding for a large body of data and information sharing with other members of the research team via a shared web-based folder. All the interview transcripts were uploaded and DL

created a mastercopy of the NVivo file to be available to DL, ES and eventually WC. DL coded the first of the previously coded transcripts on NVivo, using decided upon codes. ES coded the second of the previously coded transcripts on NVivo working also on the master copy. This process was repeated for every four transcripts, the coding list was updated by DL and circulated to ES and WC. When all of the health care workers' transcripts were coded DL, ES and WC collated codes into key themes separately and then met to agree on major themes and review the codes for accuracy. DL compiled codes into folders relevant to each theme on NVivo. The same procedure was carried out for the young people data.

2.11.3.1 Reaching consensus during the coding process

Transcripts were coded by a second researcher ES, to ensure correct and consistent coding. Codes were reviewed with the principal investigator (PI) (WC), who has subject and methodological expertise in this area of research, thus further contributing to consensus in regards to the coding process. There was little to no difference between the three separate codings. All researchers had access to coding materials and followed an agreed coding protocol where any new codes and changes to existing codes were highlighted as advised by Boyatzis (1998). Findings were compared with other study findings for the purposes of validity and reliability.

2.11.4 Converging and diverging themes

When themes for both young people and health care workers were collated and overarching themes had been identified, the researchers compared relationships between the sub-themes emerging within and across both groups, from node lists identified via Nvivo, common nodes were reviewed and checked for convergence / divergence. Converging and diverging findings were noted across sub-themes within the young study participant data set, the health care worker data set and across the two groups.

2.11.5 Presentation of results

Ellipses are used to represent words missing from quotations. In some sections participants' own words are used in the main prose, which are highlighted with quotation marks. (Table 2.5 outlines data analysis procedures).

Table 2.5 Procedure for data analysis

Step 1: Familiarisation with the data • DL and ES reviewed transcribed interviews for accuracy. • DL and ES read and re-read the first transcript (pilot interview) and recorded initial thoughts and ideas.
Step 2 Generating initial codes • DL and ES coded the same two transcripts separately by hand. • DL and ES met to review the initial coding process and agreed on initial code names. • DL set up a Dropbox account, and created a 'master copy' of the Nvivo file to be available to DL, ES and eventually WC. • DL coded on NVivo the first of previously coded transcripts using decided upon codes on the master copy. • ES coded the second of previously coded transcripts on Nvivo, working also on the master copy. • DL and ES collaborated with WC (PI) to discuss initial progress and review codes. **CODING STEPS ON NVIVO TO ENSURE COHESIVE COLLABORATION** A. If a new code arises, create new code name, use a thorough description in the description box and make a note for email to other collaborator. B. If you want to change a code name, do so, then make a note in the description and also for emailing other collaborator. C. At the end of coding, email the other collaborator with information on i) New codes created and ii) Changed code names- which ones and why? Also, import the master copy into your own files. D. Other collaborators will read this email, check the master copy to confirm changes and arrange a phone call if further discussion is needed.
Step 3: Searching for themes • DL and ES analysed all interview transcripts individually. • DL and ES collated codes for the first four transcripts into themes and liaised with WC. • Steps 1 to 3 are repeated for the next four transcripts and DL, ES and WC met to review new and existing codes / themes after every fourth transcript had been coded.
Steps 4 & 5: Reviewing the themes / Defining and naming the themes • DL, ES and WC met to review the entire coding process for health care workers and young people data, codes and themes were reviewed and amended.
Preliminary findings were presented at primary care and mental health conferences from 2011 to 2014.

2.11.6 Theoretical and inductive analysis

While the initial stages of analysis were inductive in nature, thus allowing early patterns and themes to emerge from participants' accounts (Braun and Clarke 2006), the latter stages of analysis adopted a deductive approach as some of the major themes were influenced by certain aspects of the key domains included in the study's existing theoretical frameworks. After initial inductive coding had been completed, the research team (DL and ES in collaboration with the principal investigator WC) reviewed the codes after every four transcripts and discussed potential themes that related back to the key domains of the study's theoretical frameworks and also the main research questions. Previous qualitative research that adopted a similar method referred to the combination of inductive and deductive thematic analysis as a "hybrid approach to thematic analysis" (Fereday and Muir-Cochrane 2006) which involves a balance between inductive and deductive coding. Inductive coding involved recognition of important information from the raw data, without trying to fit information into a pre-existing coding frame (Braun and Clarke 2006). This process was followed by deductive coding where inductive codes were linked with relevant domains from the theoretical frameworks and the key research questions to identify overarching themes (see chapter 3 sections 3.2 and 3.8 for a detailed overview of the process).

2.11.7 Validity and reliability of the research

To ensure the validity of the qualitative inquiry, four key facets of qualitative research were adopted in the current study: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance as advised by (Yardley 2000):

1) Sensitivity to context – an extensive literature review was conducted on knowledge of relevant literature and empirical data based on previous work in the area of youth mental health and substance use such as: psychological morbidity of youth mental health and substance use problems; experiences of young people attending primary care with mental health problems; the role of the GP in addressing such issues and the effectiveness of potential interventions for the identification and treatment of mental health problems in primary care. A literature review on methodological approaches,

ethical issues and extensive knowledge of the philosophical underpinnings of the mixed methods approach adopted for the current study.

2) Commitment and rigour – an indepth and prolonged engagement with the research topic, followed by thorough data analysis of participant accounts was undertaken.

3) Transparency and coherence – a reflexive approach was adopted in regards to the external factors which influenced the procedures chosen during data collection and analysis (e.g., stakeholder involvement, issues around participant recruitment (particularly in terms of recruiting young people, more detail on this issue is provided in the demographic description of the study population) and the "fit" between the research topic, method adopted and the philosophical perspective.

4) Impact and importance – results were compared with other study findings for the purposes of validity and reliability. Research findings were also disseminated at appropriate conferences and published in reports and peer reviewed journals.

2.12 Ethical considerations

Ethical procedures were necessary as interviews have the potential to cause harm to subjects by bringing up painful memories and uncertainties that an individual may not want to discuss (Hyde et al. 2005). This is especially true when dealing with young people who may be experiencing difficult life circumstances due to mental health or substance use problems. The researchers acknowledged this issue and set up safeguards to deal with such situations and to minimise risk to the participants. Such measures included:

2.12.1 Informed consent: All participants were given verbal and written information on the study and asked to sign (or, where applicable, a parent / guardian) a consent form. It was important all participants were aware that taking part in an interview could be an emotional experience and that they could potentially become upset during the research procedure, they would be audio-recorded and information from the study would be published at a later date. All participants were given an information sheet detailing problems that could arise from the research study before agreeing to take part and again

before the beginning of every data collection so there was adequate time to read and understand the form, as well as pose questions to the researcher if needed. They were also offered the right to leave the interview at any time and withdraw their consent without reason, however, the researcher was mindful of the possible power imbalance between young participants and adults in terms of young people being more acquiescent and less likely to challenge adults. Therefore, the researcher reminded young people that non-participation would not impact on their future level of care in participant information sheets. The interviewer made sure that the participant had read and understood the information sheet and reminded them that the interview would be recorded and some direct quotes may be used within the research, although their anonymity would be protected.

2.12.2 Confidentiality, data protection and security: The only personal data taken were names on the consent forms and contact details if participants wished to take part in subsequent phases of the study being conducted by other members of the project. There were no corresponding codes to connect personal details with data provided in any part of the study. All hard copy data has been kept confidential and secure in a locked cabinet at the University of Limerick (UL) Graduate Entry Medical School. All computers that have project information / soft copy data on them are password protected in a locked office at UL Graduate Entry Medical School. Audio recordings were kept private, confidential and secure on a password protected computer at UL Graduate Entry Medical School. The names of patients contacted were not known to the researchers until they had provided consent to take part in the study meaning patient confidentiality was respected at all times.

2.12.3 Do no harm / clinical governance: The researchers liaised closely with each collaborator to ensure that the broader research findings were fed back to health / social care workers at each site in the form of progress reports / monthly teleconferences or review meetings as requested. All young people who participated in the study were advised to speak with a member of the clinical team at the site at which they were recruited in the event that their interview raised any issues relating to mental / substance use disorders.

2.12.4 Ethical approval: Ethical approval for the study was obtained from the following Research Ethics Committees, Irish College of General Practitioners, St James's Hospital Dublin, Lucena Clinic / St John of God's and the HSE / Midwest Regional Hospital (see Appendix F for ethical approval letter from the HSE / Midwest Regional Hospital).

2.13 Method -Study two

2.14 Aims

- To examine the role of the GP in addressing mental health and substance use problems in young people.
- To determine current practice in identifying and treating mental and substance use disorders among a representative sample of GPs.
- To examine the factors associated with screening, brief intervention and referral for mental and substance use disorders.

2.15 Questionnaire design

Databases including: Google Scholar, Medline and Pubmed where search terms included "GPs", "youth", "substance use problems / disorders" "mental health problems / disorders", "attitudes" "screening", "treatment", "study instruments", "questionnaires", indicated that an instrument specific to GP attitudes towards screening and treating youth mental health problems was lacking in the literature. Available studies included: GP attitudes towards addressing mental health problems across older populations (Stensrud et al. 2012, Stensrud et al. 2014); GPs perceived learning needs towards addressing mental health problems (Stensrud et al. 2012) and GP collaboration with the mental health services (Jaruseviciene et al. 2012, Fleury et al. 2012, Bjertnaes et al. 2010).

The study instrument (see Appendix G) was informed by:

- International cross-sectional studies assessing GP practices towards addressing mental health and substance use problems (Stensrud et al. 2012, Veit et al. 1996, Jaruseviciene et al. 2012) and a qualitative study exploring GP registrars' experiences of treating such issues (Lucas et al. 2005).
- Previous work conducted by members of the *Mental Health in Primary Care Research Group*: cross-sectional studies based on GP practices for addressing mental health and substance use problems (Healy et al. 2013, Field 2013);

qualitative findings from study one (Leahy et al. 2013) and a Delphi study which aimed to create guidelines for treating youth mental health and substance use problems in general practice (Schaffalitzky et al. 2014).

- The questionnaire was developed collaboratively with the Project Steering Group, research colleagues, the Centre for Support and Training in Analysis and Research (CSTAR) and the Professor of Biomedical Statistics at UL.

The questionnaire was divided in to five main subsections to address the main research questions in regards to GP attitudes towards screening and treating youth mental health and substance use disorders:

Section A: Demography

Demographic variables in the questionnaire included questions relating to age, gender, year finished GP training, practice type and location, which were informed by a survey based on the structure of general practice in Ireland by O'Dowd and colleagues (2006). Additional questions included postgraduate training received and attitudes towards previous postgraduate training, influenced by previous work exploring GP attitudes towards training (Veit et al. 1995, Lucas et al. 2005) and also questions relating to the availability of counselling services from a previous cross-sectional study conducted among GPs in the Mid-West (Healy et al. 2013).

Section B1, B2 and B3: Screening, management and barriers to treatment of mental health and substance use disorders

Section B1 examined current screening practices, frequency of screening for mental and substance use disorders and the use of screening questionnaires. This section was informed by a questionnaire used in a similar Irish study which aimed to determine the management of problem alcohol use among problem drug users in primary care (Field 2013). In section B2, questions were included to assess: GP management of mental and substance use disorders in terms of referral to specialist mental health / addiction services and also whether GPs performed brief interventions for mental health and substance use problems and if yes, the type of brief intervention offered, the most common being counselling and CBT, as suggested in the literature (Roberts et al. 2014a, Copty and Whitford 2005, Tonge and Rowe 2003). The use of web-based

interventions was also included, given their increased use in primary care services internationally (Van Voorhees et al. 2008, Reid et al. 2011). Section B3 aimed to determine attitudes towards the main barriers to addressing mental and substance use disorders, which were identified in study one among GPs and health care workers from primary care, secondary care and community agencies and young people (Leahy et al. 2013). The main barriers included: *attitude of the family*, *attitude of the patient*, *lack of specialist staff in the practice*, *lack of interest*, *lack of time*, *lack of training, poor service availability* and *stigma*.

Section C: GP attitudes towards working with youth mental health / substance use disorders

Section C was designed to explore GP attitudes towards working with young people with mental and / or substance use disorders. The first question which included a statement as to whether *'a GP should always be the initial person consulted by a young person for a mental health or substance use problem'* was based on findings from study one where feelings among GPs, health care workers and young people were varied in this regard. Questions based on GP confidence to diagnose, treat and manage mental and substance use disorders were influenced by a study from Jaruseviciene and colleagues (2012) which aimed to assess collaboration between GPs and mental health team members. Question C12 asked GPs about their preference for seeking advice from colleagues as opposed to guidelines / information leaflets, this question was influenced by a study conducted to assess GP registrars' attitudes towards addressing mental health problems in primary care (Lucas et al. 2005). GPs in study one also highlighted a preference for collaboration with colleagues / experts in the field of mental health and addiction as opposed to guidelines and other resources. Questions relating to the prescription of psychotropic medication were based on feedback from the project steering group, which included members from specialist mental health services. Attitudes towards administering brief intervention and utilising lifestyle interventions were included to address one of the key research questions and were informed by work from Field (2013) and colleagues where use of the Shortened Alcohol and Alcohol Problems Perception Questionnaire (SAAPPQ) (Anderson and Clement 1987) was incorporated.

Section D: Interventions to address youth mental health issues

Section D was informed by a Delphi-study which was conducted by another member of the project group (Schaffalitzky et al. 2014) to inform future guidelines for addressing youth mental health problems in primary care. The Delphi-study was informed by findings from study one with health care workers and young people, in addition to feedback from an expert stakeholder panel representing primary care, secondary care and community agencies in two socioeconomically disadvantaged areas in Limerick and Dublin. Twenty individual roles in which GPs could help address youth mental health, across five domains were identified: (1) prevention, health promotion and access, (2) assessment and identification, (3) treatment strategies, (4) interaction with other agencies / referral, and (5) ongoing support.

2.16 Checking for validity

Where possible questions were used that had already been checked for validity with populations similar to the sample in the current study, e.g., Section C incorporated similar questions from the SAAPPQ on attitudes to GP administered brief interventions and GP management of mental and substance use disorders (Anderson and Clement 1987). However, validity measures were not reported for the majority of study instruments that informed the current study. Previous research has noted the reliance on content validation when using / piloting for the first time instruments that one has created especially to quantify some very specific variables of interest, in order to test a new hypothesis, as there are no other measures of the same thing of known validity to use for concurrent validation and relationships with other variables that can be used as a basis for construct validation are lacking (Bryman 2008). However, the study instrument included variables informed from study one, therefore facilitating the triangulation of research findings / repeated measure of selected variables.

2.16.1 Pilot study

Content validity (or face validity) which refers to expert opinion concerning whether the scale items represent the proposed domains or concepts the questionnaire is intended to measure (Rattray and Jones 2007), was conducted via a pilot study among a group of GPs (n=5) chosen to represent the target sample and fellow colleagues working on primary care related projects (n=8) at the Graduate Entry Medical School in UL. Piloting was conducted in combination with cognitive interviewing, where respondents were asked to provide verbal or written feedback on the questionnaire e.g., questions that made the respondent feel uncomfortable, sections that were monotonous, questions that appeared to be misinterpreted and questions that seemed to be repetitive. Feedback from the pilot study included technical changes around structure and clarity (e.g., some questions were restructured to shorten the questionnaire length, questions were rephrased for clarification and additional questions were included to obtain a more comprehensive demographic overview). The data from the pilot study was not included in the final sample.

2.17 Participants

Fourteen per cent (n=363) of a national database of 2603 GPs listed in the Irish Medical Directory were randomly sampled and invited to participate. A geographical stratified sampling framework (Bryman 2008) was employed, whereby GPs were stratified by county. Total sample was divided by 360, providing 7.04, starting with a random number between 1 and 7 (i.e. 3, after which every seventh GP from each county was chosen to be included in the sample). Where a practice from a particular county had already been represented in the sample, the next GP on the list was chosen. Alternative sampling strategies might have included a simple random sample approach or systematic sampling. However, by adopting a stratified sampling approach the resulting sample distribution was representative of the total population in terms of the stratifying criterion (Bryman 2008) (i.e. county of practice).

2.17.1 Allowing for non-response

The number of GPs required for 10% of the sample was 260, where an estimated 50-60% participation rate would provide a sufficient sample size to inform the researcher on the current practice and needs of general practitioners. The estimated sample size was informed by previous Irish based cross-sectional studies with GPs chosen from the Irish Medical Directory (Gavin et al. 2005, Byrne et al. 2010). An extra 100 GPs allowed for an expected 40% non-response rate. (Table 2.5 outlines a breakdown of the sample representative of each county).

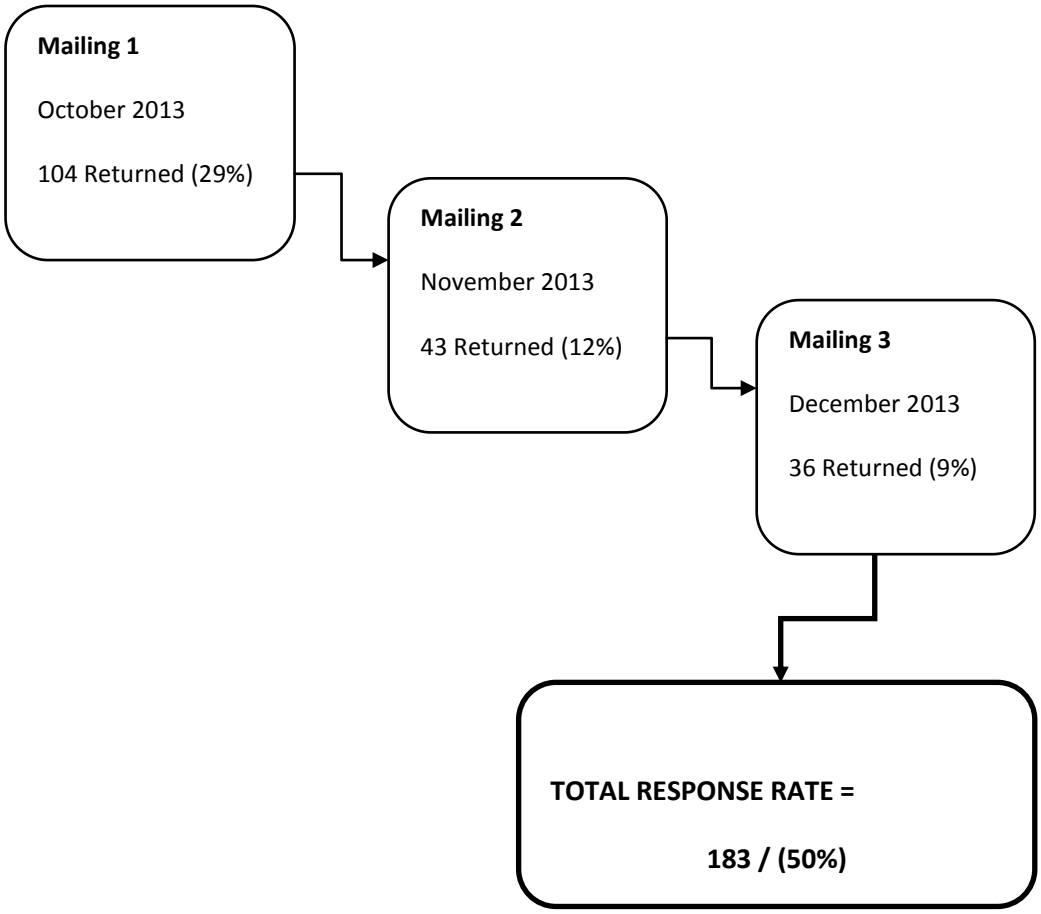
Table 2.6 The number of GPs from each county included in the overall sample.

County	No. of GPs / (%)	County	No. of GPs / (%)
Carlow	5 (1)	Longford	3 (1)
Cavan	4 (1)	Louth	10 (3)
Clare	7 (2)	Mayo	12 (3)
Cork	50 (14)	Meath	9 (2)
Donegal	13 (4)	Monaghan	3 (1)
Dublin	103 (28)	Offaly	4 (1)
Galway	24 (7)	Roscommon	4 (1)
Kerry	13 (4)	Sligo	7 (2)
Kildare	12 (3)	Tipperary	13 (3)
Kilkenny	6 (2)	Waterford	10 (3)
Laois	5 (1)	Westmeath	7 (2)
Leitrim	1 (1)	Wexford	11 (3)
Limerick	16 (4)	Wicklow	11 (3)
Total 363 (100)			

2.18 Mailing procedure

Potential participants were recruited through three mailings of the questionnaire. A single mailing of the questionnaire, an explanatory letter of invitation and a separate postcard to maintain confidentiality and avoid further mailings and a prepaid envelope was posted to each GP (see figure 2.5). The letter of invitation (see appendix H) outlined the aims and objectives of the study and indicated the anonymous and voluntary nature of participation. The proposed strategy for dissemination of findings was also outlined to potential participants.

Figure 2.6: Mailing schedule



2.18.1 Improving questionnaire response rates

Informed by a Cochrane review of strategies (Edwards et al. 2002) to enhance participant response rates to postal and electronic questionnaires, the methodology involved:

1) Shorter questionnaire – the questionnaire was reduced to two and half pages. During the pilot phase respondents completed the questionnaire in less than ten minutes.

2) Follow-up contact – non responders were sent follow up mailings at one month intervals.

3) Personalised mailings – envelopes were addressed and cover letters were signed by both the PhD student and Principal Investigator.

4) Loss of the questionnaire – questionnaires were printed in blue paper, so that it could be easily identified.

5) Assurance of confidentiality – potential participants were advised of the anonymity of their participation in the cover letter, there were no personal identifiers in the questionnaire and reply cards were returned separately.

6) University affiliation – the research team involved collaborators from three of Ireland's six universities (UL, UCD, TCD).

2.19 Data analysis

Returned questionnaires were coded numerically and input to PAS-W21 (formerly SPSS) for analysis. Descriptive data was analysed using frequency tests, cross-tabulations and independent samples t-tests. Categorical variables were analysed using chi-squared tests and a p-value of <0.05 was used to indicate statistical significance. In cases where cells had an expected count of less than five, Fischer's Exact Test was applied. Logistic regression was used to determine the main predictors of screening, referral and brief / psychotherapeutic interventions.

2.20 Ethical considerations

In the enactment of the cross-sectional study the following ethical procedures were considered:

2.20.1 Confidentiality: The data collected consisted of anonymous questionnaires. Participants in the study were not identifiable from the data collected; any potential identifiers were removed. A separate postcard was included to avoid further mailings and to maintain participant confidentiality.

2.20.2 Data protection: No third party (external to UL and the collaborative study team had access to information).

2.20.3 Data storage: All data was stored in a secure office at the host institution, which was only accessed by the Principal Investigator, PhD student and other members of the research team at UL-GEMS. Electronic data was stored on a password protected file and hard copies of the data were kept in a locked filing cabinet at the host institution.

2.20.4 Ethical approval: The study was reviewed and approved by the Research Ethics Committee of the Irish College of General Practitioners (see Appendix I).

Chapter 3 - Qualitative Inquiry

3.1 Description of the study participants

3.1.1 Young people: Twenty young people (11 female and 9 male) participated in semi-structured interviews; an equal number of participants represented both urban centres: Dublin South Inner City (n=10) and Limerick City (n=10). Participants were recruited from primary care (general practice, primary care teams), secondary care (mental health and addiction services) and community agencies. The mean age of the study sample in Dublin was 19 years and in Limerick the mean age was 21 years. One study participant was over the specified age of 16-25 years as outlined in the participant inclusion criteria, however, the participant had been interacting with services from the age of thirteen and this data was considered relevant to youth experiences of mental health / addiction problems and associated services, which was one of the main study objectives. Participants were attending services for a range of mental health and addiction problems including depression, bipolar disorder, anxiety, alcohol addiction, drug use etc.

3.1.2 Health care workers: 37 health care workers were recruited from primary care (general practice, primary care teams, speech & language therapy, clinical psychology, social work and public health nurses), secondary care (mental health and addiction services) and community agencies in Dublin South Inner City (n=18) and Limerick City (n=19). The sample was predominantly female 25 (68%), male 12 (32%) and the majority 18 (49%) had been working in their current post for more than five years. The chosen study sites were in well-known regeneration areas where considerable research had been conducted previously. Therefore, some health care workers were sceptical regarding the use of study findings and the associated benefits for service users in addition to their reluctance to expose young people to further research. However, despite the smaller number of young study participants, it did not impact negatively on data saturation as participants were recruited across a broad range of mental health and addiction services in both Limerick and Dublin. (Tables 3.1 and 3.2 outline population demographics and study settings).

Table 3.1 Demographic information for young participants

		Dublin No. / (%)	**Limerick No. / (%)**
Type of agency from which the young person was recruited	Secondary care – Mental Health Services	3 (15)	4 (20)
	Secondary care – Addiction	3 (15)	2 (10)
	Primary care – GP	1 (5)	1 (5)
	Primary care – PCTs	2 (10)	1 (5)
	Community agencies	1 (5)	2 (10)
Gender	Female	5 (25)	6 (30)
	Male	5 (25)	4 (20)
Age	<18 years	3 (15)	
	18-21 years	10 (50)	
	22-25 years	6 (30)	
	>25 years	1 (5)	
Number of people: • Diagnosed with a mental disorder • Not diagnosed with a mental disorder • With drug addiction problems • With alcohol abuse problems	7 4 6 3		
Reasons for attending services (participants reported one or more reasons)	ADHD, Alcohol addiction, Anger issues, Anxiety, Aspergers, Bipolar disorder, Depression, Drug use, Dyspraxia, Eating disorders, Panic attacks, Post-natal depression, Obsessive compulsive disorder, Social phobias / anxiety, Suicidal ideation / attempts		
Types of substances abused	Alcohol, Benzodiazepines, Cannabis, Cocaine, Ecstasy, Heroin, Poly-drug use.		

Table 3.2 Demographic information for health care workers

Demographic Information	Number of Sample / (%)	
Gender		
• Male	12 (32)	
• Female	25 (68)	
Number of years in current post		
• <1 year	2 (5)	
• 1-5 years	17 (46)	
• >5 years	18 (49)	
Health care sector	**Dublin (n=18)**	**Limerick (n=19)**
• Primary Care (general practice / primary care teams)	6 (16)	7 (19)
• Secondary Care (mental health and addiction services)	7 (19)	5 (13)
• Community Agencies	5 (13)	7 (19)
Professional background		
• Addiction (outreach / counselling)	6 (16)	
• Counselling / psychology	2 (5)	
• Extern / Youth Workers	8 (22)	
• Medical (GPs / Psychiatrists)	9 (24)	
• Nursing	8 (22)	
• Primary care other (e.g., social work, speech & language therapy)	4 (11)	
Total Sample	**37 (100)**	

3.2 Introduction

3.2.1 Inductive and deductive analysis

Five over-arching themes were identified, resulting from both inductive and deductive analysis. The method of analysis incorporated a hybrid approach to coding where initial analysis was both inductive and deductive in nature. Inductive coding involved a data-driven process where early themes and patterns from participant accounts were coded (Boyatzis 1998). The latter stages of analysis involved a deductive approach as some major themes were influenced by some of the key domains included in the study's theoretical frameworks e.g., SDH and the Chronic Care Model. An inductive coding approach was employed to answer the first research question in regards to further

understanding of the experiences of young people with mental health and substance use problems. Inductive codes were included which were strongly linked to the participants' accounts of their experiences (Patton 1990). Deductive codes were linked back to the key domains in the theoretical frameworks for example the SDH model influenced the analysis in terms of the codes relating to the key domains of the model e.g., need identification, treatment engagement, treatment sustainment and community resources. Table 3.3 outlines an example of inductive codes relating to theme 1: *Young people and their experiences of mental health problems* and table 3.4 provides an example of deductive coding for the theme *Intervention*.

Table 3.3 Inductive coding for the theme: *Young people and their experiences of mental health problems*

Subtheme: *Experiencing symptoms*	**Transcript excerpts**
o Sadness	*"I was doing a lot of crying as well, I suppose, like a lot. Looking back on it now I was crying 75% of the time."* (Young Male Participant aged 19 attending General Practice) *"At the time I was…thinking I am never going to be happy...I am always going to feel sad I'm going to be locked up in hospital for the rest of my life."* (Young Female Participant aged 23 attending General Practice)
o Feeling worthless	*"I…needed someone…to tell me 'you are going to be OK, you will get through this'…I didn't believe in myself…I felt…I wasn't worth anything."* (Young Female Participant aged 17 attending CAMHS). *"I didn't think I was worth it really. At the time I was feeling sort of worthless about myself. I had contemplated suicide."* (Young Male Participant aged 19 attending Primary Care Service).
o Social withdrawal	*"I…shut myself away in the room…stay in bed all the time…I wouldn't go places…with friends…I was ignoring everyone."* (Young Female Participant aged 19 attending Mental Health Service) *"I was kind of isolating myself drinking as well that's when I knew it was getting really out of line."* (Young Female Participant aged 23 attending Addiction Service)
o Physical symptoms	*"I had lots of sleep disturbance."* (Young Female Participant aged 17 attending CAMHS) *"I suffered from panic attacks. I felt like I was dying all the time, I thought it was heart disease at one stage."* (Young Female Participant aged 18 attending CAMHS)

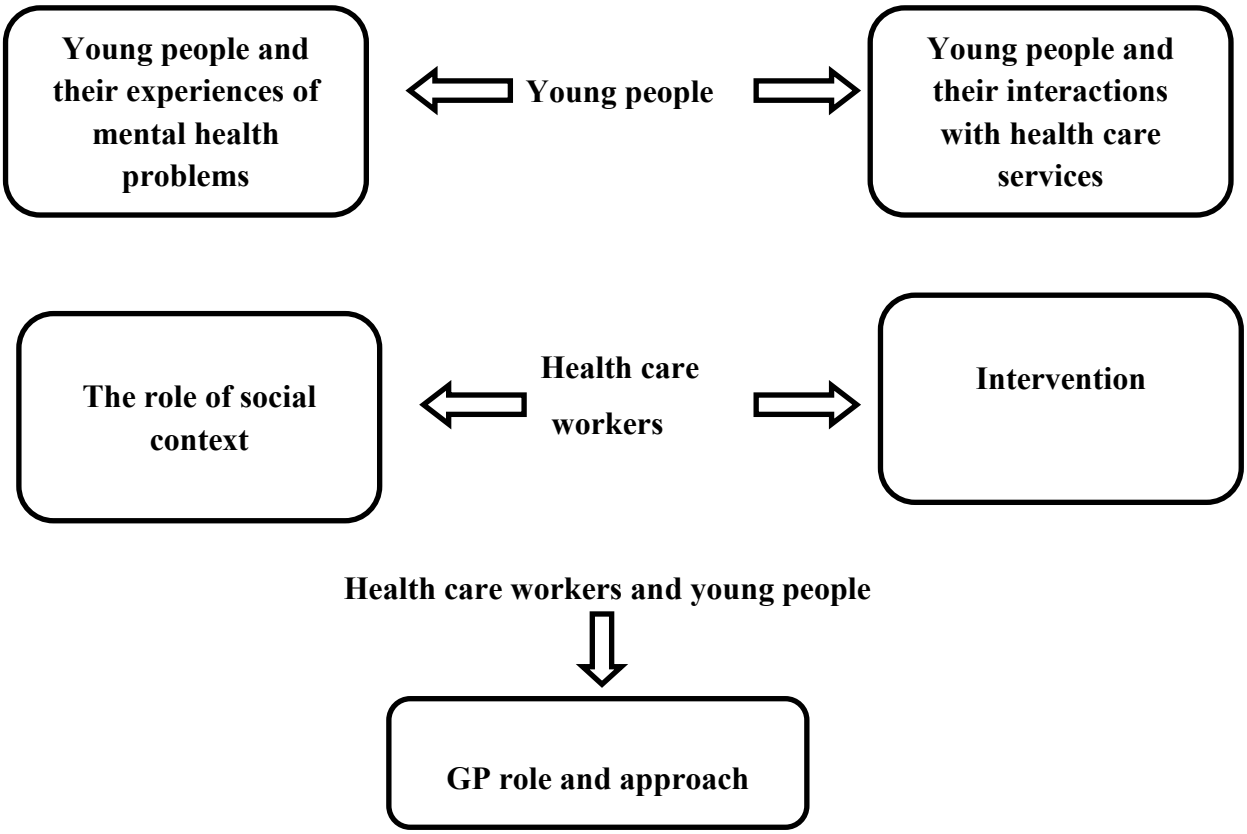
Table 3.4 Deductive coding for the theme *Intervention*

Inductive codes	**Deductive codes -** informed by SDH model, key domains (need identification, treatment engagement, treatment sustainment and community resource engagement).
Identification of mental / substance use problems - barriers ○ Attributing MH issues to puberty or adolescence ○ Consent issues ○ Non-opiate users also need treatment ○ Perception of treatment as a barrier ○ Somebody else's problem ○ Problems that don't require psychiatry, but need intervention ○ Formal treatment	***Need identification – barriers*** ○ Prioritisation of crisis cases ○ Traditional services flawed for under 18s ○ Concerns around formally treating a young person
Identification of mental / substance use problems – enablers ○ Effective use of technology to promote mental health awareness ○ Effective activity based engagement with young people ○ Experienced HCPs ○ Importance of formal assessment tools ○ Importance of outreach work ○ Building relationships, rapport, trust ○ Mental Health and Drug Awareness ○ Screening for MH issues	***Need identification – enablers*** ○ Building relationships ○ Activity based engagement ○ Promoting mental health awareness ○ Formal assessment tools ○ Outreach

3.2.2 Overview of major themes

The first two themes are based on the experiences of the young study participants: *Young people and their experiences of mental health problems* and *Young people and their interactions with health care services*. *The role of social context* and *Intervention* are based on the views of health care workers. The final theme *GP role and approach* includes accounts from both health care workers and young people. *Young people and their experiences of mental health problems* addresses the first key research question which was to further understanding of the meaning and experience of mental health problems for young people. *Young people and their interactions with health care services*, *Intervention* and *GP role and approach* were influenced by the study aims to explore experiences and / or attitudes towards screening and treatment for mental and substance use disorders in addition to the study's theoretical frameworks. *The role of social context* was influenced by Bronfenbrenner's Ecological model (see section 3.8 for more detail on the links between themes and theoretical models). Figure 3.1 outlines the over-arching themes.

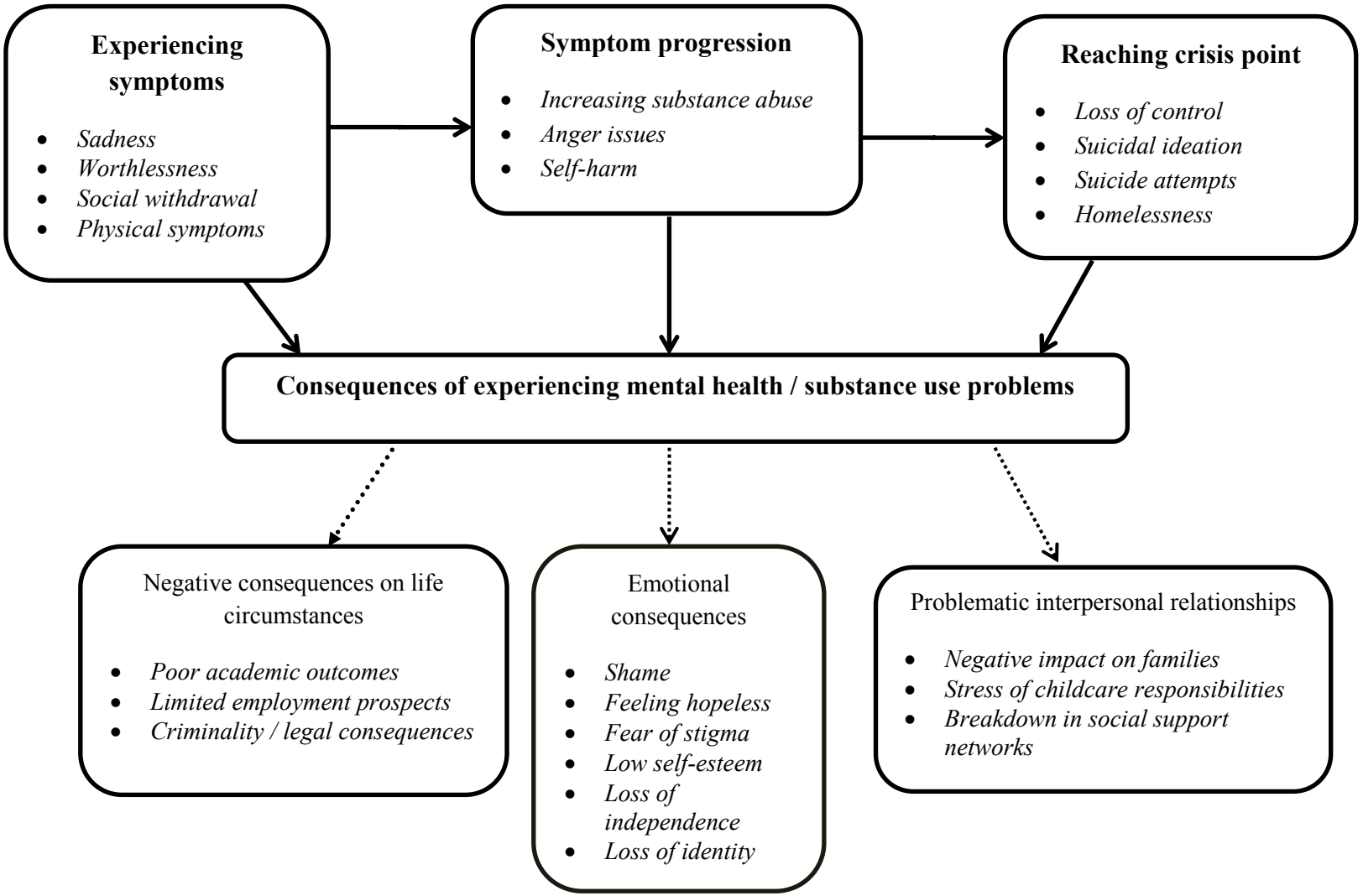
Figure 3.1 Over-arching themes



3.3 Theme 1: Young people and their experiences of mental health problems

Young people experienced many negative physical and emotional symptoms prior to seeking help. This theme also describes the psychosocial consequences of experiencing a mental / substance use problem on the social, emotional, educational and financial aspects of a young person's life (Figure 3.2 outlines main themes and sub-themes for the theme *Young people and their experiences of mental health and substance use problems*).

Figure 3.2 Young people and their experiences of mental health problems



3.3.1 Experiencing symptoms

The young people interviewed were dealing with a range of symptoms. Many had feelings of sadness and worthlessness and social withdrawal was common. Participants felt better when alone, but unable to engage with activities of daily living.

> *"I kind of withdrew from the world and…if I needed stuff from the shop I would get family members to do it."* (Young Male Participant aged 23 attending Mental Health Service)

Participants experienced negative physical and emotional symptoms such as eating disorders, insomnia, reverse sleeping patterns, panic attacks, sexual dysfunction and lethargy as a result of their mental health and substance use problems. Some participants described the negative impact of panic attacks on their daily functioning; disturbing and frightening them on a regular basis.

> *"I think that is one of the worst things that can happen…that you have a panic attack; it is…terrifying. You…feel like you are having a heart attack…people just say it is a 'panic attack' and you will scream and say that it is not a panic attack, that you are actually dying but you are not."* (Young Female Participant aged 17 attending Mental Health Service)

Initial feelings of anxiety or depression were not overwhelming, but participants knew that what they were experiencing was not 'normal'. However, they were unlikely to discuss it with anyone and let these feelings progress to the point where they were debilitating.

3.3.2 Symptom progression

As symptoms worsened, young people developed issues that exacerbated their problems. Many turned to substance use, or were frequently encountering trouble for anger outbursts or behavioural problems.

> *"I…ran to drink straight away…I was so angry all the time and the smallest thing would go wrong and I'd be lashing out…hitting wardrobes and…kicking things."* (Young Female Participant aged 23 attending General Practice).

Those already engaged in substance use were becoming addicted and dependent.

> *"I was getting really in a state. My Mam didn't know I was drinking. I was going down a hole…keeping my lunch money and buying the cheapest drink…"* (Young Male Participant aged 24 attending Community Agency)

Self-harm was used as a coping strategy to manage intense emotional pain. This could be through eating disorders or substance abuse, but also involved 'cutting' with sharp implements and one of the participants described how the physical pain she inflicted on herself facilitated a temporary release for emotional distress.

> *"I used to cut myself and…think…'if I can…feel the pain physically it's going to go away', but it never did. Yet I still didn't learn the lesson and I still cut because for those few seconds it helped."* (Young Female Participant aged 23 attending General Practice)

3.3.3 Reaching crisis point

With relationships breaking down, addiction becoming a time occupying endeavour and their negative thought processes becoming overwhelming, participants experienced loss of control. Many reached a crisis point as their problems escalated and eventually some participants described "hitting rock bottom" which often resulted in suicidal ideation, suicide attempts and homelessness. Almost half had marked suicidal ideation, with four participants having attempted suicide.

> *"I contemplated suicide and the day that I talked to my mother…I was absolutely going to go through with it but I sort of took a step back 'No, this is not worth it.'"* (Young Male Participant aged 19 attending Primary Care)

While some participants experienced continuous symptoms including negative thoughts prior to experiencing suicidal ideation / attempting suicide others described a rapid transition in their thought processes from "feeling relatively OK", having had a good day the day before to a sudden onset of suicidal thoughts. One participant described this transition in her thought process where negative feelings towards one self can become so overwhelming that suicide seems to be the only viable option.

> *"My GP…was like "you have to promise me you are not going to do anything if I let you out of here." I am like "as of now I can promise you…but I can go four minutes down the road and I am feeling shite and I am so close to it."* (Young Female Participant aged 17 attending Mental Health Service).

3.3.4 Consequences of experiencing mental health and substance use problems

Many participants experienced feelings of shame and embarrassment about their mental health and addiction problems and were reluctant to disclose problems to others. Engaging in negative social comparisons between the self and others of a similar age who they perceived to have better social circumstances than themselves resulted in lower levels of self-esteem. Some participants felt removed from their peer group because they believed that they were the only ones experiencing mental health problems and they feared negative attitudes from others or that they would be "labelled as being different."

> *"You feel…trapped…and they just say 'oh, sure... there is something wrong with her' or 'she is odd.'…You don't feel normal then."* (Young Female Participant aged 21 attending Mental Health Service)

Participants reported feeling over protected by parents or primary carers because of their mental health problems; carers worried, particularly where young people had engaged in deliberate self-harm or suicide attempts and as a result some participants felt a loss of independence as their personal space and privacy had been compromised.

> *"They kind of baby you…Mum…wouldn't leave me in the house by myself which is understandable. I was doing the whole self-harm thing and she would take every razor in the house and hide them."* (Young Female Participant aged 18 attending Mental Health Service)

In other cases, participants experienced a loss of identity, as they became consumed in a world of substance use. Participants assumed a new identity (e.g., personality change, drug gangs and new drug related acquaintances) and for those who were trying to escape from that world of substance use they had to remove all of the factors associated with that identity.

> *"I have…cut myself off from the type of friends that I…had…the main trigger of my anxiety and depression was drugs and the people that I was friends with weren't the best of influence on me."* (Young Male Participant aged 23 attending Mental Health Service)

Problematic relationships with family and friends were very often a negative consequence of mental and substance use problems. Some young people pressurised their parents for money to finance their drug habit and others stole money / valuable possessions from their families. Other parent / child relationships became so fragmented because of the on-going problem with substance use that one participant was "kicked out" of home. Participants experienced feelings of guilt when they realised the negative impact their problems had on their families.

> *"I actually feel a lot of guilt towards what I put my family through...I wasn't selfish consciously but subconsciously I was selfish…either way it's selfish…and still to this day I…lash out."* (Young Female Participant aged 23 attending General Practice)

Participants with children struggled with childcare responsibilities. Their problems with substance use meant that they were no longer trusted or considered responsible enough to look after their own children. For some, having limited access to their children exacerbated their mental health problems.

> *"My ex-girlfriend…said the only way I could see the baby was with her Da because at that time I could have a big explosion…I think then I was getting more depressed…because every night I was sleeping beside an empty cot."* (Young Male Participant aged 21 attending General Practice)

Many participants described problematic relationships with friends and peers due to broken support networks. While some felt excluded by friends because of their substance use problems, others realised the only common link they had with friends / "drinking buddies" was alcohol. Other participants recalled the negative consequences that their substance use problems had on how they treated their friends.

> *"That was one of the worst things I did to one of my mates because he needed his medication…and I just took them…and he was one of my best*

friends…I…took them when I didn't have heroin." (Young Male Participant aged 23 attending Addiction Service)

Mental and substance use problems had a negative impact on educational achievement and future career opportunities. One participant described feeling like a burden on teachers because of his mental health difficulties, while others prioritised drug use over employment.

> *"I was a year into my apprenticeship and I started smoking heroin and after that everything just went downhill. Three and a half years through my apprenticeship time I got left go. And then I was smoking and smoking, and smoking."* (Young Male Participant aged 23 attending Addiction Service)

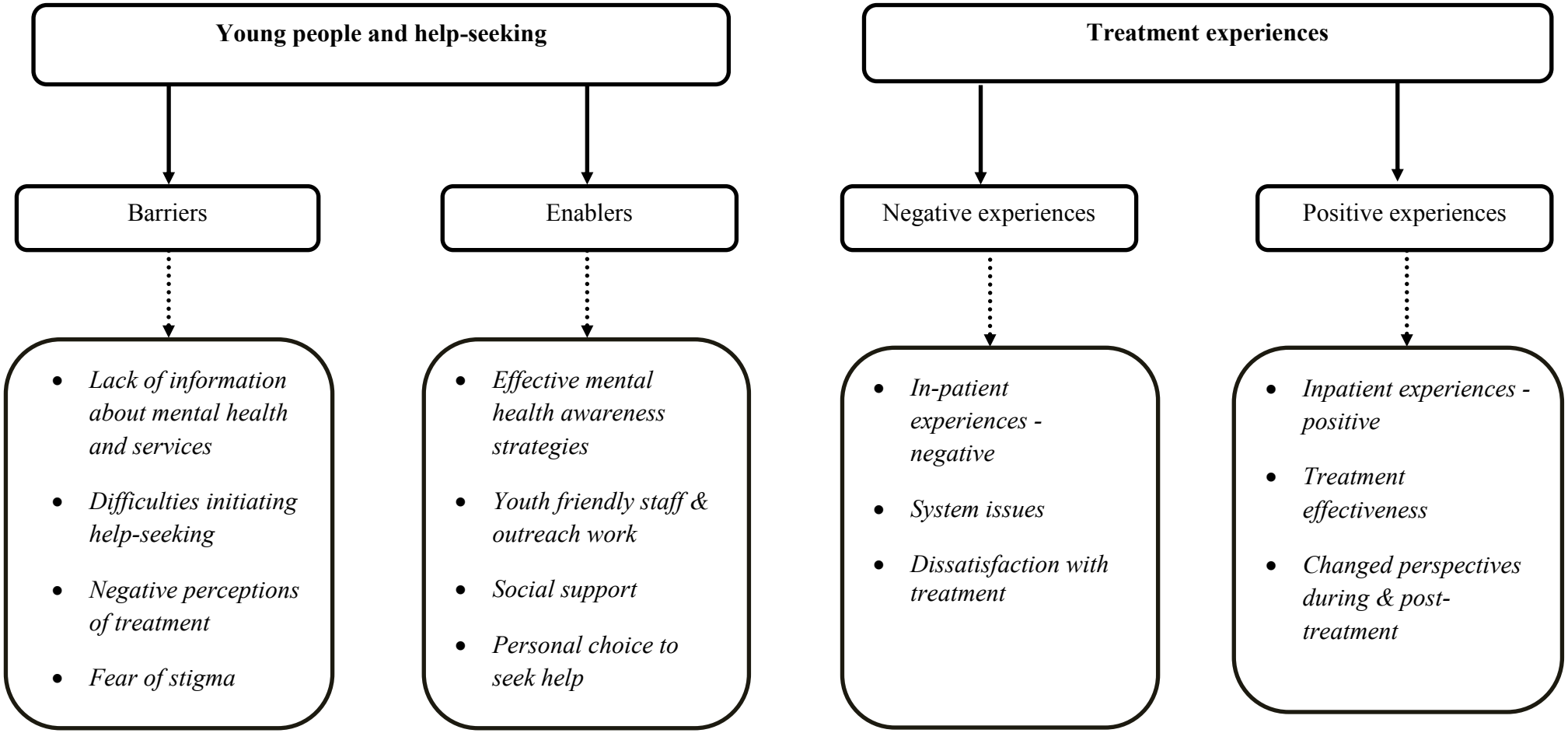
Some experienced adverse legal consequences (e.g., time in prison, court appearances, driving bans etc.) as a result of their substance use. Engaging in criminal behaviour was often a means to finance their drug habit.

> *"When I was 16-17 I got into a lot of trouble…by drinking...and I ended up in court for things I did that I can't even remember…I blacked out from drinking."* (Young Female Participant aged 23 attending Addiction Service)

3.4 Theme 2: Young people and their interactions with health care services

This theme describes the young person's journey from their initial thoughts in regards to interacting with services to their lives post-treatment. Help-seeking behaviour is based on the barriers and enablers associated with the likelihood of young people approaching health care workers to address their difficulties with mental health and substance use problems. Treatment experiences relates to both the negative and positive aspects that young people encountered during their interactions with services. (Figure 3.3 outlines the main themes and sub-themes for *Young people and their interactions with health care services*).

Figure 3.3 Young people and their interactions with health care services.



3.4.1 Help-seeking (barriers)

3.4.1.1 Lack of information about mental health and services

Limited information about mental health and the available services, both in the media and among primary health care workers was an important barrier.

> "*If I had the signposts telling me where to go with clear information like a phone number you ring up. And I have had the case where they don't know what to do – it is supposed to be their job."* (Young Male Participant aged 21 attending General Practice)

Other participants did not become aware of services until they were referred by their GP and some participants felt that services weren't adequately advertised. Awareness of services often emerged as a result of reaching a crisis point and suddenly knowledge of the health care system became a pivotal factor in their lives.

> *"I didn't know anything about this service. I didn't even know there was a hostel…in the town…till I became homeless."* (Young Male Participant aged 23 attending Addiction Service)

Limited mental health literacy also led to a delay in help-seeking, because some participants did not recognise their symptoms as being attributable to a mental health problem. For most participants, mental health awareness programmes in their school curriculum were either non-existent or very limited (e.g., a brief mention in "Social Personal and Health Education" class, watching an occasional DVD on mental health, a talk once a year, or go to the guidance counsellor). Other participants recalled very negative experiences when their schools tried to implement mental health awareness strategies such as seminars on suicide / depression, because of the immature attitudes of their peers towards mental health issues. One participant suggested incorporating mental health programmes at a much earlier stage of the school curriculum.

> *"You need to get a younger generation...from primary school…there…are plenty of smart people out there that can find…ways to incorporate mental health issues, or even just feelings into a book that a little five year old can read…it…needs to start at a young age…so that they grow up and feel it is OK."* (Young Female Participant aged 17 attending Mental Health Service)

Despite many available websites with resources specifically targeting youth mental health and addiction, many participants did not consider the internet to be a useful source of information when seeking help for such issues. A few participants who used the internet to find out more about their symptoms, reported being bombarded with vast amounts of information often indicating worst case scenarios / negative outcomes. Others felt that the internet was of little use to young people who were not computer literate, did not have access to the internet, had substance use problems or individuals who were homeless.

> *"A lot of people aren't computer literate…There is information…but I don't think that reaches the street level addicts…because many addicts don't have access to the internet."* (Young Male Participant aged 27 attending Addiction Service)

3.4.1.2 Difficulties initiating help-seeking

Despite the fact that some young people highlighted the lack of useful information as a key barrier to help-seeking, others emphasised the difficulty that a person might have in knowing how to initially engage with services and expressed the need for health care workers to take the initial steps and approach young people.

> *"There is loads of information, but…people…don't know how to contact these people…the people that do help these people, maybe if they had an idea of the people that they think might need help and they would go to them."* (Young Female Participant aged 19 attending Primary Care)

Communicating their problems proved to be a major barrier to help-seeking for many participants and some expressed a preference for health care workers to initiate the conversation. However, others found it difficult to discuss their problems with unfamiliar health care workers particularly younger participants or those who were experiencing suicidal thoughts. A few participants struggled to make sense of their thoughts thus making it extremely difficult to talk about these feelings to health care workers.

> *"I didn't want to talk to anyone I was by myself all the time…and if people were talking to me I'd give them a one word answer...it was like spaghetti junction inside in my head and I just didn't even know where to start anymore."* (Young Female Participant aged 23 attending General Practice)

Accessing services was a barrier to help-seeking for those who did not live near youth based services that were mainly located in urban centres. Additionally, strict entry criteria to access certain addiction services proved too difficult and often deterred some participants from seeking help. The need for detoxification treatment facilities and a greater understanding about the difficulties encountered by opiate users was highlighted.

> *"Treatment centres...'Give us a clean urine sample and we will take you in.' To a heroin addict that is very hard. You could end up dead trying to do that. I think detox should be done at the treatment centre…first stage…detox, second stage…clean sample after detox, then go in."* (Young Male Participant aged 27 attending Addiction Service)

3.4.1.3 Negative perceptions of treatment

Fear of attending unfamiliar treatment centres and preconceived ideas about what treatment might involve, which were mainly negative (e.g., "lying on a chair" while talking to the psychiatrist, "being institutionalised", "drugged up with medication", "ending up in a straight jacket" etc.), often resulted in the abandonment of help-seeking initiatives.

> *"So he goes out the door and all we could hear was "I am going to bring her down to* [psychiatric unit]*" and I was like "oh shit"...my aunt always told me... that if you ever go in there you will never come out again."* (Young Female Participant aged 17 attending Mental Health Service)

Some participants wanted a quick fix to their problems in the form of a tablet and were reluctant to engage in any form of psychotherapeutic treatment. Help-seeking for them did not extend beyond attending their GP for tablets / or the addiction clinic for methadone. For others, "being put on medication" was perceived as the only form of available treatment and as a result they felt that it would be a waste of time seeking help.

> *"You can tell them how you feel but all they can do is fix it with medication they can't talk to you for an hour…every week because it's a clinic they can't give you any more time....They can just give you more medication…just upping it because you're feeling a lot worse this week."*(Young Female Participant aged 23 attending General Practice)

Many were reluctant to seek help from authority figures because they feared they might relay personal information to their parents and thus some lied to health care workers about the extent of their substance abuse.

> *"If I was depressed or anxious…and they'd ask me… 'How much do you drink?'…I'd always say less than I did…because I was…16…and felt…they'd tell my parents that I was taking drugs…drinking more."* (Young Female Participant aged 23 attending Addiction Service)

3.4.1.4 Fear of stigma

Some participants perceived asking for help as a sign of weakness and therefore didn't want peers to know they were experiencing problems, fearing judgement or stigmatisation from others. One participant was reluctant to seek help because he feared bringing shame on his family.

> *"I didn't want the onus to be on me that I had mental issues, particularly when there was no history of mental illness in my family."* (Young Male Participant aged 23 attending Mental Health Service)

Some participants feared being stigmatised by friends and peers, however, others felt that they would experience more stigma from people in more senior age categories (e.g., grandparents, neighbours) who might still have outdated attitudes towards mental illness.

> *"My grandparents, I wouldn't dare tell them…they have these…notions…that I was very smart…outgoing…If I…told them I'm depressed and I hate my life…they are very old school…depression…a counsellor…it's witchcraft for all intents and purposes."* (Young Male Participant aged 19 attending Primary Care)

There was also a perceived stigma associated with being seen walking into certain treatment centres.

> *"Everyone is like 'Ah, you go to* [service for youth mental health / addiction problems]*' and 'Ah, you have been in a mental home'…other people look at you like you are…a freak because you are the outsider."* (Young Male Participant aged 18 attending Addiction Service)

3.4.2 Help-seeking (enablers)

3.4.2.1 Effective mental health awareness strategies

Some participants felt that more knowledge and awareness of mental health problems among the general population such as effective mental health and substance use awareness programmes in schools, advertising for mental health services would promote help-seeking. While young participants acknowledged existing mental health related media campaigns, their efficacy and age appropriateness was considered to be ineffective.

> *"Aware…do campaigns…I'm aware that depression exists but that doesn't really make…a difference…they are…helpful but…could be better…I hated being treated as a child when it came to depression so make people feel more…that this isn't just an adult problem… but in such a way that it doesn't make you vulnerable…because the worst thing about depression is the vulnerability."* (Young Male Participant aged 19 attending Primary Care)

One participant suggested that those who do attend mental health services should be less "secretive about it", therefore normalising the use of such services for other young people.

> *"If people that went to them* [mental health services] *didn't hide it as much...Everyone knows that I come here now. All my friends know…if they had the same problem they would be like – 'oh well, ___ goes to it, why shouldn't I.'"* (Young Female Participant aged 18 attending Mental Health Service)

3.4.2.2 Youth friendly staff and outreach work

Youth friendly staff that adopt a "less formal" approach and who were "easy to talk to" were key enablers to help-seeking. For some, the importance of being able to choose what personal information they divulged to health care workers, "being listened to" and not being under pressure to have everything said within a certain time limit was also important during their initial interaction with services. Programmes that offer services in a relaxed friendly environment were more successful in facilitating help-seeking, particularly among young male participants who often struggled to disclose their emotional problems to unfamiliar health care workers in more formal settings.

> *"The main difference…is down in the café…you are chatting away to the volunteers…they…get to know you…but the* [other service]*, they…have set times and you go down…and you do what you have to do...Whereas at the Cafe, you can…relax and be yourself."* (Young Male Participant aged 18 attending Community Agency)

Young people advocated the importance of outreach work in enabling help-seeking and initial interaction with services. Not knowing how to "open up" about their problems was often a key barrier to help-seeking for young people. Participants felt that having youth advocates to facilitate their initial visit to services would help to ease feelings of anxiety.

> *"They asked us if we wanted to take part and be in these groups. They came out and spoke to you. We weren't doing anything so they just came out and had a talk with you."* (Young Male Participant aged 21 attending Community Agency)

3.4.2.3 Social support networks

Many young people, in addition to their own gradual self-awareness in regards to seeking help, decided to engage with health services when encouraged to do so by concerned family members and friends. Family members, particularly mothers, often played a key role in making contact with services, organising appointments and motivating the young person to attend. Participants found it useful to have strong support during earlier visits with health care workers, especially young male participants who struggled to explain their feelings and symptoms.

> *"She* [participant's mother] *came with me and I was over the age of eighteen…She brought me down to him* [the doctor] *and she helped me explain."* (Young Male Participant aged 21 attending General Practice)

The influence of positive friendships was also a factor that enabled people to engage in help-seeking and for some participants, the dread of losing important relationships encouraged them to seek help. Others confided in friends and engaged in problem sharing, particularly if they were unable to access services. Learning to talk openly about their feelings with other people (e.g., family, friends and health care workers) helped some to address their problems.

> *"It is…very powerful…to…talk…to…someone who is willing to…listen to you."* (Young Male Participant aged 23 attending Mental Health Services)

3.4.2.4 Personal choice to seek help

While concerned family members enabled help-seeking for some, other participants found they were more proactive when they chose to seek help on their own initiative. Being "ready to seek help" accompanied by more timely interventions and not feeling pressurised into engaging with services by family members / health care workers resulted in young people being more open to the services that were available to them.

> *"I was in with my GP...and he gave me this number before…when I was around 17/18 I was drinking heavily...but...I wasn't doing it for me…then…it was kind of just my parents and…keeping them happy…eventually…I knew I had to do it for myself."* (Young Female Participant aged 23 attending Community Agency)

Even when opportunities were available to discuss their problems, some participants described their reluctance to engage, because they did not feel ready to seek help.

> *"I had plenty of opportunities to talk to anyone about it…I wasn't ready to come off drugs…but when I was 15 I was ready…that's when I told them…you can't really force it on anyone to say that they have an addiction…You are just going to push people away."* (Young Male Participant aged 20 attending Addiction Service)

3.4.3 Treatment experiences (negative)

3.4.3.1 Inpatient care – negative experiences

The lack of activities, resources and access to health care workers often resulted in negative experiences (e.g., "boredom" "feeling institutionalised" and "loss of independence") for young people during inpatient care. For some, the physical layout of staff quarters within the hospital environment posed a barrier / divide in terms of communicating any concerns they might have been experiencing with health care workers. Others described feeling like "a prisoner" as their personal belongings were taken from them upon admission to hospital.

> *"My bag was brought in and they checked everything and…took anything with string in it…They took my deodorant off me because it was a glass bottle and they were afraid that I was going to break it or something."* (Young Female Participant aged 17 attending Mental Health Service)

Lack of age appropriate services and privacy also contributed to negative experiences of inpatient care. Some participants recalled the negative repercussions that lack of privacy had when family members came to visit and they were confined to large communal areas with other patients because the patients' bedrooms were locked during the day.

> *"My family coming into see me…the services weren't really there…they were just kind of thrown into a large sitting room with…a mixture of...serious mental patients…Alzheimer's patients…with all these patients constantly coming over interrupting."* (Young Female Participant aged 23 attending General Practice)

3.4.3.2 System issues

Due to limited resources and funding, participants expressed negative experiences with treatment (e.g., limited staff, restricted time with health care workers during consultations and treatment delays).

> *"Because there are so many people down there waiting to go into the doctors, it's just…a quick chat and that's it, it's kind of like you are being pushed out, that's the way I felt…I didn't get to talk…about issues that I wanted to talk about because I didn't get the time…only a few minutes."* (Young Female Participant aged 18 attending General Practice)

Participants reported being dissatisfied with lack of information on treatment options, receiving higher doses of medication when their treatment was not working, not being listened to and not having the level of input in their care plan that they would prefer.

> *"I…got…Risperidal…it started off being once a day…the nurse came in with it the second time that night…I said 'I am only supposed to get it once a day',…she said…it was down on my thing for twice a day…*[the psychotherapist] *comes in the next day and tells me…they have increased my dose…I had no clue about it."* (Young Female Participant aged 17 attending Mental Health Service)

Some participants with milder symptoms felt that their needs were not prioritised and because they were not experiencing more serious symptoms, health care workers put them "on the back burner."

> *"It is harder if you don't have a serious mental illness, because once they were confident that I wasn't going to commit suicide they were…like 'ok, she…is grand'…which is a bit annoying because I deserve as good treatment as*

someone who has schizophrenia." (Young Female Participant aged 17 attending Mental Health Service)

For other participants, moving to adult services resulted in increased anxiety as they were reluctant to lose positive relationships that they had developed with health care workers in the child and adolescent services. Some advocated the need for strategies to ease the transition between services for young people. Particularly for young people who experience diagnoses normally associated with younger people, the anticipation of how their needs will be addressed in adult services caused anxiety for some.

> *"I wouldn't know…what they* [adult mental health services]*…have in place for ADHD in older people because I haven't heard very much about it compared to child and adolescence so…I'd be a bit wary."* (Young Male Participant aged 18 attending Mental Health Service)

3.4.3.3 Dissatisfaction with treatment

Some participants were disappointed having not received a diagnosis or in some cases not receiving the diagnosis they expected. Other participants felt that the diagnosis they received was inaccurate and did not explain the symptoms that they were experiencing. While other participants struggled to accept their diagnosis because they perceived it as a "label" that made them feel different to everyone else.

> *"I was…being treated for depression for a long time and I wasn't…coming out of it...So, they finally diagnosed me with bi-polar. But I really did not accept that I had bi-polar…when I was diagnosed with it I didn't believe it…I didn't want to believe it."* (Young Female Participant aged 22 attending Mental Health Service)

During counselling sessions, participants described feeling "fantastic" and experiencing a sense of "release" where a safe and secure forum was provided for them to discuss their thoughts. However, after the counselling session participants described being "back to normal" feeling "horrible again" and "hitting rock bottom" outside the safety and security of the therapeutic environment.

> *"Sometimes…when I get home from…the counsellor…I am not in the humour for stuff. Sometimes I am just angry and…down."* (Young Female Participant aged 21 attending General Practice)

For some, "being on medication" had extremely negative consequences, including suicidal ideation, increased symptoms of depression and missing school due to adverse side effects.

> "*I started taking Prozac and that made me suicidal…it was awful. It wasn't that this wasn't working. It was the tablets that just made me really, really bad."* (Young Female Participant aged 18 attending Mental Health Service)

Young people described difficult relationships with health care workers because of communication problems and perceived judgement from health care workers because of their substance abuse. Others felt that health care workers were trying to coerce them into treatment by suggesting electro convulsive therapy (ECT) as a last resort, highlighting the negative social circumstances that would result from abusing substances or expecting what some participants perceived to be unrealistic treatment goals. Some participants felt that they were not being "listened to" when they expressed dissatisfaction with treatment.

> *"I said to him nicely…'the method that we are doing is not working. It is getting worse', he closed his folder and pushed it aside and just that action alone was enough for me to get up and walk out."* (Young Male Participant aged 21 attending General Practice)

Other factors that resulted in problematic relationships between health care workers and young people were due to gender and cultural differences (e.g., language barriers where health care workers who did not speak English as a first language might struggle to relate to young people). One participant found it difficult to relate to a male counsellor because she had experienced sexual abuse.

> *"If you have a counsellor that you can't communicate with…I was abused and it was easier to talk to a woman about it."* (Young Female Participant aged 19 attending Primary Care)

3.4.4 Treatment experiences (positive)

3.4.4.1 Inpatient care – positive experiences

Time spent as an inpatient was a positive experience for some young people, as engaging in therapeutic programmes (e.g., art therapy, group therapy, CBT) enabled participants to cope with their problems. Other participants recalled the benefits of having supportive patient relationships during their time in the treatment facility, where being understood by others with similar problems helped them during treatment.

> *"I have friends that I have met in here that are clean the same length of time as me and we go out and everything."* (Young Female Participant aged 20 attending Addiction Service)

Other participants found that their inpatient experiences provided them with the opportunity to escape from daily life stresses giving them a much needed "mental rest" while they dealt with their problems.

> *"The hospital was great. It was…like a break from the world. But when I got out…I missed it...I kept thinking…about the people that were in there."* (Young Male Participant aged 21 attending General Practice)

Group based programmes made it easier for some participants to engage in treatment as they were less intimidating than a one-to-one session with a health care worker. Building social networks also facilitated a sense of belonging for participants who might previously have felt excluded from their peer group. Group activities also facilitated a greater understanding between genders, for some participants, who might have previously felt awkward in the company of the opposite sex prior to engaging in such activities during treatment.

> *"I was…the only male…and it got me to bond with young girls, especially at the age…I was. It got me into the whole thing of being able to understand where the girls were coming from and having good craic with…young ones."* (Young Male Participant aged 24 attending Community Agency)

3.4.4.2 Treatment effectiveness

Being provided with choices during treatment was very important for most participants. Such choices included: choosing an appropriate counsellor, the option to attend treatment without any external pressure from parents / health care workers, choosing the type of treatment they received and the group activities they wanted to participate in.

> *"I was asked did I want a girl or a boy counsellor and if I don't want to come, I don't have to…so it is my own choice to come really."* (Young Female Participant aged 18 attending Addiction Service)

Building good relationships with health care workers contributed towards positive treatment experiences. Feeling "reassured" and "comfortable" during their consultation facilitated positive relationships. Some participants described the importance of health care workers adopting a less formal approach where consultations resemble a "chat" rather than a more official structured appointment.

> *"She was just a really nice person and if I said that I don't want to talk about anything anymore, she wouldn't press it."* (Young Female Participant aged 18 attending Addiction Service)

Young people also highlighted the importance of continued access to treatment where they could engage with services in a casual manner.

> *"Since I came here on the Methadone programme, everyone has been nice, up front, honest, helpful...I can come in here any day of the week and sit down and have a chat with anyone."* (Young Male Participant aged 27 attending Addiction Service)

One-to-one counselling and group therapy provided opportunities for self-evaluation and to address underlying personal issues that went beyond their problems with substance use. Other participants found that psychotherapy with experienced health care workers enabled them to build on their self-esteem and make proactive decisions about managing problems with substance use to avoid a relapse. For others, the array of therapeutic options delivered at a pace that was appropriate for the young person combined with confidence building techniques helped them to overcome problems with anxiety and social phobia. Participants also found it effective to be able to discuss their

personal issues with a health care worker who was not a permanent fixture in their daily lives. However, when discussing what worked in terms of treatment the majority felt that medication combined with therapy was the most effective approach.

> *"I don't think you can have one without the other. If you are as bad as I was, I couldn't have just talked to* [the counsellor] *or…just taken the tablets. I…needed both."* (Young Female Participant aged 18 attending Mental Health Service)

Participants also described the positive impact that their treatment programmes had in terms of adopting and learning life skills, positive coping strategies, enhancing maturity levels, personal development, confidence building strategies, learning to abide by rules and having duties and responsibilities in community based programmes.

> *"I found it helpful because we were working from books and she was doing confidence building which was really good."* (Young Female Participant aged 17 attending Mental Health Services)

Attending services that were activity based resulted in positive experiences for participants who were previously bored and "hanging out on the streets." Some had opportunities to engage with treatment centres on an on-going basis, which provided them with opportunities to deal with negative thoughts in a proactive way through activities where youth workers were onsite to address any underlying issues.

> *"We do a lot down at the Cafe... if you are upset…you would go in for a chat…do something to take your mind off it."* (Young Male Participant aged 18 attending Community Agency)

3.4.4.3 Changed perspectives during and after treatment

During recovery, some participants recalled going through a phase of self-evaluation and when they compared themselves to others whose psychosocial circumstances they believed to be worse than their own, they felt better about their own life situations. Upon reflection, participants recalled the positive impact engaging with health care workers and the recommended treatment had on their lives.

> *"I didn't want to seek help…but I am glad I did…my life would be a lot different right now if I didn't. For me…the worst experience of my life was going into* [the psychiatric unit] *but the best was going in as well because it completely changed my attitude towards it whereas up until then I didn't want to be there I was taking these tablets to make my family happy."* (Young Female Participant aged 23 attending General Practice)

Some participants decided to work in community based services themselves after recovery (both in a voluntary and employee capacity) as a way of contributing to services that helped them through their own problems. For other participants with young children resuming family responsibilities was their primary focus after treatment. Some engaged in activities (e.g., learning new hobbies, learning to drive, attending social events, completing / gaining educational qualifications) that they would not have had the confidence to undertake prior to receiving treatment.

> *"I honestly feel I can do anything I put my mind to now…going to a concert that is…the ultimate test of how I have learnt to manage my anxiety. Because, obviously, being in a room with 20,000 people is really, really hard for me."* (Young Male Participant aged 23 attending Mental Health Service)

Some described how their perspectives on mental illness had changed after spending time in treatment facilities with other patients with mental health problems. The need for more awareness around mental health was highlighted by many participants to avoid the stigma and the negative attitudes towards people with mental health problems, attitudes that some young people themselves shared prior to commencing treatment.

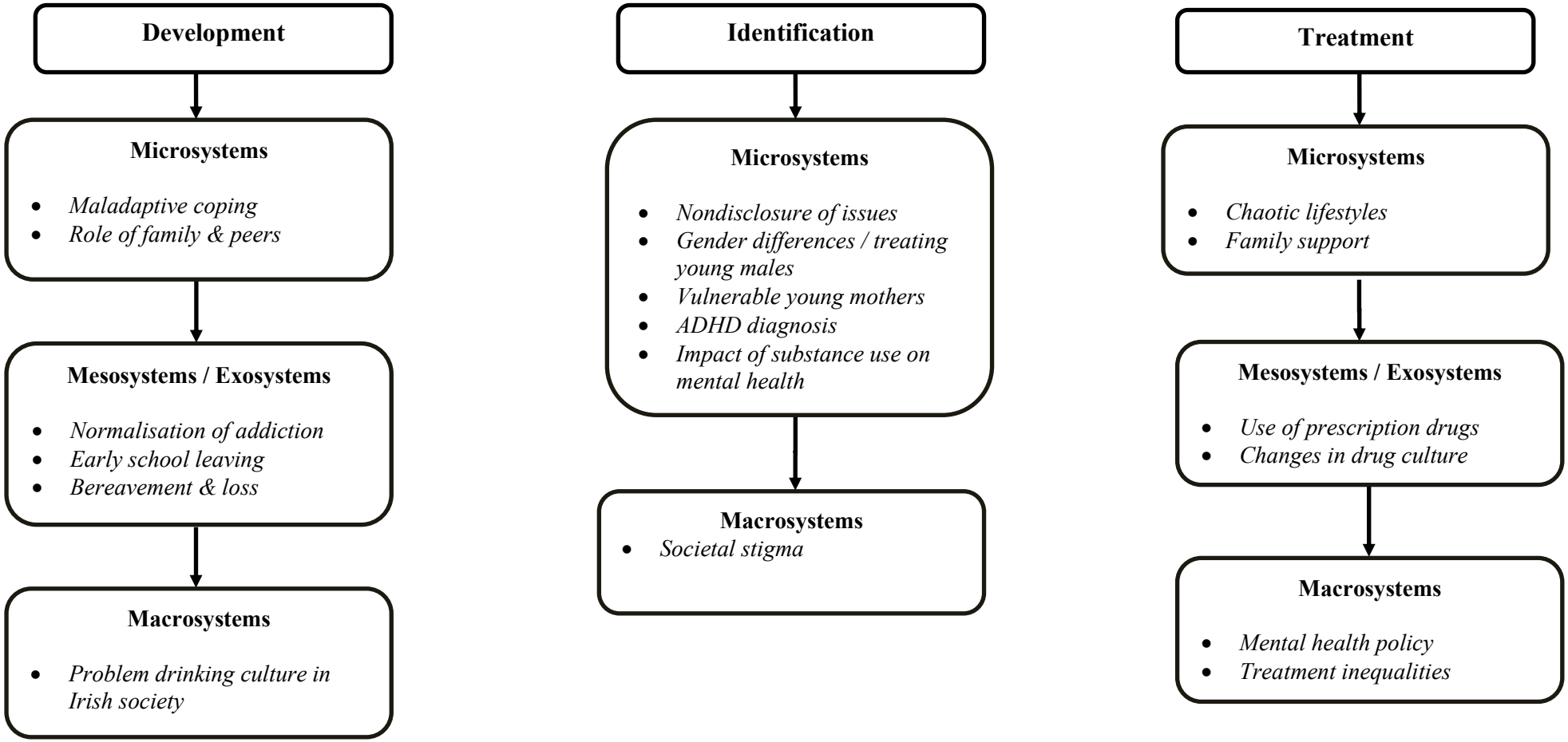
> *"I used to think…I wasn't normal…but then when I went into* [the psychiatric unit]*…there are so many people out there that are the same as me and we are not weird we are just sick not…nutcases…just sad and that was when I first…understood what was wrong with me."* (Young Female Participant aged 23 attending General Practice)

3.5 Theme 3: The role of context

Social context in socio-economically disadvantaged urban areas influenced the development, identification and treatment of youth mental and substance use disorders. The researchers recognised within the data that individuals are influenced not only by

family and peer groups, but by the local context in which they live and by society. (Figure 3.4 outlines the main themes and sub-themes for *The role of context*).

Figure 3.4 The role of context in the development, identification and treatment of mental and substance use disorders.



3.5.1 Context and the development of mental / substance use disorders

The main contextual factors associated with the development of mental and substance use disorders among young people ranged from individual characteristics within the microsystem (maladaptive coping strategies); local area context within the meso-exo-systems (e.g., the negative relationship between criminal violence and drug culture on a young person's microsystem / local community) and the attitudes towards mental health problems in Irish society within the macrosystem.

3.5.1.1 Microsystems (The individual and family / peer relationships)

Maladaptive coping: According to health care workers, young people often developed maladaptive coping skills (e.g., physical violence, substance use etc.) in an environment where there might not be appropriate role-modelling for adaptive coping skills. Suicide and suicidal ideation were common problems, in areas where there is "a general expectation" that an individual's quality of life will not be very good due to socio-economic disadvantage.

> *"There are two young people in the last six weeks that have committed suicide that my young people would know."* (Youth Worker)

Role of family and peers: Health care workers noted that the people who should be playing a key role in the young person's recovery, are very often at the core of the problem: negative maladaptive family patterns may recur and peer behaviours can expedite an individual to develop problems, most often addictive behaviour.

> *"You are looking at kids who have grown up in incredibly disintegrated families…we would have parents…or even grandparents who are heroin addicts."* (GP)

3.5.1.2 Mesosystems and Exosystems (Local area context)

Normalisation of addiction: The high incidence of substance use and mental health issues has resulted in a normalisation of severe addiction. Health care workers reported that some parents were now very tolerant in regards to cannabis use.

> *"The argument that the parent has is that he is only using marijuana now. They think that is nothing at all."* (Child Psychiatrist)

Early school leaving: Many health care workers found that a lack of incentive within their local environment to stay in school seemed to exacerbate psychosocial problems in young people. Some health care workers identified parental barriers as key contributing factors to early school leaving, particularly where both parents and children had literacy issues.

> *"Those children will arrive at twenty years of age with no skills, many…would be semi-literate, almost all would be out of school very young and then they are like twenty three year old thirteen year olds."* (Outreach Worker)

Bereavement and loss: Health care workers could identify many cases where young people must cope with loss for health reasons, suicide, or family members being in prison. Some health care workers felt that witnessing a considerable amount of loss at a young age tends to result in "disassociation and avoidant behaviour patterns" as a mechanism of maladaptive coping for young people.

> *"All the girls have the same issue. They are all self-harming…fifty per cent of the girls we work with…have a dead parent. Seventy per cent of the girls…have a parent in jail."* (Youth Worker)

3.5.1.3 Macrosystems (Wider society)

Problem drinking as part of Irish culture: Alcohol as a socially accepted maladaptive coping strategy was highlighted as a cultural concern. Some health care workers found that young people could only express emotional distress while intoxicated. Many health care workers also experienced difficulties trying to determine the key contributing factor to a young person's problem when mental health problems were linked to excessive alcohol consumption. With alcohol use so ingrained in the culture of the nation, it becomes difficult for health care workers to persuade young people and parents alike they are using alcohol in harmful ways.

> *"If you say to the parents - do you know what the recommended amount that you drink is? They look at you like you are a bit weird and go – 'are you sure?'"* (Child Psychiatrist)

3.5.2 Context and the identification of mental and substance use disorders

Identification of mental and substance use disorders proved difficult for health care workers due to problems within the individual's microsystem including: non-disclosure of issues and conflicting views on the diagnosis of Attention Deficit / Hyperactivity Disorder (ADHD). Societal stigma within the macrosystem towards mental health problems often deterred young people from engaging with services.

3.5.2.1 Microsystems (The individual and family / peer relationships)

Young people and non-disclosure of issues: Some participants identified the lack of communication between health care workers and young people as a major barrier to identification of mental health problems. Participants identified several factors as possible reasons for communication issues (e.g., concealing substance use, fear of other violent family members, choosing to talk to peers instead of parents / health care workers, lack of maturity, low self-esteem, avoidant coping, feeling uncomfortable disclosing problems in the presence of parents).

> *"I have had so many times where they just won't talk to me at all. That guy that I was saying was in the clinic… He came into me and he literally wouldn't open his mouth."* (GP)

Gender differences and treating young males: Young men not disclosing issues was common, with some health care workers describing consultations that consisted of "a series of monosyllabic answers." Other factors contributing to reluctance to discuss personal problems were the culturally accepted idea that "men don't talk, men don't cry" and "gang mentality." It was also clear that expressing negative emotions is perceived differently for young men and young women.

> *"Boys…when they are emotionally upset, present as angry…people don't…think of somewhere like here. They just think he is a teenager and he is angry as opposed to maybe he is depressed. A lot…would refer here if there is a girl presenting with behavioural problems because they feel it is gender inappropriate."* (Child Psychiatrist)

Vulnerable young mothers: Young mothers were identified as a particularly vulnerable group. There were worries that many would develop post-natal depression because participants felt that young mothers very often receive little support from the children's fathers. In contrast to young males, social supports, encouragement and positive affirmation are common for young mothers.

> *"We need something accessible like the Well Woman Centres* [a national chain of health services for women]*...In big regions like a city you need a clinic for young men…that get STDs…they can go in to this place incognito?... But they could go somewhere like that for psychiatry as well and say 'I am not in the best of form.'"* (Psychiatric Nurse)

Diagnosing young people with Attention Deficit Hyperactivity Disorder (ADHD): There were a number of instances where drug addiction and criminality were linked to a diagnosis of ADHD. However, some health care workers suggested that the diagnosis can lead to better acceptance of a young person's behaviour, as it reframes them within the context of the disorder, rather than being attributed to behavioural problems alone. Conversely, one health care worker believed that the number of young people receiving ADHD diagnoses and taking prescribed medication was unnecessary, instead highlighting the need for lifestyle changes.

> *"With a lot of young people, they have been given ADHD tablets since they were one* [year old]. *When really…their nutrition is crap and they are not engaged in anything."* (Youth Worker)

Impact of substance use on mental health: Many health care workers considered substance use to have devastating effects on the young person's mental health, academic ability and social development. Health care workers felt that engaging in treatment might not be an option for some because of drug related paranoia and trust issues.

> *"There are lots of self-help groups but...drugs can really affect them and make them feel paranoid."* (Counsellor)

3.5.2.2 Macrosystems (Wider society)

Societal Stigma: Respondents identified societal stigma within Irish culture as a barrier to young people seeking help for their problems. Furthermore, clinicians felt some young people, even when help had been sought, were reluctant to engage with services due to the stigma attached to mental health issues and attending certain treatment centres.

> *"I have had personal experience of someone not coming to an appointment…she met a friend of hers and they walked past the clinic…because she couldn't say to her friend, I'm going into that* [clinic] *and I'm talking to the psychiatrist."* (Adult Psychiatrist)

3.5.3 Context and treatment of mental / substance use problems

Health care workers often experienced difficulties treating young people because of their chaotic lifestyles. Factors within the local area context (e.g., changes in drug culture and drug related violence) posed further difficulties in terms of providing appropriate treatment. Treatment barriers within the macrosystem included restrictions resulting from mental health policy and segregation between health care services.

3.5.3.1 Microsystems (The individual and family / peer relationships)

Chaotic lifestyles: According to many health care workers, factors associated with chaotic lifestyles included: families, peers, the local environment and the larger societal context of being young in Ireland. Thus it is not uncommon for young people to miss appointments or struggle to continue with treatment. Youth workers (in the absence of parents who may also have their own mental health / addiction issues) often have to provide a link between the young person and the health care workers to ensure treatment engagement.

> *"The mental health and substance abuse issues tend to be more predominant in areas where socio-economic factors are big and that also affects their ability to get to the clinic."* (Clinical Psychologist)

Family support: Most health care workers reported that young people were more likely to progress in treatment if their parents were willing to proactively engage with health care workers, (e.g., participation in family conferences, attending appointments with the young person, encouraging treatment engagement etc.). However, health care workers also emphasised the danger of caregiver burden on family members when trying to support the young person.

> *"All you can do is try and encourage people but not let them consume your life…what we would experience here with the family support programme that the addict becomes the other person's life."* (Addiction Counsellor)

Use of prescription drugs: Health care workers expressed concerns about the common use of prescription drugs (especially antidepressants, sedatives / hypnotics) among young people and their parents in socio-economically disadvantaged communities. According to some health care workers, prescription drug use was often viewed as an "acceptable way to treat" emotional problems. Furthermore, health care workers indicated their worry about prescribing any medication for mental health issues due to the potential for addiction or reselling.

> *"I never gave him any meds, much to his disappointment, but the difficulty is that…a lot of them go out there and sell it. It has a street value."* (Adult Psychiatrist)

3.5.3.2 Mesosystems / Exosystems (Local area context)

Changes in drug culture: The introduction of a wider and cheaper range of psychoactive drugs and 'head shops' meant health care workers were faced with more difficulties in their efforts to treat young people with substance use problems. Changes in drug culture also resulted in increased violence and gang affiliation where "power, abuse and intimidation" leave families living their lives in fear. Health care workers struggled to

help young people with treatment strategies that are often lost when the young person returns to their destructive neighbourhoods.

> *"People can come…and put in a hell of a good effort…but if they're going back to an environment where it's just full of chaos, drug dealing…anti-social behaviour, it's...very difficult."* (Addiction Counsellor)

3.5.3.3 Macrosystems (Wider society)

Health policy and its implementation: Mental health policy in Ireland (especially 'A Vision for Change' and the 'Mental Health Act' 2001) was not viewed favorably by health care workers, especially in respect of its failure to deliver appropriate services to young people, particularly 16 and 17 year olds. The Mental Health Act also poses difficulties in terms of parental consent being necessary for treatment.

> *"A lot of adolescents…are trying to meet the developmental tasks of adolescence. And part of that is being…more responsible, more adult and we are…taking that away from them."* (Child Psychiatrist)

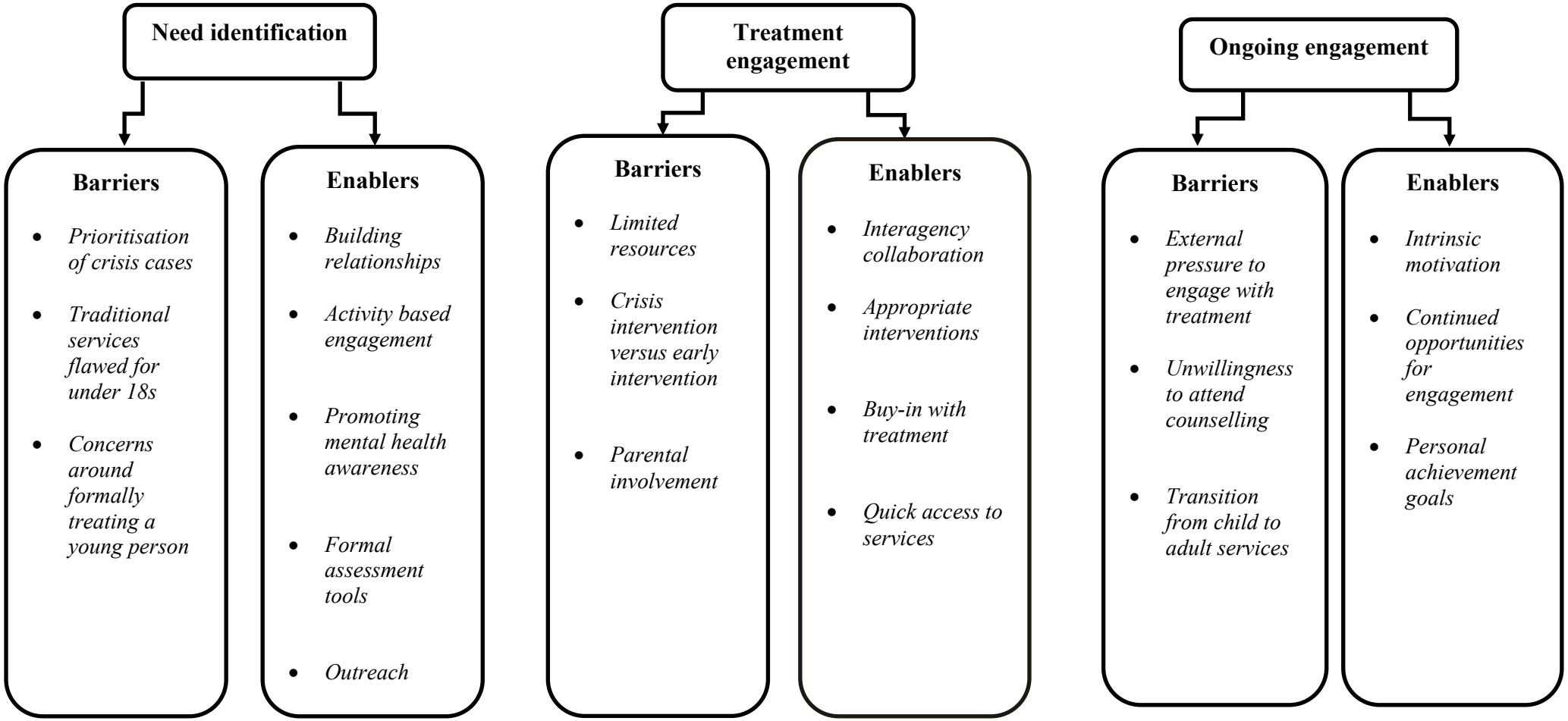
Treatment inequalities because of socio-economic circumstances: If people from socioeconomically disadvantaged areas do seek treatment, they may have difficulty in getting the best care due to financial barriers.

> *"It goes back to…economic apartheid…if they have health insurance and are wealthy they can get themselves off to a nice expensive clinic. If they have none of those…you are dealing with very limited services."* (GP)

3.6 Theme 4: Intervention for mental and substance use disorders

The *Intervention* theme comprised three themes: (i) *Need identification*, (ii) *Treatment engagement* and (iii) *On-going engagement* in regards to addressing youth mental and substance use disorders (see figure 3.5).

Figure 3.5: Intervention



3.6.1 Need identification – (barriers)

3.6.1.1 'Prioritisation of crisis cases'

Health care workers described feeling "overwhelmed" and "stretched" when discussing the provision of screening services for young people. The most commonly reported barriers to identifying youth mental and substance use disorders related to care of acutely unwell young people having to take precedence over those with less acute or severe problems. Some health care workers felt that there was "a huge gap" for young people with less severe mental health problems or those in the initial stages of a mental illness who would benefit from early intervention from services within primary care or community based programmes that currently do not exist or have lengthy waiting lists.

> "*The people who end up getting referred to mental health services are the tip of an absolutely enormous iceberg. It is one in a hundred…and it is getting tinier all the time."* (GP)

3.6.1.2 'Traditional services flawed for under18s'

Young people and their parents often faced barriers trying to find the appropriate service to address their problems. Access to services was a challenge if the young person was under eighteen years, and the few services available for this particular age group were often costly, with limited availability. Young people with ADHD that are over eighteen struggle to find appropriate services because adult psychiatry services do not recognise ADHD as an adult mental health problem.

> *"If there was more clarity about what happens to 18 years old…there's this gap of care between 16 and 18 and it's not entirely clear…who has responsibility for someone who is…between 16 and 18, is it child and adolescent or is it us."* (Adult Psychiatrist)

Health care workers also felt restricted due to confidentiality and consent issues and described them as a major barrier to the identification of mental and substance use issues in young people under 18 years where parental involvement was often unavoidable. Consent issues often deterred young people from engaging with services

particularly in socio-economically disadvantaged areas where parental issues may be a major contributing factor to the young person's problems.

> "O*ne of the big concerns is that if you are going to have a screening process, you are going to have to have parental consent…the kids who are most likely to need the help are the ones whose parents are less likely to sign the consent form. So, I think that is one challenge."* (Psychiatric Nurse)

3.6.1.3 'Concerns around formally treating a young person'

Variable access to community-based, non-pharmacological interventions, adopting a 'watchful waiting' approach to management and misattributing mental and substance use disorders to developmental changes also delayed identification. In the absence of training in mental health, some health care workers described their difficulty in determining whether young people were affected by difficult life circumstances or if they had a diagnosable mental health issue.

> "*Because a lot of people have such…difficult…lives, I would be less likely to say that they are suffering from depression. If their brother was killed, their partner was just put in jail for the next five years. I will say that of course they are going to get anxious and depressed. It is not really a medical thing. It is a two-edged sword."* (GP)

Treating a young person for (and fear of labelling them with) a mental / substance use disorder was also cited as an important barrier to identification because of the associated potential long term implications of such a diagnosis.

> *"Occupation wise and college wise… they usually ask the GP for medical records. The GP will have our letters on file so realistically, if they are dealing with a substance abuse problem I try and keep it separate, because then there is less information on their file that would prevent them getting…a job."* (Child Psychiatrist)

3.6.2 Need identification – (enablers)

3.6.2.1 Building relationships, rapport, trust

The importance of building positive therapeutic relationships with young people was a key enabler to the identification of mental and substance use disorders, particularly

when young people initially engaged with services. An environment where the young person did not feel judged or ridiculed facilitated a forum of trust where personal problems could be discussed in a relaxed manner. Health care workers highlighted the importance of "normalising" what might be a very difficult experience for young people by building friendly and positive relationships.

> *"It can't be nice coming to see a psychiatrist at the age of sixteen…if you can…get to know them, what their interests are…and get a laugh out of them, you will often find it breaks the ice and they are more at ease."* (Child Psychiatrist)

Health care workers emphasised the importance of interacting with the young person; validating their opinions rather than relying solely on their parent's opinion. The importance of choice, being able to interact with young people in a language they can relate to and maintaining a respectful relationship during consultations also facilitated a positive bond between health care workers and young people.

> *"With the younger age bracket as opposed to speaking at them and coming down on them you have to be at their level that they will open up and they will talk to you."* (Practice Nurse)

Health care workers also felt that it was important to include the young person in the identification / screening process by offering them the opportunity to have an opinion on their assessment scores.

> *"I would have done the Beck's* [Depression Inventory] *with the young person and…talk it through with them…we should not be doing anything that isn't meaningful for them."* (Addiction Counsellor)

For participants working with young people who were homeless, initial identification was often dependent on the health care worker approaching the young person and offering help. One health care worker described the importance of being mindful of the limited understanding that they could afford to young people living in circumstances that were very different to their own.

> *"I will never know what it means, for somebody who is drinking in a laneway…to have somebody from the supposedly settled, homed community…stand and talk to them for a few minutes."* (Addiction Counsellor)

In other cases, health care workers might initially interact with young people in their family home. The importance of building a trusting relationship, adopting appropriate communication skills and engaging at a pace that was appropriate for the young person were key steps to securing strong links between health care workers, young people and their family members.

> *"It's how well you can…communicate because if people don't like you they're not going to let you back into their family homes…talk to them at their level rather than pulling around big medical terminology."* (Public Health Nurse)

3.6.2.2 Effective activity-based engagement with young people

Most health care workers commended activity-based programmes (e.g., sports facilities, youth clubs, youth cafes, educational programmes, youth focussed support groups etc.) effectively identifying mental and substance use problems among young people. Trusting relationships between health care workers and young people may develop in a relaxed setting and thus provide a forum for the young person to communicate any difficulties they might be experiencing.

> *"I suppose you would call the activity the carrot that they are coming to do something that they like and they are going to build the relationship through you with that. If they need support, in anything else, at least they know you and they can come…and talk about it."* (Youth Worker)

For some young people activity-based programmes enabled them to address their issues in a more positive way as opposed to the more regimental school environment which they often struggled with, particularly for young people who would be considered more high risk.

> "*Young people who are most at risk in the youth service are the ones that have serious issues in school. So, the learning experience is different. Also there are a lot of recreational outlets…It helps with the boredom. It is a particular need that type of child has."* (Parent / Volunteer, Youth Service)

3.6.2.3 Promoting mental health and drug awareness

Similar to the recommendations from the young participants, health care workers also highlighted the importance of promoting awareness and educating young people about

mental health and drug use in addition to the services that are available. Incorporating mental health programmes in schools at an early age was identified as a key strategy to identify such issues.

> *"Schools…could be a lot more open around drug use…you have to get kids...very young…early primary school and…start drilling that stuff into them as being the norm rather than the abnormal…if we teach them enough early maybe they will be able to make more educated decisions rather than just fall into it."* (Addiction Counsellor)

Using newer technologies to promote mental and substance use awareness programmes and advertising services was considered an appropriate medium to communicate with young people. Some health care workers noted the potential benefits of incorporating interactive technology (e.g., mindfulness bells on iPhones etc.) as a strategy that young people could relate to, to enable early identification and remove the stigma associated with mental health problems.

> *"One way we can overcome that* [stigma] *is by creating funky, cool programmes in school…introducing much earlier this notion that…our mental health gets challenged at all stages…and if you are having problems here is a signpost…about what you need to do…interactive technology could be used because that is where they spend a lot of their spare time."* (Clinical Psychologist)

Health care workers also stipulated the importance of promoting a greater level of awareness and training on youth mental health problems for teachers. Opportunities to identify such problems in a timely manner in the school environment would enable early identification, thus resulting in faster referrals to appropriate services.

> *"Some of the schools seem to be much better than others at picking up mental health problems. I think that is because teachers don't necessarily have any training in mental health…You could have somebody who is really clued in and could spot…that guy has ADHD. They will get him seen. Someone else would look at him and think he is a bold child and they never get referred anywhere."* (Child Psychiatrist)

3.6.2.4 Importance of formal assessment tools

Using formal instruments to assess factors that might contribute to a mental and substance use disorder was considered to be a necessary step, particularly in making a diagnosis more meaningful to a young person who might perceive such a diagnosis as a "label". For some health care workers, formal assessments enabled identification of mental and substance use disorders and also confirmed their clinical opinion upon initial assessment. Health care workers who were not trained to use formal assessment tools or did not have access to them also felt that they would be useful for screening the young people that they work with.

> *"If we had a proper tool that…everybody where they have a young person for any condition that they go through a…list of stuff, and one of those things is maybe "do you take alcohol, do you smoke, do you take drugs", that would be on it."* (Public Health Nurse)

However, while the importance of formal assessment tools was highlighted and most respondents had received training in an array of courses related to mental health and substance use (e.g., systemic family therapy, motivational interviewing, CBT, National Addiction Training Programmes, child protection training etc.) the experience of working with young people and their families over a number of years was identified as the most important learning tool that facilitated them in their everyday working lives.

> *"I suppose they* [training courses] *taught the basics of working with young people…but nothing prepares you more than the experience of working with young people and their families, because every case you get is different. It gives you structures to work with if there are psychological issues."* (Youth Worker)

3.6.2.5 Importance of outreach work

Health care workers identified outreach work as a key enabler to identification, particularly for young people with substance use problems who were homeless. Generally, people who are homeless have limited engagement with health care services and would struggle to interact with a "formalised agency", or keep appointments. The loss of outreach services in some socioeconomically disadvantaged areas which was

replaced by a referral system resulted in a decrease in the number of young people interacting with services.

> *"We have seen where outreach has been really successful and when outreach is taken away…and it was referrals only in from schools…child psychology and…nobody goes there…outreach to me is the way in poorer areas like this."* (Public Health Nurse)

Other health care workers highlighted the importance of conducting outreach work via home visits, particularly to gain a more coherent picture of the young person's home / community life. Accessing a young person's home environment provided health care workers with a deeper understanding of the environmental / psychosocial factors that might contribute to the problems on a level that might not be achieved during a consultation or at a treatment centre.

> *"I think home visits are brilliant because you gain that insight that you just can't get here…Every mental health service could have an outreach team who could do home visits."* (Child Psychiatrist)

Identification of issues relating to mental and substance use via outreach work was also seen as a way of providing early intervention, particularly through building collaborative links with external agencies (e.g., schools / teacher groups, residential rehabilitation units, family resource centres, youth groups, community groups, parent groups etc.).

> *"Outreach services need to come here at an early age and to be linking in with the schools. Before mental health issues develop there is the grief, the loss, the violence...the poor parenting… If we can support all those things…and help them cope with it. I don't think it would develop."* (Youth Worker)

3.6.3 Treatment engagement – (barriers)

3.6.3.1 'Limited resources'

The majority of participants stressed the negative impact of "government cutbacks", "tightly managed budgets", staff shortages, lengthy waiting lists, bed shortages and limited resources as major barriers to offering effective treatment. As a result of limited

resources, opportunities for the health care workers to replicate effective programmes in other countries have been lost.

> "*We have about half the staff that we are supposed to have. If we had more staff…the one thing that would be good to do is, in Australia…in schools…they do a CBT programme which has been shown to reduce the number of young people who develop anxiety disorders. It would be very easy to do but we absolutely wouldn't have the time to do it."* (Child Psychiatrist)

Youth based services struggle to plan activities for young people because financial budgets have become so uncertain and in many cases staff members had to engage in fund raising initiatives themselves. Awareness of limited funds and the unpredictable future of services had a negative impact on young people.

> *"I have to start preparing the kids...that…we mightn't be opening…in the New Year…the young people disengaged. They felt let down…they invested emotionally into the space… I had about ten chairs thrown at me….I didn't accept it, but I could understand where they were coming from. Regeneration's attitude was 'why can't they…move the project somewhere else?'…And I said 'you are actually telling them they are losing their home'…because, that is what the kids would look at this place as, their second home."* (Youth Worker)

3.6.3.2 'Crisis intervention versus early intervention'

Optimum use of scarce treatment resources, especially the perceived tension between crisis intervention and early intervention, was highlighted as a priority issue. While the importance of early intervention was recognised, many health care workers expressed concerns about using scarce resources for young people with less severe (rather than more severe and debilitating) problems. Promoting access to community-based psychosocial interventions was highlighted as key mechanism to reduce workload of specialist psychiatry services. However, other health care workers stressed the benefits of using financial resources to provide early intervention for young people at younger ages (i.e., pre-adolescent years), thus preventing a drain on resources later on where that young person might end up with a chronic mental health condition.

> *"He is involved in lots of anti-social stuff…he was referred to community care social workers but they just didn't pick up the case. If that had been done early*

on, he would never have the difficulties that he has now. You would be saving a lot of money. He has already been in [specific service]*, which is a locked unit. That costs a bomb. He is going to end up in jail; that is going to cost a bomb…If they put the money into early intervention instead, it would make much more sense."* (Child Psychiatrist)

3.6.3.3 Parental involvement in treatment – pros and cons

The role of parents in a young person's treatment may be beneficial in terms of facilitating their initial interaction with health care workers. However, parents may not always be supportive of the young person's treatment (e.g., not helping the young person to make their appointments, dominating family conferences and not allowing the young person to express their views). Other parents might feel judged in their parental role and some parents struggle to accept that their child might have a mental health problem. Parental treatment expectations may not be in accordance with the type of treatment their child needs (e.g., expecting intensive therapy in the absence of acknowledging home and school based factors).

"*But you get very difficult parents. That is totally understandable…No one wants their child to have to see a psychiatrist…I suppose some of the difficulties…are expectations as well."* (Child Psychiatrist)

3.6.4 Treatment engagement – (enablers)

3.6.4.1 'Inter-agency collaboration'

Some health care workers stressed the need for improved inter-agency communication and collaboration, (especially between addiction services and mental health services). Staff members from different sectors who work with young people, would also benefit from a more integrated approach, in addressing the young person's multifaceted needs (e.g., addiction services, mental health services, school environment, accommodation needs etc.). A holistic client-centred approach would be far more constructive particularly for young people (who might have interacted with multiple services) and especially if there has been a breakdown in communication between health care workers.

> *"I think it is not only feasible…but it is imperative that they do work* [together], *for the good of the client…I don't see why agencies that…are populated by people who have got to third level education and have had access to educational facilities, that their clients will never get near…why they can't put their intelligent heads together and put their differences aside and work for the common good."* (Addiction Counsellor)

Primary care and generic community services where health care workers are based in one building facilitates collaboration between staff members, multidisciplinary team assessments, faster referral timeframes, in addition to assisting young people / parents who might otherwise have to attend several services in various locations.

> *"When I am dealing with a client I might think 'if I could just run over to speech and language now'…There is…something about that proximity…that makes it easier to communicate."* (Psychologist)

Health care workers from community agencies prioritised becoming more aware of other services in the area where they work that are essentially providing similar treatment programmes to young people. Awareness of these services could improve referral options and pathways for young people in addition to providing collaborative links among health care professionals.

> *"There are fantastic agencies out there, people working really hard to help young people. But, if we all continue paddling our own canoes, we are not really going to get anywhere."* (Mentor Co-ordinator)

3.6.4.2 Appropriate interventions

Most health care workers reported that young people adapted very well to psychological interventions (e.g., CBT, mindfulness approaches, motivational interviewing, etc.), particularly when the young person had a choice in the type of psychological therapy. Adopting similar approaches to international best practice models in terms of training more health care workers to offer specific psychotherapeutic interventions within services such as CBT and dialectic behaviour therapy were considered useful.

> *"In Australia they have a service for fifteen to twenty-five* [year olds]. *If somebody presents to the GP or a CAMH service…you go – I have just the right*

person to meet you and they are very well trained. So, if…our service and [other related services]*…got together and got a few people trained…some of the adult services in Ireland…have started to do that…for people who self-harm with borderline personality traits…it is working very well. They have reduced the number of admissions to hospital."* (Child Psychiatrist)

While access to psychology and counselling services was a key enabler to treatment, health care workers also stressed the importance of interventions tailored to meet the needs of a specific population, thus interventions that might be appropriate in one area might not be relevant to a young person in a socioeconomically disadvantaged setting.

"There is a lot of talk about not having enough counsellors. It is true. There is not enough access to free counselling…Throwing a whole pile of counsellors into a [socio-economically disadvantaged area]*, just any old type of counsellors, is not the solution."* (GP)

3.6.4.3 Buy-in with treatment

Providing treatment interventions that are both client-centred and timely were considered the most important factors when trying to engage young people with treatment. Health care workers also stressed the importance of ensuring that young people were prepared to take responsibility for their treatment. Various strategies were useful in encouraging young people to engage with services, while some young people were aware they had reached a crisis point and needed help, health care workers negotiated with others, such as helping them to tackle substance use problems to avoid trouble with authority figures.

"A lot of our clients are fairly reluctant customers. They are sixteen year olds who are smoking cannabis. They don't see themselves…as having a problem…they have been brought by parents or sent by a probation officer." (Psychiatric Nurse)

Aside from providing treatment for mental health or substance use problems, health care workers tried to address the young person's needs more holistically; addressing other factors in their life that were of importance to them while also relevant to their recovery. Individualised treatment was also prioritised as a key enabler to a young person's progress, where treatment packages are designed to meet individual needs.

> *"We develop a plan around each individual young person…rather than developing an overall great service, we develop a great service for the individuals that we actually work with."* (Youth Worker)

3.6.4.4 Quick access to services

Health care workers were "fire fighting" in terms of trying to keep waiting lists as low as possible and provide rapid access to treatment for young people. Most health care workers prioritised treating younger people (e.g., under 18s) as soon as possible.

> *"We prioritise the under eighteens, so we would always make every effort to see them within the first two weeks. To at least assess them and....to assess how great is their need." (Counsellor)*

Participants described the benefits of triage in offering short-term appointments and quick referrals to more appropriate services which would act as a more proactive gate keeping mechanism. Other health care workers found that a collaborative approach between different teams within the treatment facility abolished the waiting list in their service.

> *"Instead of having a six months waiting list for assessment....co-operation between nursing teams, counselling teams, outreach teams and management, we got rid of the waiting list…a person can be assessed* [for a methadone programme] *every Monday."* (Outreach Worker)

3.6.5 On-going engagement – (barriers)

3.6.5.1 'External pressure to engage in treatment'

Health care workers recalled their struggle to work with young people who were not intrinsically motivated to engage with them during treatment, with up to 30% of young people failing to attend appointments in some services. Most health care workers noted that young people attend services as a result of pressure arising from external factors (e.g., parents, social workers, probation officers etc.). Thus in some cases young people feel that it is in their best interest to engage with services for external reasons where

they might have a requirement to complete a probation service as opposed to addressing their mental health / substance use problems.

> "*This guy doesn't want to be there. He has not come in specifically, I want to address my ADHD…my substance use and…the fact that I am involved in anti-social behaviour. He was given a letter saying that you must attend...That is not going to work. You do what you can with it."* (Drug Worker)

External pressure to engage with treatment seemed to be particularly counterproductive for young people with substance use problems. Health care workers based in addiction services found that any effort to engage the young person in treatment was only worthwhile when they were ready to address their issues.

> *"I can sit down with someone for the next…twenty years but until that guy…goes – 'right that is it, I am finished with it'. You know when that happens…they will present to you very differently. Their body language would be different. You just know…something has changed for them."* (Drug Worker)

3.6.5.2 'Unwillingness to attend counselling'

Other health care workers struggled to motivate young people to attend counselling for various reasons (e.g., counselling being perceived as a 'middle-class' intervention, the time commitment associated with engaging in counselling, fear of bringing up painful memories, difficulties talking to a stranger about their personal issues, lack of maturity to deal with the process, reluctance to seek answers where the alternative solution was to mask problems with substance use and previous negative experiences with counselling etc.).

> *"Counselling is a very middle class medium. The idea of self-examination is a very middle class concept…Where…lives are very, very chaotic...complicated and difficult…they don't want to go and sit for weeks and weeks and examine themselves."* (GP)

Some health care workers found that young people wanted an immediate solution in the form of a tablet rather than interacting with health care workers in any form of counselling.

> *"Alot of people come in just wanting tablets…and we say 'let's do some relaxation or anxiety management techniques' and they say 'no, I just want a tablet'…there is a culture of 'I want it straight away and I want you to make me better' without people taking responsibility for their own health."* (Social Worker)

3.6.5.3 'Transition from child to adult services'

For health care workers trying to ease the transition for young people from child to adult mental health services at 18 years was also identified as a barrier to on-going engagement, especially as many young people may have developed a trusting relationship with a member of the clinical team which they were reluctant to end. Some health care workers felt that 18 years was not an appropriate transition age and suggested services be developed that were more focused towards late adolescence / early adulthood.

> *"If…adolescent or young adult mental health took over from…15 until 25…Because…it's the wrong time for there to be a transition in care...People get lost…and relationships get broken up." (Psychiatrist)*

Young people that are making the transition to adult services may not require acute psychiatric services; a young person with Asperger's syndrome or ADHD might find services that address issues in the milder domain of mental health to be more appropriate.

> *"She went up to adult services she said…it was horrible. There were lots of people who were obviously quite unwell and it was a bit scary and the girl said she was never going back there again."* (Child Psychiatrist)

3.6.6 On-going engagement – (enablers)

3.6.6.1 'Intrinsic motivation'

Most health care workers emphasised the need for young people to be intrinsically motivated to attend services and continue with treatment. One participant highlighted the benefits of motivational interviewing with young people to increase confidence during treatment engagement.

> *"People grow in confidence by being respected in whatever effort they make...I…do a lot of motivational interviewing. I would really....be attentive to the positive and just be aware of the negative…if they have a slip, so what…the important thing is why."* (Addiction Counsellor)

Health care workers emphasised that many young people with substance use issues must become intrinsically motivated for treatment to be effective, especially as they have to find an alternative coping mechanism for their problems to the temporary release that substance use affords them.

> *"They don't want to give up the drugs…it is the only thing that they are enjoying in their life…You are trying to say if you give it up you will feel better…you won't be feeling down... They are like – what else will I do then?"* (Adult Psychiatrist)

3.6.6.2 'Continued opportunities for engagement'

Health care workers also advocated the importance of providing continued opportunities for young people to engage with services given the infrequent / relaxed approach that some young people have when it comes to keeping appointments. In other cases, young people may not be ready to engage in the treatment process when offered. One participant stressed the importance of "being flexible" in their "attitudes" towards understanding how young people engage with services.

> *"Sometimes being that facilitator and opening up that avenue of support even though it is not taken up…Very often you will hear people ringing to make an appointment and two or three years later they turn up. That is progress. It is long, it is drawn out and it demands patience."* (Counselling Psychologist)

Health care workers often struggled between trying to provide timely interventions for young people who may have missed several appointments because they were not ready to engage with treatment and lengthy waiting lists with other young people who also required treatment. In many cases by the time young people interact with services their symptoms have worsened.

> *"One of the big issues when you are working with youth…while everybody else might think it is a good idea for them to engage with services, it is getting their*

> *buy in…they come back you have to look at the waiting list issue. Do I take them now or do I have to go back to the back of the waiting list?"* (Clinical Psychologist)

3.6.6.3 'Personal achievement goals'

Health care workers stressed the importance of negotiating and setting achievable goals that were relevant to the young person as a key enabler to engaging with treatment (e.g., initial engagement with services, abstaining from substance use for short periods of time, reducing the quantity of substance use etc.).

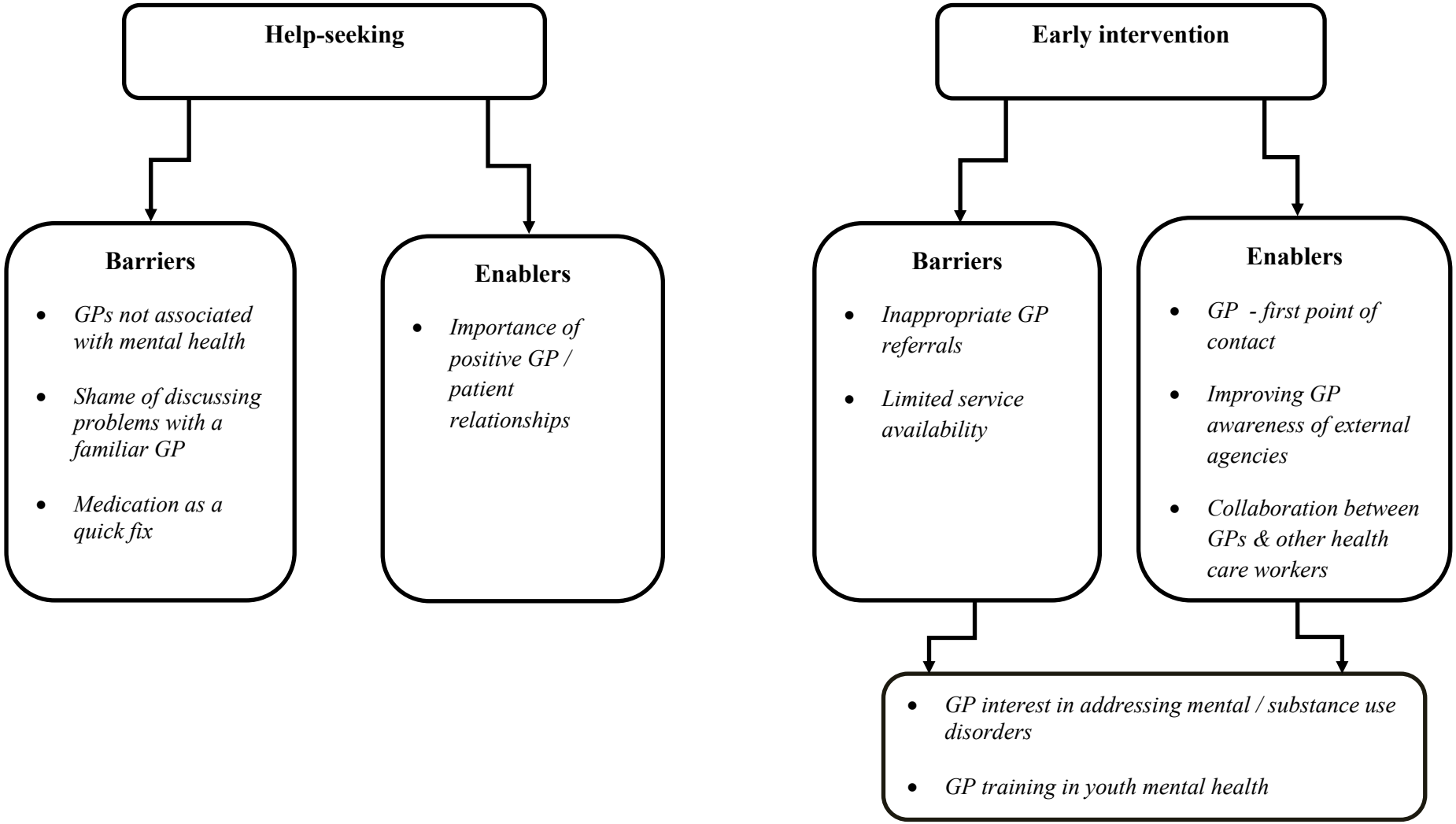
> *"Some would say "I never thought I would do three days without cannabis". That would be a major* [achievement for them] *and every day you build on that and…really applaud each little step they make in the right direction. Because....anybody who really stops, I would so affirm every effort they make."* (Addiction Counsellor)

Additional strategies included connecting them with other people in the recovery programme, encouraging return to school, leisure activities and return to work initiatives.

3.7 Theme 5: GP role and approach

GP role and approach emerged as a key over-arching theme across both data sets with health care workers and young people in regards to barriers and enablers associated with (1) help-seeking and (2) early intervention for mental and substance use disorders (see figure 3.6 for themes and sub-themes).

Figure 3.6 GP role and approach



3.7.1 Help-seeking - (barriers)

3.7.1.1 GP not associated with mental health

Generally, feelings were mixed across all the participants (both health care workers and young people) in regards to approaching the GP with a mental health or substance use problem. Some young participants did not associate the GP with mental health and assumed that the primary role of the GP was to address physical problems. Other participants said they would become suspicious and in some cases defensive, if their GP asked them to participate in a screening assessment for a mental / substance use disorder. Participants tended to avoid discussion around issues that that they felt their GP was not qualified to engage with.

> *"With the GP it is kind of like coming in and talking to you about how to make music, it is not your field. You are not really going to understand it. So, when I do see my GP, I try not to go into it too much because I feel - he is a GP, he doesn't work with the brain."* (Young Male Participant aged 21 attending General Practice)

Health care workers from other health care sectors, including psychiatry, seemed to hold a similar view that the GP is not a person that young people would engage with about their mental health problems.

> *"If you are a young person and you are feeling a bit off...you certainly aren't going to talk to your parents about it, you would talk to your peers I would imagine. I don't think it would dawn on young people to go to their GP."* (Psychiatric Nurse)

3.7.1.2 Shame of discussing mental health problems with a familiar GP

Other young participants experienced feelings of anxiety and shame because they were discussing their mental health problems with a GP who was well known to them. Some participants were reluctant to admit to the large quantities of substances / alcohol that they had consumed fearing judgement from their GP. One young participant questioned whether it would have been easier to approach a GP he didn't know.

> *"It was…nerve-wracking when I went to see my GP…if I had gone to a GP that I didn't know…I probably would have found it easier to talk about the depression…the fact…I knew him, he was a member of my community…made it that much harder."* (Young Male Participant aged 23 attending Mental Health Service)

3.7.1.3 Medication as a quick fix

Some health care workers, particularly from community agencies, felt that GPs tended to overly rely on medication as a quick fix to address mental health problems. The provision of counselling / support groups was considered to be more appropriate.

> *"For prescription medication, they are probably over utilising the GP…We are over medicating people. Parents included…no wonder kids are getting addicted…That's what they see at home, 'I will take one of mam's pills to relax.'"* (Youth Worker)

However some young participants highlighted the importance of the GP's willingness to prescribe medication for people who are struggling with withdrawal from heroin and other substances without assuming the young person just wants easy access to prescribed medication.

> *"I think GPs should definitely be more open to say 'yes, I will give you something for a week'…but GPs at the moment are like 'no, we won't prescribe that.' There is a total ignorance. Because if you are an addict they say 'he is in here looking to get stoned.' My GP was great, she put me on Xanax, which I am addicted to now I will admit, but if I didn't have Xanax I would have been a total nutcase…violent…angry the whole time."* (Young Male Participant aged 27 attending Addiction Service)

3.7.2 Help-seeking – (enablers)

3.7.2.1 Importance of positive GP / patient relationships

Some young participants reported very positive experiences with their GP, where they were provided with much needed reassurance and comforting words when they initially experienced symptoms or upon receiving the news that they would have to take medication for their mental health problem. One participant felt a sense of relief when his GP reassured him that there were other young people experiencing similar problems

and that mental health problems should be viewed in a similar context to "a person who has diabetes / cholesterol."

> *"The initial stigma of having to take the medication…Dr. X…told me that 'if a pill had the colour of a person's eyes differently, you'd be amazed by the amount of different colours of eyes walking past you', so that was very reassuring to be given that analogy."* (Young Male Participant aged 19 attending Primary Care)

3.7.3 Early intervention – (barriers)

3.7.3.1 Inappropriate referral practices

Inappropriate or poorly written GP referral letters such as limited information regarding: symptoms, family history of mental illness, suicidal tendencies, whether screening assessments have been completed, treatment options provided, medication prescribed and outcomes from treatment / medication already administered can result in further delays for young people when trying to access services. In some cases, young people were referred on to mental health services without being assessed by their GP.

> "*The quality…of the referral letter is the initial requirement to get past the gatekeeper. If the quality of the referral is not suitable, the letter will go back."* (Psychiatric Nurse)

GPs duplicate referral letters in the hope that another service will "pick up" the referral rather than trying to identify the most appropriate service for the young person. Some health care workers were concerned about the effect of inappropriate GP referrals on specialist mental health services, where individuals with disorders at the more severe end of the spectrum must take priority as opposed to young people who might be struggling with milder emotional difficulties.

> *"We should really only take on referrals…that are appropriate to us and discharge back to Primary Care, after giving a service. But sometimes the GPs simply don't have access to services, or they don't know, so they refer them on to us."* (Social Worker)

GPs themselves highlighted the dilemma of trying to determine an appropriate referral route for young people presenting with milder symptoms.

> *"I suppose mild is… a…bit more tricky than the moderate or severe end of the spectrum because then it is a very clear cut pathway you know if you're referring them on specifically to a psychiatrist."* (GP)

3.7.3.2 Lack of GP training in youth mental / substance use disorders

All GPs interviewed did not feel that they had sufficient training to address youth mental health and substance use problems in their practice and some felt under pressure to diagnose the young person without sufficient training prior to referring the patient to a mental health service. Their perceived lack of competence in administering psychotropic medication to young people with more severe mental health conditions was also a concern for many GPs interviewed.

> *"Adolescent schizophrenia…is…very specialised. And I would be very careful about monitoring them with some of the drugs that they are on, because I wouldn't have a whole pile of experience in that…that is maybe something we could have training on."* (GP)

Some GPs struggled to relate to people in the younger age group (i.e., early adolescents) because of their limited training in the area of youth mental health. Additionally, GPs felt that adhering to parental consent laws posed further barriers in addressing the needs of young people under the age of eighteen.

> *"The people that…I am not so good at working with are…thirteen, fourteen and fifteen. They are withdrawn, there are issues around parental consent. They have got issues around me and confidentiality and they kind of live in a world that I don't understand very well…by the time that they have reached seventeen…it is a more…adult world and it is easier for me to relate to."* (GP)

Contextual factors such as the external influences contributing to the young person's problems meant that GPs could not deal with the young person as an individual, the role of family and community also had to be addressed which some GPs felt they were not trained to manage appropriately.

> *"I think…a child's problems are really important because you can actually make a huge difference and sort them out for the rest of their lives…it is complex it rarely involves just a child. It is usually as a consequence of other family*

issues…It is going to involve meetings with the rest of the family and that is something that GPs aren't trained to do." (GP)

A younger participant recalled her frustration with her GP when she did not take her problems seriously during her initial consultation and stressed the need to provide further training for GPs in counselling and mental health.

> *"*[GPs] *should have some counselling skills because, if you are sick they are good for that, but mentally...they are not that good at it…They just talk about general stuff and…think it is the norm."* (Young Female Participant aged 18 attending Mental Health Service)

3.7.3.3 Limited service availability for referral

Some GPs described their reluctance to take on youth mental health and substance use problems when there were no appropriate services for referral. GPs felt that they would be at a loss to address the issues that would unfold in the absence of adequate support from other services.

> *"The mental health services are overwhelmed. So me picking up yet another child who might be a bit depressed and…referring them to a service that for them effectively doesn't exist, is probably inappropriate. Maybe they would be better off being picked up by the school psychology services…where they might have more skills."* (GP)

The lack of youth-focused counselling services was also emphasised. Additional barriers included the time constraints associated with a busy practice and lack of appropriate training to offer therapeutic treatment themselves.

> *"We need a dedicated youth counselling service which is designed to be more acceptable to young people. None of it exists. It is woefully inadequate, psychiatry is a big step. We desperately need…something in-between…you try and do that role yourself which isn't so practical…Because…I have no training and…no time."* (GP)

3.7.3.4 The level of GP interest in addressing mental / substance use disorders

The discrepancy between some GPs who are interested and engaged with mental health and substance use and others who are not, was a challenge. GPs who do not hold the same level of interest in the area of mental / substance use disorders might not encourage an open discussion with patients about such issues.

> *"There is a massive discrepancy in terms of how much people want to deal with this stuff…you can send out a very clear message to a patient which is…'Yes, I want to talk to you about psychological things or I am…not interested.' Loads of people I think are not. It is very time consuming…it has a lot to do with…confidence in dealing with it. If you don't know what to do then you are not going to inspire people to talk to you."* (GP)

Other health care workers felt that demographic characteristics (e.g., age, gender, number of years as a GP) might determine their willingness to engage with youth mental health / substance use disorders and how they relate to their patients.

> *"If you are sending somebody into a sixty four year old GP who is about to retire, that has gotten really worn out from being a GP…you would wonder what would their approach be compared to say a GP, who is in his thirties or forties…and…would be of the attitude let's get it done…a female GP with a young man may have a different approach, and maybe a young guy of eighteen or nineteen wouldn't listen to what a lady GP has to say to them."* (Public Health Nurse)

3.7.4 Early intervention – (enablers)

3.7.4.1 GP as a first point of contact and link to external agencies

The GP was recognised as a first point of contact as well as a source of information for both young people and other health care workers in terms of providing initial referral to external agencies and local support groups, particularly for young people who were unaware of the referral pathway to secondary care services and community agencies. The importance of linking in with the GP early to access appropriate services and thus prevent subsequent deterioration of mental health problems was highlighted by most health care workers.

> *"I think the GPs are underutilised…GPs could be a great source of referrals....to more counselling…services…sometimes the interventions can be so severe…especially with mental health services."* (Youth Worker)

3.7.4.2 Collaboration between GPs and other health care workers

Collaboration between GPs and other agencies particularly between different health care sectors (e.g. primary and secondary care) was highlighted as an important step towards promoting awareness of the services that are available for young people with mental and substance use disorders. The benefits of collaboration between GPs and other health care workers was also evident in areas where GPs were linked in with primary care teams and therefore had the advantage of providing more immediate and direct access for their patients.

> *"We have the GP sitting on the Primary Care Team…they would bring up clients they want seen…we would be discussing them at Primary Care meetings."* (Social Worker)

GPs themselves advocated the potential benefits of having access to relevant psychology services (with a specific focus on young people living in socio-economically disadvantaged areas), particularly in situations where referrals to psychiatry were unnecessary.

> *"Having a psychologist who we could have regular meetings with would be very beneficial. If they were dedicated to our primary care team and were able to see our patients….if it was the right kind of psychologist with the right range of skills to look after this very particular population."* (GP)

Other health care workers emphasised the benefits of adopting a stepped care model where GPs / sufficient staff in the practice could offer brief psychotherapeutic interventions to young people experiencing less severe mental / substance use problems. Adopting a stepped care approach would free up waiting lists in other services for people with more severe and debilitating problems.

> *"A stepped care model where the GP has…access to a service that is short and quick that is…an efficient way of working…the clients don't necessarily need to be…on a community psychologist's waiting list."* (Psychologist)

3.7.4.3 Further training for GPs

Providing further training for GPs was highlighted as a key enabler to early intervention for mental / substance use disorders by most health care workers including GPs themselves and young people. Recognition of the early signs and symptoms of mental health problems can result in timely and appropriate referrals for young people before symptoms progress to serious chronic and enduring conditions.

> *"Mental illness underpins a lot of the problems and if a young child comes in with anxiety or depression, the GP may just take it at face value and say that is depression. Often that is how a serious psychotic illness can present in the very early stages…Everyone needs to be aware of different stages of illness that can manifest."* (Adult Psychiatrist)

Health care workers from the mental health services also stressed the benefits of training GPs to screen for mental / substance use disorders and carry out risk assessments among young people, to facilitate early intervention. In many cases by the time young people access psychiatry services, screening assessments are of little value as their symptoms have worsened and treatment outcomes are less satisfactory.

> *"We shouldn't be the service doing the screening…It should be happening…at the primary level…as to whether it is mild, moderate, or severe. And a decision made as to where does that go."* (Psychiatrist)

However, when asked about the benefits of further training in the area of youth mental health GPs were very specific about the type of training they required, given the limited time for such an endeavour in a busy practice environment.

> "*It needs to be realistic and focused, it can't be…course based…lasting for years...whoever is providing that needs to come into the practice…and see what is presenting to us…develop some tools* [specific to us] *if somebody gives you a book…about youth mental health', 99% of GPs…would put it in their bag and that is probably the last they would see of it…it needs to be accessible, at your elbow when you need it."* (GP)

Some health care workers from addiction services noted the importance of providing more specified training in the area of substance use for GPs, particularly to avoid inappropriate / unnecessary referrals to psychiatry which may have devastating consequences for young people.

> *"GPs…don't…have a lot of experience with drugs…if they are referred to a GP...I have seen a lot of cases that have gone to psychiatry, as a result of smoking marijuana…there are often devastating results down the line, whereas if they are referred here* [the addiction service]*…we have counsellors…psychotherapists, who have seen situations like this time and time again."* (Outreach Worker)

3.7.4.4 Improving GP awareness of external agencies / community services

Health care workers also noted the importance of improving GP awareness of other services by providing easy access to contact information for external agencies (e.g., community agencies, counselling services, local support groups etc.) to improve their referral process. One health care worker described a consultation-liaison model that worked well in terms of linking the mental health services with general practice and also reducing lengthy waiting lists in a specialist mental health service when milder forms of therapeutic intervention were sufficient.

> *"We would…ring the GP and say 'I think it is more appropriate that this person goes to* [specific addiction services]*, or adult counselling...' So we are beginning to develop a consultation liaison model with GPs to tell them… 'you sent us this referral, there is no identifiable psychiatric illness, or that it requires more specialist care.'"* (Social Worker)

While further training for GPs in the area of youth mental health and substance use emerged as a key issue, health care workers from other disciplines acknowledged the considerable progress that some GPs have made in understanding youth mental health and forming appropriate links with secondary care.

> *"Ten years ago we would be saying that a lot needs to be done with GP education, I think it is much less the case now, GPs have a much better understanding."* (Child Psychiatrist)

3.8 Links between themes and theoretical models

Five over-arching themes were identified in study one:

1) Young people and their experiences of mental health problems

2) Young people and their interactions with health care services

3) The role of social context

4) Intervention

5) GP role and approach

The theme *Young people and their experiences of mental health problems* was based on inductive coding, as one of the primary research aims was to further our understanding of the experiences of young people with mental health and substance use problems / disorders. Therefore, it was important to include inductive codes which were strongly linked to the data / participants' accounts of their experiences (Patton 1990) to address this question.

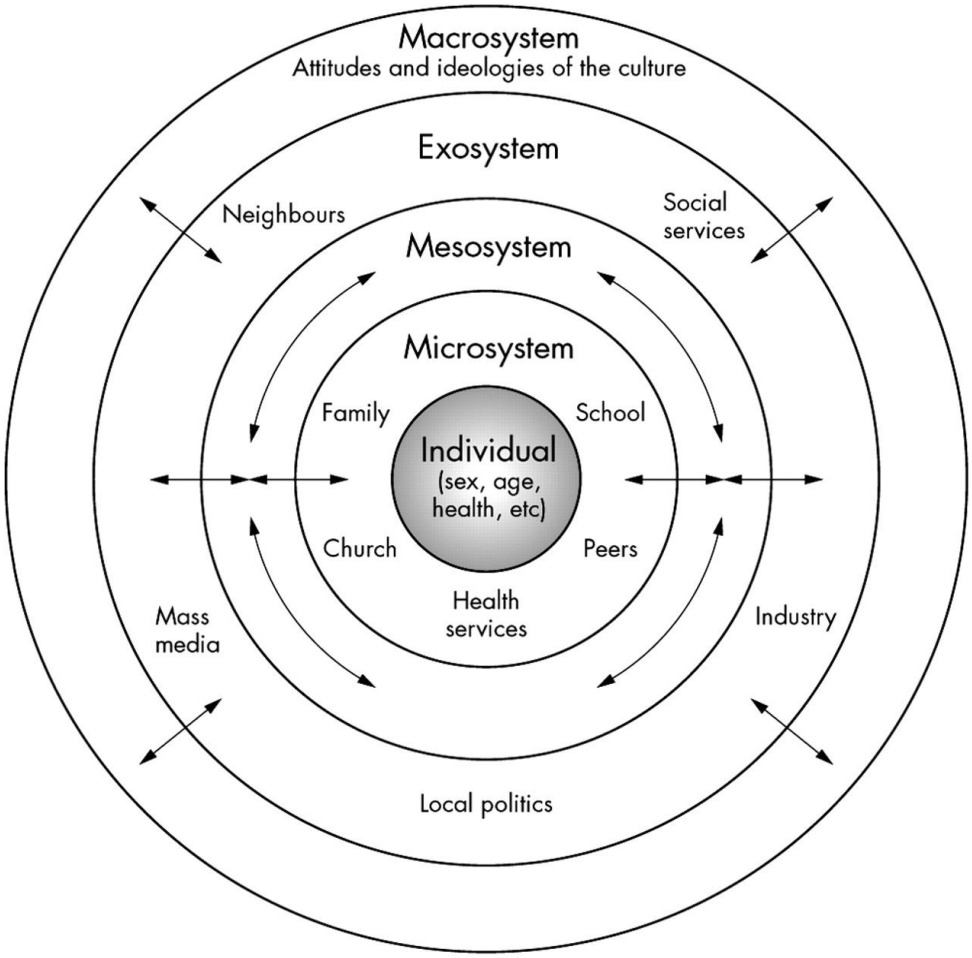
Young people and their interactions with health care services, *Intervention* and *GP role and approach* were categorised according to the key domains in the Social Determinants of Health (SDH) (e.g., need identification, treatment engagement, treatment sustainment, and community resource engagement). Related themes included: need identification, treatment engagement and ongoing engagement with respect to addressing mental / substance use disorders and the associated barriers and enablers.

Some of the sub-themes related to key elements of the Chronic Care Model: self-management support, community resources, clinical information systems, delivery system redesign, decision support and healthcare organisation. (See table 3.7 for an overview of the main sub-themes related to aspects of the CCM).

The role of social context is consistent with Bronfenbrenner's ecological model (1979) (see figure 3.7). Therefore, the format of the theme was structured similar to Bronfenbrenner's theory where the *development*, *identification* and *treatment* of mental and substance use disorders were analysed through an ecological model to determine how the individual, family, local area context / community and wider societal characteristics can promote health or health disparity (Reifsnider et al. 2005).

In the theory, 'Ecology of Human Development', Bronfenbrenner (1979) suggests that the world of the child consists of five systems of interaction: (1) Microsystem – the child's most immediate environment (physically, socially and psychologically); (2) Mesosystem – this system helps to connect two or more microsystems in which the child, parent and family live; (3) Exosystem - describes the interaction of two or more microsystems that influence the child even though they are not directly involved in the environmental setting (e.g., parents experiencing stress at their workplace may influence parent / child relationships at home) (Swick and Williams 2006); (4) Macrosystem – the wider cultural, societal and political events that shape one's social context and (5) Chronosystem - the historical context as it occurs within the different systems. Each system depends on the contextual nature of the person's life and offers a continual range of options and sources of growth (Swick and Williams 2006).

Figure 3.7 Bronfenbrenner's Ecological Theory of Human development



Adapted from Bronfenbrenner (1979)

(Table 3.5 provides an overview of links between over-arching themes and the SDH and Bronfenbrenner's Ecological model and table 3.6 outlines a sample of how initial inductive codes were categorised according to the study's theoretical models).

Table 3.5 Links between over-arching themes and theoretical models

Theme	**Theoretical Model**
Young people and their interactions with health care services • Young people and help-seeking (barriers / enablers) • Treatment experiences (positive / negative)	*Social Determinants of Health* • Need identification / community resource engagement • Treatment engagement / treatment sustainment
The role of social context • Individual / family peer factors • Local area context • Wider society	*Bronfenbrenner's Ecological Model* • Microsystems • Meso / exo systems • Macrosystems
Intervention • Need identification (barriers / enablers) • Treatment engagement (barriers / enablers) • Ongoing engagement (barriers / enablers)	*Social Determinants of Health* • Need identification / community resource engagement • Treatment engagement • Treatment sustainment
GP role and approach • Help-seeking (barriers / enablers) • Early intervention (barriers / enablers)	*Social Determinants of Health* • Need identification • Treatment engagement / community resource engagement

Table 3.6 Categorisation of inductive codes according to key theoretical models

Inductive codes →	Theoretical Models
Intervention theme *Inductive codes:* *(Treatment engagement – facilitators)* • Effective activity based engagement with young people • Building relationships, rapport, trust • Promoting mental health / drug awareness • Importance of formal assessment tools • Importance of outreach work • Individualised treatment • Less formalised treatment • Quick access to services • Agency collaboration • Experienced health care workers • Buy-in with treatment	*SDH Model /*: Key domains (need identification, treatment engagement, treatment sustainment and community resource engagement) *Identification (enablers)* • Building relationships, rapport, trust • Effective activity based engagement with young people • Promoting mental health / drug awareness • Experienced health care workers • Importance of formal assessment tools • Importance of outreach work *Treatment (enablers)* • Interagency collaboration • Appropriate interventions specific to a population • Buy-in with treatment • Quick access to services
Social context theme *Inductive codes: (Contributory factors to youth mental health problems)* • Context • Early school leaving • Alcohol / problem drinking culture in Irish society • Changes in drug culture • Difficulties for young males • Suicide / suicidal ideation • Anger issues and coping skills • Bereavement • Parental addiction and mental health issues • Learning difficulties	*Bronfenbrenner's Ecological Model*: (micro- meso- exo and macrosystems) *Development of mental / substance use disorders* *(Microsystems)* • Delayed maturity / maladaptive coping strategies • Role of family / peers *(Meso / exosystems)* • Normalisation of addiction • Early school leaving • Bereavement and loss *(Macrosystems)* • Problem drinking culture in Irish society

Table 3.7 Links between sub-themes and elements of the Chronic Care Model

Theme / sub-theme	CCM domain

Theme: *Young people and their interaction with health care services*
 	
• Sub-theme: *Treatment experiences (negative)*
  o Loss of independence
  o Lack of privacy
  o "Feeling institutionalised"
• Sub-theme: *Treatment experiences (system issues)*
  o Limited resources, staff, lengthy waiting times
  o Moving to adult services
  o "Being fobbed off with higher doses of medication"
	Self-management support / (patient autonomy)
	
	Healthcare organisation / (communication between health care workers)

Theme: *Intervention*
 	
• Sub-theme: *Identification (enablers)*
  o *Training in youth mental health*
• Sub-theme: *Treatment (enablers)*
  o Interagency collaboration
	Decision support / (evidence based practice)
	
	Delivery system redesign / healthcare organisation / (interagency collaboration)

Theme: *GP role and approach*
 	
• Sub-theme: *Early intervention (barriers)*
  o *Inappropriate GP referrals*
• Sub-theme: *Early intervention (enablers)*
  o *Interagency collaboration*
  o *Improving GP awareness of other services*
  o *Collaboration between GPs and other health care workers*
	Delivery system redesign / clinical information systems
	
	Delivery system redesign
	Healthcare organisation
	Decision support

3.9 Results Summary

This research describes the experiences of 20 young people and 37 health workers from primary care, secondary care and community agencies in socio-economically disadvantaged areas in Limerick City and Dublin South Inner City to reflect the range of settings where young people seek help for mental and substance use problems. Five overarching themes were identified which summarise accounts from young people and their experiences of mental health and / or substance use problems / disorders and their interactions with health care services. Health care workers described the contextual factors associated with the development, identification and treatment of mental health and substance use disorders and the barriers and enablers associated with identification, treatment and ongoing engagement. Accounts from both health care workers and young people described the role of the GP in terms of barriers and enabler associated with help-seeking and early intervention for mental health and substance use problems.

3.9.1 Young people and their experiences of mental health problems

The journey for young people from experiencing symptoms to crisis point often led to thoughts of suicide and in some cases suicide attempts, prior to their engagement with the health care services. The psychosocial consequences of experiencing mental and substance use problems had negative repercussions on many aspects of their lives: interpersonal relationships often became problematic, educational opportunities were lacking and in some cases young people were faced with legal consequences because of their problems with substance use.

3.9.2 Young people and their interactions with services

Young people were often reluctant to seek help for their problems due to feelings of shame, fear of stigmatisation and negative perceptions of treatment. Lack of relevant information and an inability to initiate help-seeking were barriers to engaging with health care workers. Participants also highlighted system issues in regards to confidentiality and access to services as barriers to help-seeking. The strategies that

facilitated help-seeking included: support from family and friends, youth friendly staff, mental health awareness and service availability. Some participants reported negative treatment experiences as an inpatient due to feeling "institutionalised", loss of independence and lack of age appropriate services. Participants experienced additional treatment difficulties due to medication side effects, limited resources, difficult relationships with health care workers and the transition from child to adult mental health services. Positive patient experiences were facilitated by having choices in treatment, social supports, good relationships with health care workers and effective therapeutic approaches.

3.9.3 The role of social context in addressing youth mental health problems

Social context had a major influence on the development, identification and treatment of youth mental and substance use disorders in socio-economically disadvantaged areas, from the microsystems the individual young person's immediate environment to the macrosystem – the wider societal influences. Health care workers noted that the individual young person may experience challenges within their microsystem that can contribute to the development of mental and / or substance use disorders: such as maladaptive coping skills and repetitive maladaptive family structures. Multiple microsystem factors among young people such as nondisclosure of issues, vulnerable young mothers etc. posed several challenges for health care workers in the identification of mental and substance use disorders. Community based factors relating to the young person's mesosystem and exosystem such as drug related violence and early school leaving resulted in environments that offered limited incentives for self-betterment and personal achievement. Larger societal issues occurring within the macrosystem such as stigma and outdated mental health policy contributed negatively to the development of mental and substance use problems in addition to posing further barriers for young people during their interactions with health care services.

3.9.4 Intervention

Barriers to the identification of mental and substance use disorders included: prioritisation of crisis cases over milder cases, flaws in traditional mental health services

for young people under eighteen years and concerns about formally treating a young person. Building relationships with at-risk young people, further training in youth mental health, formalised assessment, outreach work and promoting mental health awareness among young people were highlighted as key enablers to identification. Barriers to treatment included limited resources, prioritising crisis intervention over early intervention and parental involvement. Treatment was enhanced by closer inter-agency collaboration, implementing appropriate interventions and providing quick access to services. On-going engagement proved to be difficult due to external pressure to engage with services, the young person's unwillingness to engage in counselling and the transition from child to adult mental health services. Ongoing engagement was enhanced by motivational work with young people, continued opportunities for engagement and setting achievable treatment goals.

3.9.5 GP role and approach

Most young participants did not associate the GP with mental health difficulties. Some participants were too embarrassed to discuss their mental health or substance use problems with a familiar GP. Enablers to help seeking were mainly facilitated by having positive GP / patient relationships. Barriers to early intervention included: inappropriate GP referrals, lack of training, limited service availability and lack of GP interest in the area of youth mental and substance use disorders. In terms of enablers to early intervention, the GP role was specified as something which could facilitate early intervention. This role included being: the first point of contact and a liaison with other agencies. Furthermore, collaboration between the GP and other services, appropriate referral pathways and specific training in youth mental health and substance use were additional facilitators to early intervention.

3.10 Convergence between health care workers and young people

Barriers and enablers to health care workers' identification of mental and substance use disorders were very often similar to the barriers and enablers that young people experienced during their interactions with services.

- In the identification of mental and substance use disorders, both groups described access to services and confidentiality issues as key barriers.
- Positive relationships between health care workers and young people, effective activity based programmes, experienced health care workers, outreach work and promoting mental health awareness facilitated the identification of mental and substance use disorders for health care workers and eased the help-seeking process for young people.
- Treatment of mental and substance use disorders was very difficult at times for both health care workers and young people due to system issues (e.g., limited staff, restricted time during consultations, lengthy waiting lists, limited or discontinued funding). Both groups reported difficulties associated with milder mental health issues. Health care workers struggled with meeting the demands of crisis cases while young people who experienced milder symptoms felt that their needs were not prioritised. The transition from child to adult mental health services was also a key barrier to treatment, as both health care workers and young people felt that eighteen years was not the right time to experience a changeover in care. Similar concerns were apparent among most health care workers and young people in regards to formally treating a young person / being "labelled" with a diagnosis.
- Young people and health care workers emphasised the importance of strong support networks, quick access to services, improved referral pathways and providing choices as key enablers to treatment. Both groups advocated the role of school and community as a key enabler to early intervention (e.g., counsellors in schools, training teachers to deal with mental health / substance use problems and incorporating international strategies for addressing youth mental health in the school curriculum.
- Both groups emphasised the importance of engaging with treatment without external pressure. Health care workers often found it difficult to encourage young people to engage with counselling services and young people described negative post counselling experiences.

- Continued opportunities for engagement, setting realistic personal achievement goals and being intrinsically motivated during the recovery process were key enablers to ongoing engagement.

3.11 Divergence between health care workers and young people

- Some health care workers highlighted the importance of incorporating technology in mental / substance use awareness strategies but many young people did not advocate the internet as a useful source of information due to: excessive / inaccurate information, limited access and low computer literacy levels.

3.12 Divergence between young people

- While some participants found post counselling experiences to be negative others benefited from the psychotherapeutic approaches they experienced during treatment.
- Some participants felt that information was lacking in regards to promoting mental / substance use services, however others believed that the key difficulty in seeking help was initiating contact with services.
- Teacher training in youth mental health issues was identified as a key enabler among some young participants, however, others suggested that specific counsellors should be on-site as they would feel uncomfortable discussing emotional problems with teachers that are assigned to address their academic needs.

3.13 Divergence between health care workers

- The main diverging factor between health care workers was the perceived pressure between crisis intervention versus early intervention. Most health care

workers from mental health services reported concerns about utilising limited resources for young people with milder psychological problems rather than those with severe conditions. However, health care workers from other sectors (e.g. primary care and community agencies) stressed the cost effective benefits of providing early intervention for young people in the initial stages of their symptoms rather than waiting until their problems have escalated to a point where expensive specialist services are required.

- Health care workers had conflicting views about ADHD diagnoses, while some health care workers (e.g., GPs and psychiatrists) suggested that many young people were falling through the system, not receiving diagnoses, other health care workers from community agencies felt that many young people were being over medicated, receiving unnecessary diagnoses.

- Health care workers from the mental health services described the potential benefits of getting the young person to "buy-in" with treatment, however, other workers, particularly from addiction services noted that if a young person is driven by external factors to engage with treatment outcomes tend to be less positive.

Chapter 4 - Quantitative Inquiry

4.1 Descriptive results

4.1.1 GP characteristics

A total of 183 GPs (n=363) returned the questionnaire (50% response rate); 104 (29%) in mailing one, 43 (12%) in mailing two and 36 (9%) in mailing three. Eight of these questionnaires were not usable; six questionnaires were returned where, GPs were deceased or had retired and two of the questionnaires arrived after all of the data had been analysed. To allow comparison with a national sample of GPs in Ireland we compared the characteristics of respondents with a study based on the structure of general practice in Ireland (1982-2005) (O'Dowd et al. 2006); demographic information extracted from the report was based on the most recent cohort (2005 participants). Unlike O' Dowd's sample which was predominantly male, the gender of the sample in this study included 82 (47%) males and 79 (45%) females. Similar to O'Dowd's study population, the majority of GPs were in the older (50+) age range (98, 56%), with 64 (37%) in the (35-49) age group and only 8 (5%) in the (<35) age group. The mean number of years since completing GP training was 22. The mean GMS list size was 1390 and the median number of GPs at a practice was 2. Forty six (26%) GPs worked in one doctor practices. Most GPs worked in mixed (GMS / private) practices (153, 87%). Practices were mainly in urban areas (70, 40%) and mixed (61, 35%) areas. In regards to HSE area, GPs were based mainly in the Eastern region (46, 26%), the South (36, 21%) and Southeast (21, 12%).

4.1.2 Education and training

Only 9 (5%) GPs had not completed any postgraduate GP training. Comparable with O'Dowd's (2006) study, the majority of the sample had completed vocational training (103, 59%) / (171, 36%) and continuing medical education (CME) (96, 55%) / (395, 83%). Forty one (23%) GPs had completed training courses in substance use / methadone treatment / alcohol etc. Thirty nine GPs (22%) had completed CME and vocational training. Responses to postgraduate training satisfaction for adult mental health, CAMH and substance use indicated that the majority (133, 76%) were satisfied with postgraduate training in adult mental health, however, training satisfaction with CAMH (29, 17%) and substance use (37, 21%) was low.

4.1.3 Counselling services

Most respondents (138, 79%) reported that counselling services were available to GMS patients in their practice. However, waiting times ranged from 1-3 months in many practices (80, 46%) and in some practices (30, 17%) waiting times extended beyond three months. Unlike O'Dowd's study where 238 (50%) practices had direct access to counselling services, in the current study, only thirty two (18%) GPs had counselling services delivered at their practice; counselling services were delivered on a daily (8, 5%) and weekly basis (21, 12%), however these services were mostly in private practices.

With univariate analysis, counselling services for GMS patients were more available in mixed practices compared to private and GMS practices (85% compared to 60% and 50% $p<.010$). GPs were less likely to screen for substance use disorders where counselling services were available to GMS patients (89% compared to 76%; $p<.022$). Counselling services delivered at the practice were more likely to occur in private compared to mixed and GMS practices (55% compared to 18% and 0%; $p<.001$) and in urban and mixed practices compared to rural practices (23% and 25% compared to 7%; $p<.021$). GPs who had counselling services delivered at their practice were more likely to use screening questionnaires (55% compared to 16%; $p<.028$). (Table 4.1 provides sample characteristics and how this compares to a larger national sample).

Table 4.1: Demographic information, practice type, experience, and education and training of the sample

Characteristic	(N)	Comparative Sample (CS) (N)	No. / (%)	CS No. / (%)
Age range	(170)	(451)		
• <35 years			8 (5)	21 (5)
• (35–49)			64 (37)	205 (45)
• (50+)			98 (56)	225 (50)
Gender	(161)	(468)		
• Males			82 (47)	327 (69)
• Females			79 (45)	141 (30)
Number of years finished training as a GP	(152)	--------	22 (Mean)	--------
			23 (Median; IQR (13, 29)	--------
No. of doctors in practice	(168)	(476)	3 (mean)	(1 ,3)
			2 (median) IQR (1, 4)	
GMS list size	(154)		1390 (mean)	--------
			1075 (median) IQR (700, 1700)	--------
Type of practice	(170)	(476)		
• Private			13 (7)	19 (4)
• Mixed			153 (87)	456 (96)
• GMS			4 (2)	--------
Location of practice	(172)	(476)		
• Rural			41 (23)	97 (20)
• Urban			70 (40)	192 (40)
• Mixed			61 (35)	162 (34)

HSE area of practice	(175)	(476)
• Eastern		46 (26)	366 (77)
• Midlands		15 (9)	247 (52)
• Mid-West		15 (9)	352 (74)
• Northeast		11 (6)	471 (99)
• Northwest		8 (5)	276 (58)
• Southeast		21 (12)	471 (99)
• South		36 (21)	471 (99)
• West		20 (11)	466 (98)
Education and training	(170)	(476)
• None		9 (5)	---------
• Vocational training		103 (59)	171 (36)
• Diploma in mental health / substance use		15 (9)	--------
• CME		96 (55)	395 (83)
• Courses in substance use / alcohol etc.		41 (23)	--------
• Other (Psychiatry placements etc.)		14 (8)	--------
Postgraduate training efficiency to deal with:		
• Adult mental health	(158)	--------
○ Yes		133 (76)	--------
○ No		25 (14)	--------
• CAMH	(156)	--------
○ Yes		29 (17)	--------
○ No		127 (73)	--------
• Substance use	(155)	--------
○ Yes		37 (21)	--------
○ No		118 (67)	--------

Counselling services:		
• Available to GMS patients	(166) --------	
○ Yes		138 (79) --------
○ No		28 (16) --------
• Waiting timeframe	(134) --------	
○ <week		1 (0.6) -------
○ 1-3 weeks		23(13) --------
○ 1-3 months		80 (46) --------
○ >3months		30 (17) --------
• Counselling services delivered in practice	(164) (476)	
○ Yes		32 (18) 238 (50)
○ No		132 (75) --------
• Frequency of services in practice	(32) --------	
○ Daily		8 (5) --------
○ Weekly		21 (12) --------
○ >Monthly		2 (1) --------
○ Monthly		1 (0.6) --------

4.2 T-tests / continuous variables

Independent samples t-tests were carried out on the following continuous variables: *number of years since completing GP training*, *number of GPs in the practice* and *GMS list size* to determine differences in categorical variables relating to postgraduate training, screening, referral, brief interventions and psychotherapeutic interventions.

Participants with *less years since completing GP training (<20)* were more likely to:

- Screen for mental and substance use disorders, use screening questionnaires and screen when clinically indicated.
- Refer people with severe substance use disorders to specialist care.
- Use web-based interventions for people with mental disorders.
- Participants with *more years since completing GP training (>20)* were more likely to use one-to-one counselling for people with mental and / or substance use disorders.

Practices with *a higher number of GPs (>2)*:

- Had counselling services delivered at the practice.
- Used CBT for treating people with mental and substance use disorders.
- Participants with *less GPs (<3)*: referred young people to specialist care for moderate mental and substance use disorders.

Practices with *larger GMS lists (M=1471.43)*:

- Had counselling services available.

Practices with *smaller GMS lists (M=649.14):*

- Screened routinely for substance use disorders.

(Table 4.2 provides an overview of continuous variables and the associated differences in the management of mental and substance use disorders).

Table 4.2 Continuous variables and differences in management of mental and substance use disorders

	Number of years since completing GP training		
	Mean	**SD**	**Significance (P value)**
Screen MH			
• Yes (72)	18.96	10.40	
• No (74)	24.70	8.99	.001
Screen Sub			
• Yes (68)	18.91	11.13	
• No (78)	24.45	8.35	.001
Screening questionnaires			
• Yes (8)	12.13	8.59	
• No (73)	20.74	10.53	.026
Screen clinically indicated MH			
• Yes (47)	17.02	11.06	
• No (100)	24.20	8.72	.001
Screen clinically indicated Sub			
• Yes (49)	18.59	11.69	
• No (98)	23.56	8.76	.004
Refer sub severe			
• Yes (96)	20.25	9.80	
• No (51)	25.02	9.93	.006
Use of counselling MH			
• Yes (95)	24.27	9.82	
• No (52)	17.58	9.11	.001
Use of counselling Sub			
• Yes (81)	24.67	9.27	
• No (66)	18.52	9.19	.001
Web-based interventions MH			
• Yes (18)	17.7	9.27	
• No (129)	24.49	10.07	.055

MH = mental health / Sub = substance use / PG training = postgraduate training

Number of GPs in practice			
	Mean	**SD**	**Significance (P value)**
Counselling services at the practice			
• Yes (31)	3.95	2.123	
• No (128)	2.90	3.127	.029
Refer moderate MH			
• Yes (128)	2.39	1.603	
• No (40)	3.32	3.263	.016
Refer moderate Sub			
• Yes (122)	2.51	1.607	
• No (46)	3.32	3.328	.036
Use of CBT for MH			
• Yes (36)	4.11	5.126	
• No (132)	2.82	1.977	.021
Use of CBT for Sub			
• Yes (24)	4.42	6.114	
• No (144)	2.88	1.997	.019
GMS list size			
	Mean	**SD**	**Sig**
Counselling for GMS patients			
• Yes (123)	1471.43	1300.628	
• No (24)	1048.75	561.669	.012
Routine screening sub			
• Yes (14)	649.14	475.80	
• No (140)	1464.77	1255.54	.001

MH = mental health / Sub = substance use

4.3 Screening practices

While a large proportion screened for mental (86, 49%) and substance use (83, 47%) disorders, only 22 (13%) screened *routinely* for mental disorders and 20 (11%) for substance use disorders. Most screened for mental (51, 29%) and substance use disorders (54, 31%) when clinically indicated. Only 12 (7%) used screening questionnaires.

Univariate and multivariate analysis

Screening was associated with age, gender, practice location and satisfaction with postgraduate training. Older GPs (50+) were less likely to screen for mental and substance use disorders than younger GPs aged (35-49) (38% compared to 60% and 88%; p<.002) and GPs aged (<35) (38% compared to 53% and 88%; p<.004). Younger GPs (<35) were more likely to use screening questionnaires than GPs in older age groups (25% compared to 8% and 5%; p<.035). Female GPs were more likely to screen for substance use disorders (56% compared to 40%; p<.041). GPs based in urban practices were more likely to screen for substance use disorders (63% compared to 41% and 31%; p<.001). Satisfaction with postgraduate training in substance use was associated with screening for substance use disorders (65% compared to 42%; p<.026).

With multivariate analysis, factors associated with not screening for mental / substance use disorders included:

- More years since completing GP training (>20) (odds ratio (OR) = 0.10, p<.002) / (OR=0.03, p<.002)
- The availability of counselling services for GMS patients (OR=0.27, (p<.026) / (OR=0.15, p<.008)
- Lack of education and training as a barrier to treating people with mental disorders (OR=0.25, p<.008)

- Confidence to treat substance use disorders remained as a predictor of screening for substance use disorders (OR=9.98, p<.002). (Tables 4.3-4.6 outline factors associated with screening).

Table 4.3: GP screening of mental health and substance use disorders among young people

Screening	Mental Health N (%)	Substance Use N (%)
Do you screen?	86 (49)	83 (47)
How often do you screen?		
o Routinely	22 (13)	20 (11)
o High risk	16 (9)	13 (7)
o Clinically indicated	51 (29)	54 (31)
Do you use screening questionnaires?	*Screening questionnaires used:*	
o Yes: 12 (7)	o Becks	1 (.6)
o No: 85 (49)	o PHQ (Patient Health Questionnaire)	3 (2)
o N/A: 77 (44)	o SADQ (Severity of Alcohol Dependence Questionnaire)	1 (.6)
Other screening practices:	o Montgomery-Asberg Depression Scale	2 (1)
o Check in file 1 (.6)	o PHQ and Gotland Male Depression Scale	1 (.6)
o Ask patient direct questions 10 (6)	o Hamilton and Becks	1 (.6)
o Blood screening 1 (.6)	o CAGE Audit	1 (.6)

Table 4.4 Predictors of screening for mental health and substance use disorders – demographic factors

	Screen MH		Screen Sub		Screening Questionnaires	
	Yes (%)	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**
Age						
<35	(87%)	**(.002[F])**	(87%)	**(.004[F])**	(25%)	**(.035[F])**
Gender						
Female	(55%)	(.206)	(56%)	**(.041*)**	(8%)	(.693)
Location of practice						
Urban	(59%)	(.133)	(63%)	**(.001*)**	(10%)	(.175)
PG training satisfaction						
Substance Use	(62%)	(.082)	(65%)	**(.026*)**	(18%)	(.211)
Counselling services						
Available for GMS patients	(45%)	(.079)	(43%)	**(.022[F])**	(67%)	(.206)
Counselling services						
Delivered at the practice	(53%)	(.624)	(44%)	(.765)	(54%)	**(.028*)**

PG training = postgraduate training / MH = Mental health / Sub = Substance use / *Pearson Chi-Square (X^2) / [F]Fischer's Exact Test (FET) / [L]Linear by linear association

Table 4.5 Predictors of screening practices for mental and substance use disorders

	Screen MH Routinely		Screen MH – High Risk		Screen MH – Clinically Indicated		Screen Sub – Routinely		Screen Sub – High Risk		Screen Sub – Clinically Indicated	
	Yes (%)	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**
Age <35	(100%)	(.721)	(12%)	(.435)	(75%)	**(0.001[F])**	(25%)	(.183)	(0%)	----	(62%)	**(.006 [F])**
Gender												
Female	(16%)	(.128)	(10%)	(.729)	(38%)	(.308)	(18%)	**(.010*)**	(9%)	(.719)	(23%)	(.617)
Practice type												
Private	(31%)	**(.050 [F])**	(8%)	(1.000)	(38%)	(.800)	23%	(.139)	(8%)	(1.000)	(46%)	(.270)
PG training												
Courses in sub / addiction	(18%)	(.366)	(22%)	**(.002 [F])**	(29%)	(.942)	(15%)	(.570)	(15%)	(.085)	(38%)	(1.000)
PG training satisfaction												
Substance use	(22%)	(.168)	(14%)	(.474)	(27%)	(.735)	(24%)	**(.013 [F])**	(8%)	(.790)	(32%)	(.740)

(*)Pearson Chi-Square (X^2) / [(F)] Fischer's Exact Test / [(L)] Linear by linear association

Table 4.6: Factors associated with screening for mental and substance use disorders

Factor	N	%	Odds ratio	95% CI	P-value
Screening for mental disorders					
No. of years since completing GP training					
0-10	16	13	1.0		
11-20	38	31	0.41	(0.09-1.81)	.242
>20	65	55	0.10	(0.02-0.41)	**.002***
Barrier education.& training					
Not important	45	38	1.0		
Neither	35	29	0.36	(0.13-0.99)	
Important	39	33	0.25	(0.09-0.70)	**.008***
Counselling for GMS patients					
No	21	18	1.0		
Yes	98	82	0.27	(0.08-0.85)	**.026***
Screening for substance use disorders					
No. of years since completing GP training					
0-10	15	14	1.0		
11-20	34	33	0.12	(0.01-1.10)	.061
>20	55	53	0.03	(0.00-0.29)	**.002***
Confidence to treat substance use problems					
Disagree	46	44			
Neither	39	37	3.18	(1.05-9.60)	**.040***
Agree	19	18	9.98	(2.32-42.80)	**.002***
Counselling for GMS patients					
No	18	17	1.0		
Yes	86	83	0.15	(0.03-0.60)	**.008***

4.4 GP management of people with mental / substance use disorders

Most respondents referred young people to specialist care for moderate and severe mental (132, 75%) / (120, 69%) and substance use (126, 72%) / (114, 65%) disorders. However, more GPs referred young people with mild substance use disorders (49, 28%) compared to mild mental disorders (25, 14%). GPs were more likely to use brief interventions for people with moderate and severe mental disorders (94, 54%) / (51, 29%) compared to people with moderate and severe substance use disorders (72, 41%) / (44, 25%). Sixty nine (39%) GPs indicated they never used psychotherapeutic interventions for people with substance use disorders compared to (51, 29%) for people with mental disorders. One-to-one counselling was the most commonly used intervention for people with mental disorders (111, 63%) and people with substance use disorders (94, 54%). Very few GPs used web-based interventions.

Univariate and multivariate analysis

Referral of patients with mental and substance use disorders was associated with: practice type, practice location, GPs who never perform brief interventions, dissatisfaction with postgraduate training and lack of counselling services. GPs working in mixed practices were more likely to refer young people to specialist care for moderate mental and substance use disorders compared to GPs in rural practices (78% compared to 39%; $p<.008$) and (76% compared to 41%; $p<.001$). GPs in private practices were less likely to refer young people to specialist care for moderate substance use problems compared to mixed and GMS practices (30% compared to 76% and 100%; $p<.001$). Dissatisfaction with postgraduate training in substance use was associated with more referrals for people with mild (77% compared to 55%; $p<.013$) and moderate (76% compared to 62%; $p<.045$) substance use disorders.

Factors associated with brief interventions included: practice type, postgraduate training completed and counselling services available. GPs who worked in GMS and mixed practices were more likely to perform brief interventions for people with mild substance use disorders compared to GPs in private practices (100% and 80% compared to 46%; $p<.007$). Involvement in CME was associated with brief interventions for people with moderate mental disorders (61% compared to 40%; $p<.007$) and people with mild

substance use disorders (83% compared to 70%; p<.043). Counselling services available to GMS patients was associated with brief interventions for people with moderate mental disorders (58% compared to 32%; p<.016) and people with mild substance use disorders (82% compared to 68%; p<.041).

Factors associated with the use of psychotherapeutic interventions included: age, gender, practice location, satisfaction with postgraduate training and counselling services available. A larger proportion of older GPs (50+) and younger GPs (<35) used one-to-one counselling for people with mental disorders and people with substance use disorders than GPs aged (35-49) (79% and 75% compared to 41%; p<0.001) and (63% and 70% compared to 28%; p<0.001). Females GPs were more likely to use web-based interventions for treating people with mental disorders (18% compared to 6%; p<.022) and male GPs were more likely to use one-to-one counselling for treating people with substance use disorders (65% compared to 44%; p<.010). GPs in rural practices were more likely to use one-to-one counselling for treating people with substance use disorders than those based in urban and mixed practices (71% compared to 47% and 51%; p<.045). Involvement in CME was associated with web-based interventions for people with mental disorders (18% compared to 7%; p<.035) and one-to-one counselling for people with substance use disorders (62% compared to 42%; p<.012). Satisfaction with postgraduate training in CAMH was associated with one-to-one counselling for treating people with mental disorders (83% compared to 58%; p<.043) and training satisfaction in substance use was associated with web-based interventions for treating people with substance use disorders (13% compared to 2%; p<.030).

With multivariate analysis, the following factors remained as predictors of referral / brief / psychotherapeutic interventions

- Urban (OR=3.76, p<.012) and mixed practices (OR=5.16, p<.005) were more likely to refer people with moderate mental disorders to specialist services.
- Lack of training and education as a barrier (OR=3.28, p<.032) remained as a predictor of referral for people with moderate mental disorders.
- Mixed practices (OR=7.78, p<.001) was associated with referral for people with moderate substance use disorders.

- Counselling services delivered at the practice (OR=0.29, p<.012) and satisfaction with postgraduate training in CAMH (OR=0.37, p<.040) remained as predictors of non-referral for people with moderate substance use disorders.
- GPs involved in CME were more likely to perform interventions for people with moderate substance use disorders (OR=2.31, p<.015).
- GPs in mixed practices were more likely to perform brief interventions for people with mild substance use disorders (OR=4.51, p<.011).
- Counselling services delivered at the practice remained a predictor of using CBT for people with mental disorders (OR=2.92, p<.019).
- Age (50+) (OR=4.23, p<0.001) and satisfaction with postgraduate training in CAMH (OR=3.94, p<.040) remained as predictors of counselling for people with mental disorders.
- Age (50+) (OR=5.19, p<0.001) and involvement in CME (OR=2.45, p<.020) were predictors of counselling for people with substance use disorders.
- Number of years since completing GP training (>20) (OR=0.15, p<.010) was associated with non-use of web-based interventions for people with mental disorders and involvement in CME (OR=3.98, p<.050) was associated with the use of web-based interventions for people with mental disorders.
- Satisfaction with postgraduate training in substance use was significantly associated with the use of web-based interventions for people with substance use disorders (OR=6.33, p<.015). (Tables 4.7- 4.12 outline results based on the GP management of mental and substance use disorders).

Table 4.7 GP management of people with mental and substance use disorders

Referral / Intervention	Mental Health N (%)	Substance Use N (%)
Referral to specialist care		
o Never	1 (.6)	2 (1)
o Mild cases	25 (14)	49 (28)
o Moderate cases	132 (75)	126 (72)
o Severe cases	120 (69)	114 (65)
Brief interventions		
o Never	15 (9)	26 (15)
o Mild cases	139 (80)	136 (78)
o Moderate cases	94 (53)	72 (41)
o Severe cases	51 (29)	44 (25)
Psychotherapeutic interventions used:		
o None	51 (29)	69 (39)
o CBT	38 (22)	25 (14)
o One-to-one counselling	111 (63)	94 (54)
o Web-based interventions	23 (13)	9 (5)
o Other interventions (e.g. regular phone contact, addiction counselling, literature)	3 (2)	2 (1)

Table 4.8 Predictors of referral practices for people with mental and substance use disorders

	MH – Mild		MH – Moderate		MH – Severe		Sub – Mild		Sub - Moderate		Sub - Severe	
	Yes (%)	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**
Practice type												
Mixed (GMS / private)	(16%)	(.300)	(78%)	**(.008^{L})**	(67%)	(.450)	(30%)	(.481)	(76%)	**(0.001^{L})**	(65%)	(.346)
Practice location												
Mixed	(15%)	(.830)	(82%)	**(.022^{L})**	(69%)	(.977)	(36%)	(.206)	(84%)	**(.005^{L})**	(64%)	(.840)
No counselling services:												
for GMS patients	(25%)	(.259)	(75%)	(.855)	(64%)	(.284)	(43%)	**(p<.035^{F})**	(71%)	(.330)	(68%)	(.472)
in the practice	(14%)	(.630)	(75%)	(.864)	(70%)	(.452)	(28%)	(.320)	(76%)	**(.022^{L})**	(66%)	(.542)
Dissatisfaction with PG training												
CAMH	(16%)	(.285)	(77%)	(.234)	(68%)	(.956)	(30%)	**(.046^{L})**	(77%)	**(.013^{L})**	(67%)	(.477)
Substance Use	(15%)	(.362)	(80%)	**(.049^{L})**	(70%)	(.582)	(31%)	**(.012^{L})**	(76%)	**(.045^{L})**	(66%)	(.759)
Never perform brief interventions	(20%)	(.453)	(93%)	(.121)	(40%)	**(.019^{F})**	(40%)	(.366)	(65%)	(.416)	(42%)	**(.008*)**

(*)Pearson Chi-Square (X^2) / $^{(F)}$ Fischer's Exact Test / $^{(L)}$ Linear by linear association

Table 4.9 Predictors of brief interventions for people with mental and substance use disorders

	MH – Mild		MH – Moderate		MH – Severe		Sub - Mild		Sub – Moderate		Sub - Severe	
	Yes (%)	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**
Practice type												
Mixed (Private / GMS)	(80%)	(.071)	(52%)	(.649)	(31%)	(.258)	(80%)	**(.007[L])**	(39%)	(.401)	(26%)	(.554)
PG training												
CME	(80%)	(.770)	(61%)	**(.007*)**	(29%)	(.910)	(83%)	**(.043*)**	(43%)	(.316)	(25%)	(.759)
Counselling services:												
for GMS patients	(82%)	(.114)	(58%)	**(.016[F])**	(33%)	(.271)	(82%)	**(.041[F])**	(43%)	(.240)	(27%)	(.372)
in the practice	(83%)	(.099)	(72%)	**(.030[F])**	(38%)	(.577)	(81%)	(.279)	(44%)	(.907)	(25%)	(836)
Satisfaction with PG training:												
Substance use	(87%)	(.390)	(62%)	(.483)	(27%)	(.876)	(86%)	(.205)	(57%)	**(.025[L])**	(24%)	(.246)

(*)Pearson Chi-Square (X^2) / [(F)] Fischer's Exact Test / [(L)] Linear by linear association / PG training = postgraduate training

Table 4.10 Predictors of psychotherapeutic interventions for people with mental and substance use disorders

	CBT – MH		One-to-one counselling – MH		One-to-one counselling - Sub		Web-based interventions – MH		Web-based interventions – Sub	
	Yes (%)	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**	**Yes (%)**	**(P value)**
Age										
<35	(25%)	(.763)	(75%)	**(0.001[F])**	(63%)	**(0.001[F])**	(25%)	(.081)	(12%)	(.158)
50+	(22%)	(.763)	(79%)	**(0.001[F])**	(70%)	**(0.001[F])**	(9%)	(.081)	(3%)	(.158)
Gender										
Male	(16%)	(.095)	(70%)	(.244)	(65%)	**(.010*)**	(6%)	**(.022*)**	(5%)	(1.000)
Female	(27%)	(.095)	(60%)	(.244)	(44%)	**(.010*)**	(18%)	**(.022*)**	(4%)	(1.000)
Practice location										
Rural	(17%)	(.655)	(76%)	(.103)	(71%)	**(.045*)**	(5%)	(.106)	(0%)	-----
PG training										
CME	(26%)	(.124)	(70%)	**(.050*)**	(62%)	**(.012*)**	(18%)	**(.035*)**	(6%)	(.468)
PG satisfaction										
CAMH	(20%)	(.704)	(83%)	**(.043[F])**	(62%)	(.568)	(10%)	(.919)	(7%)	(.536)
Substance use	(27%)	(.512)	(68%)	(.857)	(70%)	(.080)	(27%)	**(.026[F])**	(13%)	**(.030[F])**

(*)Pearson Chi-Square (X^2) / [(F)] Fischer's Exact Test / [(L)] Linear by linear association

Table 4.11 Factors associated with referral of people with mental and substance use disorders

Factor	N	%	Odds ratio	95% CI	P-value
Referral of people with moderate mental disorders					
Prac. location					
Rural	36	26	1.0		
Urban	56	40	3.76	(1.34-10.66)	**.012***
Mixed	46	33	5.16	(1.62-16.41)	**.005***
Barrier educ. & training					
Not important	52	38	1.0		
Neither	42	30	3.52	(1.184-10.49)	
Important	44	32	3.28	(1.107-9.74)	**.032***
Referral of people with moderate substance use disorders					
Prac. location					
Rural	37	25	1.0		
Urban	65	44	2.31	(0.94-5.71)	.067
Mixed	47	32	7.78	(2.33-25.69)	**.001***
Counselling services at practice					
No	120	81	1.0		
Yes	29	19	0.29	(0.11-0.76)	**.012***
PG training satisfaction					
CAMHs					
No	120	20	1.0		
Yes	29	80	0.37	(0.14-0.95)	**.040***
Referral of people with severe substance use disorders					
Age					
Under 50	65	45	1.0		
50+	81	55	0.36	(0.17-0.77)	**.009***
Perform brief interventions for sub use					
No	21	14	0.33	(0.12-0.88)	**.028***
Yes	125	86	1.0		

Table 4.12 Factors associated with performing brief / psychotherapeutic interventions

Factor	N	%	Odds ratio	95% CI	P-value
Brief intervention for people with moderate mental use disorders					
CME					
No	58	40			
Yes	87	60	2.31	(1.17-4.57)	**.015***
Brief intervention for people with mild substance use disorders					
Practice type					
Private	13	8	1.0		
Mixed	151	90	4.51	(1.41-14.40)	**.011***
GMS	4	2	1.0		
Factors associated with using CBT for people with mental disorders					
Counselling at practice					
No	110	79	1.0		
Yes	29	21	2.92	(1.19-7.18)	**.019***
Factors associated with using counselling for people with mental disorders					
Age					
Under 50	55	44	1.0		
50+	70	56	4.23	(1.89-9.50)	**0.001***
PG CAMH					
No	100	80	1.0		
Yes	25	20	3.96	(1.06-14.75)	**.040***
Factors associated with using web-based interventions for mental disorders					
No. of yrs since completing GP training					
0-10	16	12	1.0		
11-20	40	29	0.49		
>20	81	59	0.15	(0.03-0.64)	**.010***
CME					
No	60	44	1.0		
Yes	77	56	3.98	(0.98-16.18)	**.050***
Factors associated with using counselling for people with substance use disorders					
Age					
Under 50	60	44	1.0		
50+	77	56	5.19	(2.43-11.05)	**0.001***
CME					
No	60	44	1.0		
Yes	77	56	2.45	(1.15-5.22)	**.020***
Factors associated with using web-based interventions for people with substance use disorders					
PG training satisfaction – substance use					
No	117	77	1.0		
Yes	35	23	6.33	(1.43-28.01)	**.015***

4.5 Barriers to treating mental and substance use disorders

Participants considered the main barriers to addressing youth mental and substance use disorders and ranked each on a scale of 1 to 5 where (1 = not at all important and 5 = very important). Respondents considered the following factors to be very important barriers: attitude of the patient (85, 49%) / (101, 58%), attitude of the family (45, 26%) / (46, 26%), lack of specialist staff (43, 25%) / (51, 29%), lack of time (48, 27%) / (40, 23%) and poor service availability (49, 28%) / (44, 25%). Seventy six (43%) GPs considered lack of interest in the area to be a not at all important barrier for addressing people with mental disorders compared to 57 (33%) for people with substance use disorders. Attitude of the family was a more important barrier for addressing people with mental disorders (47, 27%) compared to people with substance use disorders (39, 22%) whereas attitude of the patient was considered a more important barrier for addressing people with substance use disorders (101, 58%) compared to people with mental disorders (85, 49%) (see table 4.13).

Univariate analysis

Barriers to treating people with mental and substance use disorders were associated with: age, gender, practice type, dissatisfaction with training and non-screening. In contrast to older GPs (50+), younger GPs (<35) were more likely to identify attitude of the patient (75% compared to 57%; p<.50) and poor service availability (38% compared to 27%; p<.038) as barriers to addressing people with substance use disorders. Female GPs were more likely to identify lack of training and education as a barrier to treating people with substance use disorders (39% compared to 26%; p<.008) and poor service availability as a barrier to addressing people with mental disorders (37% compared to 21%; p<.030) and people with substance use disorders (38% compared to 18%; p<.002). Dissatisfaction with postgraduate training in CAMH and substance use was associated with: lack of interest in the area and lack of training and education. There was an association between GPs who do not screen for mental / substance use disorders and the following barriers: lack of specialist staff, lack of interest in mental health / substance use and lack of training and education (see table 4.14).

Table 4.13 Barriers to treatment of people with mental and substance use disorders

Barrier	Very Important (%)		Important (%)		Mental disorders		Substance Use	
	MH	Sub	MH	Sub	Mean rating / SD		Mean rating / SD	
Attitude of family	45 (26)	46 (26)	47 (27)	39 (22)	3.58	1.16	3.48	1.29
Attitude of patient	85 (49)	101 (58)	48 (27)	37 (21)	4.24	.955	4.46	.831
Lack of specialist staff	43 (25)	51 (29)	25 (14)	33 (19)	3.21	1.38	3.43	1.40
Lack of interest in the area	5 (3)	6 (3)	10 (6)	17 (10)	1.98	1.09	2.28	1.16
My lack of time	48 (27)	40 (23)	36 (21)	47 (27)	3.32	1.40	3.40	1.32
Lack of training & educ.	11 (6)	25 (14)	42 (24)	52 (29)	2.86	1.16	3.25	1.24
Poor service availability	49 (28)	44 (25)	43 (25)	44 (25)	3.53	1.28	3.48	1.30
Stigma	19 (11)	17 (10)	43 (25)	33 (19)	2.94	1.28	2.89	1.23

MH = mental health; Sub = substance use

Table 4.14 Factors associated with barriers to treating people with mental and substance use disorders

	Attitude of family		Attitude of patient		Lack of specialist staff		Lack of interest in MH / Sub		Lack of time		Lack of training / educ.		Poor service availability	
	(P value)		(P value)		(P value)		(P value)		(P value)		(P value)		(P value)	
	MH	Sub	MH	Sub	MH	Sub	MH	Sub	MH	Sub	MH	Sub	MH	Sub
Age: (<35)	(.726)	(.673)	(.451)	**(.050^{L})**	(.171)	(.052)	(.689)	(.553)	(.681)	(.650)	(.941)	(.827)	(.333)	**(.038*)**
Gender: Female	(.926)	(.564)	(.197)	(.626)	(.469)	(.521)	(.863)	(.160)	(.446)	(.648)	(.457)	**(.008^{L})**	**(.030^{L})**	**(.002^{L})**
Prac. type: Mixed	(.108)	**(.006^{F})**	**(.032^{F})**	(.593)	(.295)	(.927)	(.378)	(.485)	(.333)	**(.029^{F})**	(.336)	(.655)	(.496)	(.053)
Lack of PG training:														
Vocational	(.182)	(.065)	**(.049^{F})**	(.513)	(.679)	(.637)	(.935)	(.761)	(.715)	(.076)	(.583)	(.674)	(.384)	(.368)
Diploma	**(.029^{L})**	**(.006^{F})**	(.184)	(.352)	(.094)	(.792)	(.496)	(.260)	(.204)	(.291)	(.196)	(.674)	(.636)	**(.049^{L})**
CME	(.882)	(.875)	(.851)	(.879)	(.869)	(.659)	**(.045^{F})**	(.684)	(.207)	(.738)	(.617)	(.950)	(.227)	(.466)
Courses in Sub etc.	(.254)	(.587)	(.685)	**(.047^{F})**	(.857)	(.957)	(.488)	**(.005^{L})**	(.367)	(.374)	(.707)	**(.001^{L})**	(.773)	(.763)
Other training	(.757)	(.274)	(.103)	(.937)	**(.029^{F})**	**(.049^{L})**	(.909)	(.692)	**(.029*)**	**(.027*)**	**(.044^{F})**	(.053)	(.097)	(.147)
Dissatisfaction with PG training:														
Adult MH	**(.032^{F})**	**(.004^{F})**	(.092)	(.673)	(.827)	(.497)	**(.028^{F})**	**(.048^{F})**	(.093)	(.102)	(.119)	(.171)	(.220)	(.966)
CAMH	(.256)	**(.035^{F})**	(.578)	(.578)	(.228)	(.137)	**(.027*)**	**(.031^{L})**	(.068)	(.117)	**(.002^{F})**	**(.004^{F})**	(.339)	(.340)
Sub use	(.101)	(.072)	(.885)	(.424)	**(.022^{F})**	**(.006^{F})**	**(.032*)**	**(.003^{F})**	**(.001^{F})**	**(.001^{F})**	**(.001^{L})**	**(.001^{L})**	(.588)	(.649)
Screen – No	(.468)	(.349)	(.776)	(.199)	**(.024^{L})**	**(.017^{L})**	**(0.15^{L})**	**(.049^{F})**	(.163)	(.339)	**(.032^{L})**	**(.034^{L})**	(.286)	(.085)

(*)Pearson Chi-Square (X^2) / $^{(F)}$ Fischer's Exact Test / $^{(L)}$ Linear by linear association

4.6 GP attitudes to working with youth mental health problems

Attitudes were measured on a Likert scale of 1 (strongly disagree) to 5 (strongly agree). GPs were more confident diagnosing (94, 54%) and treating (78, 45%) people with mental disorders compared to people with substance use disorders (57, 33%) and (24, 14%) and were more likely to agree that GPs should manage people with mental disorders (68, 39%) compared to people with substance use disorders (35, 20%). GPs were more likely to prescribe psychotropic medication for people with mental disorders (56, 32%) compared to people with substance use disorders (14, 8%) and felt less competent in the use of psychotropic medication for treating people with substance use disorders (24, 14%) compared to people with mental disorders (55, 31%).

Univariate analysis

GPs in the older age group (50+) were less confident treating people with mental disorders (10% compared to 14% and 25%; $p<.012$), were more likely to strongly disagree with GP management of people with substance use disorders (8% compared to 3% and 0%; $p<.044$) and were less likely to initiate psychotropic medication for people with substance use disorders (15% compared to 29% and 37%; $p<.029$). GPs who were dissatisfied with their postgraduate training in substance use were less confident diagnosing, treating, initiating prescription of psychotropic medication or feeling competent in the use of psychotropic medication for young people with substance use disorders. Screening for mental and substance use disorders was associated with more confidence in diagnosing people with substance use disorders and treating people with mental and substance use disorders. GPs who screened people for substance use disorders were also more likely to agree with: GP management of people with substance use disorders, the effectiveness of GP administered brief interventions, the importance of other lifestyle interventions and the use of lifestyle interventions before administering psychotropic drugs. (Tables 4.15-4.17 outline factors associated with GP attitudes to working with youth mental / substance use disorders).

Table 4.15 GP attitudes towards working with youth mental and substance use disorders

Attitude	Strongly Agree (%)		Agree (%)		Mental disorders		Substance Use	
	MH	Sub	MH	Sub	Mean rating / SD		Mean rating / SD	
GP as first point of contact	15 (9)	12 (7)	28 (16)	14 (8)	2.71	1.20	2.42	1.18
Confidence to diagnose common problems	38 (22)	23 (13)	94 (54)	57 (33)	3.91	.844	3.28	1.12
Confidence to treat the most frequent disorders	21 (12)	9 (5)	78 (45)	24 (14)	3.57	.891	2.67	1.04
GPs should manage mental / substance use disorders	28 (16)	16 (9)	68 (39)	35 (20)	3.52	1.04	2.97	1.09
Advice from colleagues rather than guidelines	46 (26)	54 (31)	53 (30)	55 (31)	3.68	1.06	3.80	1.07
Frequent prescription of psychotropic medication	56 (32)	14 (8)	65 (37)	35 (20)	3.82	1.16	2.67	1.28
Competence in use of psychotropic medication	15 (9)	9 (5)	55 (31)	24 (14)	3.13	1.09	2.48	1.20
GP administered brief interventions are effective	17 (10)	14 (8)	76 (43)	45 (26)	3.58	.828	3.11	1.01
Other lifestyle interventions are important	88 (50)	70 (40)	67 (38)	67 (38)	4.36	.793	4.14	.942
Use of lifestyle interventions before medication	37 (21)	39 (22)	55 (31)	48 (27)	3.53	1.10	3.44	1.23

MH = mental health; Sub = substance use

Table 4.16 Predictors of GP attitudes to working with people with mental disorders

	Confidence to diagnose MH	Confidence to treat MH	Preference for advice from colleagues / guidelines	Frequent prescription of psychotropic medication	Competence in use of psychotropic medication	GPs administered brief interventions are effective	Other lifestyle interventions (e.g. exercise, diet, etc.) are important.	Use lifestyle interventions before administering psychotropic drugs
	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)
Age	(.147)	**(.012[L])**	(.954)	(.377)	(.477)	(.479)	(.618)	(.065)
Gender	(.525)	(.326)	(.903)	**(.009*)**	(.779)	**(.015[F])**	**(.010[L])**	(.085)
Practice type	(.310)	(.195)	(.127)	(.604)	(.789)	(.518)	(.107)	**(.038*)**
PG training completed	(.059)	**(.046[F])**	------	-------	**(.039*)**	**(.037[F])**	------	**(.048[F])**
PG training adequate	------	**(.001[F])**	**(0.001[F])**	-------	------	------	------	------
GPs who screen	(.070)	**(.049[L])**	(.646)	(.672)	(.626)	(.064)	(.158)	(.218)
Counselling								
GMS	(.470)	(.760)	(.348)	(.708)	(.559)	(.318)	(.634)	**(.029*)**
At practice	(.879)	(.071)	(.551)	(.635)	(.909)	(.424)	(.303)	**(.009*)**

(*)Pearson Chi-Square (X^2) / [(F)] Fischer's Exact Test / [(L)] Linear by linear association

Table 4.17 Predictors of GP attitudes to working with people with substance use disorders

	GP – initial contact for sub	Confident to diagnose sub	Confident to treat sub	Appropriate for GPs to manage sub	Preference for advice from colleagues	Frequent prescription of medication	Competence in use of psychotropic medication	GP brief interventions are effective	Other lifestyle interventions important	Lifestyle intervens. before meds
	(P value)	**(P value)**	**(P value)**	**(P value)**	**(P value)**	**(P value)**	**(P value)**	**(P value)**	**(P value)**	**(P value)**
Age	(.133)	(.647)	(.375)	**(.044^{F})**	(.929)	**(.029^{F})**	(.889)	(.754)	(.717)	(.306)
Gender	(.626)	(.102)	(.491)	(.669)	(.767)	(.068)	(.395)	**(.037^{L})**	(.081)	(.568)
PG training completed	------	------	------	------	**(.033^{F})**	------	**(.008^{L})**	**(.027^{L})**	------	------
Lack of PG training	------	**(0.001^{L})**	**(0.001^{L})**	**(.015^{L})**	------	**(.001^{L})**	**(.021^{F})**	------	------	------
PG training: adequate	------	------	------	------	**(.001^{F})**	**(.004^{F})**	------	------	------	------
PG training: inadequate	------	**(0.001^{F})**	**(0.001^{F})**	**(0.001^{L})**	------	**(.013^{F})**	**(.038*)**	------	------	------
Screen – yes	(.307)	**(0.001^{F})**	**(0.001*)**	**(.006^{L})**	(.066)	(.658)	(.674)	**(.002^{L})**	**(.007^{L})**	**(.006^{L})**
Counselling										
GMS	**(.037*)**	**(.036^{L})**	(.236)	(.949)	(.254)	(.077)	(.492)	(.361)	(.156)	(.290)
At practice	(.593)	**(.040*)**	**(.031^{F})**	(.383)	(.986)	(.726)	(.422)	(.341)	(.685)	(.483)

(*)Pearson Chi-Square (X^2) / $^{(F)}$ Fischer's Exact Test / $^{(L)}$ Linear by linear association

4.7 Interventions to address youth mental health problems

Access to services (especially for psychological interventions) (117, 67%), appropriate time and space to explore youth issues (82, 47%), clear definitions of which interventions can be initiated in primary care (77, 44%) and access to a youth worker (73, 42%) were identified as the most important interventions to facilitate screening and treatment of mental and substance use disorders. However, GPs were less likely to agree that stepped care (20, 11%), specific wording for difficult questions (22, 13%), primary care having a more active role in the community (29, 17%) and stronger links with schools (33, 19%) would enhance their capability to address youth mental and substance use disorders in their practice.

Univariate analysis

Interventions to address youth mental and substance use disorders in general practice were associated with gender, practice type, training dissatisfaction and screening, referral, performing brief / psychotherapeutic interventions for people with mental / substance use disorders. Female GPs were more likely to agree with having access to services (78% compared to 63%; $p<.004$) and access to a youth worker (50 % compared to 37%; $p<.030$). GPs working in mixed practices were more likely to agree with a clear definition of which interventions can be initiated in primary care (48% compared to 25% and 17%; $p<.026$). However, GPs working in GMS practices were more likely to agree with interagency collaboration (50% compared to 26% and 8%; $p<.044$).

Dissatisfaction with training in CAMH was associated with: time and space to explore youth issues, stronger links with schools and training for practice nurses. GPs who did not screen for mental / substance use disorders were more likely to identify the following interventions to enhance their capability to address youth mental health issues: access to services, guidelines for interagency collaboration, time to explore youth issues, interagency collaboration, patient friendly information, primary care as an agent for social care in the community, specific wording for difficult questions, training for practice nurses and access to a youth worker. (See table 4.18 and 4.19 for predictors of interventions to address youth mental health issues in general practice).

Table 4.18 Interventions to address youth mental and substance use disorders in general practice

Intervention	Strongly agree (%)	Agree N (%)	Mean rating	SD
Access to services (for psychological interventions)	117 (67)	39 (22)	4.54	.806
Definitions of interventions initiated in primary care	77 (44)	58 (33)	4.10	1.07
Formalising GP role across youth environments	49 (28)	65 (37)	3.80	1.08
Guidelines for interagency collaboration	55 (31)	64 (37)	3.90	1.07
Appropriate time & space to explore youth issues	82 (47)	65 (37)	4.31	.850
Stronger links with schools	33 (19)	54 (31)	3.52	1.03
Interagency collaboration	45 (26)	83 (47)	3.94	.891
List of appropriate resources	62 (35)	79 (45)	4.14	.831
Patient friendly information	40 (23)	69 (39)	3.76	.964
Personal knowledge and skills	51 (29)	51 (29)	4.08	.752
Primary care – more active role in the community	29 (17)	58 (33)	3.49	1.02
Specific wording for difficult questions	22 (13)	59 (34)	3.36	1.04
Stepped care	20 (11)	78 (45)	3.61	.864
Treatment guides	44 (25)	44 (25)	3.98	.797
Training for GPs	63 (36)	63 (36)	4.21	.731
Training for practice nurses	39 (22)	80 (46)	3.82	.932
Access to youth worker	73 (42)	76 (43)	4.26	.779

Table 4.19 Predictors of interventions to address youth mental health issues in general practice

	Gender	Practice type	Lack of training	Training inadequate	Screen Yes / No	Referral Yes / No	Brief Interventions Yes / No	Psycho-ther. Interventions Yes / No
	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)
Access to services	**(.004[F])**	(.789)	------	------	**(p<.043*) (No)**	------	**(p<.020) (No)**	**(p<.023) (No)**
Definition of interventions	(.136)	**(.026[F])**	------	------	(.669)	**(p<.019) (No)**	------	------
Formalise GP role	(.533)	(.058)	------	------	**(.050[L]) (Yes)**	**(p<.030) (Yes)**	**------**	**(p<.020) (No)**
Guidelines for collaboration	(.654)	(.059)	(.063)	------	**(p<.021) (No)**	**(p<.037) (No)**	------	------
Time to explore issues in youth	(.464)	(.071)	------	**(.047[F])**	**(p<.047) (No)**	------	**(p<.004) (No)**	------
Stronger links with schools	(.679)	(.393)	------	**(.035*)**	**(.020*) (Yes)**	------	------	**(p<.011) (No)**
Interagency collaboration	(.181)	**(.044[L])**	------	------	**(.038[F]) (No)**	**(p<.012) (Yes)**	**------**	**-------**
List of resources	(.801)	(.757)	------	------	(.133)	**(p<.006) (No)**	------	------
Patient friendly information	(.783)	(.298)	------	**(.016[F])**	**(p<.024) (No)**	**(p<.025) (Yes)**	------	------
Skills development	(.446)	(.532)	**(.001*)**	**(.003[F])**	(.215)	------	**(p<.005) (No)**	**------**
Primary care more active role	(.061)	(.421)	**(.006[F])**	(.622)	**(.050*) (No)**	------	**------**	**------**
Specific wording for questions	(.691)	(.682)	------	------	**(p<.009) (No)**	**(p<.017) (Yes)**	------	------
Stepped care	(.194)	(.329)	------	**(.011[F])**	(1.000)	------	------	------
Treatment guides	(.062)	(.456)	**(0.26[F])**	**(.002[F])**	(.430)	**(p<.007) (Yes)**	------	------
Training for GPs	(.466)	(.411)	------	**(.045)**	(.189)	------	------	**(p<.037) (Yes)**
Training for practice nurses	(.950)	(.787)	**(0.17[F])**	**(.031[F])**	**(p<.040) (No)**	------	**(p<.007) (No)**	**(p<.039) (Yes)**
Access to youth worker	**(.030[L])**	(.973)	-------	**------**	**(.026[F]) (No)**	------	**(p<.039) (No)**	**------**

(*)Pearson Chi-Square (X^2) / [(F)] Fischer's Exact Test / [(L)] Linear by linear association

4.8 Barriers and attitudes associated with interventions

The following variables were recoded / collapsed (due to the small sample size) to determine the relationships between barriers and attitudes to working with youth mental / substance use disorders and potential interventions that could enhance the GP to address these issues. Barriers were recoded from (1 = not at all important to 5 = very important) to (1 = not important to 3 = important). Attitude and intervention variables were recoded from (1 =strongly disagree to 5 = strongly agree) to (1 = disagree to 3 = agree).

4.8.1 Barriers and interventions

- Attitude of the family as a barrier to treating people with mental disorders was associated with: clear definitions of interventions in primary care and time and space to explore youth issues.
- Attitude of the patient as a barrier to treating people with substance use disorders was associated with time and space to explore youth issues.
- Lack of specialist staff in the practice as a barrier for treating people with mental / substance use disorders was associated with: formalising the role of the GP across youth environments, interagency collaboration and stepped care.
- Lack of time as a barrier to treating people with mental / substance use disorders was associated with: time to explore youth issues, interagency collaboration and access to services.
- Lack of training and education as a barrier to treating people with mental disorders was associated with: training for practice nurses.
- Poor service availability for treating people with substance use disorders was associated with: access to services, formalising the GP role, stronger links with schools and a list of appropriate resources / agencies. (Table 4.20 outlines barriers associated with interventions to address youth mental health issues)

Table 4.20 Barriers associated with interventions to address youth mental health issues in general practice

	Attitude of the family / MH	Attitude of the patient / MH	Lack of specialist staff MH / Sub	Lack of time MH / Sub	Lack of training / educ. MH / Sub	Poor service availability Sub
	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)
Access to services	------	------	------	(.040^{L}) (Sub)	------	(.022^{F})
Interventions for PC	(.007)^{L}	------	------	------	------	------
Formalise role of GPs	------	------	(.006^{F}) (MH) (.036$^{F)}$ (Sub)	(.048^{F}) (Sub)	------	(.005^{L})
Time to explore issues in youth	(.034)^{F}	(.020^{F})	------	(p<.013^{L}) (MH) (.004^{L}) (Sub)	------	------
Links with schools	------	------	------	------	------	(.020^{L})
Interagency collaboration	------	------	(.0001^{F}) (MH) (.001^{F}) (Sub)	(.031^{F}) (MH)	------	------
List of resources	------	------	------	------	------	(.047^{F})
Patient information	------	------	(.028^{F}) (Sub)	------	------	------
Stepped care	------	------	(.009^{L}) (MH) (.016^{F}) (Sub)	------	------	------
Treatment guides	------	------	(.043^{L}) (Sub)	(.053^{F}) (Sub)	(.018^{L}) (Sub)	------
Training for PNs	------	------	------	------	(.035^{F}) (MH)	------

(*)Pearson Chi-Square (X^2) / $^{(F)}$ Fischer's Exact Test / $^{(L)}$ Linear by linear association / PC = primary care / PN = practice nurse

4.8.2 Attitudes and interventions

- Participants who agreed that the GP should be an initial contact for people with mental / substance use disorders were more likely to agree with primary care having a more active role in the community.
- Confidence in diagnosing people with mental disorders was associated with access to services and access to a youth worker.
- Participants who agreed that it was appropriate for GPs to manage mental and substance use disorders were more likely to agree with access to a youth worker.
- Preference for advice from colleagues / experts in the field as opposed to guidelines for addressing people with mental / substance use disorders was associated with formalising the GP role, guidelines for interagency collaboration and specific wording for difficult questions.
- GPs who did not initiate frequent prescription of psychotropic medication for substance use disorders were more likely to agree with a list of agencies / web resources and disagree with clear definitions of interventions for primary care.
- Competence in the use of psychotropic medication for people with mental / substance use disorders was associated with a preference for stepped care and time and space to explore youth issues.
- Participants who agreed that GP brief interventions were effective were more likely to identify interagency collaboration and training for GPs as important interventions for mental disorders and personal knowledge skills and stepped care for substance use disorders.
- Utilisation of lifestyle interventions before psychotropic medication for people with mental disorders was associated with interagency collaboration and training for GPs (see table 4.21 for overview of attitudes associated with interventions).

Table 4.21 Attitudes associated with interventions to address youth mental / substance use disorders in general practice

	GP initial contact MH / Sub	Confidence in diagnosing MH	Confidence in treating MH	GPs should manage MH / Sub	Advice from colleagues / guidelines	Prescribing psycho-tropic meds Sub	Competent in use of psycho-tropic meds MH / Sub	GP interventions are effective MH / Sub	Lifestyle interventions important MH / Sub	Lifestyle interventions before drugs MH
	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)	(P value)
Access to services	------	(.030^{F})	------	------	------	------	------	------	(.001^{F}) MH	------
Interventions for Primary Care	------	------	------	------	------	(.036*)	------	------	(.018^{L}) MH	------
Formalise role of GPs	(.002^{L}) MH	------	------	------	(.013^{F}) MH (.005^{F}) Sub	------	------	------	(.001^{L}) MH	------
Guidelines for interagency collaboration	------	------	------	------	(.038*) MH (.026*) Sub	------	------	------	(.004^{L}) MH	------
Time to explore youth issues	------	------	------	(.019^{L})	------	------	(.024^{L})	------	(.001^{F}) MH (.047^{F}) Sub	------
Stronger links with schools	(.048^{L}) MH	------	(.015^{F})	------	(.023*) Sub	------	------	------	------	------
Interagency collaboration	------	------	------	(.013^{F})	------	------	------	(.041*) MH	(.041^{L}) MH	(.034^{F})
List of resources / agencies	------	------	------	------	------	(.030^{F})	------	------	(.012^{F}) MH (.038^{F}) Sub	------
PC more active role	(.029^{L}) (MH) (.042^{F}) (Sub)	------	------	------	------	------	------	------	-------	------
Wording for difficult questions	------	------	------	------	(.004*) (MH) (.006*) (Sub)	------	------	------	------	------
Stepped care	------	------	------	------	------	------	(.030^{L}) (MH) (.041^{L}) (Sub)	(.025^{L}) (Sub)	------	------
Treatment guides	------	------	------	------	------	------	(.002^{F}) (MH)	------	------	------
Training for GPs	------	------	------	------	------	------	------	(.050*) (MH)	------	(.011^{F})
Access to youth worker	------	(.020^{L})	-------	(.008^{F}) (MH) (.024^{F}) (Sub)	------	------	------	------	------	------

(*)Pearson Chi-Square (X^2) / $^{(F)}$ Fischer's Exact Test / $^{(L)}$ Linear by linear association

4.9 Results summary for study 2

4.9.1 Demographics

The study participants were representative of the national sample in terms of age, number of doctors in the practice, practice type, location of practice and postgraduate training completed, but not in terms of gender and counselling services available.

- Majority of the sample were >50 years (98; 56%)
- Gender - 82 (47%) males and 79 (45%) females
- Mean number of years post GP training - 22
- Mean GMS list size - 1390
- Median number of GPs at a practice - 2
- Majority of GPs worked in a mixed practice 153 (87%)
- Practices were based mainly in urban 70 (40%) and mixed 61 (35%) areas

4.9.2 Key findings

- Satisfaction with training in child and adolescent mental health (CAMH) 29 (17%) and 37 (21%) substance use was low.
- Thirty two practices (18%) had counselling services delivered at the practice.
- Older respondents (i.e., aged 50+) and those who had completed GP training for longer than (>20) years, were less likely to screen for mental / substance use disorders or use screening questionnaires.
- Twenty two (13%) GPs screened routinely for mental disorders and 20 (11%) for substance use disorders. Routine screening was associated with gender (female), practice type (private) and training satisfaction (substance use).
- Factors associated with referral for people with mental / substance use disorders included: practice type (mixed), less years since completion of GP training (<20), practices with less GPs (<2), dissatisfaction with postgraduate training (CAMH / substance use) and no counselling services available.
- Performing brief interventions was associated with: working in mixed practices, postgraduate training courses completed, counselling services available and postgraduate training satisfaction (particularly in substance use).

- GPs were more likely to perform brief interventions for people with mental disorders compared to people with substance use disorders. One-to-one counselling was the most commonly used intervention. Very few GPs used web-based interventions.
- Important barriers to addressing people with mental and substance use disorders included: attitude of the patient, attitude of the family, lack of specialist staff in the practice, lack of time and poor service availability.
- GPs were more confident in diagnosing, treating and prescribing psychotropic medication for people with mental disorders compared to people with substance use disorders.
- GPs felt it was more appropriate to manage people with mental disorders compared to people with substance use disorders and brief interventions and lifestyle interventions were considered to be more effective for addressing people with mental disorders compared to people with substance use disorders.
- Most respondents indicated a preference for seeking advice from colleagues rather than guidelines for addressing people with mental / substance use disorders.
- Competence in using psychotropic medication was associated with age (younger GPs), gender (males), postgraduate training courses completed and satisfaction with postgraduate training (substance use).
- The most important interventions to facilitate screening and treatment of people with mental and substance use disorders in general practice included: access to services, appropriate time and space to explore youth issues, clear definitions of interventions for primary care and access to a youth worker.
- Lack of postgraduate training, dissatisfaction with postgraduate training, GPs who do not screen / perform brief interventions were more likely to agree with the following interventions to enhance their ability to address mental / substance use disorders: access to services, formalise GP role, stronger links with schools, skills development and training for GPs / practice nurses.

4.10 Integration of study one and study two

4.10.1 Introduction

Results from study one and study two were integrated (in keeping with the mixed methods approach) and reviewed for convergence and / or divergence (see table 4.22). The following procedures as advised by (Woolley 2009) were utilised during the integration of findings from study one and two:

1) Major findings from the qualitative inquiry with health care workers and young people and the quantitative inquiry with GPs were reviewed separately.

2) A table was used to organise the data and findings from each of the methods. The table and subheadings served two purposes: first, organising the initial analyses into more manageable chunks and second, facilitating the linking process within these chunks.

3) The table was divided into specific subsections which were relevant to both study one and study two (e.g., attitude of the family as a barrier to addressing people with mental health problems, interagency collaboration, lack of specialist staff etc.)

4) Having established an analytic framework through the use of a table and specific subsections, the writing and analysis of study one and two was conducted with an integrated approach.

5) Throughout the process of integration between study one and study two, key findings were reviewed for convergence / divergence.

4.10.2 Areas of convergence: The main areas of convergence between health care workers and GPs included: attitude of the family and lack of time and specialist staff as barriers to addressing people with mental health problems and the importance of interagency collaboration. Health care workers and GPs identified varying levels of GP interest in mental and substance use disorders as a potential barrier or enabler to addressing such problems. GPs and health care workers also identified the contextual influences associated with socio-economically disadvantaged areas as a barrier to addressing youth mental health problems. Lack of time during GP / patient

consultations and financial restrictions were major barriers for GPs and young people. Most participants identified the need for further GP training and access to a youth worker. GPs and young people highlighted the importance of further recognition of the GP role as a health care worker who can address youth mental health problems. GPs in study one and two identified the importance of linking in with experts in the field / colleagues in mental health services for advice rather than guidelines / training manuals.

4.10.3 Areas of divergence: GPs identified patient attitudes as a barrier to treating substance use problems, while young people feared judgement from the GP in regards to their substance use problems. Health care workers highlighted GP lack of awareness of community agencies as barrier to early intervention, however, GPs were reluctant to address youth mental health problems due to limited service availability. Practice nurses were not identified as an enabler to addressing mental health problems in study one, however, GPs who did not screen or perform brief interventions in study two identified the need for further training for practice nurses.

Table 4.22 Integration of research findings from study one and two

Topic	Study one finding	Integration to study two	Convergence / Divergence
Attitude of the family as a barrier to addressing people with mental health problems	• Health care workers identified the inclusion of family members as a barrier to treatment due to unrealistic treatment expectations / concerns about having their child "labelled" with a mental disorder. • GPs highlighted their lack of training in dealing with family members when trying to address youth issues.	• GPs identified attitude of the family as a key barrier to addressing mental health problems. • The attitude of the family was a more important barrier for addressing mental health problems compared to substance use problems (27% compared to 22%).	**Convergence:** *Health care workers from other disciplines and GPs both identified the role / attitude of family members as a barrier to addressing mental health problems in young people.*
Attitude of the patient as a barrier to addressing people with substance use problems	• Some young participants gave an inaccurate account of the extent of their substance use fearing judgement from their GP. • Young participants indicated their frustration with GPs for assuming that patients with substance use disorders were looking for easy access to medication as opposed to managing their withdrawal symptoms.	• 58% identified the attitude of patients as a key barrier to addressing substance use problems.	**Divergence:** *GPs identified patient attitudes as a barrier to treating substance use problems and young people feared judgement from the GP in regards to their substance use problems.*
Time as a barrier to addressing people with mental and substance use problems	• GPs highlighted the time constraints associated with a busy practice as a major barrier.	• Time to explore youth issues was the most predominant intervention associated with the	**Convergence:** *Lack of time to address youth mental / substance use problems was a major barrier.*

	• Young people noted time as a barrier to treatment during their (sometimes) brief appointments.	main barriers identified by GPs for treating mental / substance use disorders.	
Lack of training and education as a barrier to addressing mental and substance use problems	• Health care workers from (mental health and addiction services), young people and GPs themselves identified GP lack of training as a barrier to early intervention. • Some GPs felt under pressure to diagnose young people and others were not comfortable managing psychotropic medication for youth mental / substance use disorders without sufficient training. • Health care workers from the addiction services highlighted (GP) lack of training in substance use problems and the negative repercussions for young people when they are referred ('unnecessarily to psychiatry services').	• Lack of training and dissatisfaction with postgraduate training was associated with less confidence in the diagnosis / treatment / and use of psychotropic medication for addressing youth mental / substance use disorders. • GPs were more willing to refer people with mild substance use disorders to specialist care compared to people with mental disorders (28% compared to 14%). • GPs were also more confident in diagnosing, treating and prescribing psychotropic medication for mental disorders compared to substance use disorders.	**Convergence:** *GPs, health care workers and young people identified the lack of training in the area of mental and substance use disorders for GPs as a major barrier to early intervention.*
Inappropriate referrals and limited service availability	• GPs were reluctant to treat young people with mental / substance use problems due to limited services for referral.	• GPs who did not refer young people to specialist care for mental / substance use problems noted poor service availability as	**Divergence:** *Some health care workers highlighted GP lack of awareness of community agencies as a barrier to early intervention.*

	• Other health care workers noted GP lack of awareness of other services and inappropriate referral of young people with milder issues to psychiatry.	a barrier. • There was an association between GPs who did not refer / perform brief interventions and those who identified guidelines for interagency collaboration as a key intervention	*However limited service availability often deterred GPs from initiating a discussion with young people about mental / substance use problems in the absence of guidelines for interagency collaboration and appropriate follow-up services for referral.*
Interagency collaboration	• Interagency collaboration (particularly between GPs and mental health services) was identified as a key enabler to treatment for youth mental / substance use disorders. • GPs indicated the benefits of having access to psychological support staff for their practice and on their primary care team.	• GPs based in GMS practices (50%) were more likely to identify liaison and collaboration between agencies as an important intervention.	**Convergence:** *Interagency collaboration was highlighted as a key enabler to treatment of youth mental / substance use disorders across both studies; in study one across clinical sites in socioeconomically disadvantaged areas and in study two predominantly GMS practices (where patients are dependent on a multidisciplinary approach from different health care sectors as opposed to attending a private clinic).*
Role of practice nurses	• Health care workers including GPs identified the benefits of additional psychological support staff to address youth mental health problems in the practice. • Practice nurses were not identified as people to address mental / substance use problems.	• GPs who did not screen or perform brief interventions for mental / substance use disorders identified training for practice nurses as a key enabler to treating youth mental health in their practice.	**Divergence:** *Practice nurses were not identified as an enabler to identification or treatment in study one. However, in study two GPs identified the need for further training for practice nurses in youth mental health.*

Lack of specialist staff	• The majority of health care workers including GPs identified the benefits of having specialist staff in their practice to deliver brief psychotherapeutic interventions.	• Lack of specialist staff was identified as a major barrier to treating mental / substance use problems. • Stepped care and formalising the GP role across youth environments were highlighted as key interventions.	**Convergence:** *Similar to study one, lack of specialist staff in the practice proved to be a major barrier to treating mental / substance use problems and a stepped care approach was identified as a key enabler to address the gap in services.*
Lack of interest in addressing youth mental and substance use problems	• Health care workers including GPs identified the varying level of interest some GPs might have in regards to addressing mental / substance use problems. • Some health care workers suggested that demographic factors might contribute to the varying levels of interest (e.g., age, sex, number of years as a GP). • GPs noted the lack of training / skills in the area in addition to the time constraints as key contributors to the lack of interest.	• There was an association between GPs who agreed that they should be the initial contact for mental / substance use problems and those who agreed that GPs should manage such issues and GPs who identified the following interventions to facilitate screening in their practice: primary care having a more active role in the community; stronger links with schools; formalising the GP across youth environments; access to a youth worker and interagency collaboration. • Participants with more years since completing GP training were less likely to screen for mental / substance use disorders.	**Convergence:** *GPs demonstrated varying levels of interest in regards to addressing youth mental / substance use disorders. In both studies it was suggested that demographic factors (e.g., age and more years since completion of GP training and dissatisfaction with previous training received in youth mental and / or substance use problems indicated a decreased level of interest in the area of youth mental / substance use disorders).*

		• Older GPs (50+) were more likely to strongly disagree with GP management of substance use disorders or initiation of psychotropic medication for substance use disorders. • There was an association between dissatisfaction with training in CAMH and lack of interest in the area of mental and substance use disorders.	
Youth advocate / access to a youth worker	• Young participants expressed their initial anxiety about engaging with services and some noted the potential benefits of having somebody (e.g., youth advocate) to facilitate the link between them and the service.	• GPs identified access to a youth worker as one of the most important interventions to enhance their capability to address youth mental / substance use problems in primary care.	**Convergence:** *The importance of having a youth worker to ease the young person's initial transition into services and facilitate health care workers to address youth mental / substance use disorders was prioritised in both studies.*
Contextual issues	• The role of social context associated with living in socio-economically disadvantaged areas was highlighted as a major barrier to identification of mental / substance use disorders by most health care workers. • GPs highlighted the difficulty in determining whether young people were affected by difficult	• Appropriate time and space to explore youth issues was identified as one of the key interventions to enhance a GPs capability to address youth mental health problems.	**Convergence***: GPs in socio-economically disadvantaged areas face additional challenges in diagnosing and treating youth mental health problems during limited consultations, particularly where contextual factors have a major impact on a young person's life.*

	circumstances or if they had a diagnosable mental health issue.		
Treatment inequalities because of socio-economic circumstances	• Health care workers highlighted the limited treatment options for young people without the financial means to attend private clinics. • GPs highlighted the lack of dedicated counselling services for young people.	• Counselling services were available to patients attending private practices on a weekly and (in some cases) daily basis; whereas for GMS patients waiting times often extended beyond three months (17%).	**Convergence:** *Inequalities in health care were highlighted in both studies for young people who did not have the financial means to avail of counselling in private practices and those who were not eligible for free health care.*
GPs not associated with mental health	• Some young participants and health care workers did not associate the GP as somebody who could address mental and substance use problems.	• One of the main interventions identified by GPs to address youth mental health problems was formalising the role of the GP across youth environments.	**Convergence:** *Both studies indicated the need for recognition of the GP as a health care worker who can address mental / substance use problems.*
GP training preferences	• GPs highlighted the need for specific training relative to their individual practice needs as opposed to treatment guides. • Interagency collaboration with other colleagues in the field was identified by most health care workers as a key enabler to treating mental / substance use disorders.	• GPs were more likely to indicate a preference for advice from colleagues / experts in the field as opposed to information leaflets / guidelines for addressing mental / substance use disorders.	**Convergence:** *GP training should be focused on interagency collaboration with experts in the field / health care workers from mental health / addiction services as opposed to guidelines / training manuals / reports.*

Chapter 5 - Discussion

5.1 Introduction

The main aim of this research was to gain a better understanding of the experiences of screening and treatment for mental health and substance use problems from the perspectives of both health care workers and young people. Five empirical research questions were addressed by linking qualitative and quantitative data analyses. This chapter includes a synthesis of evidence produced from findings based on study one and study two, combined with influencing theoretical frameworks and other empirical research.

5.2 Key findings and how they relate to previous literature

Four core areas were identified from findings based on the qualitative inquiry with health care workers and young people and the quantitative inquiry with GPs.

1) Young people and their experiences of mental health and / or substance use problems

2) GP role

3) Management of mental and substance use problems

4) System issues

5.3 Young people and their experiences of mental health problems

5.3.1 Experiencing symptoms and consequences

This theme described the various ways that mental health problems can affect the physical, social, emotional, educational, and financial aspects of a young person. These were all negative in nature, with young people finding that after an initial experience of mental health symptoms many delayed getting help out of embarrassment or an inability to discuss their problems. This meant symptoms worsened, disrupting their normal educational and social activities. As symptoms progressed, it became harder for young people to seek help. Many had to reach a crisis point /of "rock bottom" before they sought out help, leaving their potential for a successful life diminished. These findings

are similar to previous qualitative work, which showed that the experience of mental health issues in youth tends to progress from bad to worse without intervention, eventually leading to crisis (Dundon 2006). Consistent with previous research, participants described a loss or disconnect from one self and other people (Dundon 2006); feelings of anger, loss of control and acts of violence were also common (Farmer 2002). Farmer (2002) noted that while irritability is mentioned as a symptom for depression in the DSM IV criteria, our sample experienced more significant levels of anger which resulted in the deterioration of relationships, academic performance and increased negativity towards one self.

5.3.1.2 Portrayal of mental health problems in the media

Anger as a symptom of depression and other mental disorders is often poorly or inaccurately portrayed in the media; television advertising captures isolation and the need to talk but attention to other aspects / symptoms (e.g., aggression, violent outbursts, extreme bingeing, etc.) is lacking. Many young participants highlighted the need for more awareness of mental health problems in the media that are youth-focused. Additionally, one participant emphasised his dissatisfaction with the current mental health adverts because he felt that they depicted people with mental health problems as being vulnerable. The vulnerability of experiencing a mental health problem often deterred young people from seeking help as they feared being stigmatised by others. Moreover, a key barrier to help-seeking for many study participants included the fear of being perceived as "weak", especially among their peers. In a review of studies regarding the mass media's role in shaping and reducing the stigma associated with mental illness, Klin and Lemish (2008) noted that inaccurate media depiction of mental illness can result in further discrimination for people with mental health problems, where "the ill are portrayed as peculiar and different". Most young people in the current study highlighted the need to normalise help-seeking to address the stigma associated with experiencing a mental health problem, however, media portrayal of mental health problems that are associated with vulnerability and loneliness can be counterproductive in terms of such efforts to normalise mental health.

5.3.2 Help-seeking

Mental health and / or substance problems often removed participants from friends and family as they became isolated and socially withdrawn and non-disclosure in addition to hiding their true feelings from others delayed their help-seeking. In a qualitative study with young adolescents and their understanding of depression, Hetherington and Stoppard (2002) described the isolation associated with experience of depression as 'purposeful distancing', where awareness of being different to peers combined with efforts to hide true emotional feelings resulted in further distancing from the individual's peer group. Additional factors which deterred young people from seeking help included: denial, maladaptive coping mechanisms, access and cost, which have been noted in previous studies (Pailler et al. 2009, Meredith et al. 2009, McCann et al. 2012).

Similar to previous qualitative research that explored the experience of accessing mental health care from the perspectives of young people and parents, stigma was a major barrier to accessing support (Buckley et al. 2013, Sayal et al. 2010). Coughlan et al. (2013) highlighted stigma as an ongoing barrier for young people when seeking help for mental health problems, where the terminology and language used to explain mental illness can be "daunting". Participants identified similar strategies to those described in earlier studies to improve services including: access to services, service user inclusion in treatment, access to a key worker, peer support and age adapted facilities for younger patients (Buckley et al. 2013). One young participant suggested abolishing the secrecy associated with attending services as a key enabler to help-seeking. This would hopefully normalise the experience of interacting with mental health and addiction services among peer groups. Previous research highlighted the potential of primary care settings as opposed to specialist services to normalise the experience of seeking help for mental health and substance use problems, before problems reach more severe levels (Mason et al. 2011, D'Amico et al. 2008).

In line with international research examining the identification of emotional distress in young people, key enablers to help-seeking identified among young people and health care workers included: mental health literacy programmes, promoting education and awareness about mental health, normalisation of help-seeking, positive past experiences with health care workers, social support, flexible appointments, easing problematic

transitions between CAMHS and adult services, skilled staff in mental health care and protecting young peoples' ability to consent (National Children's Bureau 2004, Sayal 2006, Sayal et al. 2010, Biddle et al. 2006a, Haller et al. 2009, Gulliver et al. 2010). Conversely, in regards to the provision of information for mental health problems, most young participants did not consider the internet to be a useful resource. This finding was in divergence with the views of some health care workers who considered incorporating new technologies into mental health awareness strategies (e.g., mindfulness bells on IPhones, interactive websites etc.) as an opportunistic method of promoting mental health information and awareness. However, some participants felt that the internet was not accessible to many young people, particularly those who were homeless with addiction problems. Others noted the vast quantum of inaccurate information that can be retrieved from the internet, often suggesting worst case scenarios. This finding is also in contrast with results from previous studies that advocated the benefits of internet-based information and interventions to engage young people in the help-seeking process (Oh et al. 2009, Dooley and Fitzgerald 2012b). In the 'My World Survey', 77% of young people reported that they would obtain information / support from the internet for mental health problems (Dooley and Fitzgerald 2012b). Our study being situated in socio-economically disadvantaged areas is a possible explanation for this divergence from the 'My World Survey' which included 8195 (57%) participants from third level institutions.

In a UK based survey, Bradford and Rickwood (2014) found that most participants indicated a preference for face-to-face services, 16% indicated a preference for online treatment when asked about their preferred mode of service delivery for mental health problems. While online services can facilitate self-reliance, autonomy from parents and improve mental health literacy (Wright 2002, Rochlen et al. 2004), face-to-face treatment is more likely to be the preferred option because of the ability to obtain reassuring human contact and nonverbal and visual cues that are fundamental to the traditional counselling process (Rochlen et al. 2004). In the current study, building positive relationships with health care workers and opportunities to engage in groups based activities were key enablers to help-seeking and treatment engagement. Face-to-face service delivery may also be more important for young people in socio-economically disadvantaged settings, where family support networks are often lacking (Ferrin et al. 2009). Furthermore, face-to-face delivery is more likely to be favoured due

to concerns regarding the quality of online therapeutic programmes and the staff credentials of online therapists (Barak et al. 2009, Bradford and Rickwood 2014).

5.3.2.1 Gender differences and help-seeking

Barriers and enablers to help-seeking were similar for the majority of young male and female participants in the current study. The stigma associated with seeking help for a mental health or substance use problem was a major barrier for both male and female participants. Family members, particularly mothers, played a major role in facilitating the help-seeking process and for the majority of male participants, female family members e.g., mothers and / or partners facilitated initial engagement with health care services, attended appointments and often advocated the young participant's needs to health care staff. Furthermore, health care workers identified non-disclosure of issues among young males, in addition to 'mono-syllabic' answers during consultations as a major barrier to the identification of mental and substance use problems. Similar findings were reported by Hennessy and Mannix-McNamara (2014) in a study which aimed to determine the factors that influenced a sample of Irish males to seek help for health related issues. The study found that women were often seen as the 'gatekeepers' of men's health in terms of assisting men to interpret symptoms and encourage help-seeking.

Young male participants in the current study were also more likely to identify activity based services as a key enabler to help-seeking, where relationships are built up over time with youth workers. Help-seeking difficulties and communicating concerns in regards to emotional problems among young males have been well documented in the literature (Dooley and Fitzgerald 2012b, Patulny et al. 2013, Klineberg et al. 2011). Previous research indicated help-seeking barriers that may be specific to males in terms of fear and the pressure to conform to masculinity norms, which dictate that men should be strong and resilient when experiencing health problems (Hennessy and Mannix-McNamara 2014). Therefore, activity based programmes may be even more beneficial to young males, where opportunities to build positive relationships with health care workers / youth workers are available prior to disclosing emotional problems.

5.3.3 Treatment experiences

Young people were mainly dissatisfied with treatment when they weren't given sufficient time during consultations. Previous literature suggests that the 'ten minute' consultation is a barrier to developing positive relationships between GPs, young people and family members (Iliffe et al. 2012, Sayal et al. 2010). Some young participants had mixed views on counselling and medication. While most found psychotherapeutic approaches to be of great benefit during their recovery, some experienced negative feelings in the immediate stage post counselling. Most young people were reluctant to take psychotropic medication and similar to previous studies (Meredith et al. 2009, Tanielian et al. 2009), this deterred them from seeking help initially, however, upon reflection many suggested that a combined psychotherapeutic and pharmacologic approach was the most effective. March and colleagues (2004) reported that on a sliding scale of decreasing efficacy from Fluoxetine and CBT, Fluoxetine alone, CBT alone and placebo, the combination of fluoxetine with CBT offered the most favourable balance between benefit and risk for adolescents with major depressive disorder. So whilst young people may have a preference for psychological interventions, they may not achieve optimal outcomes. Similar to the self-stigmatising attitudes experienced among young participants in previous research where having depression was perceived as more stigmatising than being in a wheelchair or having HIV / AIDS (Jaycox et al. 2006), young participants described their negative attitudes towards "being on medication" / "having to take psycho tablets" etc. Additionally, there was a certain degree of age-related stigma associated with being on medication and having to take a large amount of tablets, particularly when self-comparisons were made with more senior relatives who were also taking similar quantities of medication.

5.3.4 Treatment enablers

Similar to previous qualitative studies based on young people and their experiences with primary care services, key enablers to treatment identified among young people and health care workers included: strong support networks, quick access to services, improved referral pathways, the provision of choices during treatment and continued opportunities for treatment engagement (Wisdom et al. 2006, Sayal et al. 2010, McCann

and Lubman 2012a). The treatment enablers identified among study participants are also line with service models proposed internationally which have prioritised the following service developments for young people: 1) youth participation at all levels, 2) holistic approach to treatment, 3) early intervention and social inclusion, 4) contextual factors, 5) continuity of care and 6) seamless transitions between services (McGorry et al. 2013). Comparable with findings from Ferrin et al. (2009) where low socio-economic status was associated with treatment engagement, health care workers noted the negative impact on some young people when the future of service delivery was under threat, as many viewed such centres as a 'second home', thus providing perhaps the only environment offering stability and security in their lives.

5.4 GP role

5.4.1 Enhancing the relationships between GPs and young people

Consistent with previous studies, most participants did not readily identify the GP as a source of help for mental health problems (Biddle et al. 2004, Biddle et al. 2006a), thus highlighting the need to educate young people about the role of the GP in mental health (Biddle et al. 2006a). Furthermore, young people were reluctant to approach GPs for help with emotional problems fearing judgement, embarrassment and that GPs would be unsympathetic and unable to address their mental health problems (Kari et al. 1997, Churchill et al. 2000, Jacobson et al. 2001, Aarseth et al. 2014). However, Iliffe and colleagues (2012) noted the benefits of the TIDY intervention which incorporates a non-judgemental diagnostic approach as a way of mitigating such concerns. Previous findings are conflicting in terms of young people and their attitudes towards attending a familiar GP with a mental health problem. In contrast to findings from Booth et al. (2008), where young people reported a preference to seek help from health care workers who they knew and trusted, some participants in the current study thought it would be easier to discuss mental health concerns with an unfamiliar GP. Similarly, other studies reported fear of stigmatisation and perceived judgement from the GP as key barriers to engaging with primary care services for youth mental health problems among young people (Meredith et al. 2009, Wisdom et al. 2006). However, some participants reported

the importance of having a positive relationship with their GP as a key enabler to help-seeking which has also been noted in previous research (Wisdom et al. 2006)

Some GPs in study one reported difficulty communicating with younger adolescents, particularly those aged 13-15 years, due to concerns about confidentiality, nondisclosure of issues and a general inability to relate to people in this age group compared to older adolescents. Previous research has reported that GPs spend less time in consultation with young people compared to adults (Jacobson et al. 1994) and qualitative studies found that GPs generally find younger adolescents more difficult to communicate with, particularly young males (Iliffe et al. 2008, Roberts 2012b). Furthermore, Raine et al. (2000) reported that GPs had greater difficulty identifying mental disorder in young people than in older age groups and in a UK study which assessed GP detection of mental health disorders in 5-11 year olds, 74% went unrecognised by participating GPs (Sayal and Taylor 2004). Mauerhofer et al. (2009) assessed differences between 16-20 year olds who sought help for psychological problems and found that 'older' young people and those who were a student had higher rates of disclosure. Additionally, concerns in regards to over-medicalising young lives has also been documented in previous qualitative studies with GPs (Iliffe et al. 2004, Iliffe et al. 2012).

5.4.2 The GP as a link to external agencies

The GP was seen as an enabler to help-seeking in terms of being an initial point of contact and a link to external agencies, particularly among health care workers from mental health services and community agencies. In a study including a GP-led intervention, Roberts and Bernard (2012) noted the importance of the GP role in terms of facilitating initial and sustained engagement with parents and external agencies where the referral process was explained and the subsequent pathway of care was outlined. Roberts and Bernard (2012) reported the benefits of GPs liaising with external agencies in terms of 'building up a richer picture of locally available services', in addition to linking in with schools where teachers might view a young person's behavioural problems in a more holistic way.

5.4.3 GP training needs

Overall, most GPs across both studies did not feel they had sufficient training in youth mental health and in study two, satisfaction with training in CAMH and substance use was in the minority in contrast to training received in adult mental health. GP dissatisfaction with training in mental health has been documented in previous Irish studies (Copty and Whitford 2005, Jabbar et al. 2011). Similar to findings from a GP survey in Ireland on attitudes towards postgraduate training in mental health (Copty and Whitford 2005), the main factors contributing to GP referral of patients to specialist mental health services included: dissatisfaction with training and limited access to counselling and other therapeutic interventions in their practice. GPs in study one highlighted their lack of training in addressing the psychosocial needs of a young person, where additional family issues may be a contributory factor and participation in case conferences with family members may be necessary. Similar to previous findings GP difficulties communicating with young people was a barrier to screening and treatment during consultations (Iliffe et al. 2008) and in many cases participants were reluctant to initiate discussion around mental health problems due to lack of confidence in their own skills and the treatment options available (Gask et al. 2004).

Consistent with previous research assessing GP attitudes towards addressing child and adolescent mental health problems, most GPs did not feel confident in the use of psychotropic medication (Cockburn and Bernard 2004) particularly for people with substance use disorders. Furthermore, GPs were less confident diagnosing, treating and prescribing psychotropic medication for people with substance use disorders compared to people with mental disorders. Health care workers from addiction services echoed GP concerns for training needs in youth substance use problems which would prevent inappropriate referrals to psychiatry, particularly for cannabis users. Previous research found that GPs generally have negative and pessimistic views about treating substance use disorders, do not screen patients routinely for such disorders (Miller et al. 2001) or feel competent treating substance use disorders (Miller et al. 2001, Brewster et al. 1990). GPs in study two identified the attitude of the patient to be more of a barrier to addressing substance use problems than mental health problems. In a systematic review based on training health care professionals in substance abuse, Ewan and Whaite (1982)

reported that GPs did not like working with patients who have substance use disorders and did not find treating patients with such disorders to be rewarding.

GPs in the current study were very specific about the type of training they should have in terms of being adaptable, not requiring away days, focused to their individual needs and accessible. This was similar to the attributes outlined by Iliffe and colleagues (2012) associated with GP up-take for a training intervention, such attributes included: user compatibility, ease of use, relative advantage, trialability, result demonstrability and reinvention (Iliffe et al. 2012). Additionally, GPs identified a preference for collaboration with experts / colleagues in the field of youth mental health as opposed to seeking advice from guidelines. Similar findings were reported in a Canadian mixed methods study (Fleury et al. 2012), which included questionnaires and interviews to document the management of mental health problems, facilitators to early intervention included: liaison and interagency collaboration with mental health resources, multidisciplinary practice teams and further / specified training in mental health care. Furthermore, Fleury and colleagues also highlighted limited access to psychiatric services as an enabler to early intervention (forcing them to be involved). In the current study, GPs became overly reliant on specialist psychiatry services where community based services had lengthy waiting lists or were non-existent. Therefore limited access to specialist psychiatric care may encourage GPs to address young people with milder problems, thus avoiding unnecessary referrals to psychiatry. Similarly inter-professional collaboration was supported when GPs worked primarily in health and social service centres (Fleury et al. 2012), particularly those workings with primary care teams which resulted in more opportunities for immediate referral.

5.4.4 GP interest in youth mental health

Health care workers from other sectors and GPs themselves noted the varying levels of GP interest in engaging with youth mental health problems. Some health care workers from other sectors attributed such varying levels of interest to GP demographic characteristics (e.g., more senior GPs being less engaged). Interestingly, in study two, GPs in the older age group (50+) were less likely to screen for mental / substance use disorders or feel confident diagnosing, treating or using psychotropic medication for

such issues. GPs themselves reported varying levels of interest which were often associated with skill level and confidence to address youth mental health problems and the time constraints associated with a busy practice environment. In a qualitative study with 14 Danish GPs, Davidsen (2009) noted mixed feelings among GPs when their attitudes were assessed in regards to the process of understanding patients with emotional problems. When asked to describe their own emotional and physical responses to patient narratives, participants described feeling "weighted down", their work load was "heavier and more oppressive", however, other participants found that their work became more "meaningful."

5.5 Management of youth mental and substance use problems

5.5.1 Screening / identification

Use of screening tools was reported by only 12 (7%) of GPs in study two. Some authors suggested that the lack of appropriate instruments was the main barrier for GPs to provide early intervention for youth mental health problems (Kramer et al. 2008, Haavet et al. 2010). Furthermore, previous research noted that screening tools in primary care can be problematic because they may be too lengthy to be feasible for use during a consultation, or, if shorter, they tend to focus on only a single risk behaviour (McPherson and Hersch 2000). Conversely, GPs in study two were more likely to identify collaboration with health care workers in mental health and advice from colleagues / experts in the field as being the main facilitators to addressing youth mental health problems compared to guidelines. Previous research with GPs noted that the majority who participated in an intervention to improve screening and identification of depression and suicidal risk attributed improved screening practices to interactive sessions with standardised patients as opposed to the second phase of the intervention which included screening tools (Fallucco et al. 2012). Additionally, Ozer et al. (2005) in an intervention to increase screening for risky behaviour in adolescents noted that provider training resulted in significantly higher rates of clinician screening and counselling of adolescent patients compared to the addition of a modified screening tool which did not further significantly increase screening and counselling rates.

5.5.2 GP characteristics and implications for screening

While most GPs screened for mental and substance use disorders when clinically indicated, routine screening was rare. Similar findings were noted by Fallucco et al. (2012) where lack of training, knowledge and confidence in the area of youth mental health were the predominant reasons for low rates of screening. A common finding emerging from study two was that older GPs aged (50+) and GPs who had more years since completing GP training (>20) were more reluctant to engage with screening and psychosocial interventions in addition to being less competent / confident in the use of psychotropic medication. A GP registrar who participated in the TIDY study, suggested in a qualitative follow-up study, that it would be more difficult for senior colleagues to change "their whole method of consultation", and it would be easier "to develop that tool into your actual consultation skills before…you firmly set them…to a very doctor-centred position." (Iliffe et al. 2012). Moreover, Bernard and colleagues emphasised the benefits of training at postgraduate level for improving practitioner performance and confidence, where a short programme for GP registrars to improve detection and management of common mental health problems in children and adolescents resulted in improvements when pre and post intervention scores were compared (Bernard et al. 1999).

5.5.3 Contextual factors

Consistent with previous research which was also based on young people attending general practices in socio-economically disadvantaged areas (Iliffe et al. 2012), GPs in the current study, were reluctant to diagnose young people with depression particularly given the broader social context of the young person's life. Reducing the risk of medicalising normal moodiness has been documented elsewhere and the need for specific interventions to address this issue was also highlighted (Iliffe et al. 2012, Iliffe et al. 2008). Horwitz and Wakefield (2009) questioned whether routine depression screening in young people risks medicalising and stigmatising the normal emotions that coincide with adolescence. Additionally, DSM V criteria and screening instruments may not distinguish between normal human responses to environmental stressors and symptoms associated with depressive disorders (Sanci et al. 2010). This is particularly

relevant to health care workers who are based in socio-economically disadvantaged areas where psychosocial problems prevail.

5.5.4 Treatment / interventions

Counselling was the most commonly used intervention, particularly among GPs in the older (50+) age group, however very few GPs used web-based interventions. Furthermore, practices with a higher number of GPs (>2) were more likely to use psychotherapeutic interventions. In a previous audit of primary care practice, GPs who saw a large number of patients per day and worked in a 'solo practitioner-style environment' delivered the poorest quality mental health care (Hickie et al. 2007, Hickie et al. 2001). Previous intervention based studies have reported the benefits of training GPs in screening and treatment, in terms of increasing GP recognition of psychological distress, depression, suicidal ideation and significant increases were reported in GP knowledge, skills and confidence to address youth mental health problems (Asarnow et al. 2005, Sanci et al. 2000a, Asarnow et al. 2009). Additionally, GP intervention studies have indicated a decrease in youth mental health problems via CBT and internet based interventions (Van Voorhees et al. 2008) and mobile phone-based interventions (Reid et al. 2011). However, evidence from randomised controlled trials is lacking (Saitz et al. 2010) and most of the interventions were delivered in a controlled test setting, thus, their transferability into clinical practice warrants further research.

5.6 System issues

5.6.1 Fragmentation between services

When the Expert Group on Mental Health Policy was initially established in 2003, Minister O' Malley (Minister of State at the Department of Health and Children with special responsibility for mental health) stated that:

> *"A collaborative approach between service users and carers, professionals and health service providers represented the best way forward."*

And the Expert Group was appointed accordingly (Expert Group on Mental Health Policy 2006).This study highlighted the importance of collaboration between mental health care professionals and GPs' preference for interaction with colleagues / experts in the field of mental health / substance use as opposed to clinical guidelines. Fragmentation between primary care, secondary care and community agencies was a major barrier to treating youth mental health and substance use problems in the current study. A lack of interagency collaboration resulted in services striving towards a similar goal in terms of addressing youth mental health and substance use problems, but some health care workers felt that they were working independently of one another. In a systematic review of adolescents' perceived needs for and access to primary health care services, Gleeson et al. (2002) noted that while a diverse range of services for young people may be a positive approach, it should not lead to fragmentation and competition. Lundstrom (2014) reported the challenges for young people who may experience multiple transitions across health care services including: risk of information being lost and subsequent problems, delays and flaws in care. Furthermore, health care workers from different educational and organisational backgrounds may also hinder co-ordination of care, thus when planning collaborative care, a seamless transition between services should be the primary goal.

The provision of specialist expertise was also proposed in AVfC, where CMHTs include a multidisciplinary team of clinicians to address service user needs across the lifespan (Expert Group on Mental Health Policy 2006). Furthermore, in a manifesto which aimed to reassert the policies outlined in AVfC, the need to reorganise the roles and workload of CMHTs was highlighted, where medication was one of many therapeutic options in addition to a range of therapeutic expertise offered by staff members on the team which would be made available to more people (Mental Health Reform 2012). In the current study links between CMHTs and specialist mental health teams were poor, as a result, specialist services were dealing with young people experiencing milder mental health problems in addition to young people with more severe mental health disorders.

Diverging attitudes between the importance of crisis intervention versus early intervention was a key cause for concern where health care workers from specialist mental health services were under pressure to treat people with milder issues while also

treating people with severe and debilitating conditions in an environment where resources were extremely limited. This issue has been noted previously, Iliffe et al. (2012) noted the importance for specialist services to focus on those with more severe disorders. Recommendations were also highlighted by most health care workers, including GPs to have sufficient links with primary care and psychology based services for the provision of behavioural support. The benefits of having medical and counselling services co-located has been documented previously in terms of increasing help-seeking in young people; additionally young people attending services also noted that they would be more likely to take advice from 'Headspace' clinicians because they were working in collaboration with health care workers from psychology and mental health (McGorry et al. 2013).

The need for formalised links, clarification of boundaries and access arrangements between primary care and specialist mental health and main stream community agencies have also been highlighted in AVfC (Expert Group on Mental Health Policy 2006). Furthermore, the AVfC manifesto highlighted the need for stronger links between the voluntary sector and the mental health services in the planning and delivery of mental health supports (Mental Health Reform 2012). Fragmentation between the different services was a major barrier for health care workers to provide adequate support and young people were challenged with exposure to multiple services which were often disjointed during the help-seeking process.

According to the WHO recommendation, possible ways to enhance collaboration include involving other sectors in policy formulation, delegation of specific responsibilities of certain activities to agencies from other sectors, information networks which incorporate agencies from other sectors and in terms of gaining government support, it is important to include representatives from relevant agencies outside of the mental health sectors (World Health Organisation 2003b). Therefore, a wide variety of partners need to be engaged in the wider community including support groups, schools, voluntary organisations, the local county council and the local chamber of commerce (Expert Group on Mental Health Policy 2006). Health care workers expressed the importance of such collaborative efforts for young people with mental health and / or substance use problems in socio-economically disadvantaged areas, where a holistic

approach that incorporates multiple psychosocial needs in a young person's care plan is essential.

Additional initiatives to promote multidisciplinary service provision have included the recommendation of the electronic patient record (EPR) with a unique identifier for every patient in the state which would improve the quality of information available in addition to improving patient care (Expert Group on Mental Health Policy 2006). The West Cork mental health service have taken proactive steps towards adopting a recovery oriented approach, where clinical staff incorporate a multidisciplinary team working initiative to develop care plans for service users and family members. They operate a 24 hour 'listening service' where staff have trained or re-skilled as counsellors / psychotherapists, providing rapid access to talking therapies. Furthermore, they have also collaborated with voluntary sector providers e.g., National Learning Network, Rehab Care etc. and a team coordinator was appointed as a first point of contact for many referrals and facilitates regular contact with local GPs (West Cork Mental Health Service 2011).

5.6.2 Mental health policy and its implications

The Mental Health Act (2001)

The Mental Health ACT 2001 was not viewed favourably by most health care workers, particular concerns related to the limited and inappropriate services for young people under 18 years with mental health problems. In 2011, Amnesty International Ireland, called for The Mental Heath 2001 Act to be updated to comply with current human rights, particularly with regards to more recent policy developments e.g., 'A Vision for Change' in 2006 and the introduction of the UN Convention on the Rights of People with Disabilities (CRPD) in 2007, which includes people experiencing mental health problems (Amnesty International Ireland Expert Advisory Group 2011). The report highlighted the urgent need for protecting the rights of children and young people (under the age of 18), particularly for children over the age of 14 to make decisions about their detention and treatment and the requirement that no one under the age of 18 should be detained in an adult ward (Amnesty International Ireland Expert Advisory Group 2011). The Mental Health Act 2001 also had implications for young people

under 18 years who may present with psychosis, where proxy from their parents may be used as evidence of voluntary care, however, in severe cases compulsory admission may be necessary against the young person's wishes (Clark 2001). A child is considered a voluntary patient once their guardian or parent agrees to their admission. Baily and Harbour (1999) highlighted the dilemma for both health care professionals and the law in terms of:

> *"Finding the balance between conceding to the wishes and respecting the wishes of adolescents who may be highly disturbed and ensuring their safe translation into adulthood, where the nature of adolescence, compounded by mental illness, renders this a complex task."*

The Mental Health Act 2001, while primarily focused on reforming processes of involuntary admissions and strengthening mechanisms for assuring standards of mental health care (Kelly 2007), also had repercussions for young people attending services for mental health problems and the health care workers who deliver the services in terms of restrictions on treatment. Under the Act: "a child is a person under the age of 18 years other than a person who is or has been married" (Jabbar et al. 2011). Health care workers felt restricted due to confidentiality and consent issues and described them as a major barrier to the identification of mental and substance use disorders in young people, particularly when this related to parental involvement for those aged under the age of 18. Young people shared similar concerns and as a result, fear of health care workers disclosing their information to parents was a major barrier to help-seeking. Health care workers expressed concerns about compromising adolescents' autonomy when having to adhere to parental consent regulations. Sanci et al. (2004) noted similar concerns in a discussion paper regarding youth health research ethics and suggested that consent laws need to evolve in parallel from the former legal view of children and adolescents as "property items of their parents" to the present day recognition of "children as autonomous beings with discrete rights and interests." This paradigm shift needs to be considered in terms of a young person's right to autonomy and privacy in health care (Sanci et al. 2005b).

For sensitive issues such as mental health and substance use problems, unwanted pregnancies, sexually transmitted infections, early intervention is crucial, however, concerns about confidentiality can be a barrier to accessing health care services (Booth

et al. 2004, Cheng et al. 1993) and previous studies have reported increased service use when adolescents understand a service is confidential (Ford et al. 1997, Haavet et al. 2010). In a recent French study involving a comparative analysis of adolescents consulting their GP accompanied or alone, Binder et al. (2010) found that young people were more willing to discuss their 'personal worries' when consulting alone. However, there are certain circumstances where parental involvement is necessary (e.g., when teenagers are engaging in very high risk behaviours, or there is a risk of death or serious injury) (Sanci et al. 2005b).

'A Vision for Change' (2006)

'A Vision for Change' was published in 2006 as the official Government policy for mental health services reform in Ireland (Expert Group on Mental Health Policy 2006). However, implementation of the policies outlined in AVfC have "been disappointingly slow" (Mental Health Reform 2012). Health care workers across all services noted the poor delivery of strategies as outlined in the policy and the negative repercussions for young people with mental health and substance use problems including insufficient services and gaps in services for 16 to 18 year olds. In light of Ireland's economic circumstances it is not surprising that funding promised for mental health services reform from 2007 to 2011 has failed to materialise (Mental Health Reform 2012). In the absence of adequate accountability for mental health expenditure from the HSE and the Department of Health and Children, the Independent Monitoring Group for AVfC have had difficulty in determining the effectiveness of mental health expenditure (Mental Health Reform 2012). The Expert Group for AVfC proposed a mental health budget of 8.2% for the implementation of the policy, while economists have indicated that a target for mental health funding should be set at 10% of the overall health spending (O'Shea and Kennelly 2008), however the latest mental health budget is only 5.3% of the total health budget (Mental Health Reform 2012).

Many participants stressed the negative impact of financial limitations, with government financial cuts, restricted budgets and staff shortages which resulted in major barriers to offering effective treatment. Internationally, global expenditure on mental health across the lifespan has been modest with less than two US dollars per person per year and less

than 25 cents in low income countries (WHO 2011). In the International Declaration for Youth Mental Health, Coughlan and colleagues (2013) emphasised the insufficient provision of services for young people with mental health problems in addition to the gaps in services for young people in the 16 to 18 year age group, which was a key barrier to identification and treatment for most study participants. This critical time period for people aged 16 to 18 years combined with inadequate service provision often results in young people not being able to access specialist mental health services or they may experience an untimely and traumatic transition to adult mental health services (McNamara et al. 2013). Additionally, previous research has emphasised the paradoxical link between increasing psychological needs among adolescents during their developmental transition to adulthood and the weakest point of service delivery in the transition from child and adolescent mental health services to adult mental health services (McGorry 2007).

The HSE prioritised development of CAMHS services following the publication of AVfC and positive outcomes included: an increased number of child and adolescent inpatient beds, a reduced number of children and adolescents being admitted to adult wards, an increase in the total number of CAMHS community teams and a reduction of 20% in waiting lists for CAMHS services between 2010 and 2011. Additionally, the Government has supported the establishment of youth initiatives such as ten 'Jigsaw' mental health projects around the country (Bates et al. 2009). Furthermore, the Government's allocation of €16M for an additional 150 community CAMHS posts was perceived as a positive step in the progression of services for children and young people (Mental Health Reform 2012).

However, despite prioritisation of CAMHS services there are still significant gaps in policy implementation (Mental Health Reform 2012). A recent HSE report on child and adolescent mental health services, reported that, in 2010, only 9 out of 39 CAMHS services accepted referrals of all young people up to and including 17 years of age (HSE 2011). By the end of 2011, CAMHS services had just 39 of the 108 inpatient beds recommended in the policy document, even though this was a substantial increase on the 12 beds that were in place in 2007 (Mental Health Reform 2012). Furthermore, staffing levels for CAMHS community teams included 42% of that recommended in A Vision for Change (HSE 2011).

Mental Health Reform (Mental Health Reform 2012) recommended:

• Fulfilment of the HSE's planned 150 additional community team posts in CAMHS services.

• Abolish inappropriate admissions of children and adolescents to adult units.

• An individualised transition plan to facilitate the transition for young people before transferring from child and adolescent services to adult services, where service user inclusion is given priority.

• The HSE and mental health education providers should ensure staff working in CAMHS services are adequately trained to work with young people between the ages of 16 and 18.

'AVfC' and primary care

AVfC (Expert Group on Mental Health Policy 2006) set out specific strategies in relation to primary care, some of which are applicable to the current study:

7.4 "Appropriately trained staff should be available at the primary care level to provide programmes to prevent mental health problems and promote wellbeing."

Accessing psychological therapies is a key area that was omitted in AVfC. A common deterrent for young people attending primary care services was cost, particularly if they were not entitled to avail of GMS (free medical care) services. Health care workers, particularly GPs were also reluctant to refer young people for counselling because of poor service availability, lengthy waiting lists and cost. Previous reports have documented similar concerns among GPs (HSE Working Group on Mental Health in Primary Care 2006). Similar to the treatment barriers experienced by some participants, there is also limited availability of psychological therapies through mental health services, with a waiting time of up to two years for therapy (Inspector of Mental Health Services 2011). In 2003 counselling services were developed such as the Primary Care Counselling Service (PCCS), however, PCCS are only available to people who are over the age of eighteen and those who have a GMS or GP-visit only card. Similar to

recommendations outlined in the AVfC manifesto, health care workers, particularly from specialist mental health services advocated the need for more psychological therapies in primary care, to avoid overloading services where the focus should be on people with more severe and debilitating mental health problems. Therefore, with sufficient resources primary care has the potential to offer psychological supports to young people that are affordable and timely (Mental Health Reform 2012).

7.5 "It is recommended that the consultation-liaison model should be adopted to ensure formal links between community mental health teams (CMHTs) and primary care."

Additional barriers which were highlighted by the study participants included the lack of CMHTs and the lack of priority given to mental health within PCTs. The views of health care workers were similar to policy recommendations outlined in the AVfC manifesto in terms of the importance of developing good relationships between mental health and primary care staff to improve the quality of care and reduce the number of hospitalisations (Mental Health Reform 2012). However, key barriers to the identification and treatment for mental health and substance use problems for many healthcare workers in study one and GPs in study two included time, resources and fragmentation between services. Similar to the recommendations of many health care workers, AVfC favoured the consultation-liaison model of mental health in primary care which is a model of shared care between primary care and other levels of care (Expert Group on Mental Health Policy 2006). Additionally, the Mental Health Commission supported the consultation-liaison model and has since recommended that a 'stepped care' model be adopted which can further specify the consultation-liaison approach, thus minimising inappropriate referrals (Byrne and Onyett 2010). However, the consultation-liaison model has yet to be implemented on a national level, with the slow development of primary care teams in some regions due to lack of sufficient resources posing further barriers to implementation of the model (Mental Health Reform 2012).

The effectiveness of the consultation model is unknown, particularly as the model can be implemented in various ways depending on the related context. Furthermore, the

consultation-liaison model requires considerable time and dedication from GPs and psychiatrists to attend regular meetings (McDaid 2013). Time and limited resources were major barriers for the majority of health care workers in the current study, particularly GPs. Moreover, the limited availability of primary care services in socio-economically disadvantaged communities may pose further barriers to the implementation of the consultation-liaison model (Chan et al. 2011). In accordance with findings emerging from the HSE report in 2010, progress in the implementation of the consultation-liaison model has been slow, six regions did not have a referral or discharge protocol with primary care (Health Services Executive 2011a) and in a separate survey the HSE found that 58% of the 78 primary care teams who responded had no formal referral protocols set up with the mental health services (HSE Primary Care and Mental Health Working Group 2012).

Alternative models might include the CMHT Coordinator role, where a Coordinator appointed to each CMHT facilitates links between primary care and specialist mental health services. The West Cork Mental Health Service appointed a CMHT Coordinator as a first point of contact for all referrals, and a nurse-practitioner role was also appointed to provide onsite liaison for GPs in neighbouring towns, where the nurse can provide psychotherapy and family therapy onsite (West Cork Mental Health Service 2011). Some of the GPs in study one highlighted the potential benefits of having a liaison approach similar to the East Cavan Primary Care Liaison Service, where a psychiatrist, a psychiatry trainee and a community psychiatric nurse visited five practices every six weeks to facilitate collaboration with GPs. When this structure was in place, GPs rarely made referrals to specialist services, only patients with severe mental health problems (Russell et al. 2003). In order to facilitate collaboration between the mental health services and primary care, the WHO & WONCA (2008) developed a set of principles for integration between the two sectors, key strategies included: 1) Inclusion of primary care in mental health policy; 2) appropriate staff training; 3) achievable goals; 4) primary care support from specialist mental health services; 5) mental health service coordinator driven integration and 6) primary care collaboration with government non-health sectors and non-government / voluntary agencies.

7.11 "The education and training of GPs in mental health should be reviewed."

The majority of GPs in the study one felt that they did not have sufficient training to address youth mental health problems and postgraduate training satisfaction among GPs in study two was quite low for CAMH and substance use problems compared to adult mental health. Since 2006, the HSE has made attempts at implementing GP training strategies, however progress has been modest with only one hundred GPs from approximately 3600 GPs in Ireland having received training in an accredited programme in Mental Health in Primary Care (McDaid 2013). In line with previous recommendations from the WHO, this study provides further evidence for the provision of training at every stage of a GP's education, continuing profession development (CPD), CME in addition to on-going supervision and support (World Health Organisation 2005). AVfC noted that GP training tends to occur mainly within specialist mental health services and therefore training opportunities in the type of mental health and social problems that present to primary care are lacking (Expert Group on Mental Health Policy 2006). This was particularly relevant to GPs in study one, who were based in socioeconomically disadvantaged settings where mental health problems which were often linked to the young person's broader social context posed many challenges to their identification and treatment. Some GPs also felt ill-equipped to address young people who might be experiencing family related issues and specified the need for further training and support in this domain.

Current initiatives that aim to increase mental health knowledge among GPs and other health care workers in primary care include: a HSE Mental Health in Primary Care Resource Pack, e-learning modules on mental health were made available through the ICGP (Independent Monitoring Group 2007). The ICGP also provide training in CBT and have a package in youth adolescent health education (ICGP 2011). AVfC and the primary care strategy 'Primary Care: A New Direction' noted that primary care services should address the general aspects of both mental health and substance use problems (Department of Health and Children 2001), however AVfC does not address how primary care could offer integrated treatment for individuals with milder mental health and substance use problems (McDaid 2013). GPs in study two were more reluctant to diagnose and treat substance use problems compared to mental health problems, even those in the milder domain. Furthermore, health care workers from the addiction

services highlighted the need for further training for GPs in substance use problems. Therefore strong links between local addiction services and GPs / primary care services are needed in addition to further training and resources (McDaid 2013).

5.7 Links with theoretical models

5.7.1 Bronfenbrenner's Ecological Model

Our findings highlighted the important relationship between the individual, family and peers, local community and wider society, similar to previous ecological theories of development (Bronfenbrenner, 1989, 2005; Ungar et al. 2005). Health care workers' engagement with young people was influenced by the multilevel ecological systems within the individual's social context (e.g., the young person's immediate environment / 'microsystem' (e.g., family relationships), additional relationships in the 'mesosystem' (e.g., peer and school relationships), external factors in the young person's local area context / 'exosystem' (e.g., drug culture and criminality) and the wider societal aspects in the 'macrosystem' (e.g., mental health policy, healthcare inequalities and societal stigma).

(Microsystems)

Maladaptive coping

Contextual factors had a major impact on coping strategies for young people and similar to other research, risk taking behaviour such as substance abuse, as a way to cope with stressful social environments in the absence of appropriate role models for more adaptive forms of coping was common in both study sites (Bonomo, 2001). Previously research noted that young people living in socio-economically disadvantaged urban areas are particularly vulnerable to early use and future abuse of illicit drugs and alcohol (Martino et al. 2008). The early onset of substance use was a key issue identified among health care workers and young people in the current study, where the environment's negative effects on childhood development resulted in the increased likelihood of developing mental health, substance use and criminality issues. As such, mental health

and substance use problems were somewhat unavoidable as they became a coping mechanism. Young people from these areas were identified as having increased anger issues and lacking the coping skills to deal with them.

Role of family and peers

Consistent with earlier social and environmental theories, the influence of parents, peers and community had an important role on adolescents' potential for risk-taking behaviour (Igra, 1996). In terms of family problems, most young people in the current study were exposed early in life to violence, bereavement, and addiction. Furthermore, non-existent family support made it more difficult for young people to seek help and engage with care. Chaotic lifestyles that are created by families, friends, the local environment and the societal context of being young in Ireland made it difficult for health care workers to motivate young people with substance use problems to rehabilitate, or even keep appointments and remain contactable. Several studies have noted the link between parental substance abuse and the negative psychosocial repercussions for the children (Andreas et al. 2006; Barnes et al. 2009). Additionally, Mason et al. (2011) noted the link between negative coping strategies and the increased likelihood of associating with peers who do not adhere to conventional societal norms and adopt substance use to help them cope. Young people reported how difficult it was to refrain from substance use when friends were heavily involved with it. Some felt that addiction was normalised in these areas. Drug cultures were changing and becoming more varied in terms of substances used - with an emphasis on prescription drugs - and more strongly associated with gang violence.

Gender differences / treating young males

The higher rate of referrals for female patients compared to males was an interesting finding, particularly when the majority of youth suicides occur in males (National Office for Suicide Prevention 2012) and are frequently underpinned by untreated mental illness (Houston et al. 2001). However, previous research in Ireland reported higher rates of psychiatric disorders among females (Edokpolo et al. 2010; McMahon et al. 2010). In a qualitative study with young Irish males who had attempted suicide, Cleary

(2007) noted that 'hegemonic masculinity norms', whereby more traditional or conventional male gender roles are assumed (Connell, 2005) and using alcohol as a coping mechanism were the key factors that discouraged help-seeking. Furthermore, services geared towards males tend to focus primarily on recreational needs and diversionary responses as opposed to emotional needs (Cullen et al. 2012) and previous qualitative research found that men were more likely to seek help when it was perceived as a means to preserve or restore valued masculine roles (e.g., working as a fire-fighter, or maintaining sexual performance) (O'Brien et al. 2005). In the 'My World Survey', gender was identified as both a risk and protective factor; males consistently reported higher levels of satisfaction with life compared to females but they also engaged in more risk-taking behaviour, including problem drinking, substance abuse and violence towards others (Dooley & Fitzgerald, 2012).

Health care workers noted the difficulties when trying to treat young males and their reluctance to engage with services compared to females. Previous research found that male adolescents were less likely to have psychological issues discussed or detected during GP consultations (Martinez et al. 2006), particularly those who were socially and economically marginalised. A previous study of adult populations found a similar trend in the detection of psychological problems according to gender. Although there was a similar number of high GHQ scores among males and females, physicians classified significantly more female patients than males as being 'disturbed' (Redman et al. 1991). In a review of gender differences among Irish adolescents attending a drug and alcohol service for young people under 18 years, Edokpolo and colleagues (2010) found that females differed from males in having more internalising and externalising psychiatric problems. Furthermore, Aaarseth and colleagues (2014) reported increases in utilisation of GP services by sending an informative letter to patients where the protection of adolescent privacy and information about health rights had been outlined, particularly among young males (54% to 72%). However, in the current study, concerns about confidentiality were a major barrier to help-seeking among most male and female participants.

In studies based on young people from socio-economically disadvantaged urban areas, Biddle et al. (2004) noted that help-seeking was more regular in females than males (35% and 22%) and women with suicidal thoughts more commonly sought help than

men with suicidal thoughts. Females were also more likely to seek help from family / friends than males. According to Klineberg and colleagues (2011), young males from socio-economically disadvantaged backgrounds were less likely to recognise symptoms associated with depression, recommend seeing a doctor for mild depressive symptoms but were also at greatest risk of suicide. Klineberg et al. (2011) noted the importance of such gender specific differences in help-seeking, given the higher rates of suicides among young males (Cleary 2012, National Office for Suicide Prevention 2012). Health care workers in the current study suggested that for young males in socio-economically disadvantaged areas, where community violence may be a dominant force, mental health problems and emotional difficulties are often addressed with maladaptive forms of coping e.g., substance abuse, gang violence and criminality.

ADHD diagnosis

A key area of concern in our study was health care workers' conflicting views on diagnosing young people with ADHD. While some participants felt that it explained behavioural difficulties, others were concerned about young people being incorrectly diagnosed and taking unnecessary medication. However, previous Irish studies have reported high levels of undiagnosed ADHD (Fitzgerald, 2001; Syed et al. 2010) and combined psychotherapeutic and pharmacological interventions was highlighted as a necessary treatment strategy (Van Hout & Foley, 2013). Conflicting views in regards to ADHD diagnoses highlights the need for increased training of non-mental health care workers in mental health diagnoses and better communication between mental health care professionals and health care workers from other settings.

Additionally, some young participants reported negative transition experiences from CAMHS to Adult Mental Health Services (AMHS) and for young participants with ADHD, concerns about their future trajectory of care were key prior to making the transition. Previous studies have noted that the estimated annual numbers of young people who remained in CAMHS beyond the transitional boundary and those considered suitable for transfer were both greater than the estimated annual numbers transferred (McNamara et al. 2013, Singh et al. 2010) thus further highlighting gaps in appropriate service provision for young people with mental health problems due to the rigid age cut-offs between services. A review of CAMHS provision in the UK reported

major difficulties for service users, carers and clinicians during transitions from CAMHS to AMHS where young people aged 16 to 18, including individuals with ADHD felt excluded from adult services because their health problems did not amount to serious mental disorders (National CAMHS Review 2008). Furthermore, previous research has highlighted the gaps in services for adults with ADHD (Marcer et al. 2008, Singh et al. 2010).

(Mesosystems / exosystems)

Early school leaving

Early school leaving was also a common theme in our findings and it was perceived that there was little incentive for young people to stay in the educational system. This is consistent with previous research in Ireland where three decades of illicit drug use in areas of socio-economic disadvantage have contributed to low levels of educational attainment, drug related criminal activity and families with a longstanding history of drug use (O'Kelly et al. 1988, Dean 1984, Smyth et al. 2000). Early school leaving has been linked with a higher risk of alcoholism in adulthood (Crum, 1998) and school engagement can be an important protective factor in delaying the onset of substance abuse in adolescence (Simons-Morton & Chen, 2005). Health care workers and young people identified the potential for schools to incorporate mental health awareness programmes in addition to providing training for teachers to recognise early signs and symptoms of mental health problems. In a systematic review of effective mental health promotion for young people, researchers identified the importance of a collaborative effort between parents, teachers, youth workers and young people in low income communities to facilitate the school environment as a place to promote mental health interventions (Barry et al. 2013). Furthermore, Patton and colleagues (2006) reported that a school based intervention facilitated strong engagement between teachers and students, where emotional security resulted in reduced substance abuse, violence and other antisocial behaviours in adolescents.

(Macrosystems)

Societal stigma

In line with Bronfenbrenner's Ecological Model, the larger cultural and societal systems had a powerful influence on the lives of the participants (Bronfenbrenner, 2005). The macrosystems outlined in this thesis (e.g., outdated mental health policy and stigma) left families vulnerable to great harm and deterioration. The stigma attached to living in socio-economically disadvantaged urban areas has been well documented in previous research, thus resulting in negative psychosocial consequences for the residents (Hastings, 2004) and under-utilisation of government and community services (Stevenson et al. 2014). The additional challenges within the broader societal context which health care workers experienced when working with young people living in socio-economically disadvantaged urban areas (e.g., financial restrictions, limited staff, time and resources, chaotic environments, drug related crime and violence) provide additional support for Tudor Hart's Inverse Care Law whereby the level of medical and psychosocial supports available does not meet the requirements of the population served (Hart, 1971).

5.7.2 Social Determinants of Health

Social deprivation and social cohesion were important factors in the origins, treatment and outcomes of this problem (Fone et al. 2007). Marmot et al. (2008) suggested that "the health care system is itself a social determinant of health", where it influences and is influenced by other social determinants such as gender, education, occupation, income, ethnicity and place of residence. According to Wilkinson (2006), "the most likely reason income inequality is related to health is because it serves as a proxy for the scale of social class differentiation in a society." Participants were often limited in terms of the treatment options that were available to them and access to mental health and addiction services due to financial restrictions. Marmot (2005) stressed the need to go beyond recognising the health effects of poverty and consider how social and economic policies can impact on the lives of those living in socially disadvantaged communities, therefore a more indepth understanding of the SDH is required to reduce health inequalities.

Health care workers and young people attending community agencies were often under pressure to engage in fund raising initiatives to secure the continuity of services and in some cases the resulting lack of stability had negative repercussions for youth engagement. Marmot and colleagues (2008) emphasised the factors associated with health inequalities on a macro level such as unequal distribution of power, income, goods and services both globally and internationally and the consequent unfairness on a micro level / immediate circumstance of people's lives in terms of access to health care and education, working conditions and the impact on communities and households. The unequal distribution of health-damaging experiences is a result of poor social policies and unfair economic arrangements (Marmot et al. 2008).

Living in neighbourhoods where chaotic lifestyles and community violence were common problems contributed to the development of mental health / substance use problems in young people and resulted in further difficulties for health care workers to engage with this population. Neighbourhoods represent socio-economic status, culture, structural environment and access to facilities; all aspects which may influence health outcomes (Kulkarni 2013). According to Wilkinson (2006) psychosocial influences associated with chronic stress on health not only effect the physical aspects of an individual but also have consequences for risk taking behaviours (e.g., smoking, excessive alcohol consumption, substance abuse etc.). Risk taking behaviours are harder to overcome where negative reactions to environmental factors are part of everyday life (Wilkinson 2006). Additionally, previous research noted the reduced social capital within Irish communities, where young people feel less connected with their local environment (Illback & Bates, 2009).

In keeping with the SDH, Viner et al. (2012) suggested that policy responses to adolescent health must integrate interventions at the individual, school and family level. In a summary of implications and potential actions outlined by the WHO Commission on SDH to address the challenges associated with adolescent health (World Health Organisation 2008), three key aspects were identified:

1) *Improve conditions of daily life* – An individual's daily life in relation to families, peers and school should be addressed for risk and protective factors, with a particular focus on utilising evidence based interventions in low-income settings. A primary focus on creating better education and employment opportunities for young women was

stipulated, which was particularly relevant to the current study where young mothers were identified as a particularly vulnerable group in socio-economically disadvantaged settings.

2) *Tackle the inequitable distribution of power, money and resources* – Youth empowerment within health care services, which was certainly a key aim among most health care workers in study one, should be a primary goal, particularly in policy decision making and in health service and community development. Previous research noted the health benefits of youth involvement in the design and delivery of health services (Légaré et al. 2010, Bates et al. 2009).

3) *Measure the problem, evaluate action and expand the knowledge base* – the need for a workforce that is trained in SDH, in addition to promoting further public awareness of SDH is vital for health care reform. In the current study promoting mental health awareness in addition to the provision of further training for health care workers, particularly GPs was a key enabler to the identification and treatment of mental health problems. Further systematic research of SDH is needed on a global level to determine the most effective service developments and interventions.

5.7.3 The Chronic Care Model

In keeping with the 'Chronic Care Model', the value of health care organisation, delivery system redesign and community resources were highlighted, though it is worth noting that other elements of this model (self-management support, clinical information systems, decision support) were not (Bodenheimer et al. 2002).

Health care organisation – Interagency collaboration was identified as a key strategy to facilitate identification and treatment of mental health and substance use problems among most health care workers. Breakdown in communication and care co-ordination can be prevented through agreements that facilitate communication and data sharing as young people navigate across multiple services and interact with several health care workers. This was particularly relevant to young participants during their interaction with health care services and community agencies, where fragmentation between services resulted in further treatment delays.

Delivery system redesign – A multidisciplinary approach to care was identified by most health care workers where tasks were delegated to other members of the team in terms of follow-up and behaviour change. This was particularly evident among GPs in study two where further training for practice nurses and access to a youth worker were identified as key strategies to enhance their capability to address youth mental health problems in their practice. Wagner (2000) noted that non-physician members within practice teams have the potential to provide close follow-up and help to increase adherence to treatment for patients with more complex conditions. GPs working in primary care teams were in an opportunistic position to establish important links for their patients and provide more efficient referrals.

Community resources - GP awareness of external agencies and community resources was considered a key enabler to early intervention for young people with mental health problems. However some health care workers and young people highlighted a lack of awareness among GPs in regards to community based services, which often resulted in inappropriate referrals for people with milder mental health and substance use problems. Previous research has noted the cost effective benefits of increasing awareness and access to effective programmes in the community such as community based counselling services and peer support groups (Wagner et al. 2001).

Self-management support - Promoting self-management support was not highlighted among participants. While previous research has reported the benefits of individual and group interventions in terms of promoting patient empowerment and the acquisition of self-management skills in diabetes, asthma and other chronic conditions (Norris et al. 2001), the applicability of such an approach to young people with mental health and substance use problems particularly during the early onset of symptoms may not be appropriate. Furthermore, recent evidence suggests that the long-term benefits of self-management support strategies may require an ongoing collaborative relationship between patients and health care workers (Glasgow et al. 2002).

Clinical information systems - Effective data management strategies of patient files where timely reminders for appointments could prove to be very beneficial for engaging with young people particularly as some health care workers reported the ad hoc nature

of youth engagement with health care services. Additionally, given the problematic nature of fragmentation across services addressing mental health / substance use problems in socioeconomically disadvantaged setting, a disease registry / database that includes information about the process and results of care for patients would facilitate other health care teams who are engaging with the patient, particularly in terms of monitoring medication and delivering planned care.

Decision support – Utilisation of evidence based guidelines in practice was not prioritised by most health care workers, however, collaboration with experts in the field and seeking advice from colleagues was identified as a key enabler to addressing mental health problems. Previous research suggested that guidelines only become effective when they are formally incorporated into patient care such as including guidelines in patient assessment tools (Wagner et al. 2001). Additionally if guidelines are to be implemented appropriately in practice, patient inclusion in the use of such guidelines should be prioritised. Many health care workers emphasised the importance of including patient views / feedback when using formal assessment tools and evidence from the literature reported that sharing guidelines / expectations for care with patients encouraged continuation of such efforts in practice (Wagner et al. 2001).

Alternative model

5.7.4 The Health Belief Model

The Health Belief Model (HBM) (see figure 5.1), initially described in the 1950s to explain why medical screening programmes for tuberculosis were not as successful (Rosenstock 1974, Hochbaum 1958), explains health behaviour expectancies where health behaviour is determined by personal beliefs or perceptions about a disease and strategies available to decrease its occurrence (Hochbaum 1958). The HBM has been applied to understand patient responses to symptoms of disease, compliance with medical regimens (Janz and Becker 1984) and lifestyle behaviours (e.g., sexual risk behaviours) (Glanz et al. 2008). The main theoretical constructs include: perceived severity, perceived susceptibility, perceived benefits and perceived barriers. More recent additions to the model include: cues to action, motivating factors and self-efficacy. The HBM is applicable to young people in terms of their initial experiences of symptoms to

their interaction with services, in regards to the factors which influenced their decision to seek help / address their mental health / substance use problems.

1) Perceived severity – This construct stems from the beliefs an individual has about the impact a disease would have on their life. The HBM proposes that the more a disease is perceived to be severe, an individual is more likely to engage in health behaviours to prevent increasing levels occurring (Janz and Becker 1984). Young participants were more likely to engage in the help-seeking process when they reached a crisis point in their lives due to increased symptom severity (e.g., becoming homeless, increasing suicidal tendencies, problematic life circumstances etc.).

2) Perceived susceptibility – An individual's assessment of their chances of getting the disease, the greater the perceived risk, the more likelihood of engaging in behaviours to reduce the risk (Janz and Becker 1984, Glanz et al. 2008). When some participants initially experienced symptoms and tried to make sense of their experiences some engaged in a process of self-comparison with other family members who had experienced similar symptoms or who had been diagnosed with a mental / substance use disorder. This realisation often encouraged participants to seek help. However, health care workers described some young people who did not perceive they were at risk and they often engaged in risky behaviours and initial engagement with the health care services was influenced by external factors. Moreover, previous research with college students found that even when increased perception of risk was high for HIV they still did not practice safer sex (Lewis et al. 1997). Similarly, despite the realisation among some participants, that what they were experiencing was not 'normal', they engaged in maladaptive coping strategies (e.g. excessive drinking, increased substance use, violent outbursts etc.) prior to seeking help.

3) Perceived benefits - Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease (Janz and Becker 1984). In the current study, motivating factors to engage in the help-seeking process were based on psychosocial consequences resulting from their symptoms (e.g., losing important relationships, adverse legal consequences, homelessness etc.) as opposed to concerns about the decreasing the risk of disease.

4) Perceived barriers - This refers to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease. Of all the

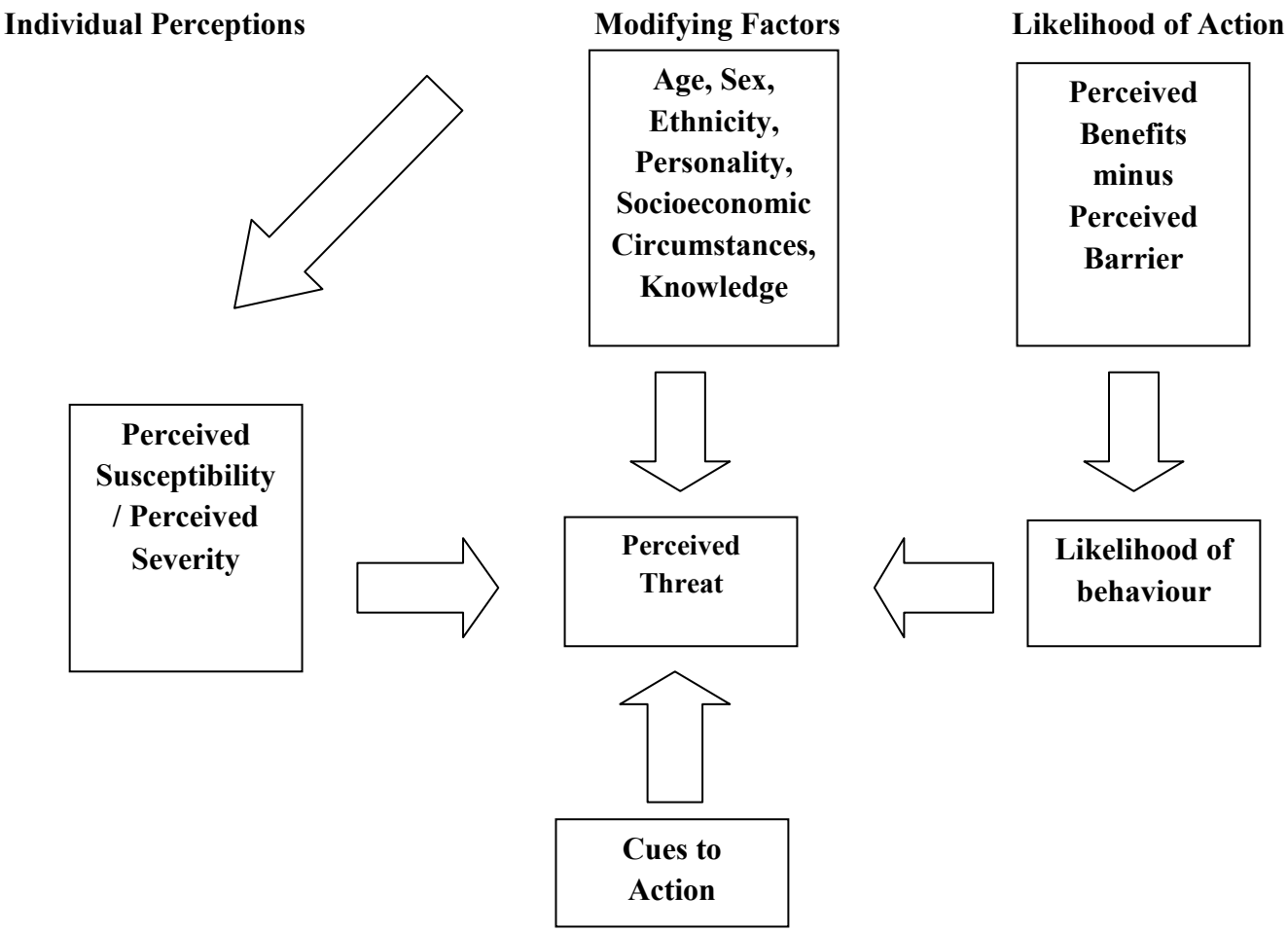
constructs, perceived barriers are the most significant in determining behaviour change (Janz and Becker 1984). This construct was particularly applicable to participants with substance use problems where participants experienced difficulties engaging with treatment in the absence of a replacement for former substances abused.

5) Modifying variables – An individual's personal factors that influence whether the new behaviour is adopted or not. The four main theoretical constructs are influenced by demographic variables, age, gender, socio-economic status etc. For some participants, negative peer influences and repetitive maladaptive family structures delayed the help-seeking process in addition to posing further barriers to treatment engagement.

6) Cues to action – Factors that will start the person on their way to changing their behaviour (e.g., events, people, media etc.). For most participants, concerned family members facilitated their initial interaction with services, other participants were motivated by external pressure (e.g., adherence to probationary sentences) and for some comparing their life circumstances to peers influenced the need for behaviour change.

7) Self-efficacy - Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour (Glanz et al. 2008). Some health care workers emphasised the importance of setting achievable treatment goals to enable ongoing engagement with treatment and some young participants recalled difficult encounters with health care workers when they perceived the goals that were set for them to be unrealistic and beyond their capability.

Figure 5.1: Health Belief Model



5.8 Methodological considerations

5.8.1 Methodological approach

The central principle of using a mixed methods approach is that the combination of qualitative and quantitative methods optimises the implication of a phenomenon. The utilisation of mixed methods in the current study facilitated a link between health care workers and young people's accounts of screening and treatment for mental and substance use disorders and also facilitated the development of an instrument to a larger population of GPs. Creswell (1994) highlighted the benefits of combining qualitative and quantitative research by stating that "a false dichotomy exists between qualitative and quantitative approaches and that researchers should make the most efficient use of both [approaches] in understanding social phenomena." Our qualitative approach allowed us to develop an in-depth understanding of the difficulties encountered in treating young people with mental health and substance use difficulties, while the quantitative study enabled key findings from study one to be assessed among a larger population of GPs.

5.8.2 Sampling

Study one: A key aim of the study was to address the perspectives of younger people who are often most misrepresented in the mental health services (i.e., young people in the 16 to under 18 age group). In contrast to recruitment of health care workers in study one, we experienced difficulties recruiting young people, particularly those in the 16 to under 18 age range where parental consent is required. Similar methodological issues have been noted in previous research with young people, where Haavet and colleagues (2010) reported a higher response rate to a questionnaire administered to a Danish sample of 14 to 16 year olds compared to a Norwegian sample where parental consent was a requirement. Sanci and colleagues (2004) noted that research into adolescent health issues is often hindered by absolute requirements for parental consent and previous studies that adopted school based surveys where active parental consent was required resulted in lower response rates, thus resulting in underrepresentation of at-risk groups (Australian Institute of Health and Welfare 2003). Additionally, our chosen study sites are well known regeneration areas where a much previous research has been

conducted since 2007. Therefore, some health care workers were reluctant to assist with the recruitment of young people attending their service due to concerns in regards to the associated benefits for young people, in addition to over exposure to additional research. However, Arnold et al. (1995) suggested that a particular danger associated with becoming overly protective is that young people become "research orphans", with little progress being made in relation to their health issues. Furthermore, research studies based on young people under the age of 16 is required, particularly given the early onset of mental health and addiction problems among children and young adolescents (McGorry et al. 2007a).

The influence of the study's theoretical frameworks combined with participants' accounts provided significant information which should influence future service planning and development. Incorporating a broad range of stakeholders from diverse clinical settings aimed to reflect the various sites where young people seek help for mental and substance use disorders. However, our sampling methods are likely to have biased participants towards those health care workers more engaged with the issue of youth mental health. Half of the respondents had been working in this setting for more than five years which suggests these communities are fortunate to have health care workers who are committed to working with them for a long time. The applicability of our findings to health care workers who are relatively less engaged with this issue should be the focus of future research to determine the factors that might motivate health care workers to work in socio-economically disadvantaged settings with youths who are considered high risk. Additionally, young people with more severe disorders who were unable to provide informed consent were excluded from this study, thus their specific needs warrant further research.

Study two: Findings should be interpreted with a degree of caution due to a relatively low response rate, in addition to the absence of a validated study instrument specific to youth mental health, the questionnaire in the current study was influenced by a range of sources – both qualitative and quantitative, where the majority of quantitative study instruments did not report validity measures. However, our results compare favourably with previous research reporting on GP attitudes to addressing mental health problems (Copty and Whitford 2005, Fleury et al. 2012, Jaruseviciene et al. 2012, Stensrud et al. 2012). Additionally, the profile of characteristics for GPs responding to the survey (in

terms of gender, age and rural / urban setting of practice) is similar to that reported for GPs nationally in a 2005 survey (O'Dowd et al. 2006). In an endeavour to maximise our response rate our questionnaire adhered to strategies as advised by Edwards et al. (2002) such as keeping the instrument short and concise, hand written signatures on the letter of invitation, coloured paper, multiple mailings etc. We were rewarded for this effort with minimal missing data among returned questionnaires. However, caution needs to be applied when interpreting the results of this study. The findings may be affected by non-response bias. Low response rates are a common limitation of research in general practice due to the considerable number of surveys that GPs receive (Templeton et al. 1997). Additionally, non-responders among GPs may be less interested in mental health problems and a responder bias may be present.

5.9 Recommendations for research, education and clinical practice

Key findings and associated recommendations for future research and clinical practice are outlined in the sections that follow for: 1) Delivery of mental health / addiction services for young people and 2) GP training and education.

5.9.1 Delivery of mental health / addiction services for young people

1) Key finding – Context specific factors to be included in health service delivery: The role of context in a young person's life is vital, (particularly young people living in socio-economically disadvantaged settings), within each system from the micro to the macro, opportunities for positive growth and development can be lost or gained. Each system has an important part to play, from the family home to the health care services. Combined with adult service providers reporting that they had to prioritise the acutely ill over less serious problems, early intervention becomes nearly impossible outside of primary care for young people living in socio-economically disadvantaged areas. Relying on community services was also difficult, due to treatment inequalities also arising in the variable access available to community-based, non-pharmacological treatments, in addition to the number of services that were available free of charge.

Recommendation: Practitioners and policy makers should understand the reciprocal relationship of dependency and influence with all other systems (Ungar et al. 2013) when creating treatments and interventions for young people. Interventions that enhance the capacity of health and social care workers to identify and appropriately respond to the specific needs of youth mental and substance use disorders in socio-economically disadvantaged areas are a priority. The Mental Health Expert Group noted the problem of inequitable allocation of resources across the country and found that there was a ten-fold variation in per capita funding for mental health across different services nationwide (Expert Group on Mental Health Policy 2006). Additionally, a study by the Irish Psychiatric Association (IPA), known currently as the College of Psychiatrists of Ireland (CPI) found that areas of greatest socio-economic disadvantage received the least resources (Irish Psychiatric Association 2003). Moreover, Coughlan and colleagues (2013) in a discussion of the key priorities emerging from the 'International Declaration for Youth Mental Health', highlighted the need for equality in the provision and access to services regardless of socio-economic background.

Mental health services need to consider local deprivation patterns when planning and delivering mental health care, many urban areas in socio-economically disadvantaged areas experience interrelated problems such as long-term unemployment, separated families and low quality environment (Office for Social Inclusion 2003). One of the key aims outlined in AVfC manifesto was the provision of services which are based on best international practice, and more importantly where people have equal access to good quality services across the country (Mental Health Reform 2012). More than 20% of the recommendations outlined in AVfC concern broader contextual factors that are the responsibility of departments other that health e.g., housing, education, income and employment (Expert Group on Mental Health Policy 2006). Most health care workers in the current study were struggling to address multiple needs for the young person in their care, in addition to their mental health and / or substance use issue, therefore a holistic approach to a young person's care needs to be supported, where broader contextual factors are addressed.

2) Key finding – Supporting young people and their families: Some health care workers in the current highlighted the removal of outreach services as a key barrier to the

identification of mental health problems, particularly for young people living in socio-economically disadvantaged areas, where such services facilitate a positive relationship between young people, their families and the health care services. In socio-economically disadvantaged urban areas, interventions that support and engage with families and their local communities are most likely to be effective in preventing and treating mental and substance use problems. Previous research identified key areas to facilitate drug prevention in families: school based prevention programs, working with parents and health care workers and collaboration with schools, parents and the wider community (Cuijpers, 2003). However, previous research noted that parents from socio-economically disadvantaged areas were less likely to engage in interventions, with lack of time, financial restraints, childcare responsibilities and fear of stigma being the predominant barriers to engagement (Velleman *et al.* 2005; Murry *et al.* 2011).

Recommendation: Additional supports such as outreach work and home-based interventions for families in socioeconomically disadvantaged urban areas are necessary to establish initial links and facilitate proactive relationships with the health care services. Previous policies including AVfC and the International Declaration for Youth Mental Health, indicated the need to support families in their role as the primary care giver, where they are consulted more on their needs (Mental Health Reform 2012). When family members have a good understanding of mental health problems and are facilitated in the coping process they have the potential to play a positive and proactive role in supporting recovery (Mental Health Reform 2012). The Mental Health Commission stated that CMHTs should support family members, including on-going emotional support, respite care assistance with accessing services, and educational tools about mental health (Byrne and Onyett 2010). The role of the family and other primary care givers is lacking in AVfC and in Ireland's mental health legislation (Mental Health Reform 2012).

3) Key finding – Parental perspectives: The negative and positive role of family members, particularly parents emerged as a key theme in terms of repetitive maladaptive family structures and their impact on the development of mental and substance use problems. Additionally, the parental role was identified as both a barrier and enabler associated with identification and treatment for mental health problems.

Some families played a pivotal role in terms of assisting participants to initiate initial engagement with services, however, other health care workers found that parents had unrealistic treatment expectations and became defensive as they felt that their role as a parent had been compromised. Similarly, Sayal et al. (2010) in a series of focus groups conducted with parents of young people with mental health problems, found that some parents were reluctant to access services because they feared being judged as 'a poor parent'.

Recommendation: Further research should include parental perspectives to investigate their experiences of navigating through mental health services as the primary caregiver, particularly for young people under the age of sixteen years. Furthermore, Roberts (2012a) emphasised the importance of exploring the family context suggesting that adolescents' consulting behaviour may be influenced by earlier experiences of consulting as a child and observing how their family and peers discuss consulting behaviour.

4) Key finding – Gender differences – Identification and treatment: Consistent with previous findings, gender differences were reported among health care workers in terms of the difficulties encountered in the identification and treatment of young males. Health care workers were less likely to refer young males to services and often experienced greater difficulties communicating with this client group during consultations. Additionally, young males were less likely to seek help for mental health / substance use problems. Furthermore, young males were more likely to depend on family members (particularly mothers) to facilitate the help-seeking process and this population also advocated the benefits of activity based engagement as a key enabler to help-seeking.

Recommendation: Strategies to engage with young males are necessary given the high rate of suicide among this demographic. In accordance with the AVfC manifesto, it was suggested that the original policy drafted in 2006 was 'gender blind' in terms of specific recommendations that ensure appropriate service delivery, despite the fact that gender differences in regards to help-seeking, initial presentation of symptoms have been widely documented in previous literature (Mental Health Reform 2012). Further training programmes for health care workers where communication skills specific to

addressing young males is a key component, in addition to activity based treatment with continued support across services is likely to be of most benefit to engaging with this population.

5) Key finding – Role of schools in mental health promotion: Most health care workers advocated the need for increased youth mental health literacy and identified schools as the most appropriate environment to incorporate this strategy. Additionally, young participants also expressed the need for a more extensive focus on youth mental health within the school curriculum as their current exposure to mental health awareness initiatives was very limited e.g., a brief mention in SPHE, a talk once a year, watching an occasional DVD etc.

Recommendation: Ideally all schools should have behavioural support staff (e.g. counsellors, youth advocacy workers etc.) on site but such a strategy seems unlikely with current financial limitations. However, teachers should receive training on the identification of mental health problems to facilitate the detection of early signs and symptoms, in addition to incorporating mental health awareness programmes within the school curriculum. Preliminary findings suggested that the provision of adequate knowledge about mental health conditions to parents, teachers and students resulted in improved awareness and increased detection of mental disorders in school children (Hoven et al. 2008). However, previous research in Ireland has highlighted the challenges experienced by teachers within the educational system, where pressure to meet the demands of the Leaving Certificate exam which has become "a dominant force in Irish post-primary schooling", has compromised the provision of a balanced and holistic education for students (Mannix McNamara 2012).

SPHE classes were initially developed to promote the social and personal development of students in addition to providing them with health education, however in accordance with guidelines from the Department of Education and Skills, one SPHE class lasting approximately 40 minutes per week has been recommended. SPHE is compulsory for all students at the junior cycle level (approximately 12-15) years. However, compulsory SPHE has not been extended for students at the senior cycle level (approximately aged 16-18) years (Mannix McNamara et al. 2012). Furthermore, teacher training in SPHE tends to be ad hoc "as there is no nationally mandated university-based programme",

therefore pre-service teacher training provision is SPHE is varied with some colleges offering a brief overview of the subject (Lyons 2008). SPHE provides an opportunistic forum for young students to learn about health promotion, particularly in regards to mental health and drug awareness. The provision of SPHE should be made compulsory for students in senior cycle who are already exposed to anxiety and stress in order to meet the pressures of the Leaving Certificate exam (Mannix McNamara 2012). Teachers need to be supported in their role to offer effective SPHE classes and the current national offering of 40 hours of in-service training needs to be reviewed, where a stronger focus on SPHE at the University level, to enhance future teachers to view their role in a holistic way as opposed to focusing on a "subject speciality" (Mannix McNamara et al. 2012).

6) *Key finding – Implications of early school leaving:* Early school leaving was a major concern for some of the health care workers, as young people who were not engaged in any activities and those who were removed from their peers had a tendency to become involved in criminal behaviour and substance abuse. Some of the young participants left school before reaching the junior cycle, for some mental health problems such as undiagnosed ADHD made the school environment more difficult and for others it was considered the norm among their peers to leave school early.

Recommendation - In accordance with AVfC recommendations, ensuring children remain engaged in education is vital to break the cycle of social exclusion, therefore liaison between schools and mental health services are essential (Expert Group on Mental Health Policy 2006). For children who are struggling to adapt to their school system, alternative placements should be made available. Programmes such as 'Youthreach' can be effective in this regards although rigid age criteria can limit its usefulness. Furthermore, the provision of adult education for early school leavers is essential for young people with mental health problems (Expert Group on Mental Health Policy 2006).

7) Key finding – Youth friendly services: Worryingly, the high rate of suicidal ideation among young participants, coupled with their ability to mask their problems from others, indicated that while it is essential for them to be identified as struggling with

mental health issues, it is still difficult to do so. Certainly it has been noted previously, that identification of mental health and addiction problems in this age group can be challenging (Patel et al. 2007). Previous cross-sectional studies in Australia noted a link between suicidal ideation and unwillingness to seek help among adolescents (Wilson et al. 2005, Deane et al. 2001). Furthermore, the admission from some young people, especially those with addiction problems, that they had refused previous offers of help adds to the problem of how early interventions might work.

Recommendation: Clearly how services are offered plays a role in whether young people will avail of them and future interventions should aim to ensure they are acceptable to the young person in terms of incorporating a youth friendly focus and offering timely support to encourage treatment engagement. The need to move away from institutionalisation was a key factor outlined in a manifesto for AVfC, which was described as "robbing people of their personal autonomy, individuality and power" (Mental Health Reform 2012). Many young people described their initial experiences in care as feeling "institutionalised" where their privacy and independence had been compromised. Previous qualitative research reported similar experiences among a group of individuals who had been former inpatients in psychiatric hospitals in Ireland, where a sense of 'powerlessness' was described as participants were not allowed to make personal decisions in relation to their everyday lives (Mannix-McNamara et al. 2012). Future structural changes in service design and delivery are paramount. The recovery approach which is a key premise to the reform of mental health services as outlined in AVfC, suggests a shift in the relationship between health care workers and young people, where services offer a person-centred approach to care that values the expertise of the person who has been affected by mental health problems (Mental Health Reform 2012).

Young participants in the current study were very attuned to their mental health problems in terms of the treatments that worked, maintaining their mental health after treatment and what proved to be ineffective (e.g., external pressure to engage in treatment, not being listened to by health care workers or having choices in their treatment options), therefore, a person-centred recovery oriented approach is essential where young people have the ability to define their own recovery. The 'Jigsaw' youth project has been commended by members of 'Headstrong's Youth Advisory Panel' for

creating youth-friendly, non-stigmatising and peer-driven environments for young people while also facilitating access to mental health support and services (Mental Health Reform 2012). Access to specialist mental health services was also problematic for most young participants. Current referral routes to specialist mental health services include: 1) GP, 2) primary care team staff members or 3) through ED, in a briefing paper discussing the role of mental health in primary care, McDaid (2013), highlighted the need for the Government to support alternative routes of access into mental health services for young people such as the 'Jigsaw' projects.

8) Key finding – Multidisciplinary services: Many young participants and health care workers reported the benefits of effective activity based programmes for the identification of mental health problems in less formal settings. Furthermore, a collaborative relationship between primary care, secondary care and community agencies was currently lacking, therefore resulting in: lack of awareness about community based services, inappropriate referrals and poor transition between services for the young person.

Recommendation: However it is important to ensure linkage with more formal services – not just for referral of more acute / severe problems but also to support ongoing engagement, therefore promoting further interagency collaboration across services is a key enabler to enhance service development. In line with what was proposed in previous policy documents e.g., AVfC, WHO reports, the need for youth-based mental health services that are multidisciplinary, provide a comprehensive range of interventions and are locally based was identified as a key enabler to screening and treatment in the current study. To achieve effective multidisciplinary service provision, it is necessary to ensure involvement from primary care, secondary care, community agencies and sectors outside of mental health e.g., schools, county councils to gain government support (Expert Group on Mental Health Policy 2006).

9) Key finding - Transition from CAMHs to AMHs: The structuring of the Irish healthcare system was a barrier to care for many young people, where the transition from child and adolescent mental health services to adult mental health services at 18 years was identified as an inappropriate age for a transition between services. The cut-

off ages in CAMHS and adult services led many young people to fall through the gap, and transitions between the two were described as not well planned among health care workers and young people. For young participants with ADHD, concerns in relation to how their trajectory of care would continue, when they made the transition to adult services, was a key cause for concern.

Recommendation: Consistent with recommendations from previous research, mental health services need to reorganise the transition age in accordance with the variable transition that many young people experience from adolescence to adulthood which often spans from mid-teens to mid to late twenties (McGorry et al. 2007a, Arnett 2007, McNamara et al. 2013). Youth mental health advocates have emphasised the need for service provision to reflect this extended development phase from adolescence to emerging adulthood, to ensure seamless transitions during care (Coughlan and Doyle 2015). In an editorial paper which reviewed the progression of youth mental health service provision in Ireland, Coughlan and Doyle (2015) indicated that services geared towards 16-18 year olds should be informed by epidemiological evidence and service user needs as opposed to "historically embedded service structures that date back as far as the 17th century."

10) Key finding – Mental health promotion and challenging stigma: Fear of stigma was a major barrier for young people and often delayed the help-seeking process for mental health and substance use problems. Additionally, some health care workers were reluctant to diagnose 'label' a young person with a mental disorder, fearing the adverse repercussions of the disorder for the young person later on which might hinder their future career prospects.

Recommendation: Similar to the participants in the current study concerns about stigma and the impact of having mental health problems might have on their future career prospects was documented in a report by MacGabhann and colleagues regarding the experience of discrimination by people with mental health problems. In 2010, 47% of the public agreed that a diagnosis of a mental health condition would have a negative effect on their job and career prospects (MacGabhann et al. 2010). Implementation across Government Departments is necessary specifically where mental health action plans are lacking, "to establish a cross-departmental group to ensure that good mental

health is a policy across a wide range of people's life experiences including education, employment and housing" (Independent Monitoring Group 2010). Furthermore, in AVfC, educational initiatives were considered as a key strategy where more openness would remove the stigma. Current educational initiatives in Ireland include 'Mental Health Ireland' which holds a debating competition in secondary schools. In accordance to a report from the 'Social Exclusion Unit', educational programmes are more effective when they target specific audience, support local activity and include people with first-hand experience of discrimination (Social Exclusion Unit 2004).

5.9.2 GP training and education

1) Key finding – Further research for GP based youth mental health interventions: General practice has an integral role in any future collaborative community based service delivery model which aims to support and care for psychosocial issues among young people. Previous research (Roberts et al. 2013, Kramer et al. 2013) and GPs in the current study indicated a commitment to addressing youth mental health problems with adequate support and resources. The main barriers for most GPs in study one and two in regards to addressing youth mental health problems were inadequate training, limited service availability for referral and insufficient links with the mental health services.

Recommendation: Supporting general practice to realise its potential, by further exploration and addressing barriers to identification is a priority for future research, training and service development. Complex multifaceted interventions (education and promoting awareness) are likely to support its role. Randomised controlled trials are lack in regards to screening and treatment interventions to address youth mental health problems in general practice. Previous research has mainly been conducted in controlled test settings therefore the transferability of such interventions into real world clinical settings remains unknown. Furthermore, the need for a nationwide communication system between GPs and mental health services are necessary if primary care teams are to provide good quality healthcare, which may also reduce inappropriate referrals to specialist care and crisis referrals to ED (McDaid 2013).

2) Key finding – Implications for GP training in youth mental health: Given the considerable contact many young people have with primary care and its longitudinal nature (Tanielian et al. 2009) and that most mental health problems are addressed in primary care (Copty and Whitford 2005) it is vital that health care workers are equipped to identify such problems accurately and early. Use of screening tools was rare and many GPs advocated the benefits of collaboration with colleagues in mental health services. Furthermore, in study two, GPs were more likely to opt for advice from colleagues / experts in the field of mental health as opposed to guidelines and information booklets.

Recommendation: A strong focus on youth mental health within undergraduate and postgraduate health care professions' educational curricula is vital, in addition to further training for existing professionals in the field (Sawyer et al. 2012). Findings from the current study have informed further work by members of the *Mental Health in Primary Care Research Group* which aimed to develop an educational intervention for addressing youth mental health problems in primary care (Schaffalitzky et al. 2014, Birrane et al. 2014) and work in computer-assisted technology involved the development of a health finder tool to enable GPs to identify and monitor patients with mental health problems in general practice (Swan et al. 2014). Additional work in is currently underway, which includes the development of a smartphone app for GPs to identify depression among young people. Future GP training programmes should aim to incorporate interactive learning sessions in educational programmes. Additionally, previous research has noted that in the absence of a broader implementation strategy, guidelines tend to be ineffective (Kramer et al. 2013, Lomas et al. 1989).

3) Key finding – Raising awareness of the GP to address youth mental health problems: GPs were also not recognised by many as a person to approach about mental health or substance use problems: young people, and also community health care workers, saw them as treating only physical illnesses, or older patients. It was not unusual for young people to think that seeking treatment would be a negative experience – they imagined medication as their only option, or feared "being institutionalised" where they would be "pumped full of drugs".

Recommendation: In order to create better practice for young people, it is important that health care professionals are trained in the specificities of their care. Making practices more 'youth-friendly' by increasing knowledge on consent issues and creating a more relaxed consultation and training service providers in effective youth care. It was stated in previous literature (Copty and Whitford 2005, Roberts 2012a) and in study one and two that confidence in treating young people's mental health and addiction issues was one of the main reasons GPs especially avoided the topic. With training, service providers can become not only more proficient, but also more confident in this domain.

4) Key finding – Younger GP perspectives: Most GPs who participated in study two were in the older age group (50+) and rates of screening and confidence to diagnose / treat mental health problems or use psychotropic medication were quite low among this age group and also among GPs with longer years since competing their GP training.

Recommendation: Further research is required to determine the attitudes of GPs in the younger age range, particularly those who are at the early stages of their career, where feedback could be incorporated into future GP training programmes in youth mental health.

5.10 Conclusion

In Ireland, great efforts have been made to address youth mental health problems and abolish the stigma associated with experiencing such issues. The efforts of dedicated health care workers and policy makers should be acknowledged. Youth mental health initiatives including 'Headstrong' and the associated 'Jigsaw' projects aimed to deliver community based programmes to support young people aged 12-25 years (Bates et al. 2009), charitable organisations and community agencies have made a considerable difference to the lives of many young people, where early identification has resulted in timely referrals to appropriate care (Illback 2014). Additionally, the progressive shift of care from psychiatric hospitals to community based settings has aimed to abolish the stigma associated with former mental health institutions (MacGabhann et al. 2004).

Furthermore, health care workers from other sectors acknowledged the positive progression of GPs in their attitudes to addressing youth mental health problems.

Our findings highlight why early intervention is not just a 'best buy' in terms of reduced costs to public expenditure, but also in improving the lives of those who struggle daily with emotional pain, high anxiety and debilitating addiction. It is important to move forward with changes to current systems to ensure that young people in socio-economically disadvantaged areas, who are known to be at-risk of developing problems, do not have to wait until they are a danger to themselves before receiving help. General practice can play a key role in the identification and treatment of youth mental health and substance use disorders due to its availability and familiarity with young people from socio-economically disadvantaged areas and their wider communities, as well as its ability to target young people who present for physical rather than mental health problems (Connolly et al. 2012, Sanci et al. 2012, Haller et al. 2009). However, future research should aim to promote interventions that further enhance this role such as increasing awareness among young people of what general practice can offer, increasing the role of outreach for general practice and defining / supporting how general practice can make this happen in practice. The recommendations outlined in this thesis are consistent with targets proposed by the International Declaration on Youth Mental Health (Coughlan et al. 2013) which aims to:

> *"Enhance our potential to positively alter the mental health trajectories for thousands of young people and in so doing, to reduce the experience of enduring mental health difficulties among our adult population into the future."*

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Appendices

Appendix A - Publications

Leahy *et al. BMC Family Practice* 2013, **14**:194
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BMC Family Practice

RESEARCH ARTICLE Open Access

Primary care and youth mental health in Ireland: qualitative study in deprived urban areas

Dorothy Leahy[1*], Elisabeth Schaffalitzky[1], Claire Armstrong[1], Gerard Bury[2], Paula Cussen-Murphy[3], Rachel Davis[4], Barbara Dooley[5], Blanaid Gavin[6], Rory Keane[7], Eamon Keenan[8], Linda Latham[9], David Meagher[1], Pat McGorry[10], Fiona McNicholas[6], Ray O'Connor[1,3], Ellen O'Dea[11], Veronica O'Keane[12], Tom P O'Toole[13], Edel Reilly[14], Patrick Ryan[15], Lena Sanci[16], Bobby P Smyth[17] and Walter Cullen[1]

Abstract

Background: Mental disorders account for six of the 20 leading causes of disability worldwide with a very high prevalence of psychiatric morbidity in youth aged 15–24 years. However, healthcare professionals are faced with many challenges in the identification and treatment of mental and substance use disorders in young people (e.g. young people's unwillingness to seek help from healthcare professionals, lack of training, limited resources etc.) The challenge of youth mental health for primary care is especially evident in urban deprived areas, where rates of and risk factors for mental health problems are especially common. There is an emerging consensus that primary care is well placed to address mental and substance use disorders in young people especially in deprived urban areas. This study aims to describe healthcare professionals' experience and attitudes towards screening and early intervention for mental and substance use disorders among young people (16–25 years) in primary care in deprived urban settings in Ireland.

Methods: The chosen method for this qualitative study was inductive thematic analysis which involved semi-structured interviews with 37 healthcare professionals from primary care, secondary care and community agencies at two deprived urban centres.

Results: We identified three themes in respect of interventions to increase screening and treatment:
(1) Identification is optimised by a range of strategies, including raising awareness, training, more systematic and formalised assessment, and youth-friendly practices (e.g. communication skills, ensuring confidentiality);
(2) Treatment is enhanced by closer inter-agency collaboration and training for all healthcare professionals working in primary care; (3) Ongoing engagement is enhanced by motivational work with young people, setting achievable treatment goals, supporting transition between child and adult mental health services and recognising primary care's longitudinal nature as a key asset in promoting treatment engagement.

Conclusions: Especially in deprived areas, primary care is central to early intervention for youth mental health. Identification, treatment and continuing engagement are likely to be enhanced by a range of strategies with young people, healthcare professionals and systems. Further research on youth mental health and primary care, including qualitative accounts of young people's experience and developing complex interventions that promote early intervention are priorities. (350 words)

Keywords: Young people, Urban deprivation, Mental health, Substance use, Primary care, General practice

* Correspondence: Dorothy.Leahy@ul.ie
[1]Graduate Entry Medical School, University of Limerick, Limerick, Ireland
Full list of author information is available at the end of the article

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Background

Mental and substance use disorders contribute the largest disease burden in young people [1,2], with three-quarters first emerging between the ages of fifteen and twenty five [3]. In Ireland, psychological morbidity has been reported in 21-27% of young adults [4], while the rate of youth suicide is the fourth highest of 26 European Union countries [5]. Young people attend primary care regularly and as they often present with coexisting risk behaviour / psychosocial problems, primary care is ideally placed to address these issues opportunistically [6]. However, healthcare professionals face many challenges when trying to identify youth mental and substance use disorders, including interpreting the developmental changes that coincide with adolescence as a mental disorder [1], fear of 'over-medicalising' young lives and misinterpreting depression as a normal response to the wider psychosocial context of a young person's life [7].

Many health professionals, including GPs may not be entirely comfortable with identifying / treating young people with emotional mental / substance use disorders. Previous research found that an exploration of psychological issues does not always take place in GP consultations, even when the doctor feels that these are present and the adolescent is similarly aware [8,9]. In the US, the median rate of recognition of youth mental health problems by GPs was only 18%, and was often initiated as a result of parental concerns [10]. Findings from Fleury and colleagues (2012) suggested that GPs rarely used clinical screening tools or collaborated with other healthcare professionals, and tended to limit treatment options to monitoring medication or providing support therapy [11]. Other studies have found that most primary care clinicians do not routinely screen for suicide risk [9,12] and nearly 60% of youth in need of mental health services do not receive the care they need, even after suicide attempt [13].

Lack of time and training are often mentioned by healthcare professionals in primary care as major barriers to a comprehensive psychosocial diagnosis [14–16]. Other barriers included lack of financial reimbursement for uncompensated time spent on mental health screening [17], limited knowledge about suicide risk, poor availability of mental health services for referral [18], insufficient time to discuss mental health problems during consultations, restricted resources for screening (e.g. space, computers and staff) [12], patient confidentiality issues [9], lack of clearly defined guidelines, ineffective communication skills and reluctance to discuss sensitive issues [19] and in some cases healthcare professionals own stigmatising attitudes towards mental illness [20]. Additionally young people themselves may be reluctant to contact healthcare professionals, or even recognise them as a source of help when distressed [7].

The challenge of youth mental health for healthcare professionals is especially evident in socio-economically disadvantaged areas where risk factors for mental health problems are especially common [21–23], in addition to associated adverse psychosocial outcomes, like homelessness and drug use [24–26]. This concentration of health and social problems creates a level of demand which places substantial and continuous pressures on healthcare professionals [27].

There is a dearth of evidence regarding the experiences of and attitudes towards screening and treatment of mental and substance use disorders among healthcare professionals and young people in the Irish healthcare system and to date no clinical guidelines in relation to screening and early intervention have been published. However a similar approach has been employed in the development of clinical guidelines to inform hepatitis C management among current or former injecting drug users [28,29]. In order to create future interventions for this population, it is important to understand how current practice with youth mental health in urban deprived areas is experienced by those who work within it: This knowledge ensures interventions will be tailored to the context and will address the relevant domains for improved services and outcomes. Since 2011, our study group has been working towards developing an intervention which addresses barriers to 'early intervention' for mental and substance use disorders that is evidence based, feasible and acceptable to young people and healthcare professionals. This work includes three phases:

Phase 1: will describe the experience of (and attitudes towards) screening and early intervention for mental / substance use disorders by interviewing a purposive sample of young people / healthcare professionals recruited from community agencies and primary / secondary care.
Phase 2: will develop a 'complex intervention' to improve screening and early intervention that is informed by the findings of phase 1, scientific evidence and a Delphi-facilitated expert consensus process.
Phase 3: will provide iterative feedback to participating healthcare professionals in the study from phase 1, 2 and determine what if any care components have been incorporated and any barriers encountered.

The current paper is based on findings from the first phase of the study, where one of the key aims was to describe healthcare professionals' experience of (and attitudes towards) screening and early intervention for mental and substance use disorders among young people in primary care in deprived urban settings. Definitions of youth in the current study are in line with previous work on youth mental health where the terms

'youth' or 'young people' are often used to describe people within the 12 to 25 age range [6,30].

Methods

Overview

A qualitative study employing semi-structured interviews with 37 healthcare professionals working with young people at a diverse range of health and social care agencies in two deprived urban centres.

Body giving ethics approval

The project was reviewed / approved by the following research ethics committees: Irish College of General Practitioners, St James's / Federated Dublin Voluntary Hospitals, Lucena / St John of Gods, HSE - Midwest Regional Hospital.

Setting

The study took place in Limerick and Dublin South Inner City during 2011–12. Both centres contain some of Ireland's most deprived local areas, with 15 of Limerick city's 37 electoral divisions receiving deprivation scores in the disadvantaged or extremely disadvantaged categories [31]. As a result, youth mental health [32,33] and problem drug use are priority issues [34]. In Dublin South Inner City, this has been the case for over thirty years [25].

Sampling and recruitment

Based on previous research examining similar questions among similar populations [35,36], we estimated 16–32 health / social care professionals would need to be interviewed to reach theoretical saturation. The study sample were health and social care professionals at agencies and practices which interact with primary care, and reflect the range of settings where young people seek help for mental and substance use disorders. We adopted a purposive sampling framework, which included geographical region and health / social care agency as sampling parameters. The conceptual framework for this study is based on two well established and studied theoretic models: (1) '*Social Determinants of Health*', which emphasises the role of social deprivation and social cohesion in the effective treatment of mental illnesses [21]. Thus, the current study's placement in areas of urban deprivation (in Dublin and Limerick) where GP and primary care sites have the potential to liaise with community resources to address youth mental health, reflect this relationship.

The (2)'*Chronic Care Model*', describes how six interdependent facets of primary care delivery (*self-management support, clinical information systems, delivery system redesign, decision support, health care organisation, and community resources*) can effectively improve patient satisfaction and chronic disease outcome measures in a variety of health care settings including low income communities [37]. Mental illness is applicable to the Chronic Care Model in terms of its chronicity, need for monitoring, care adjustments, and multifaceted interventions. Study settings included primary care itself (general practices, primary care teams), secondary care (adult mental health services, child and adolescent mental health services, addiction services) and community agencies. Healthcare professionals at each participating site were identified by a member of the Project Steering Group and invited to participate. In total, 37 health professionals were interviewed (see Table 1 for breakdown of occupation and healthcare sector).

Data collection

Interviews elicited information on participants' experience of mental and substance use disorders among young adults and attitudes towards screening and early intervention. The interview topic guide (see Appendix 1) was informed by a literature review on the role of general practice in addressing youth mental health [38], and theoretic frameworks, Social Determinants of Health [21] and the 'Chronic Care Model [37]. Interviews were conducted in person, in a quiet room, ranged in length from 16–120 minutes, and were digitally recorded.

Table 1 Demographic information for study participants

Demographic information	Number of sample	Percentage of sample
Gender		
• Male	12	32.4
• Female	25	67.5
Number of years in current post		
• <1 year	2	5.4
• 1-5 years	17	45.9
• >5 years	18	48.6
Healthcare Sector		
• Primary Care	13	35.1
• Secondary Care		
o Mental Health Services	9	24.3
o Addiction Services	3	8.1
• Community Agencies	12	32.4
Professional Background		
• Addiction (outreach / counselling)	6	16.2
• Counselling / psychology	2	5.4
• Extern / Youth Workers	8	21.6
• Medical (GPs / Psychiatrists)	9	24.3
• Nursing	8	21.6
• Primary Care other (e.g. social work, speech & language therapy)	4	10.8
Total Sample	**37**	**100.0**

The topic guide served as a guiding framework for the interview rather than a prescriptive line of questioning, thus every effort was made to allow participants to elaborate on aspects of key importance to them [39]. All of the participants were interviewed in their work place, thus in some cases the interview duration was dependent on external factors related to the participant's work environment. Interview material was reviewed after every 2–3 interviews to allow researchers identify new issues to explore in subsequent interviews and to note emerging / diverging consensus.

Data analysis

Data were analysed using an inductive thematic approach to analysis in accordance with Braun and Clarke's five-step process e.g. 1) Familiarisation with the data; 2) Generating initial codes; 3) Searching for the themes; 4) Reviewing the themes; 5) Defining and naming themes [40]. Thus, each transcript was transcribed verbatim and reviewed by the interviewers for accuracy. Interviews were openly coded to allow concept categories to occur without prior assumptions. The researchers analysed interview transcripts in groups which were representative of the various study settings e.g. (addiction clinics, mental health services, general practices etc.) to identify common codes for each group. Transcripts were read repeatedly and constant collaboration used to ensure codes created were accurately reflective of the data. Transcript data was entered into the qualitative research package NVivo 9. As transcripts were coded new codes emerged and were added to the coding list. Coded information was sorted into categories and themes were identified from these categories. Three researchers (DL, ES, CA) coded the interviews individually and corroborated themes with the principal investigator (WC) to reach inter-rater reliability. All researchers had access to coding materials and followed an agreed coding protocol where any new codes, and changes to existing codes were highlighted as advised by Boyatzis [41]. Findings were compared with other study findings for the purposes of validity and reliability. A narrative analytic account, supported by verbatim extracts from each participant, was developed.

Results

Two Meta / key overarching themes emerged from the healthcare professional data: 1) The role of *Context* in screening and treating youth mental and substance use disorders and 2) *Intervention* and the associated barriers and enablers with respect to screening and treatment. Of direct relevance to this paper on healthcare professional perspectives, is the *Intervention* theme which comprised three distinct subthemes: (i) *Identification*, (ii) *Treatment*, and (iii) *On-going engagement*. Each of these subthemes was further disaggregated into the barriers to and enablers of each process (see Table 2).

Theme 1: Identification – Barriers

'Prioritisation of crisis cases'

Healthcare professionals described feeling "over whelmed" and "stretched" when discussing the provision of screening services for young people. The most commonly reported barriers to identifying mental and substance use disorders in a young person for healthcare professionals, related to care of acutely unwell young people having to take precedence over those with less acute or severe problems. Thus some healthcare professionals felt that there was "a huge gap" in services for young people with less severe mental health problems or those in the initial stages of a mental illness who would benefit from early intervention.

> "*The people who end up getting referred to mental health services are the tip of an absolutely enormous iceberg. It is one in a hundred. It is tiny and it is getting tinier all the time. Their criteria for who they will see, which in a way, I can understand but it still leaves this huge gap*" (GP).

'Confidentiality and consent issues'

Healthcare professionals also felt restricted due to confidentiality and consent issues and described them as a major barrier to the identification of mental and substance use issues in young people, particularly when this related to parental involvement for those aged under 18. Treating a young person for (and fear of labelling them with) a substance use problem was also cited as an important barrier to identification because of the associated potential long term implications of such a diagnosis.

> "*Occupation wise and college wise…they usually ask the GP for medical records. The GP will have our letters on file so realistically, if they are dealing with a substance abuse problem I try and keep it separate, because then there is less information on their file that would prevent them getting a place or a job*" (Psychiatrist).

'Concerns around formally treating a young person'

Variable access to community-based, non-pharmacological interventions, adopting a 'watchful waiting' approach to management and misattributing mental and substance use disorders to developmental changes were additional mechanisms that can delay identification.

> "*So there's* [the difficulty in] *distinguishing between what's normal and what's not and what's distressing and harmful and what's just adolescent stuff*" (Psychiatrist).

Table 2 Barriers to and enablers of identification, treatment and on-going engagement

Theme	*Enabler*	*Barrier*
Identification of mental health and/ or substance use problem in a young person	• Outreach work	• Prioritisation of crisis cases at the expense of early intervention
	• Activity-based engagement	• Confidentiality and consent issues, particularly around parental involvement for under 18s
	• Mental health/drug awareness promotion	• Concerns around formally treating a young person for a mental health or substance use problem
	• Specific training in youth mental health/substance use problems	
	• Experience in dealing with young people with mental health/ substance use problems	
	• Using formal assessment tools	
	• Building a trusting relationship with the young person	
Treatment of young person for mental health and/or substance use problem	• A holistic/collaborative approach, including high quality communication, between healthcare agencies, e.g. primary care, secondary care and community-based agencies	• Limited funding resources result in a lack of age-appropriate services
	• Training for primary healthcare professionals, in particular, GPs in addressing youth mental health and substance use problems effectively.	• Crisis intervention taking precedence over early intervention
On-going engagement	• Intrinsic motivation of the young person	• If young person is attending because of external pressure
	• Continued/repeated opportunities for engagement	• Unwillingness of some young people to attend counselling
	• Personal achievement goals	• Transition from child to adult services
	• Having the structure of school or work to continue with during treatment or return to after treatment	

In the absence of training in mental health, some healthcare professionals described their difficulty in determining whether young people are affected by difficult life circumstances or if they have a diagnosable mental health issue.

> *"Because a lot of people have such hard, difficult, tough lives, I would be less likely to say that they are suffering from depression. If their brother was killed, their partner was just put in jail for the next five years. I will say that of course they are going to get anxious and depressed. It is not really a medical thing. It is a two-edged sword. There might be a higher level of awareness but also there is a certain degree of inevitability and saying this is part of the territory"* (GP).

Identification – Enablers

'Importance of outreach work'

Healthcare professionals identified outreach work as a key enabler to identification, particularly for young people with substance use problems who are homeless. Through initial identification on the street, healthcare professionals were able to provide opportunities for young people to interact with services at a pace that is suitable for them.

> *"The first point of contact might be on the street. You might see somebody begging on the street and they are an obvious opiate user, so…from street work you can offer needle exchange, from needle exchange you can offer Methadone, from Methadone you can offer stability, and then we can take it from there"* (Outreach Worker).

'Activity-based engagement'

The majority of healthcare professionals commended activity based programmes (e.g. sports facilities, youth clubs, youth cafes etc.) for being the most effective way of identifying mental and substance use problems among young people, where trusting relationships between healthcare professionals and young people may develop in a relaxed setting and thus provide a forum for the young person to communicate any difficulties they might be experiencing.

> *"I suppose you would call the activity the carrot that they are coming to do something that they like and they are going to build the relationship through you with that. If they need support, in anything else, at*

least they know you and they can come to you and talk about it. You have built up the relationship in a positive way through something positive that they like to do" (Youth Worker).

'Promoting mental health and drug awareness'

Promoting awareness and educating young people about mental health and drug use and the services that are available was identified as a priority among participants. Some of the healthcare professionals noted the importance of promoting mental health and drug awareness programmes in schools to enable early identification and remove the stigma associated with mental health problems.

"*I think one way we can overcome that* [stigma] *is by creating funky, cool programmes in school about being well and minding your health. Life Skill programmes, we all go through ups and downs and it is about coping. So introducing much earlier this notion that challenges come in life, our mental health gets challenged at all stages, this kind of approach. And, oh by the way, if you are having problems here is a signpost for you about what you need to do*" (Clinical Psychologist).

'The importance of experience, training, formal assessment and building relationships'

The importance of being experienced and having specific training in youth mental and substance use, in addition to using tools that enable formal assessment and building a trusting relationship with young people were also prioritised by healthcare professionals as key enablers to identification.

"*With emotional mental health it is not always as obvious I suppose except to the most experienced youth workers. It takes experience to recognise and identify that*" (Youth Worker).

"*I would also use formalised standards and formalised questionnaires as a means of backing up my clinical opinion as to the level of distress*" (Clinical Psychologist).

"*The employees that work in these services are so personable, that the young people have a tendency to attend*" (Youth Project Coordinator).

Theme 2: Treatment – Barriers

'Limited funding'

The majority of participants stressed the negative impact of "government setbacks", "tightly managed budgets", staff shortages, lengthy waiting lists, bed shortages and limited resources as major barriers to offering effective treatment. As a result of the financial barriers opportunities for the healthcare professionals in the current study to replicate effective youth programmes in other countries or provide school based training programmes have been lost.

"*We have about half the staff that we are supposed to have. There are lots of things that we would like to be able to do but we are not able to do. If we had more staff for example the one thing that would be good to do is, in Australia they do these programmes in schools. They do a CBT programme which has been shown to reduce the number of young people who develop anxiety disorders. It would be very easy to do but we absolutely wouldn't have the time to do it*" (Child Psychiatrist).

'Crisis intervention versus early intervention'

Optimum use of scarce treatment resources, especially the perceived tension between crisis intervention and early intervention, was highlighted as a priority issue. While the importance of early intervention was recognised, many healthcare professionals expressed concerns about using scarce resources for young people with less severe (rather than more severe and debilitating) problems. Promoting access to community-based psychosocial interventions was highlighted as a key mechanism to reduce workload of specialist psychiatry services.

"*If we dilute our service…and deal with a number of people with difficulties in adjusting to life situations, you dilute your service to the point where you would no longer be able to give a proper service to people with severe and enduring mental illness*" (Social Worker).

"*If there was a better provision of talking therapies , that would be great and that's suitable for most people who would be presenting to GPs with mild to moderate depression or anxiety disorders,* [they] *can probably do just as well with a talking therapy as with any drug therapy*" (Adult Psychiatrist).

Treatment – Enablers

'Inter-agency collaboration'

Some healthcare professionals felt that more inter-agency communication and collaboration with other healthcare professionals in different agencies, (especially between addiction services and mental health services) would benefit them in addressing the needs of young people (who might have interacted with multiple services). As the healthcare professional in the quote that follows suggests adopting an inter-agency approach where the focus is client-centred rather than being about professional competitiveness, would facilitate

more effective treatment for young people with both mental and substance use disorders.

> *"I think it is not only feasible, but I think it is imperative that they do work* [*together*], *for the good of the client…I don't see why agencies that, for the most part, are populated by people who have got to third level education, and have had access to educational facilities, that their clients will never get near it for the most part, why they can't put their intelligent heads together, and put their differences aside and work for the common good*" (Addiction Counsellor, Limerick).

Another healthcare professional commented on the benefits (particularly the positive impact of inter-agency links for young people) of having a collaborative relationship in her local area between two different healthcare sectors in the community.

> *"I think that's one good thing about the unity of services. Certainly I notice that the GPs are very supportive if we are running programmes in the community, they're more than willing to put up things on their* [noticeboard] *and that shows that the system is all working together and not all working independently of one another and we are supporting them, they are supporting us and that in turn has an impact on the clients*" (Social Worker).

'Training in youth mental health and substance use'

Some of the participants felt "unskilled" in the area of mental health particularly GPs and the importance of receiving further training for GPs in youth mental health and addiction was suggested as a key enabler.

> *"I feel very unskilled when it comes to dealing with youth mental health issues*" (GP).

> *GPs are given really no training in this at all, anywhere along the line, not in college; maybe now in the GP schemes but when I did the GP schemes there was nothing. I think it is a big ask. If you are going to ask GPs* [to address these issues] *then you have got to train them*" (GP).

Healthcare professionals from the mental health services echoed the need for further training particularly for GPs to avoid inappropriate referrals to their service.

> *"GPs need to be up skilled in the type of assessment they do for mental health problems. Some of the referrals are good, and some are terrible that we get in. So, initially the GPs probably should be up skilled a little bit in doing a fuller assessment of the nature of the problems*" (Social Worker).

Theme 3: On-going Engagement – Barriers

'External pressure to engage in treatment'

Healthcare professionals recalled their struggle to work with young people who were not intrinsically motivated to engage with them during the treatment process. In the majority of cases healthcare professionals noted that young people attend services as a result of pressure from external factors e.g. parents, social workers, probation officers etc.

> *"This guy doesn't want to be in there. He has not come in specifically; I want to address my ADHD, I want to address my substance use and I want to address the fact that I am involved in anti-social behaviour. He was given a letter saying that you must attend, you must…That is not going to work. You do what you can with it*" (Drug Worker).

'Unwillingness to attend counselling'

Other healthcare providers struggled to motivate young people to attend counselling for various reasons e.g. counselling being perceived as a 'middle-class' intervention, the time commitment associated with engaging in counselling and a fear of bringing up painful memories. Some of the healthcare professionals found that young people wanted a "quick fix"/ immediate solution in the form of a tablet rather than to engage / interact with healthcare professionals in any form of counselling.

> *"A lot of people come in just wanting tablets, particularly Benzodiazepines. And we say "let's do some relaxation or anxiety management techniques" and they say "no, I just want a tablet." So I think there is a culture of "I want it straight away, and I want you to make me better" without people taking responsibility for their own health, and doing what needs to be done. So that might be a barrier as well*" (Social Worker).

'Transition from child to adult services'

For healthcare professionals trying to ease the transition for young people from child to adult mental health services at 18 years was also identified as a barrier to on-going engagement, especially as many young people may have developed a trusting relationship with a member of the clinical team which they are reluctant to end.

> *"It's the wrong time for there to be a transition in care because transitions in care are unsatisfactory. People get lost you know and relationships get broken up*" (Psychiatrist).

On-going Engagement – Enablers

'Intrinsic motivation'

The majority of healthcare providers emphasised the need for young people to be intrinsically motivated to attend services and continue with their treatment. One of the participants highlighted the benefits of motivational interviewing with young people to increase confidence and address any "slips" during treatment engagement.

> *"People grow in confidence by being respected in whatever effort they make and....I would do an awful lot of motivational interviewing. I would really....be attentive to the positive and just be aware of the negative. And if they have a slip, so what? Of course they slip but the important thing is why, I would explore the reasons. Maybe they had a row. Somebody said something nasty to them, or they perceived somebody said something nasty to them. We would kind of explore that"* (Addiction Counsellor).

'Continued opportunities for engagement'

Healthcare professionals also advocated the importance of providing continued opportunities for young people to engage with services given the infrequent / relaxed approach that some young people have when it comes to keeping appointments. One of the participants stressed the importance of "being flexible" in their "attitudes" as healthcare professionals towards understanding how young people engage with services.

> *"Sometimes being that facilitator and opening up that avenue of support even though it is not taken up. It might be eighteen months, two years or as recently as four years down the road. We will open the file and we will leave it there. Very often you will hear people ringing to make an appointment and two or three years later they turn up. That is progress. It is long, it is drawn out and it demands patience. It depends on an ability to be flexible in terms of our own attitudes"* (Counselling Psychologist).

'Personal achievement goals'

One of the healthcare professionals stressed the importance of building on and commending the young person's personal achievements as a key enabler to on-going engagement. Additional strategies included connecting them with other people in the recovery programme, encouraging return to school, leisure activities, return to work initiatives etc.

> *"Some would say "I never thought I would do three days without cannabis". That would be a major (achievement for them), and every day you build on that and try to reconnect them with other people who are in recovery as well. And, really applaud each little step they make in the right direction. Because.... anybody who really stops, I would so affirm every effort they make. And to re-engage maybe in school... other activities"* (Addiction Counsellor).

Discussion

Key findings

We identified three themes (identification, treatment and engagement) and associated barriers and enablers, in respect of interventions to promote screening and treatment for mental and substance use disorders among young people in primary care. Healthcare professionals felt restricted in the identification of young people with mental and substance use disorders due to the need to prioritise emergency / crisis cases over young people with less severe problems, consent and confidentiality issues and fear of the future implications that might be associated with a formal diagnosis. In the absence of sufficient training in mental health, distinguishing between the impact of difficult life circumstance and the symptoms of a mental health problem proved to be a major barrier to identification. However identification of youth mental and substance use disorders were facilitated by outreach work and activity based programmes where healthcare professionals had the opportunity to interact with young people in a less formalised setting and therefore build positive relationships. Specific training in mental health and the use of formalised assessment tools were also identified as key enablers to identification.

Barriers to treatment were mainly due to financial cuts, which hindered healthcare professionals in their efforts to offer the level of treatment that they would like to. Healthcare professionals working in the mental health services felt that their services should only be utilised for young people with severe problems and in most cases community based services would be sufficient for young people experiencing mild psychological difficulties. Enablers to treatment included an inter-agency approach between services, further training particularly for GPs who felt "unskilled" in the area of mental health. Barriers to on-going engagement included external pressure on young people to attend services, young people's reluctance to engage in counselling, and moving young people to adult mental health services. On-going engagement was facilitated by helping young people to be intrinsically motivated during treatment, providing continued opportunities to engage with services and building on the young person's personal achievement goals during the recovery process.

Strengths and limitations of the study

Our qualitative approach allowed us to develop an in-depth understanding of the difficulties encountered in treating young people with mental health and substance

use difficulties. Our sampling methods are likely to have biased participants towards those practitioners more engaged with youth mental health. The applicability of our findings to practitioners who are relatively less engaged with this issue should be the focus of future research. Incorporating a broad range of stakeholders from diverse clinical settings was beneficial in terms of reflecting the various sites where young people seek help for mental and substance use disorders. However, differences and similarities in opinion between professional disciplines in regards to the challenges experienced warrants further analysis. The extreme variance in interview length with healthcare providers e.g. 16–120 minutes is another limitation. All of the participants were interviewed in their work place, thus in some cases the interview duration was dependent on external factors related to the participant's work environment. An additional limitation to this study was the inability to remove researcher bias as four of the authors (DL, ES, CA and WC) analysed the data.

Comparison with existing literature

Our findings regarding enablers of identification, treatment and further engagement compare to those previously documented, including outreach, education and awareness, intrinsic motivation, positive relationships with healthcare professionals, familiarity with a clinic or practice [2,42–45]. Our findings also highlight the value of service configuration, especially inter-agency collaboration [2,46,47], accessibility [48], transition services that ensure on-going care for young people [30] and further service integration [49].

Youth mental health was clearly a priority for this study's participants; and in keeping with the Social Determinants of Health, social deprivation and social cohesion are clearly important factors in the origins, treatment and outcomes of this problem [50]. In keeping with the 'Chronic Care Model', the value of healthcare organization, system redesign and community resources were highlighted, though it is worth noting that other elements of this model (self-management support, clinical information systems, decision support) were not [37].

Implications for further research and clinical practice

Given the considerable contact many young people have with primary care and its longitudinal nature [51] it is vital that healthcare professionals in primary care are equipped to identify such problems accurately and early. Thus a strong focus on youth mental health within undergraduate and postgraduate health programmes is vital, in addition to further training for existing professionals in the field [47,52]. Providing a safe and supportive environment in which a young person can initiate a conversation on mental health, ensuring healthcare professionals are confident in this conversation and have appropriate services to which they can refer more challenging cases, are key to early intervention.

Complex interventions to support formal identification and treatment of mental and substance use disorders can enhance healthcare professionals' knowledge, skill, competency and practice [53]. Education, supported by resources such as the 'Australian Adolescent Health GP Resource Kit' is likely to be a central component of such interventions [54], however the implications of using this resource in a different culture cannot be ignored.

Further research to enhance our understanding of this issue would include epidemiological studies and qualitative accounts of young people's experience. Greater understanding will then aid the development and evaluation of complex interventions that promote early intervention in deprived areas. It seems likely that interventions would be based on promoting mental health awareness in the community, education of practitioners, improved access to psychological treatments, and greater access to specialist care for those with more complex morbidity.

Conclusions

With youth mental health considered a key agenda to be included among the global health targets [52], the need to improve how primary care engages with this population is crucial. A responsive youth mental health system would ideally moderate the emotional distress of the young person concerned and their families, while reducing the financial burden of chronic adult mental illness [55]. While primary care might be well placed to address mental and substance use disorders in young people, healthcare professionals are presented with many challenges in fulfilling this task. Limited financial resources, lack of training and available mental health services for referral cannot be ignored. Structural changes are necessary across the healthcare spectrum if healthcare professionals are to succeed in providing early intervention for young people with mental and substance use issues. Complex strategies that promote identification, treatment and ongoing engagement are important elements to such a system, and would need to address areas such as outreach, awareness, intrinsic motivation, positive relationships with healthcare professionals, familiarity with a clinic or practice, and service configuration.

Appendix 1. Topic Guide – Healthcare Professionals

Demography/Descriptive Data

1) How long have you been in your current profession?
2) What kind of training have you had in youth mental health?

3) How do you usually become aware of young people who might have a mental health or substance use disorder?
4) What proportion of your time is spent working with young people with such conditions?
5) Can you tell me about your previous/current practice of screening/early intervention for mental distress and/or substance use amongst young people?

Experience of mental and substance use disorders among young people

1) How are young people's needs identified?
2) What are the main challenges in regards to meeting the needs of young people with respect to:
   a) treatment engagement?
   b) treatment sustainment?
   c) need identification?
   d) resources available?
   e) differences between adults and young people?
3) Are there additional supports / community resources available outside of this service for young people?
   a) If so…can you tell me more about them?
4) How would you improve your service with respect to:
   a) access to services for young people?
5) What is your view on the inclusion of parents/ guardians in a young person's treatment for mental/ substance use difficulties?

Attitude towards screening/early intervention

1) Do you think it would be feasible to have screening in your service?
2) What are the main factors that facilitate screening/ early intervention for mental distress/substance use in young people?
3) What are the main barriers that prevent screening/ early intervention for mental distress/substance use in young people?
4) If the child of a friend of yours had a mental health or substance use difficulty, what would you advise them to do in the first instance?
5) If you have a young person presenting with both mental and substance use difficulties what kind of treatment options are available to them?
6) Could you tell me briefly about a young person that you cared for that resulted in a positive outcome? What was the condition? How did you help? Why was the outcome so good?
7) Are there any other comments you would like to make?

Competing interests
The authors declare that they have no competing interest.

Author's contributions
WC conceived the study and wrote the proposal, obtained research funding / ethics approval and established project steering group. DL, ES and CA collected the data in collaboration with WC, DM, BG, EK, FM, ROC, VK, BS, EOD, RD, BD, LL, PCM and ED. DL, ES and CA analysed the data in collaboration with WC. WC, DL, ES, CA, DM, BG, EK, FM, ROC, VK, PR, LS, TOT, RK, EOD, ER, and BS drafted the manuscript. All authors read and approved the final manuscript.

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Author details
[1]Graduate Entry Medical School, University of Limerick, Limerick, Ireland. [2]UCD School of Medicine & Medical Science, University College Dublin, Belfield, Dublin 4, Ireland. [3]HSE Mid-West, Limerick, Ireland. [4]Child & Adolescent Mental Health Services, HSE Mid-West, Limerick, Ireland. [5]School of Psychology, University College Dublin, Belfield, Dublin 4, Ireland. [6]Department of Child & Adolescent Psychiatry, Lucena Clinic, Rathgar, Dublin 6, Ireland. [7]Sláinte Drug & Alcohol Services, HSE Mid-West, Limerick, Ireland. [8]Addiction Services, HSE Dublin Mid-Leinster, Dublin, Ireland. [9]Thomas Court Primary Care Centre, Dublin 8, Ireland. [10]Orygen Youth Health Research Centre, University of Melbourne, Melbourne, Australia. [11]HSE Dublin Mid-Leinster, Dublin, Ireland. [12]Trinity Centre for Health Sciences, Tallaght Hospital, Dublin 24, Ireland. [13]Providence VA Medical Centre & Warren Alpert Medical School, Brown University, Rhode Island, USA. [14]Fatima Regeneration Board, Rialto, Dublin 8, Ireland. [15]Department of Psychology, University of Limerick, Limerick, Ireland. [16]Department of General Practice, University of Melbourne, Melbourne, Australia. [17]Department of Public Health & Primary Care, Trinity College Dublin, Ireland.

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"Nobody really gets it": A qualitative exploration of youth mental health in deprived urban areas

Schaffalitzky, Elisabeth; Leahy, Dorothy; Armstrong, Claire; Gavin, Blanaid; Latham, Linda; McNicholas, Fiona; O'Connor, Ray; O'Toole, Thomas P; Smyth, Bobby P; Cullen, Walter

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Youth mental health in deprived urban areas: A Delphi study on the role of the GP in early intervention.

Schaffalitzky, Elisabeth; Leahy, Dorothy; Cullen, Walter; Gavin, Blanaid; Latham, Linda; O'Connor, Ray; Smyth, Bobby P; O'Dea, Ellen; Ryan, S

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How social context impacts on the development, identification and treatment of mental and substance use disorders among young people - a qualitative study of health care workers

Leahy, Dorothy; Schaffalitzky, Elisabeth; Armstrong, Claire; Latham, Linda; McNicholas, Fiona; Meagher, David; Nathan, Yoga; O'Connor, Ray; O'Keane, Veronica; Ryan, Patrick; Smyth, Bobby P; Swan, Davina; Cullen, Walter

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Appendix B - Participant information sheets (Study one)

Participant information sheet for health care workers

Dear "name of health/social care professional"

We would like to invite you to take part in a study, which aims to improve our understanding of services that can be offered to young people where mental and substance use disorders are concerned. Before deciding whether or not to take part, please read this information leaflet. If after reading this information, you think you would like to take part in the study, then a meeting with a member of the research team to discuss the study further, will be arranged.

What is the purpose of the study?

This study aims to develop a 'complex intervention' (i.e. including educational, clinical and organisational supports) which addresses barriers to 'early intervention' for mental and substance use disorders among young people that is both informed by international best practice and sensitive to local contexts.

What will you be asked to do?

If you are willing to take part in this study, then a researcher will arrange to have a private interview with you. The interview will take about 15-30 minutes, will involve just one interviewer and you and will be audio-recorded. During the interview, you will be asked about your experience of (and attitudes towards) mental and substance use disorders amongst young people and your attitudes towards screening and early intervention for these issues as well as suggestions for how they might be improved.

The findings form the interviews will be used to inform the development of clinical guidelines for identifying/treating mental and substance use disorders amongst young people, in primary care. Later we will seek the perspective of health and social care professionals regarding how to best implement these guidelines. If you are also willing to participate in this phase of the study, we will contact you in 12-18 months.

Why have you been asked to take part?

You have been asked because you are a health or social care professional at a community agency, in primary care (including HSE addiction services and general practices), or in a more specialist service related to mental health or substance misuse.

Can you decline to take part or withdraw once you have agreed to take part?

Certainly, participation in this study is completely voluntary. Even if you do agree to participate, you are still free to withdraw at any time (and withdraw your information), even after conducting the interview, without giving a reason. Should you do decide to withdraw at any time, please inform the researcher that you have had contact with (contact details below).

Will you be paid for taking part in the study?

No, payments for taking part in the study are not offered.

Will your taking part in this study be kept confidential?

Yes. All information which is collected from you during the course of the research will be kept strictly confidential. All information will be held securely and will be accessed by authorised personnel for research purposes only and will not be given to anyone else.

What will happen to the results of the study?

The results of the study will be written up in reports that will be given to healthcare professionals, health service providers and the Health Services Executive (HSE). The reports will contain individual quotes to emphasise important points made by the participants, but we will in no way identify the quote as coming from you or anyone else. The results may also be presented at conferences and/or published in scientific journals.

Who is doing the study?

The study is being led by Prof Walter Cullen of the Graduate Entry Medical School at the University of Limerick and the main researchers on the project are Dorothy Leahy (PhD student), Dr Claire Armstrong and Dr Elisabeth Schaffalitzky. The study is being done in conjunction with researchers from the F2 Centre (formerly Fatima Regeneration Board), 'Headstrong', HSE-Addiction Services, Adult Mental Health Services and Primary Care, Lucena Clinic, UCD School of Medicine, University of Limerick (Department of Psychology) and Limerick Regeneration Agency.

When is the study being conducted?

The research is starting in January 2011 and finishing in November 2013.

Contact details for researchers:

	Telephone	E-mail
Walter Cullen	061 202812	walter.cullen@ul.ie
Dorothy Leahy	061 234949	dorothy.leahy@ul.ie
Claire Armstrong	061 202679	claire.armstrong@ul.ie
Elisabeth Schaffalitzky	01 4020532	elisabeth.schaffalitzky@ul.ie

Thank you for reading this information sheet

_____	_____
Prof Walter Cullen	Name of clinician / coordinator at participating agency

Participant information sheet for young participants

Dear "name of young participant"

We would like to invite you to take part in a study to explore the services that are offered to young people who might have mental health and/or substance misuse issues. Before you decide whether or not you would like to take part, it is important for you to understand why the study is being conducted and what it will involve. If after reading this information, you think you would like to take part in the study, then a meeting with the member of the research team to discuss this further, will be arranged.

Please take a few minutes to read through the following and to discuss it with others if you wish. Feel free to contact any member of the research team if there is anything that is not clear, or if you would like more information. If you are aged under 18, please read this information with your parent / guardian.

What is the purpose of the study?

This study aims to develop a set of guidelines to decrease barriers to the early recognition and treatment of mental and drug/alcohol use disorders among young people.

What will I be asked to do?

If you are willing to take part in this study, a researcher will arrange to have a private interview with you. The interview will take about 30-45 minutes, will involve just one interviewer and you and will be audio-recorded.

During the interview, you will be asked about your experience of (and attitudes towards) mental disorders and drug/alcohol abuse amongst young people and your attitudes towards how such issues are currently dealt with, as well as your thoughts about early recognition and treatment of such issues and how this might be improved.

Are there any risks to me from the study?

The risk of harm resulting from the study is minimal. However, speaking with a researcher about your experience of health care might be upsetting. Therefore, if you do feel upset by the interview, you should contact your doctor/nurse. Also, the researcher who interviewed you will contact you 1-2 days after the interview to make sure that the interview has not upset you. If the researcher feels at any stage of the study that you might benefit from seeing a doctor, she will arrange an appointment with an appropriate agency for you.

Why have I been asked to take part?

You have been asked because you have attended a health agency such as your GP, the HSE or other more specialist service related to mental health or substance use.

Do I have to take part and can I withdraw once I have agreed to take part?

You do not have to take part in the study and it is entirely up to you to decide whether or not you would like to. You are completely free to withdraw at any time (and withdraw your

information), even after conducting the interview, without giving a reason. If you do decide not to take part or withdraw at any time, this will not affect access to services that you might wish to receive or the standard of care that you receive. Should you decide to withdraw, please inform the researcher that you have had contact with (contact details below).

Will I be paid for taking part in the study?

No

Will my taking part in this study be kept confidential?

Yes. All information which is collected from you during the course of the research will be kept strictly confidential. All information will be held securely and will be accessed by authorised personnel for research purposes only and will not be given to anyone else.

What will happen to the results of the study?

The results of the study will be written up in reports that will be given to health care professionals and the Health Services Executive (HSE). The reports will contain individual quotes to emphasise important points made by the participants, but we will in no way identify the quote as coming from you or anyone else. The results may also be presented at conferences and/or published in scientific journals.

Who is doing the study?

The study is being led by Prof Walter Cullen of the Graduate Entry Medical School at the University of Limerick and the main researchers on the project are Dorothy Leahy (PhD student), Dr Claire Armstrong and Dr Elisabeth Schaffalitzky. The study is being done in conjunction with researchers from Fatima Regeneration Board, 'Headstrong', HSE-Addiction Services, Adult Mental Health Services, Primary Care, Lucena Clinic, UCD School of Medicine, University of Limerick (Department of Psychology) and 'Limerick Regeneration Agency'.

Contact details for researchers

	Telephone	E-mail
Walter Cullen	061 202812	walter.cullen@ul.ie
Dorothy Leahy	061 234949	dorothy.leahy@ul.ie
Claire Armstrong	061 202679	claire.armstrong@ul.ie
Elisabeth Schaffalitzky	01 4020532	elisabeth.schaffalitzky@ul.ie

Thank you for reading this information sheet

_____ _____

Prof Walter Cullen Name of clinician / coordinator at agency

Appendix C - Consent forms

Health care workers

Title of Study: Towards early intervention for youth mental health in primary care: A mixed methods study from two perspectives

Please tick the appropriate answer.

I confirm that I have read and understood the Service Provider Information Leaflet attached.	Yes ☐	No ☐
I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason, and without this decision affecting my future treatment or medical care.	Yes ☐	No ☐
I understand that my identity and personal information will remain confidential at all times.	Yes ☐	No ☐
I have been given a copy of the Health/Social care provider Information Leaflet and this Consent form for my records.	Yes ☐	No ☐
I agree that my data may be used as set out in the Service Provider Information Leaflet	Yes ☐	No ☐
I consent to the researchers holding my contact details and being contacted to participate in a focus group in 12-18 months time	Yes ☐	No ☐
I consent to the researchers holding my contact details and being contacted to read a copy of my transcript and check it for accuracy	Yes ☐	No ☐

Participant Name _____ Participant Signature _____ Date _____

To be completed by an independent witness

Witness Name _____ Witness Signature _____ Date _____

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explain to the above person, and where applicable a parent/guardian, the nature and purpose of this study in a manner that he/she could understand. I have explained the risks involved, as well as the possible benefits and have invited him/her to ask questions on any aspect of the study that concerned them.

Name _____ Signature _____ Date _____

Young people

Title of Study: Towards early intervention for youth mental health in primary care: A mixed methods study from two perspectives

Please tick the appropriate answer.

I confirm that I have read and understood the Service User Information Leaflet attached.	Yes ☐	No☐
I understand that my participation in this study is entirely voluntary and that I may withdraw at any time, without giving reason, and without this decision affecting my future treatment or medical care.	Yes ☐	No☐
I understand that my identity and personal information will remain confidential at all times.	Yes ☐	No☐
I have been given a copy of the Patient Information Leaflet and this Consent form for my records.	Yes ☐	No☐
I am aware of the potential risks of this research study.	Yes ☐	No☐
I agree that my data may be used as set out in the Service User Information Leaflet	Yes ☐	No☐

Participant Name	Participant Signature	Date

Where participant is aged under18:

Parent / Guardian Name	Parent / Guardian Signature	Date

To be completed by an independent witness

Witness Name	Witness Signature	Date

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explain to the above person, and where applicable a parent/guardian, the nature and purpose of this study in a manner that he/she could understand. I have explained the risks involved, as well as the possible benefits and have invited him / her to ask questions on any aspect of the study that concerned them.

Name	Signature	Date

Appendix D – Codebooks for health care workers and young people

Health care workers Codebook

1) **Agency Collaboration -** Agencies working together for the benefit of the client - lines of communication being open between agencies in cases where clients may be linked in with multiple agencies.
2) **Less Formalised Treatment** - Providing a more client centred approach, some clients find it difficult to relax in structured treatment centres.
3) **Context** - The importance of the social and environmental context in addressing youth mental health and addiction problems - e.g. meeting clients where they're at, socially as well as psychologically.
4) **Treatment engagement cannot be forced -** Clients have to be willing to engage in treatment themselves without pressure from outside influences (parents, healthcare professionals, probation services etc.).
5) **Individualised Treatment** - Each client is different, and may require a different approach to treatment, depending on their personal and social circumstances.
6) **Integrating Mental Health and Addiction Services** - Lack of cohesion between mental health and addiction services means that clients presenting with comorbid problems end up going through several channels prior to receiving treatment and lines of communication are often quite poor or non-existent between the agencies involved resulting in poor outcomes for the client - a holistic/collaborate approach would be better.
7) **Changes in Drug culture -** Changes in drug culture and how they affect the area and services.
8) **Headshop substances -** Proliferation of use and effect on body/mental health
9) **Impact of drugs and YMH** - The impact of not addressing these issues: on self, community, society etc.
10) **Early Intervention** - How early intervention can prevent issues in the future
11) **Underutilised talking therapies -** The lack of take up of counselling etc. - fear of introspection? Coping mechanisms aren't in place.
12) **Holistic approach to treatment** – Bio-psychosocial approach - addiction and mental health do not occur in isolation
13) **Cuts to services, lack of funding** resources - Cuts to services are impending, how this will affect clients. Also how a lack of funding resources affects clients now (not YMH specific)
14) **Continued opportunity for engagement -** Giving the opportunity to take up services whenever they are needed - making sure they are always available
15) **Learning issues and Coping skills - maladaptive or non-existent** - Learning and developmental issues, lack of coping skills - lack of maturity, turn to drugs to cope, repress things etc.
16) **Timely interventions** - Interventions are happening when the client is ready, but also they are age appropriate
17) **Parental involvement - pros and cons -** How parental involvement can be a good and bad thing for young persons
18) **Stigma** - Stigma arising from association with addiction or mental health issues - from attending services, diagnosis etc.

19) **Gap in Services for Younger People** - Services for people under 18 are lacking, mainly referred to Aislinn centre in Kilkenny for addiction problems.
20) **Service User Identification** - How service users initially engage with services
21) **Mental Health and Drug Awareness** - Educating young people about mental health and the dangers of substance misuse, particularly in schools and youth groups.
22) **Screening for MH issues** - Barriers to screening young people for mental and or substance use difficulties, and how screening is utilised in services if at all.
23) **Quick access to services** - Making services available asap for young people - not always possible despite being important
24) **Confidentiality issues** - How confidentiality is handled with this age group - an issues for engagement, building a relationship, but also safety and parental rights.
25) **School and Community setting involvement** - How can schools and community youth centres help?
26) **GP Role and approach** - What can the GP do? How should they approach these clients? What knowledge should they have?
27) **Gaps in Primary Care** - The need for more primary care teams that can offer multidisciplinary services to young people and perhaps avoid the need to attend secondary care with less severe mental health problems.
28) **Further Training in Youth Mental Health** - Opportunities for healthcare professionals and staff members that may have regular contact with young people to engage in further training to address youth mental health problems efficiently.
29) **Building relationships, rapport -** Encourages attendance at a service and interactions within treatment.
30) **Parental addiction and mental health issues** - How addiction and mental health in parents affects the child's development of MH issues.
31) **Moving from Child to Adult MH services** - The transition from child to adult services for those with longer term issues/those who are starting late in child services
32) **Homelessness** - Separate group of people who often fall through the system and don't access any services
33) **Prison and its potential benefits** - Greater opportunities for screening and treatment in prison
34) **Benzodiazepines and other prescription drugs** - Listed as one of the current drugs of choice amongst young people
35) **Alcohol - Extreme drinking** - Another popular substance abused by young adults possible sub-theme extreme drinking in relation to today's problematic drinking culture in Ireland.
36) **Somebody else's problem** - Clients being referred on to the next agency
37) **Value of psychological therapy (e.g. CBT)** - CBT and other psychotherapeutic interventions can be very effective for mental health and addiction problems either in isolation or combined with prescribed medication.
38) **Importance of intrinsic motivation** - Incentives for clients enables better client interaction and treatment engagement
39) **Discrepancies between services** - Some services are far better resourced than others
40) **Inefficient use of resources** - Waste of resources due to inefficient management of services

41) **Appropriate Referral Process** - The importance of appropriate referrals to determine which service best suits the needs of the client, secondary services e.g. mental health services dependency on the standard of GP referrals.
42) **Common youth mental health problems** - Frequent mental health problems in younger people
43) **Minimise staff-client exposure** - Young people would benefit from interactions with fewer staff members that are more focused on the client's needs as opposed to being referred on to numerous healthcare professionals where communication and follow-up are lacking.
44) **Consent issues** - Under 18s have to have parental/guardian consent, which limits their wish for privacy or need to undergo treatment without parental involvement
45) **Misuse of prescribed medication** - Clients selling their prescribed meds on the street
46) **Lack of awareness about other services –** Agencies / services are often unaware of each other thus resulting in poor / inappropriate referrals
47) **Traditional roles of professionals perhaps not the most appropriate** - Formal agency structures working with clients on a one to one basis can be ineffective for young people.
48) **Experienced HCPs** - The experience of healthcare professionals of working with YMH and addiction
49) **Organisations under stress** - Staff conflict, limited resources - part of cuts to services, limited funding resources
50) **Re-engaging with life after illness –** Can be difficult for young people if not in as structured environment like school/work. Might have to readjust expectations as well
51) **Perception of treatment as a barrier** - How perception of MH services might prevent interaction - fear of over-medication, institutionalisation etc. A barrier to care.
52) **Bereavement** - Bereavement can be very frequent for young people living in urban deprived areas
53) **Learned dependency and its pitfalls** - Families should be supported to help themselves rather than becoming too overly reliant on agency support
54) **Differences between CAMHS and adult MHS** - Differences related to diagnoses, common issues, input from outside parties, dealing with schools, jobs etc. Why adult psychiatrists might not work well with children
55) **Diagnosis and its effects** - How a diagnosis of a specific condition can be a good or bad thing for clients and parents
56) **Previous training in addiction and or youth mental health** - Different types / levels of training (if any) received for mental and or substance use issues in young people amongst healthcare professionals
57) **Buy-in with treatment** - The importance of this and how to achieve it with young people
58) **Prioritisation of cases in services** - Certain individuals are prioritised over others in care services - mostly crisis intervention over early intervention, younger over older etc.
59) **Benefits of a multidisciplinary team approach** - In regards to decisions concerning referral and treatment service users may benefit from a MDT approach e.g. counsellors, psychologists, social work etc.
60) **Difficulties and differences for young males** - Young males can be treated differently and also react differently to treatment engagement than young females. Some issues are specific to males.
61) **Guidelines** - Which ones are used, how, when etc.

62) **Inappropriate treatment for young people** - Treatments that are inappropriate due to the demands on the person, their age, the people delivering the service, the issues they are dealing with etc.
63) **Role of Peers** - Importance of peer support for young people however peers can also haved a negative influence re: drug use and anti-social behaviour
64) **Health policy and its implementation – evaluation** - Impact of health policy and its implementation on services
65) **Importance of formal assessment tools** - e.g. Beck's youth inventory, child depression inventory, Maudsley, SADQ, etc.
66) **Personal achievement goals** - Achievements relative to a patient's individual circumstances
67) **Downward social comparisons** - Making negative comparisons about one's own circumstances when measured against their peers
68) **Crisis situations** - How they manifest, how they are dealt with, how they might lead to further long term interventions
69) **Giving options, choices, facts not judgement** - Making sure adolescents are informed, letting them make their own choices, not judging drug/alcohol use, giving them a chance to make a decision
70) **Importance of outreach work** - In terms of identifying potential service users and linking in with other agencies
71) **Family support** - Impact of a young person's addiction and or mental health issues on families and concerned others and the benefits of counselling for them
72) **Client-centred approach** - Implementing services that meet the needs of the client, arranging the structure and delivery services for the benefit of clients
73) **Non-opiate users also need treatment** - The importance of providing treatment for non-opiate users not just focusing on heroin users
74) **Effective activity based engagement with young people** - Engaging with young people through activities e.g. sport, drama, art, etc. can be more effective particularly in community based projects
75) **Geographical structure of services as a barrier to treatment** - Young people might find it less daunting to utilise services if they were all in once space and it might also enable a more collaborative relationship between agencies
76) **Increase in suicide rates** - Increasing rate of suicide amongst young people
77) **Gender specific needs** - Young people may relate to male and female staff members in different ways, where they might relate to one far better than the other also, male and female service users may have gender specific needs re: programmes and activities on offer in treatment centres
78) **Outcomes** - Difficult to measure in this area, very much long term, or hard to do comparisons
79) **Young mothers and postnatal depression** - Young mothers often experience mental health problems particularly postnatal depression
80) **Mental health and addiction problems are the norm in urban deprived areas** - Youth mental health and substance misuse issues are viewed as a typical everyday/ non taboo issues in urban deprived areas

81) **Treatment inequalities because of socio-economic circumstances** - Some services or access to particular HPs might not be possible to some clients because of their socio-economic circumstances
82) **Suicide and suicidal ideation** - Young persons who have attempted suicide or have suicidal thoughts
83) **Consistency and reliability** - A service that is consistent in its approach, and reliable in terms of offering what it says it will always. Important when so much is unreliable and chaotic for these people
84) **Non-disclosure of issues by young people** - Sometimes it is evident there is a problem, but it will not be disclosed: a young person may not wish to share, or may not think it is important or relevant.
85) **Chaotic lifestyles** - Young persons can have chaotic lifestyles, find it hard to keep appointments, follow timetables etc.
86) **Attributing MH issues to puberty or adolescence** - How some MH issues are ignored, not taken seriously with teenagers, due to the perception that it is hormonal.
87) **Expectation Management** - Making sure people have the right expectations about what can be achieved in the service - how they are going to be helped, and the time line on recovery/treatment
88) **Problems that don't require psychiatry, but need intervention** - The vast amount of young persons at GP offices do not need psychiatry, but do need some kind of intervention to prevent them from escalating to a crisis situation
89) **Problematic drinking culture in Irish society** - Societal acceptance of drinking and in some cases "extreme drinking" at key family events in Ireland and its impact on young people
90) **Loss of identity to drugs** - Young people who may have been actively involved in sporting activities and other hobbies, lose interest and become addicted to drugs and engage in drug related activity
91) **Delayed maturity** - Young people, despite being over the age of 18 are emotionally not mature due to substance misuse and environmental factors e.g. negative peer influences, early school leaving etc.
92) **Effective use of technology to promote mental health awareness** - Use of internet sites to educate young people about looking after their mental health
93) **Learning difficulties -** Someone is borderline, or has a diagnosis, of a learning difficulty - ADHD, autism spectrum, speech and language issues etc.
94) **Changing addictive behaviour -** Addiction can become a way of life for people who abuse substances and when they engage in a treatment programme the main challenge can often be about changing their behaviour / altering a daily routine that was previously centred around their addiction.
95) **Who should educate young people about drug and mental health awareness** - Schools may be well placed to offer educational programmes re: drug and mental health awareness - but such programmes might be more effective it external people were brought into schools to deliver the programmes as opposed to teachers in the school that offer SPHE etc.
96) **Repetitive maladaptive family structures -** Where teen pregnancies, domestic violence, addiction problems etc. reoccur in families particularly in areas of urban deprivation.

Young people code book – December 8th 2012

1) **Crisis Point (Rock bottom)** - Realisation that something was wrong, due to worsening symptoms that eventually led to crisis point
2) **Benefit Finding -** Trying to find the positive aspects, upon reflection on an event that was perceived to be negative at the time
3) **Information on treatment options (lack thereof) -** Limited information provided to SUs about available treatment options
4) **Institutionalisation (daily experience) -** Aspects of daily living in a psychiatric institution, regimental routine, loss of independence, limited activities etc.
5) **Importance of individualised treatment** - Why individualised treatment is important for outcomes
6) **Break from daily life stresses** - Opportunity to get away from daily life stressors during hospitalisation
7) **External pressure to engage with treatment -** Pressure on young people to seek help from parents, friends, probation services, concerned others. Ideally treatment engagement works better without pressure from external sources.
8) **Stigma -** Fear of stigmatisation from others about experiencing MH problems or attending a MH service
   (Sub-node):
   - Stigma associated with specific services
   - **Lessening stigma with education -** Providing more info to the general public, and young people, to create awareness to lessen stigma
   - **Varying levels of stigma associated with specific disorders -** More stigma associated with e.g. depression that ADHD
9) **Treatment effectiveness -** Positive outcomes resulting from effective treatment
10) **Anger issues and Coping skills - maladaptive or non-existent -** Poor coping strategies to cope with difficult life situations, thus young person may often abuse substances or lash out with frustration as a way of coping
11) **Fear of institutionalisation -** Barrier to engaging in help seeking, fear of being locked up in a "mad house".
12) **Hopelessness -** Feelings of despair about their illness and never getting better
13) **Fear of diagnosis -** Fear of being labelled with a MH illness
14) **Unmet needs -** Young people's specific needs being unmet by health services, e.g. limited resources in terms of opportunities to attend counselling etc., lack of age appropriate facilities for young people with MH problems
15) **Treatment delay (frustration with) -** Waiting to receive treatment, e.g. on waiting list for counselling
16) **Mental health literacy (lack of)** - Limited or no knowledge about MH issues to recognise that they may need to seek help
17) **Self-stigmatisation -** Feelings of stigmatisation towards the self about experiencing MH difficulties
18) **Escapism** - Escaping from negative feelings, temporary release from feelings of sadness and other problems associated with MH difficulties
19) **Symptom progression -** Deteriorating symptoms
20) **Self-Harm -** Self harm as a maladaptive coping strategy
21) **Alcohol – Extreme drinking -** Substance misuse / excessive drinking as a negative coping strategy
22) **Sadness and lethargy -** Limited energy or willingness to engage in life, or previously enjoyed activities / hobbies

23) **Medication as a panacea (expectation) –** Some young people particularly those attending addiction services may often view medication as a quick fix to their problems
24) **Importance of formal assessment tools -** e.g. Beck's youth inventory, child depression inventory, Maudsley, SADQ, etc.
25) **Building relationships, rapport, trust -** Positive relationships between HPs and SUs are important for engaging in the treatment process
26) **Family history of mental illness -** Genetic factors contributing to the onset of MH problems
27) **Reluctance to seek help -** Reluctance to seek help due to fear of the unknown, lack of MH awareness, or the young person may not feel they need any additional support from the health services.
    (Sub-nodes):
    - **Reasons for not seeking help** – Fear of HP involvement in family life, social workers etc.
28) **Perception of treatment as a barrier -** Fear of being institutionalised, being over medicated, only receiving tablets and not being offered any other type of treatment
29) **GP role and approach -** The importance of how GPs engage with young people during consultation thus providing a secure and relaxed environment for young people to discuss MH / addiction issues.
    - **(Sub-nodes):**
    - **Perception of GP in mental health -** How young people perceive their GP and the role they play in MH and SU.
    - **GP role: as a source of information**
    - **GP role: to treat acute drugs / alcohol detoxification**
    - **GP role: as first point of contact**
    - **GP role: liaison with other agencies**
    - **GP role: as patient advocate**
    - **GP role: prior relationship with young person**
    - **GPs are not associated with MH** - Young people's reluctance to discuss their MH problems with their GP
30) **Continued opportunity for engagement -** Importance of having counselling, treatment programmes available to young people when they are ready to engage in the process
31) **Difficulty Persisting with Treatment -** Struggling to maintain treatment engagement, treatment withdrawal, loss of motivation
32) **Loss of control -** Loss of self-control, while conforming to hospital routine, being on medication, relying on others to determine what is best for them in terms of treatment
33) **Appropriate Referral Process -** Appropriate referral of young people experiencing MH / addiction problems to relevant treatment centres / services
34) **Changed Perspective on Mental Illness -** Having experienced MH problems themselves some SUs found that their perspective on MH changed, and they developed a greater understanding and empathy for others with MH problems
35) **Inappropriate services for young people -** Lack of age appropriate services for young people
36) **Acceptance of hospitalisation process -** Trying to understand the regimental process that needs to be in place during hospitalisation for patient safety
37) **Negative Impact on family –** Impact of SU's MH difficulties on family, concern, worry, etc.
38) **Suicide and suicidal ideation –** Suicide attempts or experiencing suicidal thoughts
39) **Guilt –** Service user guilt over the negative impact their illness had on family / friends
40) **Untimely support efforts –** Concern from family and friends may hinder service users in their quest to re-engage with life after illness

41) **Importance of social support –** Importance of social support from family and friends during the recovery process
(Sub-nodes):
- Importance of peer support

42) **Timely Interventions –** Service users may not always be ready to engage with support when it is made available to them
43) **Social withdrawal / isolation –** Withdrawal from friends and peers, isolation as a recognisable symptom for the onset of MH difficulties
44) **Downward social comparison –** Comparing one's social circumstances to those who are worse off
45) **Being on medication –** Negative impact on the self as a result of taking tablets - perception of an aged self, loss of independence
(Sub-nodes):
- **Medication - side effects** - Dizziness, nausea etc., other side effects for young people on medication

46) **Early Intervention –** Detecting MH problems early on, and providing appropriate treatment asap
47) **Role of school and community –** To address youth mental health and addiction issues
(Sub-nodes):
- **Educating young people about drugs -** Educating young people about the dangers of drugs, using scare tactics etc.
- **More emphasis on mh and drug awareness needed in school system** - Schools need to incorporate modules re mental health, drugs, life skills in the curriculum

48) **Inability to initiate help-seeking –** Young people may need assistance from others to make the first steps towards seeking help, due to lack of info, fear of the unknown etc.
49) **Scare tactics - coercion into treatment engagement –** HPs provided SUs with a worst case scenario e.g. undergoing ECT as a means of shocking SUs into engaging in treatment
50) **Lack of awareness about services –** Young people's lack of awareness about available mental health and addiction services
51) **Role of the internet - Importance of new media in promoting awareness: internet (especially) / TV / video / email –** The role of the internet as a medium for providing information re: YMH issues and also maintaining one's anonymity.
(Sub-nodes):
- **Problems re: using the internet and gaining access –** Some young people may not know how to use the internet, or may not have access, also some young people may find inaccurate information re: MH and substance use issues
- **Incorrect information on the internet -** While the internet can be useful in terms of providing information for MH and substance use problems, young people may also access a lot of inappropriate or incorrect information

52) **Access to services as a barrier –** Young people may not always have access to services e.g. geographical barriers, cost, transport issues etc.
53) **Self-acceptance –** Self-acceptance of having a MH problem
54) **Effectiveness of group support –** Young people may find a one on one scenario with a HP very overwhelming thus support groups, youth cafes, and other activity based programmes may be more effective when trying to engage with young people
55) **Perception of a diagnosis –** The meaning of a diagnosis for SUs, willingness to accept diagnosis or not
(Sub-nodes):

- **Perceiving a diagnosis as means of explaining symptoms and behaviours -** Some young people were relieved to receive a diagnosis, because they were able to make sense of their experiences and understand the reason for their behaviour, symptoms etc.

56) **Value of counselling and other psychotherapeutic techniques –** As a useful treatment methods for MH and addiction problems
57) **Medication and psychotherapy as a suitable treatment approach –** Combining medication and psychotherapy may be more effective as a treatment approach than using one method only.
58) **Experienced HPs –** Importance of having access to experienced HPs for SUs
59) **Physical structure of treatment centres –** As a barrier or enabler to treatment engagement e.g. treatment centres that look like institutions maybe off putting
60) **Personal Choice to seek help –** It was the individuals choice to seek help, they were not coerced/recommended to find treatment by someone else
    (Sub-nodes):
    - **Engaging with treatment to please others -** The motivation to engage with treatment has to come from the young person as opposed to HPs, parents etc.
61) **Medication as only treatment –** When medication is the sole treatment offered
62) **Parental Involvement –** The role of parents in treatment
63) **Difficulties talking about self –** Difficulties with talking openly about the situation, their emotions, their feelings, what's going on.
    (Sub-nodes):
    - **Too young to engage with counselling process -** Some young people find it hard to engage in the counselling process and some find it easier as they get older and become more mature
64) **Inappropriate actions from HPs –** Approaches, attitudes, referrals, judgements, that are inappropriate from HPs
65) **Lack of resources –** Services lack money and time to deal effectively with people
66) **Knowing something is wrong –** They are aware that they need help, that what is happening isn't usual
67) **Stressful life circumstances –** Lives are full of different stresses which create and exacerbate issues
68) **Parental addiction and mental health issues –** Dealing with parental problems
69) **Mistrust of authorities –** Fear of what will happen if child services/gardai etc. are involved in a case
70) **Early school leaving –** Early school leaving
71) **Education for teachers, youth leaders etc. –** Informing those in touch with young people of how to help them with MH issues
72) **Communication between staff –** Need this within services to ensure best care

<u>Nodes April – June 2012</u>

73) **Social Context –**
    (Sub-nodes):
    - Role of family - in origin of the problem
    - Role of mothers - in origin of the problem
    - Social context: Suicide common
    - Social context: Addiction common
    - Abuse as a child implicated in origins

74) Consequences of mental health/substance use –
(Sub-nodes):

- **Social isolation**
- **Behaviour problems**
- **Impact on family of mental / substance use disorders**
- **Homelessness**
- **Social withdrawal - isolation**
- **Problematic relationships -** The breakdown and loss of relationships and friendships as a consequence of MH and addiction problems
- **Reversed sleeping patterns -** As a consequence of a MH or substance misuse problem
- **Sexual dysfunction** - As a consequence of a MH or substance misuse problem
- **Loss of independence**
- **Insomnia**
- **Panic attacks**
- **Feeling worthless**
- **Eating disorders**
- **Negative impact on friendships –** Friendships suffer because of drug-taking, e.g. stealing from friends. Friends not wanting to know you because you are now a different person

- **Legal consequences of drug use** – Being involved in crime, having a criminal record, court appearances etc.

- **Negative effects on job or future career –** missed opportunities for training or being fired for jobs because of poor performance/non-attendance due to drug-taking or mental health problems

- **Physical Violence -** Physical violence towards others, inability to communicate feelings, thus physical violence as a maladaptive coping strategy

75) In patient care: positive -
(Sub-nodes):

- Break from daily life stresses
- **Supportive patient relationships -** Some young people made valuable friendships with other patients that helped them during their time in hospital.

76) In patient care: negative -
(Sub-nodes):

- Institutionalisation (daily experience)
- **Privacy (lack thereof) -** Limited privacy during hospitalisation
- **Lack of access to health professionals -** Only see doctor occasionally and for short periods of time which is not conducive to recovery

- **Security problems -** Issues with safety and security when in secondary services
- **Regimented -** Strict hospital routine
- **Boredom -** During hospitalisation, limited activities on offer

77) Value of art therapy - as a useful way of engaging in treatment
78) Negative experience of private counselling

79) **Childcare: Mental / substance use disorders make caring for dependent relatives difficult**
80) **Role of family - in treatment of the problem / recovery**
(Sub-nodes):
    - Role of mothers - in treatment of the problem / recovery
81) **Effectiveness of group support –**
(Sub-nodes):
    - Value of group activities in recovery
82) **Factors that promote help seeking** - Factors that encourage young people to seek help e.g. family support, cost, geographical location.
83) **Misuse of prescribed medication** - The misuse of prescribed meds to young people e.g. meds are sold on the street or used for overdose.
84) **Misconceptions about treatment** - Some young people think of therapy, counselling etc. as something that is done to them rather that a process that they need to engage with to aid their recovery.
85) **Problematic relations between HPs and patients** - Young people sometimes found some healthcare professionals difficult to communicate with, and felt they were not being listened to or their opinions about their treatment were ignored.
86) **Post counselling blues** - Some young people feel down and more irritable after counselling, despite feeling ok during the session
87) **Types of MH and addiction problems experienced** – different types of MH and addiction problems experienced by young adults
88) **Importance of outreach work to enable young people's transition to services –** Having a staff member that can link in with young people prior to their interaction with services might ease the transition for them
89) **Self-control (lack of)**
90) **Co-morbidity**
91) **Confidentiality issues** - Young people may find it difficult to discuss their MH and addiction problems with HPs because they worry that the HPs will report back to their parents
92) **Hiding problems from others** - Keeping problems from others, like family, friends etc.
93) **Prioritised cases** - Cases which are prioritised due severity, age etc.

94) **Multidisciplinary approach** - Having a number of different people working on one case

95) **Choices provided** - Giving the young person choices on their treatment, engaging them with the process

96) **Building confidence, gaining options in life** - Helping young people to grow in self-confidence, see other options for themselves than drugs etc.

97) **Young people developmentally different to adults** - Understanding that young people need a service for young people, not an adult service, due to emotional and intellectual development

98) **Negative peer influence** - Particularly in regards to addiction

99) **Types of substances abused**

100) **Treatment centres – barriers -** People struggling to get clean to gain access to treatment centres

101) **The benefits of methadone** - As a better way of recovering from addiction as opposed to going cold turkey

102) **Reduced drug tolerance** - When a subject's reaction to a specific drug and concentration of the drug is progressively reduced, requiring a move to harder drugs achieve the desired effect

103) **Re-engaging with life after illness** - Trying to readjust to a new life post recovery from MH / addiction problems

Sub-nodes:

- **Learning to cope with MH and addiction problems -** Young people learning to managing their MH and or addiction problems effectively after treatment

104) **Shame of discussing MH and addiction problems with familiar GP -** Some young people were reluctant or ashamed to discuss their problems with their own GP

105) **Negative impact of drugs on ymh -** The negative consequences of taking drugs on a young person's mental health

106) **Effective activity based treatment for young people -** Services should have interactive activity based programmes to engage young people in treatment

Nodes June – August 2012

107) **Turning point for the better** - life changing experience / big step

108) **Dysfunctional coping strategies** - e.g. Avoidant coping strategies, denial, engaging in activities rather that addressing the problem

109) **Interventions that enhance life skills and health behaviours of value -** Interventions that promote young people to think about their future and select individual achievement goals for themselves

110) **Gender preference** - challenge engaging young men

111) **Importance of talking to others** - **especially a 'key other' (family member, HCP, GP, key worker etc)**

112) **Lots of information available, but effectiveness?**

113) **Involvement in voluntary activity**

114) **Viewing seeking help as a sign of weakness –** the young person is reluctant to seek help or even admit that they need it because they think of is as weak

115) **Stopping counselling** – strong enough without it. I've gotten what I needed from the counselling. Now I am strong so I don't need it any more.

116) **Blaming others for own drug taking –** when the young person is not accepting responsibility for taking drugs, e.g. "I took them because they were there. If they weren't there I wouldn't have taken them"

117) **Avoiding old friends as an aid to recovery –** needing to stay away from people who were once friends, but who are still taking drugs or simply bring the young person down

118) **The internet as a negative influence –**Internet can be used to promote drug-taking and mental health problems, e.g. site about how to successfully commit suicide, how to get high etc.

119) **Others need the help more than me –** Sometimes used as an excuse for not seeking help or for considering stopping counselling/treatment

120) **No interest in using internet –** Not that person thinks it is useful or not useful, just no interest in using it

121) **Unprofessional relationships with HPs –** Where the relationship between the young person and a HP is unprofessional, not actively harmful, but a bit too casual.

122) **Boredom as a reason to engage in substance misuse -** Lack of youth based activities and boredom often result in young people engaging in negative activities

123) **Youth friendly staff as a way to engage young people in services –** Engagement with services are often dependent on initial interactions with staff members.

124) **Moving from child to adult mental health services -** Issues with changing from CAMHS to adult services

125) **Young people seen alone -** Seeing young people without parents or guardian

126) **Bereavement and loss -** Impact of bereavement and loss for young people dealing with addiction and MH difficulties

127) **Fear of the unknown prior to treatment engagement** - Initial anxiety prior to attending treatment centre / clinic for the first time

128) **Staff turnover and its impact on the patient** - Changing staff means a break in the level of consistent treatment for young people

129) **Preference for one to one treatment** - While some young people prefer group based activities other feel more comfortable with one to one treatment

130) **Dissatisfaction with treatment** - Some young people were unhappy with the type of treatment received

131) **Battling with addiction -** Young people dealing with addiction are in a constant battle to avoid the temptation re-engaging in substance misuse

132) **Young people giving something back to services -** Some young people do volunteer work or get jobs in services they initially attended as service users themselves

133) **Limited local activities for young people -** Lack of activities for young people in their local community

134) **Growing up and leaving negative friendships behind -** Some young people matured in comparison to their friends and those friendships broke down as a result

135) **Observing the negative consequences of others as a reason to stop substance abuse** - Watching others struggle with addiction, drug related violence and in some cases losing their lives to drugs, motivated some young people to quit their own addiction

136) **Providing age appropriate information to young people about the dangers of substance abuse -** Information provided for young people about the dangers of substance abuse needs to be age appropriate and on a level that they can relate to

137) **Confiding in peers over HPs** - Young people feel more comfortable confiding in peers as opposed to HPs about their problems

138) **Negative perception of medication as a form of treatment -** Some young people were completely against the option of receiving medical treatment due to fear of side effects, loss of control, or feeling that their symptoms were not severe enough to warrant medical treatment

139) **The implications of mild mental health symptoms -** Young people experiencing down days, occasional negative thoughts, etc. felt that their problems did not justify treatment compared to others with more severe symptoms

140) **Celebrity role models battling with MH issues -** Young people dealing with their own mh issues my feel inspired by celebrity role models dealing with similar issues

141) **Maturity and independence -** Being treated as a mature young adult independent of parental involvement by HPs

142) **Effective mental health awareness campaigns -** Promoting awareness of MH problems and emphasising them as a common health issue, to reduce stigma.

143) **Explaining MH problems to others – difficulties -** Some young people felt that only people who have experienced a mental health problem will truly understand it.

144) **Services without financial restrictions** - Services should be accessible to everyone, without the burden of worrying about the financial cost

145) **Unhelpful support** - In some cases peers - friends might not be able to offer appropriate support

146) **Seeking parental guidance from other authority figures -** Seeking parental guidance from teachers, guidance counsellors an HPs.

147) **Fascination with mental health -** Some young people reported having a keen interest in mental health and have done their own research on the topic

148) **Out of hours access to psychiatry services -** Access to psychiatry services after 5 or at weekends

149) **Immature attitudes towards mental health problems** - Young people reacting negatively and immaturely to information talks based on mh problems

Appendix E – Interview topic guides (Study one)

Health care workers

Demography/Descriptive Data

1) How long have you been in your current profession?
2) What kind of training have you had in youth mental health?
3) How do you usually become aware of young people who might have a mental health or substance misuse disorder?
4) What proportion of your time is spent working with young people with such conditions?
5) Can you tell me about your previous/current practice of screening/early intervention for mental distress and/or substance misuse amongst young people?

Experience of mental and substance use disorders among young people

1) How are service user needs identified?
2) What are the main challenges in regards to meeting the needs of young people with respect to:
    a. treatment engagement?
    b. treatment sustainment?
    c. need identification?
    d. resources available?
    e. differences between adults and young people?
3) Are there additional supports / community resources available outside of this service for service users?
    a. If so...can you tell me more about them?
4) How would you improve your service with repect to:
    a. access to services for young people?
5) What is your view on the inclusion of parents/guardians in a young person's treatment for mental/substance use difficulties?

Attitude towards screening/early intervention

1) Do you think it would be feasible to have screening in your service?
2) What are the main factors that facilitate screening/early intervention for mental distress/substance misuse in young people?
3) What are the main barriers that prevent screening/early intervention for mental distress/substance misuse in young people?
4) If the child of a friend of yours had a mental health or substance misuse difficulty, what would you advise them to do in the first instance?
5) If you have a service user presenting with both mental and substance use difficulties what kind of treatment options are available to them?
6) Could you tell me briefly about a young person that you cared for that resulted in a positive outcome? What was the condition? How did you help? Why was the outcome so good?
7) Are there any other comments you would like to make?

Young people

Demography/Descriptive Data

1) How old are you?
2) Why are you attending this service?
3) Had there been a history of this within your own family or amongst your friends?

Experience of mental and substance use disorders

1) Tell me a bit about what has happened between the first time you sought help from a professional and now?
    a. When did you first seek help?
    b. How did you know something was wrong?
    c. What services have you had contact with since then?

2) When you thought something was wrong, did you look for help immediately?
    a. If not, why not?
    b. How were you feeling at the time?
3) How did you cope with difficult situations before attending this service?
4) How long have you been attending this service?
5) How did you find out about the service that you are currently attending?
    a. Did somebody recommend that you attend this service?
6) Before you actually got help/support/treatment from this service / agency (identified in advance), what did you think it might be able to do for you?
7) Can you tell me about what they have been able to do for you/the help you received?
8) What kind of information did you receive about your treatment options?
9) Is your family involved in your treatment? If yes, how do you feel about that?
10) Are you happy with the help/support/treatment you have received from this service?
    a. What specifically are you happy/unhappy about?
11) Do you think the service could be improved in any way?
    a. If yes...how?
12) What kind of support do you have from family friends?
13) Is there anything you could have been told in a school or community centre which might have helped you?
14) I want to talk about the role of the Internet. Do you think this could be a useful tool in promoting awareness of mental health issues among young people and if why?

Attitude towards screening/early intervention

1) Why do you think young people might not try to get help for mental and/or substance use problems?
2) How could services be made more attractive for young people in general?
3) Do you think it would have helped you if you had received help earlier on?
    a. If yes, how?
    b. Would it have been possible?

4) If you had a friend with the same ‘condition’ as you, what advice would you give them about what they should do to get help?
5) If you were attending your GP for a physical ailment, how would you feel if they were to screen you for a mental illness of substance abuse?
    a. Would you find it off putting or useful?
    b. Would you want to talk about these things with your GP? If not, why not?
    c. What would make you want to discuss these issues with him/her? (Choice / Time / Personality)
6) How would you feel if somebody tried to measure you for a mental disorder in a school or community centre using a questionnaire?
7) If you were minister for health, and money was not an issue, what services would you offer to young people?
8) Are there any other comments you would like to make?

Appendix F – Ethical approval (Study one)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE West,
Mid-Western Regional Hospital,
Dooradoyle,
Limerick, Ireland.

Tel: 00353 (0) 61 301111
Fax: 00353 (0) 61 301165
Website: www.hse.ie

21st March, 2011.

Prof. Walter Cullen,
Prof. of General Practice,
UL.

Re: Protocol Title
Towards Early Intervention for Youth Mental Health in Primary Care: a mixed methods study from two perspectives.

Dear Prof. Cullen,

Thank you for attending the Research Ethics Committee meeting on the 16th March,2011 in connection with your study.

I wish to advise that the Committee has now approved your study. However, you should note that your study cannot commence until you also receive Risk Management approval. This approval will be issued to you shortly.

You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success in your study.

Yours sincerely,

p.p. Joanne O Connor

Marie Hickey Dwyer,
Consultant Ophthalmic Surgeon,
Chairperson, Ethics Research Committee.

Appendix G – Study instrument (Study two)

Section A: About you		
Age: Under 35 □ 35 – 49 □ 50+ □	Gender: M □ F □	Year finished GP training: _ _ _ _
Number of doctors in practice_____ GMS list size: _____	Type of practice: Private □ Mixed □ GMS □	Location of practice: Rural □ Urban □ Mixed □
HSE area of practice: Eastern □ Midlands □ Mid-West □ Northeast □ Northwest □ Southeast □ South □ West □		
What kind of postgraduate training in mental health and substance use have you received? **a.** Vocational training □ **b.** Diploma / Certificate in an aspect of mental health / substance use □ **c.** CME □ **d.** Courses in substance abuse / addiction / methadone programme / alcohol □ **e.** Other _____		
Do you feel your postgraduate training prepared you adequately to deal with? **a.** Adult mental health Y □ N □ **b.** Child and adolescent mental health Y □ N □ **c.** Substance use Y □ N □		
Are counselling services available to GMS patients of your practice? Yes □ No □ If so what is the waiting timeframe for access to these services? <week / 1-3weeks / 1-3months / >3months Are counselling services delivered at your practice? Yes □ No □ If yes, how often are counselling services delivered in your practice? Daily / Weekly / > Monthly / Monthly		

Section B 1: Screening of mental health and substance use disorders among young people			
		Mental Health	**Substance Use**
1	Do you screen for mental / substance use disorders among young people (16-25 years)?	Yes □ No □	Yes □ No □
2	How often do you screen?	Routinely □ High Risk □ Clinically Indicated □	Routinely □ High Risk □ Clinically Indicated □
3	If you screen, do you use: Screening questionnaires? Yes □ No □ If yes **which questionnaire(s)** do you use? _____ Other please specify _____		
Section B 2: Management of mental and substance use disorders among young people			
		Mental Health	**Substance Use**
4	Do you refer young people to specialist care for mental / substance use disorders? (Tick all that apply)	Never □ Mild cases □ Moderate cases □ Severe cases □	Never □ Mild cases □ Moderate cases □ Severe cases □
5	Do you **personally** perform brief interventions for mental / substance use disorders among young people? (Tick all that apply)	Never □ Mild cases □ Moderate cases □ Severe cases □	Never □ Mild cases □ Moderate cases □ Severe cases □
6	Have you **personally** used any of the following psychotherapeutic interventions for treating mental / substance use disorders? (Tick all that apply)	CBT □ One-to-one counselling □ Web-based interventions □ Other, please specify: _____	CBT □ One-to-one counselling □ Web-based interventions □ Other, please specify: _____

	Section B 3: Barriers to the treatment of mental and substance use disorders among young people										
7	What do you consider to be the main **barriers** to addressing **mental and substance use disorders**? Please rank each on a scale of 1-5 for ***both*** **mental and substance use disorders** where ***(1 = not at all important; 5=very important)***										
	Barriers	**Mental Health**					**Substance Use**				
	Attitude of family	1	2	3	4	5	1	2	3	4	5
	Attitude of patient	1	2	3	4	5	1	2	3	4	5
	Lack of specialist staff in my practice	1	2	3	4	5	1	2	3	4	5
	My lack of interest in the area	1	2	3	4	5	1	2	3	4	5
	My lack of time	1	2	3	4	5	1	2	3	4	5
	My lack of training and education	1	2	3	4	5	1	2	3	4	5
	Poor service availability in locality	1	2	3	4	5	1	2	3	4	5
	Stigma	1	2	3	4	5	1	2	3	4	5
	Others? (please specify)										

Section C: The questions are designed to explore **the attitudes of GPs** working with people with **mental and substance use disorders**. There are no right or wrong answers. Please indicate the extent to which you disagree or agree with the following statements for ***both*** **mental and substance use disorders** by ticking one of the boxes after the statements where (***1 = Strongly Disagree and 5 = Strongly Agree)***

In the area of youth mental health and substance use:		**Mental Health**					**Substance Use**				
8	A GP should **always** be the initial person consulted by a young person.	1	2	3	4	5	1	2	3	4	5
9	I am confident in my own ability to **diagnose** the most common problems.	1	2	3	4	5	1	2	3	4	5
10	I am confident in my own ability to **treat** the most frequent disorders.	1	2	3	4	5	1	2	3	4	5
11	It is appropriate for GPs to manage **mental / substance use disorders** among patients.	1	2	3	4	5	1	2	3	4	5
12	I would rather seek advice from other colleagues (experts in the field) as opposed to seeking advice from information leaflets and published guidelines.	1	2	3	4	5	1	2	3	4	5
13	I often initiate prescription of psychotropic medication (antidepressants / antipsychotics).	1	2	3	4	5	1	2	3	4	5
14	I feel competent in the use of psychotropic medication in this age group (16-25).	1	2	3	4	5	1	2	3	4	5
15	GP administered brief interventions / diagnostic screening are effective.	1	2	3	4	5	1	2	3	4	5
16	Other lifestyle interventions (e.g. exercise, diet, social environment) are important.	1	2	3	4	5	1	2	3	4	5
17	I utilise lifestyle interventions before administering psychotropic medication.	1	2	3	4	5	1	2	3	4	5

Section D: Interventions to address youth mental health issues in my practice:						
Intervention would enhance my capability to address youth mental health issues in my practice ***(where 1 = Strongly Disagree and 5 = Strongly Agree)***						
19	Access to services, especially for psychological interventions	1	2	3	4	5
20	Clear definition of which interventions can be initiated in primary care and general practice	1	2	3	4	5
21	Formalising role of GP / Primary Care Team input across youth environments	1	2	3	4	5
22	Guidelines for interagency collaboration	1	2	3	4	5
23	Having appropriate time and space to explore a young person's issues	1	2	3	4	5
24	Stronger links with schools (point of contact, information sharing, visit to Primary Care Team)	1	2	3	4	5
25	Liaison and collaboration between agencies	1	2	3	4	5
26	List of appropriate agencies or web resources	1	2	3	4	5
27	Not overestimating what the patient knows – plain English, drawings for leaflets	1	2	3	4	5
28	Personal knowledge and skills development	1	2	3	4	5
29	Primary care as an agent for social care in the community – more active role	1	2	3	4	5
30	Specific wording for questions which may be awkward to ask	1	2	3	4	5
31	Stepped care	1	2	3	4	5
32	Treatment guides that are easy to use – e.g. evidence summaries	1	2	3	4	5
33	Training for GPs / CPD course	1	2	3	4	5
34	Training for practice nurses	1	2	3	4	5
35	Access to youth worker / key worker	1	2	3	4	5

Thank you for completing this questionnaire. Please return in the pre-paid envelope to:
Dorothy Leahy, GEMS3-026, Graduate Entry Medical School, University of Limerick
Faxback: +353 61 233778 Email: Dorothy.Leahy@ul.ie

Appendix H – Letter of invitation (Study two)

08/11/2013

Address line 1
Address line 2
Address line 3
Address line 4
Address line 5

Re: The role of the GP in addressing youth mental and substance use disorders.

Dear Dr XX

We are writing to invite you to contribute to a University of Limerick led initiative to improve mental health services for young people in Ireland. Please complete the enclosed brief questionnaire which examines the role of GPs in identifying and treating mental and substance use disorders among young people.

The aims of this study are:

1. To establish the practice of screening and treating mental and substance use disorders.
2. To identify the barriers and enablers to this process in general practice.
3. To identify strategies that would improve uptake of screening and treatment among young people with mental and substance use disorders attending general practice.

As this study is also anonymous, we have no mechanism to identify participants / non-participants. Can you please return your completed questionnaire in the free post envelope provided.

This study is part of a Health Research Board funded research project, "Towards early intervention for youth mental health in primary care: a mixed methods study from two perspectives", being conducted at the Graduate Entry Medical School in the University of Limerick.

We thank you for your participation.

Sincerely,

Walter Cullen
Professor of General Practice
Graduate Entry Medical School
School
University of Limerick
IMC Registration Number: 18451
T: +353-61-202812
E: walter.cullen@ul.ie

Dorothy Leahy
Doctoral Student
Graduate Entry Medical
University of Limerick
T: +353-61-234949
E: Dorothy.Leahy@ul.ie

Appendix I – Ethical approval (Study two)

10th July 2013
Ms Dorothy Leahy
Graduate Entry Medical School,
University of Limerick,
Limerick

The role of the GP in addressing mental and substance use disorders in young adults: A mixed methods approach.

Dear Ms Leahy,

I wish to confirm that on review of your additional material I am now happy to approve the above study.

Yours sincerely,

_____
Prof. Colin Bradley
Chair Research Ethics Committee