Mental Health in Family Medicine 2012;9:115–23

Article

'Can he have the test for bipolar, doctor? His dad's got it': exploring the potential of general practitioners to work with children and young people presenting in primary care with common mental health problems – a clinical initiative

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ABSTRACT

Background General practitioners (GPs) play a key role in assessing and managing adult mental health problems, but this input is not seen in their management of child and adolescent mental health. Mental health problems in 5–19-year-olds are common, yet detection rates in primary care are low. The symptoms of most adult diagnoses of mental health problems are present by mid-adolescence, yet the typical time from onset to diagnosis is 5–15 years. The role of general practice in this area has been underexplored.

Aim This pilot study explores the potential of GPs to respond to common mental health problems in children and adolescents.

Design Children and young people who would have ordinarily been referred to Child and Adolescent Mental Health Services (CAMHS) were seen in a GP setting. In a UK general practice surgery serving a disadvantaged population.

Method Children and young people were seen for an initial biopsychosocial assessment and formulation of the presenting concerns. GP-based interventions were offered as appropriate or referred to CAMHS.

Results Data from the first 50 children (2–19 years) are presented. Twenty younger children (10 years and under) and 30 older children (11 years and above) were seen. Eighteen referrals were made to CAMHS. GP interventions included watchful waiting, brief behavioural interventions, non-directive counselling, brief cognitive–behavioural therapy (CBT) and liaison with colleagues in education, CAMHS and the voluntary sector.

Conclusion This clinical pilot demonstrates that with adequate time, access to supervision and practice support, children and young people experiencing emotional and behavioural problems associated with common mental health issues can be helped in primary care.

Keywords: common child and adolescent mental health problems, early intervention in primary care, GP involvement

Introduction

Mental health problems in children and adolescents are common.[1,2] It is estimated that 10% of 5–15-year-olds experience symptoms that impact on their daily function and that 14% of 16–19-year-olds have a diagnosable mental health disorder.[1,3] Adolescence represents a period of increased vulnerability for developing a significant mental health problem, with 50% of severe adult mental health disorders presenting by age 15 and almost 74% presenting by age 18,[4] yet the time delay before diagnosis can be between 5 and 15 years.[4] The consequences of untreated psychological difficulties experienced by a child or young person can impact on their physical, cognitive, emotional and social development at a critical time in their life course and have wider ramifications within the family.[5,6] If the difficulties persist they can become lifelong, and lead to underachievement at school, poor employment prospects and impaired life chances.[6]

General practitioners (GPs) have a wealth of experience in looking after adults with mental health problems. They are the main providers of care for adults with common mental health problems and the myth that specialist services are the lead mental health providers has long been challenged.[6] GPs are equally well placed to respond to early manifestations of emotional distress in younger patients, yet the potential of general practice to provide this kind of care has not been fully explored. There have been calls at a policy level for GPs to be more proactive in this clinical area. The National Service Framework promoted the role of primary care staff to assess and intervene early. NICE guidelines[7] have actively called for GPs to be familiar with screening for mood disorders (p. 57) and to be trained in communication skills such as 'active listening and conversational technique ... so that they can deal confidently with acute sadness and distress ... following recent undesirable events' (p. 58). More recently, the role of GPs and other frontline health professionals in promoting emotional resilience through early intervention has been described in the policy document *Early intervention: securing good outcomes for all children and young people*.[8]

However, such expectations are not routinely manifest in current practice and GPs' involvement in the mental health and well-being of children and young people is not yet seen as 'core business'. GPs have been shown to respond only when the level of emotional distress in children and young people is high[9,10] and the majority of children and young people experiencing common mental health problems are not identified by primary healthcare practitioners and thus not offered professional help.[7] The reasons why GPs are less involved in the assessment and management of child and adolescent mental health are underexplored, likely to be multifactorial and complex, and have been identified as a key priority for clinical research.[11] The small number of published studies suggest that GPs consider themselves unskilled,[12] are reluctant to diagnose a mental health conditions in this age group[13] and perceive that they have a limited range of treatment options.[14] Psychotropic medication is not recommended[7] and referral into secondary care can result in variable responses.[15]

As a reflection of current practice, the first author (JR) undertook an audit of children and young people seen in her practice with presentations suggestive of emotional and behavioural difficulties over a 12-month period. The practice, located across three surgeries, is situated in a geographical location of deprivation and high need. The Marmot indicators for County Durham estimate that only 51% of children have achieved a good level of development at age 5, compared with the national best measure of 69%; 10% of young people are not in employment, education or training (England's best mean is 2.6%) and 17.7% of people are in households in receipt of means-tested benefits.[16] Key findings from the Child and Maternal Health Observatory (ChiMat) data state that the 'health of children in County Durham is generally poorer than the average for England'.[17]

In total, 33 children and young people were seen by a GP or practice nurse and 29 of these were referred to the local Children and Adolescent Mental Health Services (CAMHS). Over half of the children referred waited a minimum of 14 weeks before being seen by the CAMHS team, and 12 of the referred young people did not attend the initial assessment appointment. Ten completed their full course of treatment; two children attended only two appointments. Five referrals were declined by the CAMHS team (two of which were later re-referred because of continuing problems). For the four young people seen in surgery but not referred, the response was to offer simple advice such as to communicate with school, or they were given reassurance that the problem would be self-limiting. Given the known high prevalence of symptomatic pyschological distress in the community,[1,2,17] the results of the audit give cause for concern that psychological difficulties presenting in primary care are not being adequately addressed.

The pilot study presented in this article was designed to increase access to initial assessments and early intervention for children and young people presenting with emotional distress.

Aim

The aim of the study was to pilot a GP-led initiative to respond to common child and adolescent mental health problems within primary care and assess what is feasible for a GP to offer beyond 'routine practice'.

Objectives

The objectives of the study were for the GP to:

- conduct a thorough biopsychosocial assessment, usually over a number of appointments, gathering collateral information with consent;
- produce a formulation and management plan;
- identify appropriate sources of help and support with agreed follow-up; and
- intervene therapeutically where appropriate and safe, with the aim of promoting emotional resilience
- conduct a service evaluation and collect patient feedback.

Methods

In 2009, a GP surgery-based initiative was launched for a practice population of 9,200 patients of whom 1,410 were aged between 0 and 19 years. At the time, there were 6.5 full-time equivalent GPs and one nurse practitioner delivering healthcare across three sites, all of which are located in areas of marked socio-economic deprivation. Historically, the local CAMHS had endured a long period of unfilled posts and recruitment difficulties which resulted in prolonged waiting times for patients referred from primary care. A new initiative in 2009 saw the introduction of primary mental health workers (PMHW) to the local CAMHS team. Part of their remit focuses on working with local GP practices to improve access to advice from CAMHS clinicians and JR was keen to work with the PMHWs, supported by her employing primary care organisation (PCO), who were interested in addressing the markers of poor adolescent health in the local region.[16,17] Additional support was identified from PB who offered clinical supervision. PB has a long-standing interest in the interface between CAMHS and primary care[12,18] and had previously developed and evaluated an educational intervention supporting GP registrars in managing mental health problems in adolescence.[19] An initial planning meeting with senior CAMHS clinicians and PCT lead GPs was undertaken and the aim and objectives of the project were clarified. This clinical initiative and evaluation was classed as 'service evaluation' by the local research governance lead and as such was deemed exempt from requiring formal research approval.

The initiative was delivered as a simple internal referral process whereby children and young people presenting to any GP or the nurse practitioner were referred to JR for an initial 30-minute appointment. A referral form was available on the practice intranet system, but most referrals were communicated informally and seen within 2 weeks of their initial generic consultation. The original intention had been to set aside one session per week for these extended appointments, but in order to be flexible, appointments were issued during any one of JR's routine surgeries. The biopsychosocial assessment involved an exploration of the presenting problems with the child and family and, where appropriate, time spent with the young person alone. Permission would be sought to make contact with key teaching staff and any other health or social care professionals involved with the child or young person.

A clinical log was kept of all the children seen, along with individual case histories which included a detailed genogram, risk assessment and early formulation, to which was added collateral information gathered after speaking with school staff and/or other professionals working with the identified patient or family.

Results

This article will report on the first 50 children and young people, aged between 2 and 19 years, seen during the first 12 months of the study. The results are presented in two broad age-related categories: 'younger age group' (pre-school or in primary school education) and 'older age group' (attending secondary school or beyond). The data are given in Tables 1–5.

Tables 1 and 2 document the overarching categories of 'presenting complaint'. These have been left deliberately broad to mirror the open-endedness of initial presentations which practitioners will recognise as reflective of parents making statements such as 'Doctor, I can't cope with his behaviour' or 'She's angry all the time and I don't know why'. The category 'mood variability' emerged where children's emotionally labile state appeared to be the most prominent concern (often presented as 'She's a Jekyll and Hyde' character); presentations of anxiety which were discernible in a number of children from the outset were also added to this subset. In the older age group, a small number of more specific behavioural patterns causing distress were encountered such as

Table 1 Presenting concerns for the younger age group (pre-school and primary school)

Nature of concern	Male	Female
Adjustment difficulties		
At home and school	10	
At home only	1	2
At school only	1	1
Mood variability causing difficulties, including anxiety	1	2
Sleep difficulties	2	
Total	15	5

Table 2 Presenting concerns for the older age group (secondary school and beyond)

Nature of concern	Male	Female
Adjustment difficulties		
At home and school	3	4
At home	1	2
At school only	2	1
Mood variability causing difficulties, including anxiety	2	6
Offending behaviour/contact with the police	1	
Self-laceration	1	1
Foraging and soiling associated with learning disability	1	1
Bulimic eating pattern		1
Anorexic eating pattern		1
Hearing voices		1
Phobia		1
Total	11	19

Table 3 Interaction with local CAMHS team

Referrals	Younger age group	Older age group
Emergency	0	3
Routine	6	7
To learning disability CAMHS		2
Discussion with CAMHS team re children already known	2	3

Table 4 Management

Mode of management	Younger age group	Older age group
Watchful waiting with booked review	7	7
Direct referral to child protection services	1	
Discussion with duty social worker	2	1
Brief behavioural intervention	2	12
Psychological intervention	0	12

Table 5 Liaison activities

Service	Younger age group	Older age group
With school		
Request for educational psychologist involvement	0	2
Referral to school counsellor	1	
Referral to school nurse	0	2
Referral to behaviour support worker	1	1
Referral to parent support advisor	3	2
With paediatrics	2	0
Referral to voluntary agencies		
Local council-funded counselling	3	
Bereavement counselling		1
Young Carers support		2

foraging or soiling in two children with recognised learning disability; or disordered eating patterns which appeared to correlate with a principally bulimic or anorexic picture.

Table 3 documents the contact made with the local CAMHS team and indicates the number of referrals, routine and emergency, for both age groups (no emergency referrals were made for the younger age group). A total of 18 referrals were made for the 50 children seen. There was a small number of children and young people in both groups who were already known to CAMHS – either as active clients or recently discharged but about whom the family still had concerns which they brought to the GP.

Table 4 summarises the range and frequency of management options. 'Watchful waiting' describes the number of children for whom a referral to CAMHS did not seem warranted or a specific behavioural intervention indicated. Watchful waiting in the younger group involved discussion with the parents about factors which might be exacerbating the presenting problem or could ameliorate the situation and almost always also involved some liaison with school. The category 'brief behavioural intervention' refers to more structured discussions which addressed a child or young person's sleep hygiene, smoking behaviour, patterns of alcohol and illicit drug consumption, their pattern of social activities including use of the Internet, peer networks, intimate relationships and stress management. They might also include a referral to the school nurse for smoking cessation support or local exercise opportunities.

'Psychological intervention' refers to a more sustained engagement with a young person who would be seen over time, typically three sessions of 20–30 minutes; with a smaller subset of teenagers seen over

a longer period. In this subgroup, problems were usually associated with enduring familial conflict, often a story of marital breakdown with a history of violence in the family.

Table 5 summarises the scope and frequency of referrals made to colleagues based in schools or in the voluntary sector. Within education, referrals were made to the educational psychology service (via the school's special educational needs co-coordinator), to the school counsellor, nurse or behavioural support worker. The parent support advisor (PSA), who works primarily with the parent(s) to maximise their child's attendance and engagement with their educational programme at school was also accessed. Telephone calls for advice were made to a local experienced paediatrician regarding two children, one with persistent situational vomiting and the other with sleep difficulties including night terrors and sleep-walking. Referrals to local charities were for counselling (Action for Children) and young carers support (NSPCC).

Service user feedback

The study objectives included an intention to conduct a service evaluation. It was decided to use the validated 'experience of service questionnaire' produced by the Commission for Health Improvement (CHI ESQ) to be congruent with the local CAMHS practice. This tool is also accepted as a current core measure of user satisfaction by the CAMHS Outcome Research Consortium (CORC) and can be readily found at the CORC website www.corc.uk.net/index.php?content key=81.

The service evaluation began once the pilot project was active. Questionnaires were distributed from the final 15 children, young people and their parents. Eleven paired questionnaires (child and parent) were returned. All were strongly positive. An example of the free text statements given in response to 'What was good about your care?' included:

> 'The longer appointment time.'
>
> 'They listened to me very well and made me happy when they said I'd done well.'
>
> 'I was listened to and taken seriously. I believe the person I talked to knew how to help me.'

No suggestions were made regarding any improvements to the service offered.

The evaluation is ongoing. The completion rate for returns of the questionnaires varies. Knowing when is the most apposite time to request feedback requires clinical judgement and sensitivity. Often it is considered more appropriate to send out the evaluation form by post although the response rate is lower when compared with forms completed in surgery. We are currently asking young people for their preferred means of communicating feedback and are looking at digital options in preference to paper questionnaires for the future.

Discussion

This article describes a clinical innovation that pilots extended GP involvement in the assessment and management of the emotional and behavioural problems of children and young people presenting in primary care. Given the scope and enduring nature of common mental health problems in this age group, and the under-resourcing and often limited accessibility of secondary services, developing the capacity within general practice has been proposed as a means to increase responsiveness and to offer earlier interventions.

The key finding from this pilot study is the reduction in referrals made to secondary care. Eighteen referrals were made for the 50 children and young people seen. This equates to a referral rate of 36% of the cases seen. Such a rate compares favourably with the results of the audit, which are likely to reflect 'usual practice' and show a referral rate of 88% of children and young people (29 of 33 patients seen).

Early service user feedback also suggests that greater GP involvement is welcomed by the young people themselves and their families. This finding is supported by a recent study involving focus groups with parents who had a child aged 2–17 years who had been referred to CAMHS. The authors concluded that 'parents place a high value on GP interest in the child and family situation and GP behaviour demonstrating that they listen to and take their concerns seriously, rather than on the need for specific expertise in the area of child and adolescent mental health' (p. 480).[20] Being seen promptly, with an average waiting time of 2 weeks, was also well received.

For the younger age group, 20 children of primary school age or younger were seen, of whom 15 were boys. In this age band, the most common formulation was of 'adjustment difficulties' manifest in both the domestic and school settings. The first step involved drawing up a formulation and determining if the family required additional input. Six of the boys were assessed as needing further assessment by the local CAMHS team and routine referrals were made. In all six, there was a constellation of symptoms and signs suggesting possible neurodevelopmental delay complicated by a mixture of early

exposure to domestic violence, attachment difficulties and parental mental health problems. One of the referrals involved an initial joint assessment with JR and the PMHW working together in a GP surgery-based meeting. With this younger age group, the single most important approach was centred on acknowledging the distress being experienced and expressed by the family and the young child and offering support. Depending on the family's understanding of the nature of the problem and their receptiveness to outside intervention, it also included promoting a sustained engagement with professionals on the part of the parents and an ongoing explanation of what the referral process and subsequent care pathway might involve.

Support for the family was buttressed by connecting with the school; telephone contact with school was made for all the younger children seen, five of whom were referred to additional sources of help such as a school-based behaviour support worker or the PSA. In two cases, the boys were already being seen by CAMHS but there had been missed appointments or concerns about current treatment programmes which needed clarification.

With regard to the older age group of children, there are two notable differences when compared with the younger children which concern gender and the range of interventions offered. Almost twice as many girls as boys were seen and for the 30 young people seen (in total) there were 12 brief behavioural and 12 psychological interventions offered. The focus with this group was primarily on validating the teenager's distress and offering hope through brief interventions or referral to secondary care. Working with the family was also important but the overarching goal was to address the young person's emotional needs. For many of the teenagers seen it was possible to work with them without a parent being present and to develop a therapeutic relationship with the young person over time.

In general, the behavioural interventions focused on addressing sleep hygiene, nutrition, exercise, substance use, social support and stress management. Insufficient sleep was a common finding and exploring the consequences of, for example, being over-tired and irritable was helpful for some young people. With regard to the psychological interventions, the intention was to work collaboratively with the young person to promote a deeper understanding of their own situation. In telling their story, the descriptive accounts would help to unravel the initial confusion the young person typically expressed regarding the nature of their 'problem'. The process of naming their distress would then lead into the next stage of looking at what approaches might be most helpful to that particular individual. These might include making practical changes such as going to bed earlier, but more often concerned initiating discussions with family members or close friends about how they were feeling and what they would like to change in their lives.

The psychological interventions involved an eclectic mix of active listening, non-directive counselling, narrative therapy and elements of cognitive–behavioural therapy. General practice has a tradition of what Launer terms as 'Little-c counselling' which he describes as the occasions when GPs enter counselling or therapeutic modes of working during routine consultations and should be experienced by the patient in terms of 'the doctor being an attentive listener'.[21] It was JR's intention that therapeutic intervention during this clinical pilot would occur along those lines. The facility for clinical supervision allowed for a more detailed formulation of the presenting problem and to use 'Little-c counselling' with greater confidence.

A more recent approach has been to incorporate the use of 'emotional writing' which builds upon skills acquired during a short course in narrative practice. With a number of teenage girls the suggestion that they might use writing to capture the *melee* of their thoughts at particular moments in time seemed to be both illuminating and emancipatory. It led to a greater understanding of why they had responded in certain ways to specific triggers and allowed them to explore alternative responses. The early experience of the pilot study suggests this might be an intervention worth subjecting to the rigours of a formally executed trial.

For both age groups, the value of liaising with colleagues in education and paediatrics in a more proactive manner than is normally part of routine practice, and with workers in the voluntary sectors (e.g. with charities such as the NSPCC), offered a number of benefits. First, it demonstrated to families and to the young people themselves that their problem was being taken seriously and that their request for help was being honoured. Second, a telephone call to a school often acted as a catalyst and led to a more responsive approach from the school such as a request for the educational psychologist to reassess, or a broader discussion might encourage school-based colleagues to see a child's difficulties in a more holistic manner and be more tolerant of their behaviour. Liaising with 'outside agencies', council-based services or charities, resulted in building up a richer picture of locally available services which otherwise were not necessarily known about by the local general practice and could well offer practical help to the young person and their family. An example here might be the Young Carers scheme, run by Barnardo's, which offers a key worker to 'befriend' under-18-year-olds who are caring for a family member.

The strengths of this clinical pilot lie in its exploration of what a GP can offer in the non-stigmatising setting of a general practice surgery. The biographical–biological approach of good general practice draws upon historical, social and medical knowledge of the child and their family (and the wider community context in which they live). It approaches a child or young person with a holistic lens that is able to address concerns about acne, period pain and poorly controlled asthma, as well as feelings of low self-esteem and lack of confidence or sadness about a family bereavement. The GPs' professional standing legitimises the patient's concerns and can avoid unnecessary referrals.

Critics might suggest that a surgery-based PMHW would be a better option and historically there have been anecdotally reported experiences of general-practice-based PMHWs (or equivalent) working effectively in primary care (J Allister, personal communication); particularly with more seriously affected children and young people and their families. However, in this age of austerity with resource allocation so restricted, this study aims to explore what a GP can offer without additional on-site support.

The fundamental requirement of this pilot initiative, as the study has demonstrated, is an enthusiastic and committed GP with a passion for promoting children and young people's emotional well-being and who is well supported by access to individual clinical supervision. In addition, it requires structural support from the GP's employers or partners, and collaboration from the practice administrative team. A good relationship with the local CAMHS team is essential; this requires time and effort. This initiative has shown that such a constellation of factors can occur, but it requires a commitment to addressing child and adolescent emotional distress early in its presentation. Clearly all of these requirements will not be available in all practices.

Time is often cited as a limiting factor in promoting active GP involvement when working with patients with mental health problems. However, GPs have found a way of working with adult patients with common mental health problems and it is feasible that more flexible ways of working, which might include the option of extended appointment slots or drop-in sessions allocated to young people, might become more commonly available. Such a move is supported by a growing evidence base, emanating from work on the health needs of socially disadvantaged patients, suggesting the need for more complex consultations to be longer.[22] It is also recognised that 'the main limiting factor on clinical empathy in the consultation in primary care may be consultation length'.[23]

At a policy level, other structural changes which would promote proactive involvement in supporting the emotional well-being of younger patients might also include the incentivisation of care that is currently not part of the Quality Outcomes Framework – the absence of which has been linked to poorer outcomes for children's health in the UK when compared with similar European countries.[24] It is clear that further research is needed in this area both to help develop the evidence base of what GPs can meaningfully offer in a consultation and also to demonstrate that they can work well with the CAMHS team in a variety of settings. In so doing, this would help address the problem of high levels of need in certain communities against a chronic underfunding for secondary care services for child and adolescent mental health.

Conclusion

This clinical initiative suggests that general practice has much to offer to children, young people and their families in the assessment and management of common emotional and behavioural problems presenting in primary care. Timely and effective GP interventions can reduce the number of referrals to secondary care and can utilise the strengths of a biological–biographical approach to care which sits at the heart of good general practice. Furthermore, it is an approach that is popular with younger patients and their families.

Active involvement in addressing early signs of emotional and behavioural distress requires a motivated and enthusiastic GP, but also the opportunity for extended appointments and for clinical supervision. How these are achieved in economically straitened and pressurised times is a pertinent question. However, if mental health problems appearing early in the life course are ignored, their sequelae can be magnified and intergenerational.

GPs are uniquely positioned to offer a therapeutic role by acknowledging distress, offering hope and using simple psychological interventions that can embolden children and young people to address their personal difficulties and encourage emotional resilience. GPs have become increasingly involved in adult mental healthcare and it is perhaps now timely to look at current practice in relation to child and adolescent mental health and how GPs might be more actively and meaningfully involved. This is a significant challenge but the clinical initiative reported here offers a first and positive step.

ACKNOWLEDGEMENTS

We wish to thank the administrative and clinical staff at the Blackhall and Peterlee Practice, County Durham for their assistance in running the pilot and Easington CAMHS for their contribution. We also thank the anonymous reviewers for their constructive feedback.

FUNDING

None.

CONFLICTS OF INTEREST

None.

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Accepted March 2012