Improving access to mental health services for youth and parents

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Child psychiatrists are among the mental health professionals that are well positioned to provide mental health services to young people with major mental illnesses and their families. However, there are not enough specialists to meet the demand (1). Although the exact number of Canadian child and adolescent psychiatrists is unknown, the Canadian Academy of Child and Adolescent Psychiatry has 350 members whose practices are based disproportionately in cities with medical schools. It has been estimated that Canada has one child and adolescent psychiatrist to every 6148 young people with mental health needs (2) – a shortage likely to get worse (3). In Ontario, it is unlikely that the situation has improved since 1987, when the Ontario Child Health Study (4) reported that 18% of the province's children and youth met the criteria for at least one psychiatric disorder (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, third edition [Revision]* [5]), and two-thirds of this group met the criteria for two or more disorders. Only one in six young people with a disorder had received intervention for it in the preceding six months (4). Access to these scarce resources continues to be impeded by several factors: long waiting lists for youth psychiatrists, the geographical distribution of these professionals (chiefly in large urban centres) and the frequent discomfort of families at the prospect of seeking mental health care (6,7). Another serious impediment to access to the few resources available is that a child or youth's psychiatric disturbance is not what usually determines referral to a mental health professional. Social functioning, school-related issues, the family's socioeconomic status and other problems that are not always associated with major mental illnesses may strongly influence referral (8).

Increasing resources and access to mental health professionals are clearly important; equally important, however, is acknowledgment of the vital role played by paediatricians, who, as consultants or primary care providers, can be central to the mental health care of young people and their families (9). Indeed, many patients first reveal psychosocial distress or psychiatric illness to their paediatricians, either covertly or overtly. Some reports (10-12) estimate that young people with forms psychosocial distress or dysfunction comprise 10% to 30% of a paediatrician's practice. When these children and adolescents first approach their doctors (if they even seek medical help), their mental health problems are usually in the early stages of development and often present covertly as unexplained medical symptoms, school or social avoidance, and noncompliance with medical treatments. It is in the paediatrician's office that relationships between the parent (generally the mother) and the youth can be observed in evolution. Parents and paediatricians have the opportunity to discuss the impact of healthy attachment in mental health development. The paediatrician observes the coping strategies of the youth and family as they face the challenges associated with growth and development (eg, starting school, adolescence, family stress and death), and is in the front line to identify affective and anxiety disorders, attention deficit/hyperactivity disorder and learning disabilities. Paediatricians are the first, and often, the only clinicians to see young people and their families in crisis in the emergency department, and are often required to admit patients to paediatrics under the Mental Health Act (10). Thus, paediatricians play a key role in both primary and secondary prevention. For example, the mental health consequences for youth of parents affected by their own mental health disorders, substance abuse or marital strife are well-known.

In young people with chronic unexplained medical symptoms in which significant organic pathology has been ruled out, families often continue to attribute the symptoms (usually pain) entirely to an organic cause despite the lack of an identified pathology or clinical findings. They frequently resist suggestions that psychosocial factors may play a role in the development or perpetuation of the symptoms (10,14). Consequently, such patients develop a pattern of help-seeking behaviour involving multiple diagnostic investigations, repeated emergency department visits, hospital admissions and prolonged hospital stays. Specialists in gastroenterology, rheumatology, endocrinology and neurology are frequently consulted in an effort to find both explanations and symptom relief (15).

Chronic illnesses are associated with an increased risk of internalizing problems (anxiety, depression and social withdrawal) and externalizing symptoms related to behaviour. These psychosocial factors have a major impact on outcome

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(16,17). Mental health distress has also been associated with increased health care costs, contributing to repeat visits to emergency departments and physicians' offices and to prolonged inpatient medical stays (18). Although young people with chronic illness account for a large part of the work of paediatricians, psychosocial issues are not always adequately treated (19). Paediatricians are in a good position to identify major mental health disorders early and provide appropriate care for young people and their families. However, they receive little training in the psychosocial issues related to these conditions, because medical schools and postgraduate education do not emphasize the study of mental health disorders in paediatric training. In addition, the importance of this type of care is not reflected in the remuneration for the time required to provide it.

A promising approach to introducing paediatricians to psychiatric methods is a mental health consultation and educational clinic for paediatricians and their child and adolescent patients, held at the Department of Paediatrics, Soldiers' Memorial Hospital in Orillia, Ontario, for the past decade (20). One day a month, a child and adolescent psychiatrist provides consultation and teaching for up to four paediatricians per clinic day. Paediatricians interview their own patients while the psychiatrist and three other paediatricians sit behind a two-way mirror. Family and individual interview principles, diagnostic formulation and management strategies are then discussed by the whole group. The psychiatric consultation provides both a psychiatric opinion and an educational function for paediatricians working together. The paediatricians act as mental health consultants with support. This model of educational consultation could be applied to paediatricians who work in emergency departments, where young people often have access only to the attending physician or consulting paediatrician.

If we are to improve the accessibility of mental health professionals to treat serious mental health disorders, we must enhance support for paediatricians because they could continue to work with mental health issues with their patients and families. We might also try to raise the comfort level of adult psychiatrists in working with young people and their families. Although most serious mental health disorders begin in adolescence, psychiatry training tends to be divided into adult and youth programs. Educational programs need to put more emphasis on the teaching of mental disorders along a developmental spectrum, beginning in childhood or adolescence and continuing into adulthood. It is also important to emphasize the important role played by child and adolescent psychologists who have the training, expertise and credentials to diagnose and intervene in mental health problems. Many of the issues discussed in the present article can be applied to these mental health professionals. The opportunity for the early identification of mental health issues by teachers and the important role played by allied mental health professionals is underscored, and should be recognized if a truly comprehensive and collaborative approach is to be provided for mental health services for young people and their families.

In summary, in view of the well-known shortage of child and adolescent psychiatrists, services for young people with serious mental illnesses and their families need to be enhanced, in part by strengthening the role of Canada's 2300 practicing paediatricians (21). These front-line professionals have available to them a wealth of mental health resources for young people and their families but need more support in obtaining and applying them. Education in medical schools, and the use of education and/or consultation, and shared-care models in the offices of paediatricians can help reduce the waiting lists for child psychiatrists for young people. At the same time, child psychiatrists need to serve as resources for paediatricians by strengthening their role as educational consultants. This activity should form a major part of the training of all child and adolescent psychiatrists, and could be built into the training programs for paediatricians.

Paediatricians can be valuable mental health consultants. We have an opportunity to support them by encouraging youth psychiatrists to act as educational and/or clinical consultants and increase the remuneration for paediatricians who provide this service. Perhaps a working group with members from the federal and provincial ministries of health, the Canadian Paediatric Society and the Academy of Child Psychiatry could provide a framework to clearly articulate this clinical issue. The next step would be to develop an infrastructure that would enhance the skill and role of child psychiatrists as educational and/or clinical consultants, and the ability of paediatricians to respond to the mental health needs of young people and their families.

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