

# ACCESS TO MEDICAL AND PSYCHIATRIC CARE FOR THE ADOLESCENT POPULATION

---

## INTRODUCTION

---

In October 1997, the Bureau of the Collège des médecins du Québec received the report entitled *Accessibilité aux soins psychiatriques et aux services en santé mentale* prepared by a working group of psychiatrists and family physicians from Québec.

This report addresses specific problems with respect to services provided for youth, adolescents in particular. "As regards the professional practice of family physicians and the many other professionals working in the social services network, there seems to be some difficulty in detecting mental illnesses before a deterioration occurs. This is the case with masked depression disguising itself as what is presumed to be an adolescent crisis, which all too often results in suicide at home or in a rehabilitation centre, whether the youth is under the *prise-en-charge* of youth protection services or not. This situation could get even worse if the reaction of professionals is to guard against the intrusion of others into their area of competence, preventing the exchange of information necessary to determine whether the problem is a medical one or simply one of maladjustment."

Once this problem was identified, the Bureau of the Collège ratified the following recommendation:

"That vis-à-vis adolescents:

- the "proposed" regional departments of psychiatry ensure rapid consultation for adolescents in a crisis situation, whether they live with their family or in a foster care setting, and establish functional ties with the network of reception centres and the Department of Youth Protection (DYP);
- the Collège, in concert with representatives of youth centres and of the DYP, initiate discussions aimed at ensuring that the interventions of professionals vis-à-vis adolescents are better interlinked, with a view to defining the conditions conducive to recognizing behaviour problems suggestive of mental illness and identifying standard criteria for diagnosis and treatment;
- the problem of suicide be studied in concerted fashion so that physicians are better able to detect risk cases."



Parallel to the work of the Collège des médecins, and to other work now in progress at the Commission des droits de la personne et des droits de la jeunesse (CDPDJ), the Ombudsperson, also concerned about the situation whereby adolescents who are in the care of youth centres are suffering from problems of mental illness, created a working group composed of representatives of the medical profession appointed by the Collège des médecins, and representatives of the youth centres appointed by the Association des centres jeunesse du Québec. Its long-awaited report will formulate recommendations focussed mainly on the services to be offered to adolescents who frequent the youth centre network.

The four physicians who are members of this working group—two child psychiatrists and two family physicians involved in the care of young people—wanted their work to be in keeping with the work of the Collège and used the favourable climate to call on their professional order. While they consider it important to better organize services for all children and adolescents with mental health problems, the members chose to give priority to the need for adolescent services, thinking that it would have a positive ripple effect on all young people. They particularly wanted to convey their thinking on the adolescent population's need for medical and psychiatric services and to propose concrete recommendations to the Collège with a view to improving the accessibility and quality of such services. They met at the Collège des médecins du Québec on May 20 and October 9, 1998, and on February 3, 1999, and developed the following proposals, which were adopted at the meeting of the Bureau of the Collège on February 26, 1999.

---

***THE POSITION OF THE COLLÈGE DES MÉDECINS DU QUÉBEC  
ON ACCESS TO MEDICAL AND PSYCHIATRIC CARE  
FOR THE ADOLESCENT POPULATION***

---

- Given that some adolescents are presenting with mental illness and behaviour problems which are significant, prevalent, complex, atypical, and which stem from medical as well as social, familial and environmental factors;
  - Given that suicide (attempts, suicidal thoughts or successful suicide) is merely an indicator of these mental illnesses which attest to the significant malaise experienced by this population;
  - Given that, according to recent studies, 80 per cent of successful suicides are related to a mental illness;
  - Given that medical and social work professionals have a shared responsibility in terms of the detection, identification, treatment, follow-up and management of young people in difficulty;
- The Collège des médecins deems it important to promote the organization of medical services in mental health which adequately meet the needs of adolescents.**

---

## ***RECOMMENDATIONS ON MEDICAL SERVICES IN GENERAL***

---

**With respect to front-line medical services, it is recommended:**

1. That physicians working in front-line care, as well as in private practice and CLSCs, be made aware of :
  - the different presentations of adolescent psychopathology, including suicide;
  - the Youth Protection Act;
  - the accountability of family physicians in the continuity of care;
  - the role of family physicians vis-à-vis the parents as well as the adolescents themselves.

This training should be part of the educational programs in faculties of medicine, as well as of continuing medical education programs in Québec establishments.

2. That future regional departments of general medicine consider care given to adolescents as a priority, that they make this care available and accessible, and that this population be considered a target group; that they consult with colleagues in departments of pediatrics and child psychiatry and with the youth teams in CLSCs and social workers in youth centres for the purpose of organizing complete evaluation services.

3. That family physicians with child and adolescent patient populations, as well as pediatricians, be able to diagnose mental health problems according to the DSM-IV, to evaluate their social, family and environmental components, to institute the appropriate treatment, including its pharmacological component, and to decide on the advisability of consulting a psychiatrist.
4. That the family physician and pediatrician be able to provide follow-up care to these adolescents (pharmacological, psychotherapeutic and family approaches) as long as they are connected to and supported by a mental health team composed notably of child psychiatrists, psychologists and social workers.
5. That nurses be integrated into front-line services to foster collaboration between the physician, the patient, the family and the mental health team.

**With respect to secondary medical services, it is recommended:**

1. That family physicians with acquired specific expertise in the field of adolescent health be appointed to each regional department of general medicine to serve as a resource to all family physicians in the region and sub-region.

2. That these appointed physicians, as well as the pediatricians in the region, be associated with the youth teams and mental health teams in hospitals and CLSCs, and that they forge close links with child psychiatrists and social workers.
  3. That these physicians be available, first, to their colleagues who are family physicians in front-line care dealing with adolescents in difficulty, and that they be responsible for completing an assessment, making a diagnosis, instituting treatment and the appropriate follow-up, and consulting a child psychiatrist, if necessary, or any other appropriate resource.
  4. That these family physicians providing secondary care and these pediatricians serve as resources in crisis situations, evaluating the most acute and most serious problems of adolescents attending school, and including the parents in the process.
  5. That all psychiatrists be more sensitized to the mental health problems of adolescents and that education programs lay emphasis on:
    - the effects of a parent's mental illness on the adolescent, and the effects of an adolescent's mental illness on his parents, family circle and school milieu;
    - maintaining the competence of the physician working in child and adolescent psychiatry;
    - the Youth Protection Act.
  6. That all psychiatrists assume certain responsibilities vis-à-vis the adolescent population, in particular when on-call for psychiatry in the emergency room.
- With respect to tertiary medical services, it is recommended:**
1. That the need for child psychiatrists be taken into consideration when planning medical manpower needs and that their distribution throughout the regions be improved.
  2. That a directory of available child psychiatrists be compiled to ensure consultation services in all regions of Québec.
  3. That child psychiatrists give priority to consultations with adolescents referred to them in emergency rooms, and provide back-up support for primary and secondary care physicians, be they family physicians or pediatricians.
  4. That child psychiatrists take the initiative to plan and organize educational activities for physicians working in primary and secondary care in their area, and take part in them.
  5. That child psychiatrists see to it that primary and secondary care physicians can count on the availability of mental health teams (psychologists, social workers and others).
  6. That child psychiatrists take part in planning and programming activities concerning problems of adolescent mental health in their area.

7. That child psychiatrists ensure the management of the waiting list in pediatric psychiatry by adopting standards recognized by all (e.g.: codes 1, 2, 3).
8. That, given their responsibility as the attending physician of patients registered and admitted under their care, child psychiatrists assume responsibility for the psychiatric treatment plan of these patients, while taking part in the clinical work of the multidisciplinary team.
9. That child psychiatrists encourage patient follow-up by the most appropriate professional and that, in this sense, they favour the return of patients to the front-line physician.
10. That child psychiatrists in a given region form a group within a regional or sub-regional department of psychiatry, so as to ensure that clinical activities are coherent and the tasks shared equitably.

---

### ***RECOMMENDATIONS ON MEDICAL SERVICES IN YOUTH CENTRES***

---

The particular problem of adolescents under the *prise-en-charge* of the youth centres network must receive special attention:

- Given that the Act respecting health services and social services requires that personalized medical services be offered to all patients who require them, regardless of the milieu in which they live;
- Given that a large proportion of the youth in the *prise-en-charge* of youth centres suffer from mental illness such as those listed in the classification of mental illnesses (DSM-IV and CMI 10) and that this patient population is entitled to medical services, as indeed the Youth Protection Act stipulates;
- Given that the most vulnerable among this patient population do not have access to medical services when their state of health requires them;
- Given that this is a public health problem, since the most vulnerable segment of this population does not have access to medical services when its state of health requires them;
- Given that any delay in making a diagnosis and giving the medical care required may aggravate the morbidity and mortality of this patient population, and that this constitutes an urgent situation;
- Given that the responsibility to make available the appropriate medical services belongs to the youth centres, which must come to an agreement with the medical milieus on the best way to provide these services;
- Given that, under the Medical Act and its Regulations, the physician is responsible for making a diagnosis, eliminating illness and determining the medical care required;

- Given that under the Youth Protection Act, the DYP must act if the security and development of the child is considered to be in danger, notably due to the lack of appropriate care (subsection *b* of section 38);
  - Given that, in so doing, the DYP must assess the child's situation (section 49) and that a significant part of this evaluation may concern the practice of medicine or one of its disciplines;
  - Given that the DYP may use urgent measures (subsection *b* of section 46 and section 48.1) or an order of the tribunal to entrust the child to the care of a hospital for temporary foster care (section 62);
  - Given that a problem exists with respect to the recognition of mental illness as listed in the classifications of mental illnesses by certain professionals in youth centres, who sometimes tend to underestimate, even deny, the medical component of problems with which they are faced;
  - Given that the interventions of the DYP and physician must respect the Medical Act and the Youth Protection Act and be performed for the greatest possible good of adolescents suffering from mental health problems;
1. That medical services be organized and made available to adolescents who are in the *prise-en-charge* of youth centres, and that the parameters of these services be defined by physicians in collaboration with social workers and psychologists, and that these services respond to mental health problems as well as physical health problems.
  2. That medical services in youth centres be organized on a regional and sub-regional basis:
    - the youth centres shall call upon the regional department of general medicine, or its sub-regional constituent, and the pediatricians practising in the same territory, so as to identify the competent physicians interested in providing these medical services;
    - these physicians shall be responsible for ensuring that adolescents receive all the medical services they require for their mental as well as physical health;
    - these medical services will take the form of medical consultation and follow-up, with or without an appointment, and be offered at the rehabilitation centre, a youth centre's local service point, a CLSC or physician's office, following an agreement with the physicians concerned and the regional department of general medicine.

**The Collège proposes that the organization of medical and psychiatric services for the patient populations specifically served by youth centres be based on the following statements:**

The presence and intervention of nurses, facilitating the liaison between professionals and the continuity of care, are seen as indispensable to the proper functioning of these clinical services.

3. That all children and adolescents reported to have behaviour problems and who are in the *prise-en-charge* of rehabilitation centres undergo systematic screening and, according to need, medical assessment and follow-up.
 

To this end:

  - physicians should establish, in collaboration with social workers, psychologists and nurses, screening protocols for adolescents at risk, specifically evaluating those at risk for suicide; special attention must be paid to adolescents whose behaviour is described as “bizarre”, to adolescents who present significant changes in behaviour, and to adolescents whose parents have psychiatric illnesses;
  - physicians should promptly assess adolescents who are screened, deemed to be at risk, and referred to them, so as to make a diagnosis and prescribe the appropriate medical treatment;
  - it is important that the physician have on hand a report from the social worker on the behaviour of the adolescent who requires an assessment. Depending on circumstances, the report will be more or less detailed. The youth’s complete psychosocial record should be made available to the physician, on request, and the professionals involved should take part in the evaluation and promote the family’s participation;
  - it is also important that the physician who made the assessment convey to the professional responsible for the adolescent all the information needed for the treatment and follow-up of the health problems identified;
  - it is essential to ensure, when it is necessary, medical treatment (pharmacotherapy-psychotherapy) for these patients during their stay in the rehabilitation centre and in the context of outpatient follow-up care. In this capacity, the physician must be fully involved with the youth teams (in the rehabilitation centres and in the outpatient setting) in the development of service plans and in the adolescents’ follow-up care;
  - it is important to recognize that psychiatric consultation, transfer or hospitalization in psychiatry is first and foremost a medical decision. The youth centre intervention protocols for preventing suicide must be revised so as to include medical evaluation and follow-up.
4. That child psychiatric consultation services be made available and accessible, first, to secondary care physicians who practise in youth centres and/or rehabilitation centres:
  - the organization of these consultation services should be the responsibility of the regional and sub-regional departments of psychiatry or, if child psychiatric resources are lacking, made available through agreements with other departments;



- child psychiatrists must be involved in decisions concerning interventions and service plans proposed by social workers. This could be accomplished through back-up support given to secondary care physicians working in youth centres and/or rehabilitation centres;
  - when his expertise is required, the child psychiatrist shall act as attending physician to certain adolescents who are in the care of youth centres or rehabilitation centres, at the request of the secondary care physician. In regions where there is a shortage of child psychiatrists, ways and means must be found to provide access to consultation services, either by adding resources or by using communication modes such as telemedicine.
5. That periodic multidisciplinary activities be organized to present, discuss and assess complex cases, examples representing priority problems (such as suicide), or cases chosen at random:
    - physicians, child psychiatrists, social workers and psychologists should take part in this type of activity;
    - in regions where child psychiatric resources are in short supply, modes of communication such as telemedicine should be envisaged.
  6. That expert assessment services required by the youth tribunal be considered as distinct from medical and psychiatric services, to the extent that, barring exceptions, these expert assessments are not performed by the physician responsible for the clinical evaluation and medical follow-up of an adolescent.
  7. That the implementation of the proposed youth centre services model be a priority for the Ministry, regional boards and medical federations.
  8. That the Practice Enhancement Division of the Collège set up means of offering practising physicians a customized continuing medical education program on the screening, diagnosis and medical management of adolescent psychiatric problems.

To summarize, the Collège realizes that the organization of medical and psychiatric services for adolescents in difficulty represents a major challenge for the medical community as well as the youth centres.

---

## ***THE ORGANIZATION OF MEDICAL SERVICES MODEL: AN IMPLEMENTATION STRATEGY***

---

Given the magnitude of the suicide problem in all regions of Québec, the Collège suggests that adolescents identified by youth centres as being at risk for suicide be given the appropriate medical services as a matter of priority, according to the model recommended in this position paper.

Furthermore, with a view to generalizing this service model, it is suggested that pilot projects be set up in the regions of Québec, projects that would implement, evaluate and adapt the proposed model. These projects should ensure the establishment of medical and psychiatric services required by all adolescents, including those under the care of the youth protection system.

These projects should undergo systematic and rigorous evaluation so as to ensure access to medical and psychiatric services for this patient population.

The prevalence of mental illness in adolescents, the identification of these problems within a polymorphous population, the accessibility of services, the relevance, effectiveness and efficiency of interventions, both medical and behavioural, are all questions to which prompt answers must be found.

These pilot projects should be founded on collaboration between professionals in the medical field (mental health, epidemiology, pharmacology, etc.), the psychosocial field (psychology, rehabilitation, social work, criminology, etc.), and in the evaluative research field. Organizations funding research should indeed make it a priority to evaluate such projects.

Systematic mechanisms for analysing the problem of high suicide rates must also be implemented, and a multidisciplinary approach used to conduct a “psychiatric autopsy” on all cases of successful suicide, so as to improve measures to prevent suicide among adolescents.

Finally, medical professionals and social workers will have to work together to create and evaluate screening protocols for detecting mental illness and suicide risk, and then to intervene appropriately according to the level of expertise and responsibilities of each, so that parents, school professionals, “sentinel groups”, social workers and physicians are supplied with the tools they need to play a preventive role with adolescents.

---

## CONCLUSION

---

Creating this medical services model will enable us in the short term to:

- provide adolescents with the medical resources to address their mental as well as physical health problems;
- break down barriers between medical professionals and professionals in the social field;
- encourage family physicians and pediatricians to become involved in the mental health of adolescents;
- make the best possible use of the child psychiatrist's competence;
- develop a healthy spirit of collaboration between physicians and social workers.

In the medium term, this services model will help to decrease the incidence of suicide as well as the morbidity and mortality related to mental illness in adolescents, by giving physicians and social workers the tools they need to work together more effectively with this population at risk.

Finally, the Bureau of the Collège will give these recommendations all the attention they call for and will take the necessary steps vis-à-vis its members and partners to ensure the prompt establishment of quality medical services for Québec adolescents grappling with mental health problems.

The Collège also hopes that the working group set up by the Ombudsperson will pursue its work and take into account the proposed model set out in its recommendations.

In conclusion, the Bureau of the Collège wishes to thank the members of the working sub-group who helped to prepare this position paper. They are Doctors:

- Claude Marquette, child psychiatrist  
Hôpital Sainte-Justine, Montréal
- Johanne Piché, child psychiatrist  
CHSLD, Centre-de-la-Mauricie,  
Shawinigan
- Lambert Farand, family physician,  
Pavillon Albert-Prévost, Montréal
- Danielle Blais, family physician,  
Centre de santé intégrale, Cookshire
- Joëlle Lescop, Secretary General,  
Collège des Médecins du Québec

---

*Published by the*  
**Collège des médecins du Québec**  
Public Affairs and Communications Department  
2170 René-Lévesque Blvd. West  
Montréal, Québec H3H 2T8  
Telephone: (514) 933-4441  
Or 1 888 MÉDECIN  
Fax: (514) 933-3112  
Internet address: <http://www.cmq.org>  
E-mail address: [info@cmq.org](mailto:info@cmq.org)

Author: Executive Office

Translation: Bernadette Griffin-Donovan  
Revision of terminology: Ruth Claire Russell, MD

Reproduction authorized with mention of the source.

Note: The masculine is used in this publication  
without prejudice for the sake of conciseness.

*Une version française est disponible.*