

An Allied Mental Health Aide Memoire to Disposition of Minors, Following Presentation to Emergency Department with Mental Health Difficulties

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Abstract Assessing and managing mental health issues in minors in the emergency department (ED) can be different from the management of adults. This may cause confusion to newly recruited staff in an ED. This paper aims to give a broad overview of some of the Commonwealth-based legal concepts which apply to minors with reference to basic medical standards such as good medical practice. Practice points are emphasised that apply to the management of minors which applies to many jurisdictions. The aim is to give personnel commencing in ED a simplified but comprehensive overview. For out-of-hours a template and aide memoire, up to date in early 2015, is given on how to clarify and streamline reflection on client management, disposition and reduce potential confusion about the diverse legal frameworks that pertain to mental health care of minors.

Keywords Emergency Department, Legal Frameworks, Child Assessment, Minors, Mental Health, Out of Hours, Patient Management, Patient Flow

1. Introduction

Personnel in ED may feel overwhelmed when facing a minor in crisis, particularly as this frequently occurs out of hours. (1) The author works on call at ED, and he knows that there is evidence that junior staff are at greater risk of suffering from stress than senior staff. (2) Mental health training in many countries may appropriately commence with a focus on adult mental health issues, but specific training in child and adolescent mental health where available may not occur until later stages of training (3). Concepts which apply to adult mental health cannot always translate to children and adolescents, and the novice to the field is likely to not infrequently struggle when attempting to apply these concepts to the younger population. Thinking from the start about where a patient will “go to” helps to

focus the mind in a crisis, hence disposition is the “golden threat” in this article.

2. Methodology

This is an empirical article based on the author’s experience as supervisee and supervisor. The author is not aware of an aide memoire, such as the one presented here, that has been published internationally before. The author worked in several jurisdictions namely in the British Isles and Australia. This article is based on working as a psychiatrist for two decades. During that time the author feels he has gained an overview on certain aspects relating to his work including ED. Common themes with respect to use of legal frameworks, patient flow and disposition from ED have emerged in the author’s mind. A summary of such themes is shared aimed at the novice working in ED. The reason for selection of this topic submitted to this journal is that sometimes a mental health presentation may have for a novice a severe and intimidating behavioral element. However such a behavioral presentation may not necessarily have a mental illness component that can be managed by the mental health team. Hence disposition is of such importance. The author deems that once a novice is aware of what the management involves, seeing severely disturbed clients in an emergency context with exit strategies in place as outlined below, will be less stress provoking and may prevent burnout. This article is also aimed to assist discussion between supervisor and supervisee.

3. Literature Review

Repeated searches ending the year 2014 on the databases Pubmed, Ovid and Google Scholar does not yield a paper that addresses the complexities of the application of legal frameworks pertaining to minors and mental health in ED in a broader global context and that also reduces the

complexities to a “hands-on” overview.

London’s Royal College of Psychiatry’s “Advances in Psychiatry Treatment” frequently contains pertinent articles that address some of these issues. For instance, Shaw (4) provides a comprehensive overview of the legal aspects in the United Kingdom on treating minors. Bradley & Lofchy (5) give an overview of patients with learning disability presenting to the ED. Both papers are recommended for in-depth reading as they provide useful advice; however do not explicitly highlight selected points on assessment and management as this article purports to do.

4. Typical Clinical Scenario at ED

A minor presenting in crisis out of hours to the Emergency Department is a familiar and sometimes anxiety-provoking

scenario for personnel. The typical pathway from presentation to disposition is outlined in figure 1. The pathway is:

Crisis – Assessment at ED– Disposition

Problems not infrequently arise in the latter two stages of the sequence. The issue of obtaining “consent” in the assessment stage is a common query, and this is usually related to whether to seek consent, how to seek consent, and when consent must be obtained. The next difficulty is often encountered when considering options for follow-up if admission is not indicated (“disposition to”). This article addresses these queries, builds on the existing papers in the field, but does not repeat aspects that are not relevant to the conundrums regarding both legal aspects to assessment in ED and disposition from ED after assessment.

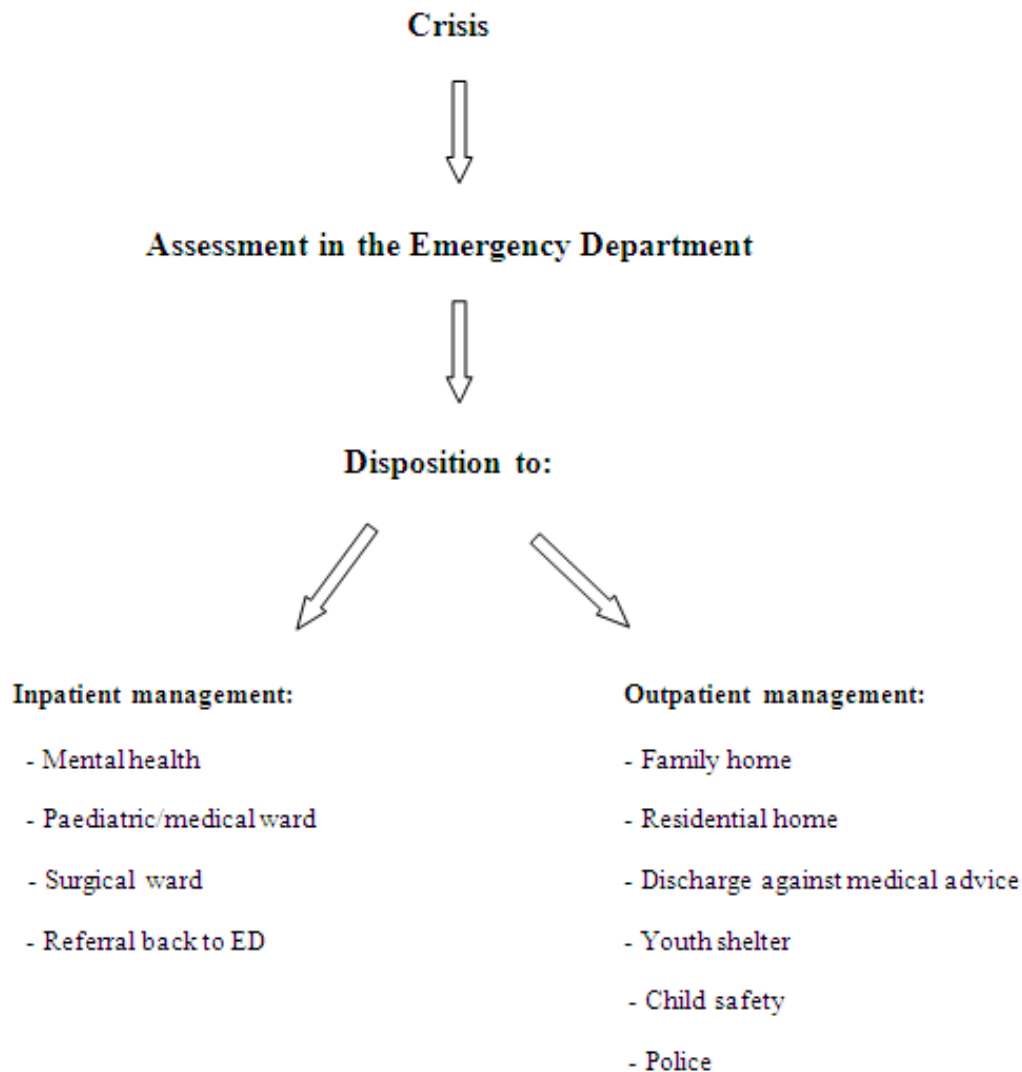


Figure 1. Flowchart: An allied mental health guide to disposition of minors, following presentation to emergency department with mental health difficulties

5. Legal Aspects to Assessment in ED

5.1. Consent and Competency Issues

Shaw (4) explains how the law is biased toward a minor consenting, compared to refusing medical treatment. Although there are many legal frameworks which endorse a competent minor consenting, there are far fewer options for a competent minor to refuse medical treatment. In order to ascertain whether a minor is competent and can legally provide consent, the minor must fulfil the formal competency criteria. This can be tested by establishing whether a minor can retain information, outweigh advantages and disadvantages of a decision, make the decision without undue influence and communicate the decision.

In many parts of the developed world adolescents between the ages of 16 and 18 are deemed capable of providing voluntary consent, although it is not possible to set a definitive age at which all children become competent to make decisions. It is also important to remember that an individual's competency to make a decision depends on the complexity of the decision and its consequences. This is reflected in the English Court's *Gillick v West Norfolk and Wisbech AHA* (6) and Australia Court's *Department of Health and Community Services (NT) v JWB ('Re Marion')* (7). These cases also include reflections on the competence of 'mature minors' to make their own decisions about medical treatments. (8)

5.1.2. The incompetent minor – defined as the minor who does not have the legal right to decide on their medical management

For a minor who is not competent and/or is too young developmentally, a guardian must be available to speak to or, preferably, be present in person (9). All reasonable steps must be taken to include the guardian in the decision-making process. If there is no guardian available, this becomes a child protection issue (10). In the interim, if no guardian is available, the treating team is responsible for the welfare of the incompetent minor (11). Clinicians have a duty of care to treat emergencies even in the absence of a guardian (12). However, once an emergency situation has been addressed, further non-emergency management can only be planned with the responsible guardian or their representative (8).

5.1.2.1. Role of the responsible adult: Custody versus Guardianship

Where children have been removed from their biological or adoptive parents, because grave things happened to the child that push state authorities to remove a child from the care of their parents, the state authority (hereafter called "Child Safety"), take over the role of the guardian or custodian. If Child Safety is the guardian they have responsibility to make all decisions for a child; if they are custodian then they have responsibility for decisions as to where the child resides, whilst all other decision such as

medical care continue to be made by the parents or where applicable appointed guardian.

In some cases where the guardian is a representative from Child Safety and may not be immediately available after-hours, liaison with the after-hours emergency Child Safety team regarding urgent consent issues may be indicated if the nominated regular contact at Child Safety is not contactable.

Where Child Safety has custody (13), guardianship is with a responsible adult (e.g. minor's biological parents). In this situation, Child Safety has decision-making powers for placement only, hence the power to make medical decisions lies with the guardian. Liaison with Child Safety may assist in obtaining guardian contact details, but only the guardian and not custodian can give legal consent for anything beyond placement issues.

5.1.2.2. The adult who attends with a minor is not always the person who has decision making power

It cannot always be assumed that the adult who attends with a minor is a responsible adult. A minor living in supported residential placement may present with an adult who is a paid carer (14). This person may not even be the best informant, for example if this is a new carer or there was a shift change just prior to presentation. This person is unlikely to have legal powers to act as the guardian. Medical decisions will still have to be discussed with the guardian or a responsible representative thereof.

5.2. The Competent Minor – defined as the minor who does have the legal right to decide on their medical management

5.2.1. Guardianship tribunal - different to guardianship

Some jurisdictions have emergency provision where a Doctor can apply for a legally binding order if there is a guardian who does not consent to treatment on behalf of a minor, but there is grave medical reason to treat a minor. This medical reason to treat will not be life-threatening immediately hence duty of care does not apply and there is time to go through the process of applying for such a guardianship order (9). Such a court process is often referred to as a Guardianship Tribunal.

In practice the Guardianship Tribunal may have a role when it comes to disputes between doctors and guardian. The doctor or legal representative of the medical team applies to the courts. However this process is rarely applicable to decision making in after-hours situations, as other legal frameworks (Mental Health Act, Children's Act) often take precedence.

5.2.2 .Mental Health Act

Mental Health Act criteria vary throughout the diverse jurisdictions. Generally however overarching principles apply: if a minor needs admission but does not consent to admission (nor the legally responsible adult), the minor does not have capacity to make decision, suffers from a mental

health disorder, is at risk and there is no less restrictive alternative to admission (15), then the mental health act may be the legal framework to keep a minor safe at hospital.

5.2.3. The competent minor refusing treatment

A minor up to age 18 who refuses treatment can possibly be treated against the minor's decision. The guardian may override the refusal and the minor can be treated with guardian permission (4).

5.2.4. Child protection

Specific child protection legal framework applies when an informant, collateral or the minor shares details of abuse (physical, emotional, or sexual nature or neglect) (10). If a minor confides such details, the child safety investigative team needs to be called as a priority. This team then takes the necessary steps to establish any evidence of harm (16) and keep the minor safe. It is important for the clinician at interview to focus on mental health issues and not to interfere with any child protection issues by asking potentially leading questions about the abuse (17). Any information elicited by the clinician with respect to abuse must be documented accurately. If the minor is to be discharged from the ED, the safe discharge destination will be organised by Child Safety.

5.2.5. Police matters

A minor who does not have a mental health disorder but acts dangerously by putting others (or depending circumstances him/herself) at risk is likely to require input under criminal law (18). Health personnel have a duty to keep others safe, including themselves, the patient, other patients and personnel. Where available security may be called, and if security requires further assistance police may also attend.

If there is homicidal ideation, and details of the proposed victim have been provided, confidentiality may well have to be breached and police and potential victim informed. Whilst in some jurisdictions a Privacy Act (7) applies, such legal framework does not apply in all nations, states and territories. If a minor has access to guns or other weapons and discloses plans to use them, depending the law applicable in that jurisdiction, police and/or gun licensing authorities may need to be informed (19). The police may arrange for the weapons to be collected.

5.2.6. Good medical practice -Duty of Care

Health professionals have to act in the best interest of a patient, whatever the age, to protect their well-being if there is an immediate risk to life and a delay for any reason (e.g. seeking consent) would jeopardise life (18).

5.3. Summary to Legal Aspects to Assessment in ED

Issues surrounding consent, who can give consent, what are the criteria that the person who gives consent has to fulfil, how may a minor refuse consent, what legal frameworks apply, how can refusal of consent be accepted and/or

overridden have been discussed. One single legal framework is unlikely to apply in solitude; it is more likely that several legal frameworks will apply together. There is reference to confidentiality and who has to be involved if it is regarding management of a minor. There is reference to when confidentiality needs to be breached.

6. Disposition from the Emergency Department

6.1. Only a Few Options for Disposition from ED

A novice to the work at ED may be at a loss in face of a young person's high expressed emotions and severe behaviours. A novice to the work at ED may find relief in knowing that following on from assessment indeed few immediate exit outcomes for disposition are available:

- Return to parents, guardian or with guardian consent the carers
- Referral to another discipline at the hospital
- Child Safety involvement regarding placement to keep a minor safe
- Police or other forensic service if crime is an issue
- Self-placement for the minor depending capacity of the minor
- Admission to a mental health ward in case of mental illness

6.2. Discharge from ED to a Guardian or Carer

The ED team needs to clarify the role of an adult present and whether they have guardian powers or not. If a carer is present in case of a minor who does not have competency then guardian approval must be sought (13).

6.3. Physical Health Issues and Disposition to a Non-mental Health Ward

Mental health assessment may yield so-far-not-identified important medical or surgical issues. Re-referral back to the medical team may be indicated. If admission to a medical or surgical ward ensues, the after-hours mental health team should inform the Consultation Liaison team so that mental health follow-up can be provided the next working day.

6.4. Child Safety and Emergency Placement

If case assessment reveals grave child harm and if immediacy criteria are met then Child Safety will be called upon. If child safety concerns have been confirmed then Child Safety will use emergency powers to immediately take over the guardian's responsibility (17). This implies that the minor does not return to their previous abode and, if applicable, an emergency placement will be arranged by Child Safety.

6.5. Police Matters and Incarceration

In case a severe crime like homicide is about to or has been committed confidentiality rules in the medical professional and patient relationship and contract do not apply and confidentiality must be breached (18). Once police are involved and physical health allows then the disposition is likely to the police or another government forensic executive service.

6.6. Self-discharge

A competent minor may be eligible for discharge or self-discharge against medical advice to, for example, a shelter (20). If indicated follow up may be with Youth Mental Health service or GP.

6.7. Disposition to a Mental Health Ward

A minor who has a mental illness and is eligible for admission may agree to hospital mental health in patient treatment. If a minor refuses admission and if mental health act criteria are fulfilled then the powers of the mental health act can be invoked and the client can be admitted against their will. Even if a minor leaves the ED despite being detained under the Mental Health Act (15), the minor may be brought back to hospital using an Act's powers. Such a decision depends on the best interests of the minor and is dictated by local legal frameworks.

7. Limitations

This article offers an overview of the legal aspects and patient dispositions after assessment of minors as may be somewhat standard in Britain and Australia. No attempt is made to give justice to the idiosyncrasies of the multiple legal frameworks in the United Kingdom, the Australian States and Territories, New Zealand or any other English-speaking countries. Hence the terms Child Safety, the courts, Mental Health Act, and Children's act are used as umbrella terms. Moreover any legal frameworks are at the author's discretion subjectively digested for an easier reference that should allow the reader to develop an overview that may assist when working in the ED. The author takes no responsibility in a medico-legal context and denies any liability for the contents of this paper. This paper has not been reviewed by a legal expert. Reference to specific legal issues and the law at the location where the reader practices is required.

8. Conclusions

In addition to a standard mental health assessment a mental health clinician assessing a child out of hours may wish to consider custody and guardianship, competency of the minor, and take developmental stage and child safety

issues of the minor into consideration. With respect to management, the clinician may wish to consider which route of disposition from the ED is best. The salient question is to ask whether hospital admission has a role. If admission were needed several options should be considered i.e. mental health, medical, surgical team or referral back to ED. In case the hospital has no role then out of hospital services will have to be taken into consideration i.e. family, youth shelter, police, child safety, residential home or even discharge against medical advice. It is unlikely that only one single option or one single legal framework only will need to be considered. Likely several agencies and legal frameworks will need to be drawn upon. This article raises awareness of the main 10 options for disposition from ED and gives a template aide memoire to assist with assessment and management of the child or adolescent presenting with mental health concerns out of hours to the ED. The author deems that a novice new to work with youth in crisis presenting to ED, if aware of those 10 options for disposition, is likely to feel more confident in light of high expressed emotion of a severely behaviorally disturbed youth.

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