Form 1 – A powerful and complex tool for managing mental health problems

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In Ontario, the process of involuntary admission to hospital is one of the most powerful tools available to physicians to safely manage serious mental health problems. This process is complex and is frequently minimally understood by clinicians in various settings.

As described in Smith et al's paper (pages 228-234), a Form 1 can be completed only by a physician based on assessment of risk that considers harm to self, harm to others or inability to care for self. These risk factors are presumed to be the result of a mental illness that directly impacts the patient's current mental state and behaviour. Form 1 completion indicates that all other reasonable options (other than hospitalization) have been considered.

Additionally, on the Form 1, physicians must select one of two components: "Box A – Serious Harm Test" or "Box B – Patients Who are Incapable of Consenting to Treatment and Meet Specified Criteria." Box A focuses on past, present and future risk of harm, while Box B considers the knowledge that a patient has an established mental disorder, has improved with treatment, and that without treatment they pose a serious risk to themselves or others and are rendered incapable of consenting to treatment. A person placed on a Form 1 under Box A is not considered a patient but rather a "detainee" under the Mental Health Act of Ontario, and the Form 1 authorizes apprehension and detainment only. A person on a Form 1 can still refuse treatment (with the exception of emergencies or life-threatening circumstances) and refuse to participate in an assessment, although if admitted under "Box B" they are considered incapable to consent to treatment. After the 72 h period of detainment and observation, a physician (other than the one who completed the Form 1) must reassess the person and determine the need for further certification on a Form 3. If not certifiable, the person must be informed and if he/she is thought to be capable to consent to treatment under the Health Care Consent Act of Ontario's (HCCA) definition of capacity, be advised to stay voluntarily, discharged, or allowed to sign out of hospital against medical advice. If the person is thought to be a risk, a Form 3 must be completed and the patient informed. The patient must then receive rights advice and have the right to appeal the certification to a review board.

Parents or caregivers frequently present to hospital emergency rooms requesting admission for their behaviourally disturbed child or youth. Often the problems are part of an underlying mental illness, in which case the Form 1 can be used. Sometimes, however, the behavioural disturbance is the result of an acute situational crisis, which may not be related to underlying mental health issues. Physicians may be pressured to admit the child. If the child does not fulfill Form 1 criteria, it is important that the physician determine the capacity to consent to treatment of the child or youth before the decision to admit. In Ontario, there is no age of consent for medical treatment (including admission to hospital). If the child or youth is capable under the HCCA, they have the right to consent to or refuse the admission. A child or youth can only be admitted against his/her will (regardless of age or the wishes of the parents or guardians) if he/she is deemed incapable to make treatment decisions. This means the child fundamentally does not understand the treatment or intervention recommended and does not understand the implications of accepting or refusing treatment. If so, the person must be declared incapable to consent to treatment. Under the HCCA, incapable patients must be assigned a substitute decision maker (SDM) to act on the patient's behalf and make decisions regarding admission. The HCCA has guidelines for the assignment of a SDM and provides for the patient to have input into the assignment, including the right to appeal the assignment. Furthermore, the HCCA deems that patients between the ages of 12 and 15 years admitted with a psychiatric diagnosis via an SDM must be informed of their incapacity (via a Form 27) and will receive rights advice, including the right to appeal the finding of incapacity. It is not clear whether these intricacies in the application of the Form 1 were a factor in the "worrisome trend" reported by Smith et al.

Issues influencing a decision to use a Form 1 are multifaceted and frequently not necessarily related to the patient's diagnosis. Risk factors around the issues of suicide, harm to others, self-harm and self-care are paramount. For

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these issues, the severity and intensity of thoughts, formulation of plans, access to lethal means, level and competency of supervision and willingness to contract for safety are important variables for consideration. The patient's support system plays a crucial role and the absence or withdrawal of support may be a deciding factor in admission independent of the diagnosis. Many group homes, for example, have policies regarding suicidal ideation and will refuse to take the child or adolescent back precipitating a systems crisis resulting in admission. Many hospitals in Ontario develop their own unique policies and procedures regarding persons placed on a Form 1. Sometimes the structure of the policy plays a factor – is a person on a Form 1 triaged directly to a psychiatrist? Does the responsibility of a person on a Form 1 rest with the emergency physician or with psychiatry? Are suicidal patients not on a Form 1 initially assessed by a crisis intervention worker or a psychiatrist? These may be deciding factors in admission, depending on the time and availability of staff.

In Smith et al's review, suicidal behaviour and behavioural disturbances accounted for approximately two-thirds of the forms reviewed. The multitude of variables previously outlined were not specifically addressed when they attempted to examine the trends observed.

Smith et al point to a variety of issues, which may be related to the increased use of a Form 1. Children's mental health services in Ontario are underfunded and under-resourced. Many programs and agencies funded by the Ontario Ministry of Community and Social Services addressing mental health needs have not received necessary funding increases to maintain their level of service in over a decade. Furthermore, we have seen significant reductions in school budgets for psychological and mental health support.

Access remains a serious problem. Demand far outstrips the resources available, resulting in long wait lists. Parents, community agencies and health care providers have limited skills in identifying symptomatic or high-risk patients, resulting in undetected cases. Children and youth themselves are reluctant to seek help. More kids report experiencing high levels of stress and suicidal ideation. The Ontario Health Study (1) reported that one in four children and adolescents in Ontario have a mental disorder, but only one in six receive any services for mental health problems. Davidson and Manion (2), reported that 51% of adolescents in their survey indicated feeling "really distressed" from once a month to "all the time". Almost 20% reported suicidal ideation, with one-fifth of that group indicating that they had made attempts. Only 29% would speak to a parent about their problems.

Families with children and youth in Canada face a number of difficult and complex issues such as growing substance use, financial stress, violence in the media, sexuality issues, abuse and trauma, and family mobility that can contribute to increased stress, isolation and limited support. Poverty for families and children remains a well-recognized risk factor for mental health problems.

These are some of a myriad of forces that help create vulnerable populations of children and youth who are more stressed, more isolated and less socially connected with fewer resources and supports. The end result is more children and their families going into crisis with increased severity, turning to the health system for support and crisis management. However, in spite of the above, the data in Smith et al's review of the use of the Form 1 point more to a single year aberration than a statistical trend.

If the findings of the Smith et al paper represent a trend, then what can be done to reverse it? Strengthening family support systems, improving psychosocial supports and interventions in schools and improving access to mental health resources in the community are essential. Raising the profile of mental health issues in this population may help reduce stigma.

Most seriously mentally ill patients require the long-term involvement of teams of providers. Increases in the numbers of allied mental health professionals (social workers, psychologists, occupational therapists, speech therapists, etc) to work with psychiatrists are also needed. These providers often deliver critical primary and ancillary care in the service of maintaining patients in the community and preventing crises resulting in presentations to emergency rooms.

More child and adolescent psychiatrists could be helpful, but more flexible models of remuneration and compensation need to be available to ensure attraction and retention of specialists in this area. The current fee-for-service model is procedure based and requires mostly direct clinical contact. Child psychiatrists, apart from providing direct services, can often be more useful by providing indirect services as consultants to community providers, schools, community agencies and mental health teams. These services are largely not covered in a fee-for-service approach. Alternate funding plans, as an example, offer remuneration for a variety of indirect interventions that can help support primary providers in their community.

However, child psychiatrists cannot meet the demand alone. Paediatric and family practice training programs need to partner more with psychiatrists and mental health programs to increase the exposure of residents and fellows to child and adolescent mental health problems so that their expertise in managing these common problems can improve, potentially reducing the numbers of referrals to the now familiar long waiting lists for specialized services. We need to create more opportunities for paediatricians in practice to be exposed to the assessment processes and interventions commonly employed by child psychiatrists so their comfort level in managing these often challenging cases in the emergency room or office can improve. Alternate funding plans and new technologies like Telehealth can improve access to mental health specialists for educational activities. Developing shared care models between paediatricians and child psychiatrists can also improve access and ensure better support for physicians in their primary care roles.

Finally, we need to see a greater commitment from government to address the needs of children and youth. Larger, more stable funding with appropriate increases over time is required to increase and maintain service levels in growing communities. The current and future services need much better coordination, cooperation and integration to address the gaps in service that presently exist, reduce duplication and improve access to services in rural areas. Only a coordinated effort of clinicians, community providers, government funders and families exploring creative and evidenced-based interventions can reduce the burden of mental health intervention on emergency services in community hospitals.

REFERENCES

1. Offord DR, Boyle MH, Fleming JE, Blum HM, Grant NI. Ontario Child Health Study. Summary of selected results. Can J Psychiatry 1989:34:483-91.
2. Davidson S, Manion IG. Facing the challenge: Mental health and illness in Canadian youth. Psychol Health Med 1996;1:41-56.

SECTION 43 UPDATE

Canadian Paediatric Society disappointed with Supreme Court decision

On Friday, January 30, the Supreme Court of Canada announced that it would not repeal Section 43 of the criminal code. The Canadian Paediatric Society (CPS) is disappointed by this decision not to revise Section 43 in the best interest of children and youth.

"It is not constitutional in Canada to use physical force on an adult but, apparently, it is constitutional to use force on a child. I find that surprising and disappointing based on our values as Canadians," said Dr Robin Walker, President-Elect of the Canadian Paediatric Society. "The Charter of Rights and Freedoms prohibits discrimination on the basis of age, but through Section 43, the court is supporting this type of discrimination by dismissing the application by the Canadian Foundation for Children, Youth and the Law to have the section amended."

Section 43 says that the use of force on a child by teachers and parents by way of correction may be justified if it does not exceed what is reasonable under the circumstances. However, in the CPS statement, "Effective Discipline for Children", the Society strongly discourages the use of physical punishment on children, including spanking. The CPS maintains that appropriate disciplinary techniques should be about teaching and guiding, not just forcing children to obey. The CPS recognizes that physical redirection or restraint to support time-out or to prevent a child from harming himself or others may be necessary, but advises that it should be done carefully and without violence.

The CPS will continue to examine the issue and to educate physicians and parents about effective discipline. For additional information or to see the CPS statement "Effective Discipline for Children", visit <www.cps.ca> or <www.caringforkids.cps.ca> / <www.soinsdenosenfants.cps.ca>.