When Truancy, Tenacity and Trauma Collide: A Child Psychiatrist's Approach to Navigating Autonomy with Adolescent Patients

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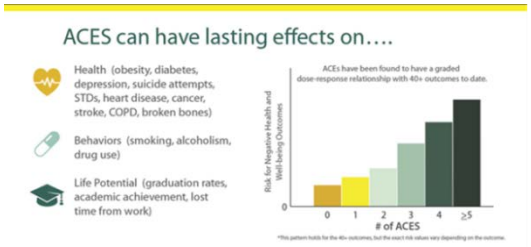
Learning Objective:

To explore the dynamic systems of care in place for a young minority male's strive for autonomy amidst increasing clinical concerns involving truancy, family court involvement, increasing substance usage and a complicated trauma history.

Independence and autonomy are at the epicenter of Adolescent years when individuals learn to create their own path and find their own voice. As clinicians assisting in this developmental process, we are often confronted with the need to protect their sense of identity and autonomy; yet simultaneously ensure safety and well-being.

In Pennsylvania, Act 147 of 2004 ("Act 147"), 35 P.S. §§ 10101.1-10101.2, addresses who can provide consent to voluntary mental health treatment for minors, and allows for someone 14 years of age or older to seek out and consent to their own mental health treatment. The ability to address one's mental healthcare needs and wellness is of vital importance. Consent within the various communities Child and Adolescent Psychiatrists serve has established guidelines clinician's must navigate and mandated stipulations one must follow to allow for true autonomy. In non-emergency situations, persons 14 years of age and greater with intact capacity in the state of Pennsylvania, have the ability to both consent and decline voluntary services.



Case Description:

15yo African-American male who presented to our local outpatient mental health clinic in December 2017 to resume services which included seeking a Comprehensive Psychiatric Evaluation, individual psychotherapy and psychopharmacological management. He was initially engaged in services at age 3 years while attending the affiliated therapeutic preschool. "Problematic behaviors" at age 3 included aggression, tantrums, speech delay, biting, defiance towards adults/authority figures, hyperactivity. He was diagnosed with ADHD, combined -type, ODD, R/o childhood onset conduct d/o, Lead poisoning. He was enrolled in a therapeutic preschool and received speech therapy.
Over the years, his family repeatedly presented desperate for assistance with his behavioral challenges. Including an arrest for assault at age 12, a suicide attempt, cruelty to animals, fire setting, substance abuse, academic decline and habitual truancy.

However, upon reaching the age to consent to mental health services, 14 years old in the state of Pennsylvania, he made the conscious, yet impulsive decision to discontinue outpatient therapy and psychotropic medications. With returning to the clinic in 2017, he was reluctant and ambivalent and no level or expertise of motivational interviewing skills appeared to excite an uninterested teenager. It was apparent from the initial interaction that this voluntary presentation to the clinic was encouraged rather than personally sought out by the patient. Much of the history was provided by guardian and infrequent head nods, shoulder shrugs, sighs and eye rolls did much of the "talking" for the teenager. It was in the midst of winter and since fall he had accrued pages of documented unexcused absences from school. His truancy sheet resulted in multiple court mandated visits, recommended outpatient treatment, possible out of home placement and ultimately substance abuse treatment. Much of his self-reported comfort was found outside of the classroom and home setting. Without hesitation, he proudly admitted to skipping most, if not all, days of school, spending time with friends, using "as much marijuana as I want" and being increasingly intrigued by the excitement of street life in his neighborhood.
Despite several medication trials and family/individual therapy over the years for management of ADHD/ODD, he was less than interested in treatment. Our clinical encounters would feel like a constant and invisible "tug of war". Several sessions started with receiving direct feedback from him as well as the Grandmother, Mother, School advocate, as well as generated written reports from Truancy officers, and both official court transcripts and school administration record.

Over the time spent, countless clinical hours were devoted to contacting outside agency systems, including- truancy court, child protective services (DHS/CUA workers), school administration and referral to intensive outpatient services to address substance abuse concerns.

Over the year, I worked alongside him exploring the changing landscape of adolescence and attempted to assist with his process. As a young child he grappled with a fragmented family structure, personal trauma, absent father, parental incarceration and substance abuse, parental mental illness and poverty as well as perceived racial discrimination. Nevertheless, weekly I met with a teenager attracted to the life outside the classroom and insatiably fascinated by the street. In spite of his strive for independence, eventually truancy, placement concerns, ongoing substance abuse and court procedures would come to interfere with his agenda. He expressed a lack of enthusiasm and asserted his right to refuse treatment. Various systems such as truancy, probation, child protect services and family court were perceived as "annoying". In the end, his autonomy to decline and terminate a voluntary treatment left myself and the clinical systems of care team wanting to intervene more, to act on his behalf to halt the apparent and inevitable path of delinquency he was venturing down.

Parents/Guardians	Children Under 13	Children 13 or Older
Summary Conviction → - $300 fine per offense; - Parenting education program; - 6 months' community service. ***Failure to Comply With Above Punishment →*** RISK: 5 days' incarceration in the county jail.	***Failure to Comply With Compulsory Attendance Law AND "Habitually Truant"* →*** Referred by school district to the local Children and Youth Services (CYS) agency for possible disposition as a dependent child under § 6302 of the Juvenile Act. **"Habitually truant" means an absence for more than three (3) school days **AFTER** the school district provides the first notice of truancy.*	***Summary Conviction →*** - $300 fine per offense; - Adjudication alternative program; - Suspension of driver's license. ***Failure to Comply With Above Punishment →*** RISK: The managerial district justice may allege the child to be a dependent child under § 6302 of the Juvenile Act. ***Failure to Comply With Compulsory Attendance Law AND "Habitually Truant"* →*** RISK: Referred by school district to the local Children and Youth Services (CYS) agency for possible disposition as a dependent child under § 6302 of the Juvenile Act.

The adolescents in today's society face a myriad of daily struggles including bullying, poverty, drug epidemics and community violence. Upon taking a closer look into local communities, the demand for resources to address mental health and social well-being become apparent. Findings from the ACEs study uncovered staggering correlations between adverse childhood experiences and adult manifestations including: overall physical health, substance usage, incarceration, homelessness and mental health. However, voluntary and choice, immerge as distinguishing factors in non-emergency situations. Despite the possible benefits achieved from seeking services, treatment must be desired and continued with the patient's goal serving as the ultimate compass. Legislation surrounding consent demands clinician diligence and appreciation for particulars surrounding medical record documentation and circumstances when parental involvement is both warranted and obligated. The parent or legal guardian of a minor (person under 18 years of age) has the ability to consent to voluntary outpatient services on the minor's behalf without necessary consent. However, the minor's willingness to participate in voluntary circumstances must be confirmed. Providers must be knowledgeable with medical records and release of protected mental health information. Within Pennsylvania, parental rights include the guardian's ability to consent to the release of past mental health treatment records when previously consented and inclusion in the current treatment being provided.

With appropriate outreach, continuity of care and collaboration rooted in compassion and advocacy involvement with the various systems of care- DHS, School administration, Family Court, resulted in greater compliance and continued treatment. It was apparent the diverse modalities and networks in place facilitated guidance and support to an adolescent male struggling to formulate his identity. Without such support over the years, it is unknown where life may have directed his path and what negative adverse life event manifestation would have occurred earlier in the projected course. In confidence it is of great importance that Child and Adolescent Psychiatrists continue to appreciate, value and promote the ongoing involvement of multiple systems of care in our patient's lives.

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