Allowing Certain Minors to Receive Inpatient Mental Health Treatment Without Parental Consent

Joint Commission on Health Care
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Genesis and Purpose of the Study

Study was requested in a policy option from 2014 JCHC study on the minor consent requirement for voluntary inpatient psychiatric treatment.

The policy option, added at the suggestion of Senator Barker, requested "a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent. The review shall include consideration of:

1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent,
2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and
3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent."

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Issues to Consider and Review

- What is the purpose of authorizing a minor to voluntarily commitment themselves to inpatient care without parental consent:
  - Overcome an objecting parent, or
  - Increasing the likelihood that a child in need of inpatient mental health treatment will seek out the treatment, or
  - Both
- Do other states have statutes that allow a minor to consent to inpatient mental health treatment without consent of their parent or a guardian? If so, what are the statutory provisions?
- How many minors might make use of a provision of allowing them to consent to their own inpatient treatment?
- What are the financial implications?

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Virginia's Current System

If parents do not consent to inpatient mental health treatment for their consenting minor child, typically either the wishes of the parent(s) will be honored and the minor will not receive inpatient treatment or another action may be taken or threatened to overrule the parent(s) objection.

- An emergency custody order or temporary detention order (TDO) may be requested.
- A report may be made to child protective services (CPS) on the basis of medical neglect on the part of the parent.

The available options for overruling parental consent are very coercive and can be perceived as adversarial by the parent, the minor child and the clinicians that are providing treatment.

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Allowing Minors to Consent to Inpatient Mental Health Treatment

Advantages	Disadvantages
Potential for improved treatment outcomes for the minor. May reduce the length of inpatient hospital stay and improve the success of the discharge process. Avoids the more coercive and adversarial actions (TDOs and CPS reports) which tend to undermine therapeutic relationships and long term treatment in part because the experience can be traumatic and humiliating for both the parent and the minor. Allowing for voluntary inpatient care minimizes the stigma associated with involuntary admissions including the perception that the child is dangerous to himself or others regardless of the reason for the admission.	Adversarial issues between the parent and the minor may lead to discharge problems since the minor is discharged back to the family. Potential steering, directing, or coercion of minors into inpatient mental health treatment when alternatives may be available. Potential reimbursement issues including that providers may not be paid in a timely manner if at all or conversely provider abuse of reimbursement systems. Issues of confidentiality of records and who should have access.

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Part 1
The Current Virginia System

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Community Services Board Perspective

CSB staff participating in a conference call through the Virginia Association of Community Services Boards (VACSB), indicated that they were never involved in a case or situation where the child wanted to be in an inpatient setting and the parents objected. It is usually the other way around.

The failure of a parent to obtain mental health treatment for a child for whom such treatment is recommended can be found to constitute child neglect, and the judge can order a child's custodian to obtain such treatment for a child in such cases, or as part of the disposition of a Child in Need of Service (CHINS) or delinquency case. The judge can place the child in the custody of someone who will obtain the treatment the child needs. The Court can effect the child's participation in outpatient treatment, and through the judge's authority under the Comprehensive Services Act the judge can effect the child's placement in residential (as opposed to acute care) behavioral health facilities.

To require inpatient mental health treatment of a minor without the consent of his/her parent(s), currently involves pre-screeners (and subsequently, magistrates and special justices) who normally become involved with a child and family at the point where there are objective criteria that provide the basis for moving forward (or not) with petitions, orders and hospitalizations regardless of the desires and beliefs of the child and parents.

One program supervisor said from her experience hospitals will not accept minors without parental consent because they are going to be concerned about reimbursement. During her career she worked for the Richmond CSB and indicated that there were a few times where the pre-screener felt a child needed to be hospitalized and the parent objected. In those cases the CSB had to seek a TDO to get the minor into the hospital – in these situations there was also a call to child protective services.

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Provider, Clinician, and Counselor Perspectives

Hospital administrators, during a conference call through the Virginia Hospital & Healthcare Association, indicated that hospitals experience parental disagreements with evaluators and clinicians over recommendations for inpatient treatment for minors once or twice every few months.

Clinicians indicated that parental disagreements over treatment occur on a regular basis and occur in both the admission stage as well as the continuation of treatment stage of the treatment plan. The disagreements may involve denial by the parents of a problem with their child and/or the costs involved with inpatient treatment.

A school official indicated that there are times when parents deny that there are problems with their children and do not want to draw attention to their family situation or have it be known that their child has a mental or behavioral health problem.

A former school psychologist said that over the years she had a number of cases in which children saw the benefit of, and wanted to use, medications and other treatments to address their condition, but their parents resisted both mental health diagnoses and treatments for their children because of their fear of stigma, not only for the children but for their families. She indicated that some parents equate a diagnosis of mental illness with being "crazy," rejecting any suggestions that they or their child might benefit from mental health treatment on the grounds that they were "not crazy" and therefore did not need any treatment.

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Three reported situations in which allowing minor consent without parental consent would have been helpful

A girl in high school is involved in multiple activities and is very popular with her peers and teachers. She is viewed as friendly, outgoing and very intelligent.

In her senior year at age 16.5 the girl has a break down in the school counselor's office. The counselor learns that the girl has been raising her younger siblings and has taken on the role of "parent" in the household.

Both parents are working through their own issues and resist consenting to treatment for the daughter. They do not want the neighbors to know that there is something wrong in the household.

A child is already in an inpatient setting. The clinical team determined that the child needed additional inpatient care. The child agrees and consents. The parents, however, do not.

The clinical team begins the process of a TDO but is concerned about how it might interfere with the treatment plan.

The child volunteers to say whatever is needed in order to continue treatment.

A child is taken from school to the emergency room. The parents are notified and show up in the ER. The examination indicates that the child needs to be in an inpatient setting. The parents object.

The CSB evaluator begins a discussion with the parents about involuntary commitment through the Temporary Detention Order (TDO).

The parents are given a choice: consent to treatment or face involuntary treatment, having the child removed from the home and the possibility of an investigation by Child Protective Services for medical neglect.

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Part 2
Other State Statutes

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Other State Statutes

The statutes of 50 states and the District of Columbia were reviewed (using internet searches through Justia Law, Socratek Law Reference and Cornell's Legal Information Institute).

While a number of journal articles and publications provide "inventories" and information on minor consent for medical, mental health outpatient and substance abuse services on a state-by-state basis, none of the identified documents provided similar information on minor consent for inpatient mental health treatment services.

As a guide for the search, the following publications were consulted:

- Minor Consent To Medical Treatment Laws, Updated January 2013. The National District Attorney Association.
- State Minor Consent Laws: A Summary 3rd Edition, January 2010. Center for Adolescent Health & the Law.
- Assisted Psychiatric Treatment: Inpatient and Outpatient Standards by State, June 2011. Treatment Advocacy Center.

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Minors Found to Be Authorized to Consent to Inpatient Mental Health Care in 19 State Statutes

The 19 state statutes are listed on the next slide; as shown, 10 states set the age to consent at 16, seven states at 14, one state each at 15 and 13.

In general, the state statutes explicitly addressed other issues, such as:

- The application and admission process
- Confidentiality
- Parental notification
- Relief to the parent for financial obligations
- Liability for providers
- Notice to leave or be discharged.

A few states simply made the minor an adult for purposes of mental health treatment, affording the minor all of the rights and authorizations that an adult has for voluntary admission.

A brief description of these 19 state statutes is included in Appendix I.

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State	Age	Authorizing State Statutes
Alabama	14	Ala. Code § 22-8-4
Colorado	15	Colo. Rev. Stat. § 27-65-103 [Formerly 27-10-103]
Idaho	14	Idaho Code § 66-318
Illinois	16	Ill. 405 ILCS Sec. 5/3-400, 3-405, 3-502; 3-507.
Kansas	14	KS Revised Statutes § 59-2949
Louisiana	16	LA Children Code CH 11. Art. 1464 & 1467, 1468
Maryland	16	Md. Code Ann., Health-Gen. §10-609 and §20-104
Massachusetts	16	Mass. Ann. Laws Part 1 Title XVII CH. 123; section 10
Michigan	14	MCL 330.1498d; e; j.
Minnesota	16	Minn. Stat. § 253b..03 & .04 c. Subdiv. 6(d); Minn. Stat. § 144.343-347.
Montana	16	Mont. Code Ann. § 53-21-112
New Jersey	14	N.J. stat. Ann. § 4:74-7a. (c)
New York	16	N.Y. MHY. Law § 9.13
Oklahoma	16	Okla. Stat. Ann. Tit. 43a § 5-503
Pennsylvania	14	Pennsylvania 50 P.S. § 7201-7204; Pennsylvania 35 P.S. § 10101.1-10105
Tennessee	16	Tenn. Code Ann. § 33-6-201 - 203
Texas	16	Tex. Health and Safety Code. § 572.001; Tex. Fam. Code ann. § 32.004
Vermont	14	Vt. Stat. Ann. Tit. 18, § 7503
Washington	13	Wash. Rev. Code ann. § 71.34.500; Wash. Rev. Code ann. § 71.34.520

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Examples of Various State Statutes that Address Other Issues	
Application And Admission Process	Approved by facility director (ID, IL, KS, LA, MD) Application through courts (NJ)
Evaluation	Physician has to determine minor has capacity to make knowing decision and ability to consent (LA, MD) Clinical criteria for evaluation consistent with the American Academy of Child and Adolescent Psychiatry (MN)
Capacity to Consent	The capacity of a minor to consent to treatment does not include the capacity to refuse treatment for which a parent has given consent (MD)
Confidentiality And Parental Notification	Facility director is required to notify parents (KS) The parent may apply for release upon notification (ID) Parents may be notified without consent of minor at the discretion of the treating physician (CO) Parents notified if in the best interest of the minor (MN)
Parental Involvement	Obtain parental consent or proceed to court process (MI) Parent informed of right to be heard upon the filing of an objection (PA)
Relief To The Parent For Any Financial Obligations If They Did Not Consent	A minor consenting shall assume financial responsibility (MN) Parent not responsible for cost of services (MD, MA)
Liability Relief For Providers	Provider not liable for damages if the child misrepresents himself (TX)
Notice To Leave Or Be Discharged	May give notice of intent to leave at any time (WA) A minor who revokes consent must be discharged within 48 hours unless the district attorney files opposition with the court (OK)

Part 3
Estimating the Number of Impacted Minors

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Survey of CSB Evaluators - UVA Institute of Law, Psychiatry and Public Policy

UVA's Institute of Law, Psychiatry and Public Policy surveyed CSB evaluators as part of a study for the Department of Behavioral Health and Developmental Services (*A Study Of Face-to-face Emergency Evaluations Conducted By Community Services Boards In April 2013*).

The survey results, which can be used to estimate the number of cases in which a parent objected to the recommendation for inpatient treatment, found:

- 387 emergency evaluations of juveniles aged 14 through 17 were completed in April 2013
  - 165 (42.6%) were recommended for inpatient mental health treatment.

The survey included three questions related to whether a parent was consulted and whether he/she were willing to approve the proposed admission of the minor to inpatient psychiatric treatment. In 10 (6.1%) cases the parent did not approve the minor's admission.

- 7 minors (3.9%) for voluntary admission
- 3 minors (8.0%) for involuntary admissions.

Seven minors were admitted, 2 were not admitted due in part to insurance issues and 1 due to other medical conditions.

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Estimating the Annual Number of Parental Objections to Recommended Inpatient Treatment Using the 2013 UVA Study Results

Description	Number of Evaluations
Reported Number of Emergency Evaluations of Minors Age 14 through 17	387.0
Estimated Full Year Number of Emergency Evaluations (n=387 x 12)	4,644.0
Percent of Evaluations Recommended for Inpatient Admission	42.6%
Estimated Annual Number of Inpatient Admission Recommendations (n=4,644 x 42.6%)	1,978.3
Percent of Parental Objections	6.1%
Estimated Number of Parental Objections in a Year	120.7

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Court Data Displaying the Number of Involuntary Commitment Petitions Not Granted for 2014 *

Final Disposition of Petitions Not Granted for Involuntary Commitment by Age, 2014

Juvenile's Age	Dismissed	Withdrawn	Released to Parents	Total
14	52	6	11	69
15	35	6	13	54
16	41	5	18	64
17	61	5	16	82
TOTAL	**189**	**22**	**58**	**269**

Grand total of 269 - It is unknown how many of the petitions were not granted due to parental objection. The UVA study suggests that some of the recorded "not-granted" petitions were the result of parental objection.

Note that some of the petitions not granted became voluntary commitments. The number, however, is unknown.

Source: Office of the Executive Secretary, Supreme Court of Virginia. As reported by the Court Clerks.

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Perceived Barriers to Adolescent Mental Health Treatment

Authors of a literature review report of 22 different studies concerning the perceived barrier for adolescents seeking mental health treatment created themes based on the various findings to determine what barrier adolescents cited most frequently. The top two perceived barriers were stigma and confidentiality.[1]

Societal stigma and confidentiality may be combined into one concern when parental consent is an issue. In a well cited study from 1993, a survey of high school students found that 58% had health concerns that they wished to keep private from their parents, and 69% from friends and classmates; 25% reported that they would forgo health care in some situations if their parents might find out. [2]

According to a study that appeared in the Archives of General Psychiatry in 2005, half of all lifetime cases of psychiatric disorders, including substance abuse disorders, begin by age 14. [3]

1. Gulliver, Amelia. Et al. "Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review." BMC Psychiatry 2010, Gulliver et al. 10:113.
2. Cheng, Tina L. MD, MPH., et al. "Confidentiality in Health Care A Survey of Knowledge, Perceptions, and Attitudes Among High School Students." JAMA. 1993;269(11):1404-1407. March 17, 1993.
3. Kessler, RC., et al. "Lifetime Prevalence and age-of-onset distributions of DSM-IV disorders in National Comorbidity Survey Replication." Archive of General Psychiatry. June 6, 2005; pages 593-602.

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Prevalence of Psychiatric Disorders in Minors

Estimating the number of minors who may need inpatient treatment but are not receiving it is difficult.

The Congressional Research Service (CRS) reported on such difficulties last month.

CRS found that the estimated number of adolescents with mental health disorders ranges from 8.0% to as high as 42.6% depending on the methodology used by the study's authors. [1]

- *The studies that found the lowest prevalence rates sought to only identify the seriously mentally ill.*
- *Studies that found the highest prevalence rates typically sought to identify every minor who had a mental disorder regardless of severity.*

CRS also cited a 2012 study on severity (from the Archives of General Psychiatry) to make the point that most adolescents with mental disorders do not necessarily need treatment. [2]

1. Bagalman, Erin et al. "Prevalence of Mental Illness in the United States: Data Sources and Estimates." Congressional Research Service; 7-5700, R43047. March 9, 2015. Page 6.
2. CRS study cited: *Ronald C. Kessler et al., "Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement," Archives of General Psychiatry, vol. 69, no. 4 (April 2012). Hereinafter, Kessler et al., NCSA Severity, (2012).*

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Identifying Minors Outside of the Current System In Need of Inpatient Mental Health Treatment

A National Institute of Mental Health study found that approximately 36.2% of adolescents identified with mental health disorders received services for their illness. [1]

According to a 2012 SAMHSA survey of youth that has been completed since 1971 and is updated regularly:

- 12.7% of youths reported receiving "Specialty Mental Health" services (defined as inpatient and/or outpatient services and does not include school counselors or family physicians);
- 2.5% of that number reported receiving their Specialty Mental Health services in an inpatient mental health setting. [3]

The estimates in the table are based on census data and findings from the previously discussed studies.

Description	Applying SAMHSA Survey Results
Virginia Population of Minors Ages 14 through 17 (U.S. Census)	459,000
Prevalence Percentage	12.70%
Estimated Number of Virginia Minors with a Diagnosable MH Disorder	58,293
Estimated Number Not Receiving Services (63.8%)	37,191
Inpatient MH Utilization for Minors Not Receiving Inpatient MH Services	**2.50%**
Minors Not Receiving Inpatient MH Services	**930**

1. Merikangas, Kathleen, et al. "Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey Adolescents Supplement (NCS-A)." Journal American Academic Child Adolescent Psychiatry. January 2011; 50(1): 32-45.
2. Source:: Substance Abuse and Mental Health Services Administration (SAMHSA), Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

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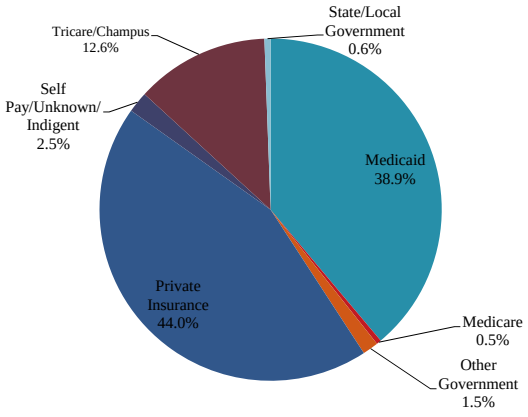
What are the financial implications of allowing minors aged 14 through 17 to consent to inpatient treatment without parental consent?

Hospital financial data reported to Virginia Health Information (VHI) indicate that from 2009 through 2011 the overall total cost-of-care * for inpatient treatment for minors aged of 14 through 17 in a private psychiatric hospital or on a mental health unit of a general hospital was $86.9 million. The average cost-per-discharge was $6,500 to $6,700.

The chart to the right displays the payer-mix based on the VHI data and indicates that Private Insurance and Medicaid made up 82.4% of the payments for this age group (43.7% and 38.7% respectfully).

There is no reason to believe that the children that may need inpatient mental health treatment will have a different "payer-mix" than those already in the system.

(Appendix II displays the details by year associated with the chart.)



** Cost-of-care was calculated based on total charges per discharge times each hospitals overall cost-to-charge ratio.*

Data does not include the Commonwealth Center for Children and Adolescents. The CCCA is considered the hospital of last resort.

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Policy Options

Option 1: Take no action.

Option 2: Introduce legislation to amend *Code of Virginia* Title 16.1 to provide minors with the same rights and responsibilities as an adult in terms of consenting to voluntary inpatient mental health treatment beginning at age:

a. 14 years
b. 15 years
c. 16 years
d. 17 years

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Policy Options

For Options 3 through 5, additional statutory provisions are described in Option 6 for your consideration.

Option 3: Introduce legislation to amend *Code of Virginia* Title 16.1 to establish a process by which a minor, whose parent(s)/guardian(s) will not consent to his/her voluntary inpatient mental health treatment, may request and receive such treatment with the approval of a clinician and/or evaluator who has examined and found the minor to be in need of and likely to benefit from the requested treatment.

Option 4: Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to access the evaluation process of the local community services board in order to receive approval for voluntary inpatient mental health treatment.

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Policy Options

Option 5: Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to petition the juvenile court in order to be examined and receive authorization for voluntary inpatient mental health treatment.

Option 6: Include the following provisions in introduced legislation to amend *Code of Virginia* Title 16.1 to address:

A. Parental Objection – provide opportunity to consider objections, by the parent(s)/guardian(s), to the minor's voluntary inpatient mental health treatment.
B. Admission criteria – establish the clinical criteria, for allowing the minor's admission for voluntary inpatient mental health treatment without the consent by his/her parent(s)/guardian(s), to be the current inpatient admission standards such as those established by the American Academy of Child and Adolescent Psychiatry

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Policy Options

Option 6 continued:

C. Other evaluation criteria – establish criteria to determine that minor has the capacity to consent and is clinically suitable for the voluntary mental health treatment that will be provided.
D. Liability Relief – add language that providers are not liable for damages if a minor misrepresents himself except for damages resulting from negligence or willful misconduct.
E. Limitations on inpatient stays – establish limitations on the number of days a minor may be treated in the inpatient facility on a voluntary basis and/or the number of times the minor may be admitted without the consent of the parent(s)/guardian(s).

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Policy Options

Option 6 continued:

F. Financial responsibility – as needed, add language regarding mental health parity provisions, financial liability of parent(s)/guardian(s), and other payment guidelines.

G. Confidentiality – determine and denote requirements in order to comply with Health Insurance Portability and Accountability Act (HIPAA) privacy provisions, such as sharing of treatment or health-insurance payment information with parent(s)/guardian(s).

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Public Comments

Written public comments on the proposed options may be submitted to JCHC by close of business on July 24, 2015.

Comments may be submitted via:

- E-mail: sweiss@jchc.virginia.gov
- Fax: 804-786-5538
- Mail: Joint Commission on Health Care
  P.O. Box 1322
  Richmond, Virginia 23218

Comments will be summarized and presented during JCHC's October 7th meeting.

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State	Age	Statute	Brief Description
Alabama	14	Ala. Code § 22-8-4: Mental health services.	• 14 years of age or older, consent to any legally authorized mental health services; consent of no other person shall be necessary.
Colorado	15	Colo. Rev. Stat. § 27-65-103 [Formerly 27-10-103] Mental health.	• Minors 15 or older can consent to mental health services rendered by a facility or a professional person without consent of parents. • Consent shall not be subject to disaffirmance because of minority. The professional person may advise the parents with or without consent from the minor. • An independent professional person shall interview the minor and conduct a careful investigation into the minor's background so that prior to admitting a minor: the minor has a mental illness and is in need of hospitalization; that a less restrictive treatment alternative is inappropriate or unavailable; and that hospitalization is likely to be beneficial.
Idaho	14	Idaho Code § 66-318. Mental health.	• Any individual fourteen (14) to eighteen (18) years of age may apply to be admitted to a mental health facility for observation, diagnosis, evaluation, care or treatment. • Facility director is required to notify the parent of the admission to a mental health facility for observation, diagnosis, evaluation, care or treatment. The parent may apply for release.

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State	Age	Statute	Brief Description
Illinois	16	Ill. 405 ILCS Sec. 5/3-502. Mental health. Ill 405 ILCS 5/3-400 Clinically suitable. Ill 405 ILCS 5/3-405 review of denial by person seeking admission. 405 ILCS 5/3-507 Objection to admission.	• Any minor may be admitted to a mental health facility voluntarily if the minor executes the application and shall be treated as an adult. • The minor's parent shall be immediately informed of the admission. • Minor must be found clinically suitable and have the capacity to consent. • If the facility director of a Department mental health facility declines to admit a person seeking admission, a review of the denial may be requested by the person seeking admission. • Objection may be made to the admission of a minor and the minor shall be discharged at the earliest appropriate time, not to exceed 15 days, unless the objection is withdrawn in writing or unless, within that time, a petition for review of the admission and certificates of examination by both a licensed mental health provider and a psychiatrist are filed with the court.
Kansas	14	KS Revised Statutes § 59-2949 Mental health.	• Minor may make written application without the consent of parent for admission to a psychiatric treatment facility as a voluntary patient; the head of the treatment facility determines need of treatment and that the person has the capacity to consent. • The head of the treatment facility shall promptly notify the child's parent of the admittance of child.

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State	Age	Statute	Brief Description
Louisiana	16	LA Children Code CH 11. Art. 1464 & 1468. Mental health LA Children Code CH 11. Art. 1467. Capacity to consent.	• Minor may apply for voluntary admission to a mental health or substance abuse treatment facility. • A minor so admitted shall have the same rights as an adult patient. • The admitting physician may admit the person on either a formal or informal basis. • No admission may be deemed voluntary unless the admitting physician determines that the minor has the capacity to make a knowing and voluntary consent to the admission.
Maryland	16	Md. Code Ann., Health—Gen. §10-609 Mental health. Md. Code Ann., Health—Gen. §20–104. Capacity as an adult to consent.	• Application for voluntary admission of an individual to a facility may be made if the individual is 16 years old or older. • The individual must understand the nature of the request; is able to give continuous assent to retention by the facility; and is able to ask for release. • A minor has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic. • The capacity of a minor to consent to treatment does not include the capacity to refuse treatment for which a parent has given consent. • The physician heading the treatment team decides whether a parent of the minor should receive information about treatment. • The parent is not liable for any costs of the treatment of the minor.

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State	Age	Statute	Brief Description
Massachusetts	16	Mass. Ann. Laws Part 1 Title XVII CH. 123; section 10. Mental health.	• The superintendent of a mental health facility may accept an application for voluntary admission by any person 16 years or older that is in need of care and treatment. • The parent shall not be liable for the payment of any care.
Michigan	14	MCL 330.1498d; e; j. Mental health, parental consent.	• A minor of 14 years or older may request, and if found suitable, be hospitalized. Once hospitalized, the hospital director is required to obtain parental consent or proceed to court process.

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State	Age	Statute	Brief Description
Minnesota	16	Minn. Stat. § 253b.04 Mental health. Minn. Stat. § 253b.03 c. Subdiv. 6(d) consent Minn. Stat. § 144.343 Mental and other health services to treat alcohol and other drug abuse. Minn. Stat. § 144.345 services provided in good faith. Minn. Stat. § 144.346 provider may inform parents. Minn. Stat. § 144.347 financial responsibility.	• Any person 16 years or older may request informal admission to a treatment facility for observation or treatment of mental illness, chemical dependency, or mental retardation and may give valid consent for hospitalization, routine diagnostic evaluation, and emergency or short-term acute care. • Facility to admit must be based on clinical admission criteria consistent with the most current inpatient admission standards established by the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry. • Minor may consent for mental and other health services to determine the presence of or to treat alcohol and other drug abuse; the consent of no other person is required. • Consent of a minor shall be deemed effective for the purposes of providing services in good faith. • Provider may inform parents if they determine it is in best interest of minor. • A minor consenting for health services shall assume financial responsibility for the cost of services.

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State	Age	Statute	Brief Description
Montana	16	Mont. Code Ann. § 53-21-112 Mental health.	• A minor is at least 16 years of age may, without the consent of a parent, receive mental health services. • Voluntary admission terminates at the expiration of 1 year. • Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. • Minors consenting assume financial responsibility unless proven to be unable to pay and who receive the services in public institutions. If the minor is covered by health insurance, payment may be applied for services rendered.
New Jersey	14	N.J. stat. Ann. § 4:74-7a. (c) Mental health.	• Any minor 14 years of age or over may request admission to a psychiatric facility and be admitted provided that the court finds the minor's request informed and voluntary.
New York	16	N.Y. MHY. Law § 9.13 Mental health.	• A person over 16 and under 18 years of age is authorized to apply for voluntary inpatient admission to a hospital; application accepted at the discretion of the hospital director.
Oklahoma	16	Okla. Stat. Ann. Tit. 43a § 5-503 Mental health.	• A minor 16 years of age or older may consent to voluntary admission for inpatient mental health or substance abuse treatment. • A minor who revokes consent must be discharged within 48 hours unless the district attorney files opposition to the discharge with the court.

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State	Age	Statute	Brief Description
Pennsylvania	14	Pennsylvania 50 P.S. § 7201 Mental health. Pennsylvania 50 P.S. § 7204. Parent notification, right to object. Pennsylvania 35 P.S. § 10101.1. mental health treatment. Pennsylvania 35 P.S. § 10101.2 Records controlled by minor. Pennsylvania 35 P.S. § 10105 Providers not liable.	• Any person 14 years of age or over may submit himself to mental health examination and treatment provided that the decision to do so is made voluntarily. • Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents and shall inform them of the right to be heard upon the filing of an objection. • Any minor who is 14 years of age or older may consent to outpatient mental health examination and treatment and voluntary inpatient mental health treatment. • The minor shall control the release of the minor's mental health treatment records and information to the extent allowed by law. • Providers not liable if minor misrepresent themselves.
Tennessee	16	Tenn. Code Ann. § 33-6-201 Mental health. Tenn. Code Ann. § 33-6-203 Admission limit.	• A person who is sixteen (16) years of age or over may apply for voluntary admission. • Admission of an un-emancipated child limited to one (1) six-month period in any twelve-month period unless the admission is reviewed and approved for further hospitalization.

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APPENDIX I

State	Age	Statute	Brief Description
Texas	16	Tex. Health and Safety Code. § 572.001. Mental health inpatient or outpatient. Tex. Fam. Code ann. § 32.004 Provider not	• The administrator of an inpatient or outpatient mental health facility may admit a minor who is 16 years of age or older to an inpatient or outpatient mental health facility as a voluntary patient without the consent of the parent, managing conservator, or guardian. • A physician, psychologist, counselor, or social worker is not liable for damages if a child misrepresents themselves except for damages resulting from negligence or willful misconduct. • Parent not consenting to counseling treatment is not obligated to compensate providers.
Vermont	14	Vt. Stat. Ann. Tit. 18, § 7503 Mental health.	• Any person 14 years of age or over may apply for voluntary admission to a designated hospital for mental health examination and treatment provided that consent is given in writing.
Washington	13	Wash. Rev. Code ann. § 71.34.500 Mental health. Wash. Rev. Code ann. § 71.34.520 Notice of intent to leave.	• A minor 13 years of age or older may admit himself or herself to an evaluation and treatment facility for inpatient mental treatment, without parental consent based on professional person consent. • May give notice of intent to leave at any time.

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APPENDIX II

Overall Total of Cost per Discharge 2009 through 2011 With Average Length of Stay and Number of Discharges

Payer Type	Total Cost Per Discharge by Payer Type	Average Length of Stay Per Discharge	Number of Discharges (includes admissions and readmissions)
Medicaid	$33,773,463	18.0	4,132.0
Medicare	$394,082	4.8	132.0
Other Government	$1,296,467	6.5	303.0
Private Insurance	$38,222,495	8.5	7,312.0
Self Pay	$969,230	8.4	186.0
Tricare/Champus	$10,967,348	18.3	1,219.0
Unknown	$690,355	28.2	58.0
Indigent	$57,007	4.5	15.0
State/Local Government	$501,478	12.5	69.0
Grand Total	**$86,871,927**	**12.3**	**13,426.0**

Source: Virginia Health Information (VHI)

Total cost per discharge was calculated using the total charges for each hospital by payer type and multiplying them by the hospital cost-to-charge ratio.

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APPENDIX II

Overall Total of Cost per Discharge by Year

Year 2009	Payer Type	Total Cost Per Discharge by Payer Type	Average Length of Stay Per Discharge	Number of Discharges (includes admissions and readmissions)
	Medicaid	$11,792,121	21.3	1,367.0
	Medicare	$143,649	5.0	45.0
	Other Government	$500,468	10.6	89.0
	Private Insurance	$12,353,571	8.7	2,415.0
	Self Pay	$425,658	8.9	71.0
	Tricare/Champus	$3,184,206	19.7	364.0
	Unknown	$353,132	21.2	41.0
	Indigent	$7,550	3.0	2.0
	State/Local Government	$350,195	26.1	25.0
Subtotal for 2009		**$29,110,549**	**13.7**	**4,419.0**

Year 2010	Payer Type	Total Cost Per Discharge by Payer Type	Average Length of Stay Per Discharge	Number of Discharges (includes admissions and readmissions)
	Medicaid	$10,452,962	16.7	1,390.0
	Medicare	$139,103	4.4	45.0
	Other Government	$460,103	5.0	112.0
	Private Insurance	$12,770,016	8.6	2,486.0
	Self Pay	$211,428	4.9	60.0
	Tricare/Champus	$3,534,589	16.9	428.0
	Unknown	$180,414	50.9	9.0
	Indigent	$19,116	6.3	4.0
	State/Local Government	$79,947	3.7	30.0
Subtotal for 2010		**$27,847,678**	**11.7**	**4,564.0**

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APPENDIX II

Overall Total of Cost per Discharge by Year

Year 2011	Payer Type	Total Cost Per Discharge by Payer Type	Average Length of Stay Per Discharge	Number of Discharges (includes admissions and readmissions)
	Medicaid	$11,528,381	16.0	1,375.0
	Medicare	$111,330	4.9	42.0
	Other Government	$335,897	4.5	102.0
	Private Insurance	$13,098,908	8.2	2,411.0
	Self Pay	$332,144	11.6	55.0
	Tricare/Champus	$4,248,554	18.6	427.0
	Unknown	$156,809	38.4	8.0
	Indigent	$30,341	4.0	9.0
	State/Local Government	$71,336	7.1	14.0
Subtotal for 2011		**$29,913,700**	**11.6**	**4,443.0**

Source: Virginia Health Information (VHI)
Total cost per discharge was calculated using the total charges for each hospital by payer type and multiplying them by the hospital cost-to-charge ratio.

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Public Comments

Written public comments on the proposed options may be submitted to JCHC by close of business on July 24, 2015.

Comments may be submitted via:

- E-mail: sweiss@jchc.virginia.gov
- Fax: 804-786-5538
- Mail: Joint Commission on Health Care
  P.O. Box 1322
  Richmond, Virginia 23218

Comments will be summarized and presented during JCHC's October 7th meeting.

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