REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Admission of Minors to Psychiatric Facilities

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 71

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Report of the
Joint Subcommittee Studying
Admission of Minors to Psychiatric Facilities
To
The Governor and the General Assembly of Virginia
Richmond, Virginia
January, 1989

To: Honorable Gerald L. Baliles, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR THE STUDY

House Joint Resolution No. 97, agreed to by the 1988 Session of the General Assembly, authorizes a joint subcommittee to examine the current law governing the admission of minors to psychiatric facilities and to develop such recommendations for improving the process as it determines to be necessary. The joint subcommittee is specifically directed to review the effects of current commitment statutes on the rights of minors and their parents, the efficacy of separate commitment laws for minors and adults, and the relationship between the availability of community services and the incidence of commitment of minors to inpatient facilities. The Joint Subcommittee is directed to complete its work and present its recommendations to the 1989 Session of the General Assembly. (Attachment 1)

BACKGROUND

The current focus on the issues presented by the admission and treatment of minors began with the Joint Subcommittee on Mental Health and Mental Retardation (HJR 10--1980; HJR 73--1982), which in 1982 studied Virginia's civil commitment laws. The Joint Subcommittee determined that attention to the laws as they applied to minors was needed but should be deferred while the basic statutory scheme was examined. The State Human Rights Committee assumed this project with the appointment of the Task Force on the Commitment Statutes Concerning the Psychiatric Hospitalization of Minors. The task force reviewed current statutes and recommended revisions, weighing state interests, parental interests, and minors' liberty interests. The task force considered children's chronological development and its effect on their decision-making skills and their family dependency needs. The task force agreed that, while minors have a liberty interest, it is qualitatively different from that of adults, and that the standard of commitment should not be the same as for adults. The task force issued its report in 1984, addressing several major issues:

Informed consent requirements for voluntary admission of minors--Current statutory law, which does not distinguish between minors and adults, requires that minors give informed consent for voluntary admission. If they are incapable of giving such

consent or object to admission, then they may only be admitted pursuant to involuntary commitment proceedings. This process does not account for the differences in minors' capacity to consent to treatment as they mature and necessitates the use of involuntary procedures for many children who are not capable of informed consent but who are not objecting or who may even desire hospitalization. The current law is frequently distorted to avoid hearings for this latter group.

Procedures for involuntary placement of minors when they or their parents refuse consent for admission--There is a need to account for the differences in capacity among minors for exercising autonomy and in their attendant liberty interests, balanced against the relative responsibilities of parents and the state to exercise authority which is appropriate to a minor's age and maturity.

Situations in which a judicial hearing is appropriate--Intervention may be justified when one custodial parent consents to admission and the other objects or when voluntary admission is by anyone other than a parent, such as a guardian or agency.

Appropriateness of current commitment criteria--A child's liberty interest is not the same as an adult's; parents and the state have a responsibility for a child's welfare. In addition, the criteria of "unable to care for himself" is confusing as applied to children.

Clarification of procedures for admission to private hospitals--Regulations of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) governing admission of minors apply only to state-operated facilities.

In 1985, a legislative proposal was developed based on the recommendations of the task force, but action on the bill was delayed to deal with concerns of the Office of the Attorney General. Work on this legislation continued after the 1985 legislative session, with the Virginia Bar Association's Committee on the Mentally Disabled and the Institute of Law, Psychiatry and Public Policy at the University of Virginia assuming the task in 1987. These latest efforts resulted in HB 414, the Mental Health Treatment of Minors Act, introduced by Delegate Warren Stambaugh in the 1988 Session of the General Assembly. That legislation was carried over to the 1989 Session by committee for more detailed consideration in the study authorized by House Joint Resolution No. 97.

ACTIVITIES OF THE JOINT SUBCOMMITTEE

In responding to its charge as set forth in HJR 97, the joint subcommittee reviewed current law governing the commitment of minors and past efforts at addressing these issues. It reviewed the findings and recommendations of the State Human Rights Committee's Task Force on the Commitment Statutes Concerning the Psychiatric

Hospitalization of Minors with the task force chairman, Dr. Beth Merwin. The task force's findings are discussed above.

The joint subcommittee reviewed the history of the development of the Mental Health Treatment of Minors Act, introduced and carried over in 1988 as HB 414. Professor Richard Bonnie, Director of the Institute of Law, Psychiatry and Public Policy, John S. Battle Professor of Law at the University of Virginia and chair of the Virginia Bar Association Committee on the Mentally Disabled, which developed the legislation, described its provisions, comparing them to the recommendations of the task force. Working on the premise that there is consensus that the commitment process for minors requires improvement, Professor Bonnie reviewed the range of approaches available for hospitalizing minors, highlighted the key issues that must be resolved in any approach, and explained how HB 414 deals with these issues.

The joint subcommittee agreed that it needed to gather data on current practices and policies regarding the commitment of minors in both the public and private sectors in order to determine the extent of any problems posed by the current statute and practice. Such a study was undertaken by the Institute of Law, Psychiatry and Public Policy, with the assistance of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Hospital Association. The findings are discussed in detail later in this report.

The Department of Mental Health, Mental Retardation and Substance Abuse Services (MHMRSAS) provided assistance and information to the joint subcommittee throughout the study. Responsible for administration of public psychiatric facilities and for licensure and certification of private psychiatric facilities in the Commonwealth, the Department provided expertise and a useful perspective on the issues presented. The Department assisted the joint subcommittee with a survey of persons involved in the minors' admissions process with regard to their view on current law and HB 414. The responses provided a helpful initial focus on the issues.

The joint subcommittee benefitted from the informal comments and formal testimony of medical, mental health and legal professionals in both the public and private sectors. These included the Virginia Bar Association and members of the judiciary; medical practitioners appearing individually or representing the Division of Child Psychiatry at MCV, the Richmond Psychiatric Society, and the Virginia Council of Child Psychiatry; the Virginia Hospital Association; the Institute for Law, Psychiatry and Public Policy of the University of Virginia; state agencies including the Department of MHMRSAS, the Office of the Attorney General, the Office of the Executive Secretary of the Supreme Court of Virginia, the Department for Children and the Department for Rights of the Disabled; the Virginia Association of Community Services Boards; advocacy groups including the Virginia Alliance for the Mentally Ill, the Mental Health Association in Virginia and the Mental Health Association of Northern Virginia; the American Civil Liberties Union and its Mental Health Law Project; and several parents of children committed for inpatient mental health treatment.

THE LAW GOVERNING COMMITMENT OF MINORS

HISTORY

By the mid-70s, about one third of the states had statutory provisions under which parents could admit their minor children to mental institutions without judicial intervention. These were considered "voluntary" admissions and the process was entirely nonadversarial. Prior to 1976, the Virginia statute authorized the voluntary admission of minors on the request of the parent or any person standing in loco parentis to such minor. These laws were justified by a pro-family rationale which defers to parental judgment and by a therapeutic rationale which holds that sensitive treatment decisions should not be made in an adversarial context. Legal precedent exists to support this exercise of parental authority and autonomy[1], although case law may also be cited which holds that in certain instances the substantive rights of children have precedence over the wishes of their parents.[2] The proponents of family autonomy in commitment decisions were confronted, however, by a number of federal district court decisions in the mid-70's holding unconstitutional provisions permitting parents to admit their children "voluntarily" without procedural protections. The most widely cited of these are J.L. v. Parham, 412 F. Supp. 112 (M.D. Ga. 1976) and Bartley v. Kremens, 402 F. Supp. 1039 (E.D. Pa. 1975).

The decision in the Parham case struck down as unconstitutional a Georgia statute which had permitted parents or guardians to admit children on a "voluntary" basis to state mental hospitals without a hearing. The case held that such children were entitled to the procedural due process safeguards of notice, opportunity to be heard, and counsel. The Bartley case likewise held that the Pennsylvania statute failed to provide adequate procedural safeguards to juveniles prior to placement in mental health facilities. Children were held to have a constitutionally protected liberty interest that could not be waived by their parents; they were entitled to a formal adversary hearing, notice, and counsel. The Pennsylvania legislature as a result amended its mental health code to treat minors above the age of 14 as adults for purposes of a voluntary admission. Virginia amended its statutes similarly in 1976.

The civil libertarian trend begun by these cases was halted, however, with the reversal of these decisions by the Supreme Court in 1979. The court decided both Parham v. J.R., 442 U.S. 584 (1979), and Secretary of Public Welfare v. Institutionalized Juveniles, 442 U.S. 640 (1979), on the same day, holding that neither state statute violated the due process clause of the Fourteenth Amendment. The court in Parham applied a test balancing (i) the private interest affected by the official action, (ii) the risk of loss of protection of this interest through the procedures used and the value of additional procedural safeguards, and (iii) the state's interest, including burdens presented by additional procedural requirements. The court found that a child does have a liberty interest in not being confined for treatment, but parents have an important interest in the rearing of their children and a significant role in the

decision to hospitalize them. The state likewise has an interest in the appropriate use of mental health facilities. Parents may, therefore, authorize the "voluntary" admission of their children. However, the risk of error in the parental decision to institutionalize a child for mental health treatment is significant enough to warrant an inquiry by a "neutral factfinder" to determine that statutory requirements are met. The court decided that this process need not be a formal adversary hearing conducted by a judicial officer; it may by conducted by the admitting physician. The inquiry should include a psychiatric examination followed by additional periodic review of the child's condition by someone free to refuse to admit any child who does not meet medical standards for admission. The court held that a more formal hearing would not significantly reduce the risk of error. Finally, different procedures for children admitted as wards of the state and those admitted by their parents were found to be unnecessary.

The Parham case slowed a trend to a civil libertarian approach to commitment of minors, but state statutes have remained distinct from their pre-Parham form. An increasing number of states have amended their voluntary commitment statutes to provide that once a child reaches a certain age, his parent may no longer admit him on the parent's petition alone without the child's consent. Some statutes allow the child to voluntarily admit himself after a certain age. Others require a judicial hearing for a voluntary admission, not relying solely on a medical screening. Discharge statutes have been amended by a number of states. About one third of the statutes grant a minor standing to request release. Most require that the request be honored unless the minor is retained pursuant to involuntary commitment procedures.

CURRENT VIRGINIA LAW

Virginia's commitment procedures now go beyond those required constitutionally by Parham. Statutory provisions governing the voluntary and involuntary admissions of minors to psychiatric hospitals in Virginia do not distinguish between minors and adults. Section 16.1-241 establishes the juvenile and domestic relations district courts' exclusive jurisdiction over the commitment of mentally ill minors and directs that such commitment shall be in accordance with the provisions of Title 37.1 with respect to such commitment. The Department of Mental Health, Mental Retardation and Substance Abuse Services has clarified the application of the statute to minors with Departmental Instruction No. 60. However, this instruction applies only to admission of minors to state mental health facilities.

VOLUNTARY ADMISSION

Prior to 1976, the Virginia statute authorized the voluntary admission of minors on the request of the parent or any person standing in loco parentis to such minor. This provision was removed from the statute in 1976 and commitment procedures for adults were applied specifically to minors at this time. Currently, any person

may be voluntarily admitted to a state hospital pursuant to § 37.1-65 if he is determined by the local community services board and a physician on the staff of such hospital to be in need of hospitalization for mental illness. Persons brought before the judge on a petition for involuntary commitment must also be provided an opportunity for voluntary admission pursuant to § 37.1-65 if such person is determined by the judge to be willing to accept and capable of accepting voluntary admission. Departmental Instruction No. 60, applying current provisions more specifically to minors, requires that a minor's voluntary admission to a state hospital be upon the signed application of the minor and his parents or legal guardian and the informed consent of the minor. The instruction requires (i) that the minor be capable of understanding that he is mentally ill and that the hospital will be treating his mental illness and (ii) that the minor be willing to have the hospital treat his mental illness and to stay at the hospital for this treatment. The instruction further specifies that each minor's ability to give such informed consent must be individually determined by the admitting physician based on factors including the minor's age, intelligence, maturity, and degree of disturbance. The instruction, however, applies only to admissions to state psychiatric hospitals, and not to private facilities.

INVOLUNTARY ADMISSION

If a minor is found to be incapable of providing informed consent for voluntary admission or if the minor objects to admission for treatment, the minor may be hospitalized only pursuant to the procedures set out in § 37.1-67.1 et seq., which govern involuntary admissions of adults. The statute provides for a commitment hearing in which the respondent is represented by counsel. The respondent must be examined by a licensed physician or psychologist, who must certify that there is probable cause to believe that he is or is not mentally ill, presents an imminent danger to himself or others and does or does not require involuntary hospitalization. The community services board must report as to whether the person is deemed to be mentally ill, an imminent danger to himself or others and in need of involuntary hospitalization, and whether there is no less restrictive alternative to institutional confinement and must also provide recommendations for the person's treatment. At the conclusion of the hearing, the judge may order that the person be placed in a hospital for treatment for a maximum of 180 days if he finds that the person (i) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable and there is no less restrictive alternative to institutional confinement and treatment.

THIRTY-DAY EVALUATION

The only provision for hospitalization which applies specifically to minors is found in § 16.1-275, which authorizes the juvenile court or circuit court to cause any child within its jurisdiction to be

examined and treated at a local mental health center or by a physician or psychiatrist. The court may send any such child to a state mental hospital for up to thirty days to obtain a recommendation for treatment upon the written recommendation of such physician or psychiatrist.

FINDINGS OF THE JOINT SUBCOMMITTEE

As a result of its inquiries throughout the study, the joint subcommittee determined that clear and specific policies and procedures with respect to commitment of minors are needed to ensure a rational and consistent approach throughout the Commonwealth. Interested state agencies, advocacy groups and members of the medical and legal profession and the judiciary indicated a consensus that the process of commitment of minors for psychiatric care needs improvement.

The need for change and clarification was also indicated by the data on current policies and practices regarding admission of minors in the public and private sectors, gathered for the joint subcommittee by the Institute of Law, Psychiatry and Public Policy, with the assistance of MHMRSAS and the Virginia Hospital Association. The joint subcommittee requested such an analysis to determine the extent of any problems posed by the current statute and practice. The study findings are reported in Psychiatric Hospitalization of Minors: A Survey of Policy and Practice in Virginia, included as Attachment 2 to this report. The study's goals were to determine how hospitals interpret current law and apply it to affect their policies governing admission of minor patients and to profile such patients with regard particularly to their legal status, age and diagnosis. The survey, therefore, included a patient sample and a description of hospital policies concerning the legal aspects of psychiatric admissions of minors.

The survey response rate was 93%, including 40 of the 43 hospitals in the state which admit minors. Seven state hospitals, 22 general hospitals with psychiatric units, and 11 private psychiatric hospitals responded. Most of the patient sample, consisting of 324 children ranging in age from 6 to 17, were older adolescents, 15 to 17 years of age. Most were diagnosed at admission as having affective disorders, most often depression. The average length of stay was twenty-one days. The majority of patients were in parental custody at admission. The minority who were in state custody were much more likely to be hospitalized in state hospitals than were children in parental custody and were twice as likely to be admitted pursuant to a court process as were children in parental custody. Most hospitals articulated identical admission policies for minors in state custody and in parental custody, however. Sixty-four percent of all minors were admitted without court intervention; about half of these had signed written consents.

The study results indicated that there was wide variation in hospitals' expressed policies for making admission decisions. Actual

practices also were seen to vary widely from stated policies. The likelihood of judicial involvement in a minor's admission appears to depend to some degree on the type of hospital making the decision, the age of the minor, whether the minor is objecting or assenting to hospitalization and the geographic region of the state in which the hospital is located. When these variables are controlled, practice still varies, but some trends emerge. State hospitals were most likely to express a policy of using judicial process in admissions of minors and also to follow this policy in practice; 75% of their admissions involved judicial process. General hospitals usually followed their expressed policy of admitting with parental consent without judicial involvement; only 25% of their patients were admitted pursuant to a judicial process. Private psychiatric hospitals articulated a preference for the use of judicial process for objecting minors and a preference for nonjudicial admission of assenting minors. However, only 27% of all sampled minors, objecting or assenting, in private psychiatric hospitals were admitted pursuant to judicial process.

The survey indicates variations between hospitals' understanding of the law and discrepancies between the hospitals' interpretation of the law and their actual practices. The survey discerned no standardization among hospitals throughout the Commonwealth in admissions policies. These findings argue for clarifying the law to enable hospitals to act with confidence in developing and implementing uniform policies regarding admission of minors.

Once the need for change was recognized, the joint subcommittee next considered the appropriate approach to take in designing a statute governing commitment of minors. Models range from the purely libertarian to the purely paternalistic. Virginia's current statutory scheme takes a libertarian approach, with minors who are capable of consenting and who consent being admitted voluntarily and objecting children, regardless of age, and children who are incapable of consenting, whether they object or not, being admitted involuntarily pursuant to judicial procedures applicable to adults. As noted above, however, some children who do not object but who have not been found capable of consenting are "voluntarily" admitted, contrary to the intent of the law. Compliance with the law, on the other hand, requires a judicial proceeding when a child does not object, interfering, perhaps unnecessarily, with parental prerogatives and assuming that parents will not act in the best interests of their children. The Parham case holds that the state should presume that parents will act in their children's best interests. In addition, for those children who can only be committed pursuant to involuntary commitment procedures, the commitment criteria applied is that applied to adults; they are strict and are inappropriate for children. The result is that a child may not be hospitalized even when it is clinically appropriate.

A pure paternalistic model, used in Virginia prior to 1976, employs a clinical, nonjudicial process to admit any minor under 18, whether he objects or consents or is competent to consent. In these cases, admission procedures conform to the Parham decision--a

parental decision is made and a neutral clinical decision-maker reviews the appropriateness of hospitalization. This approach, however, fails to account for significant clinical and legal differences between children and adolescents. Adolescents have certain legal claims to autonomy prior to majority, as reflected in abortion and contraception decision-making. Also, risk of abuse varies according to a child's age; troubled children are more difficult to deal with as they approach adolescence, which makes parental decisions regarding placement of difficult adolescents more open to abuse. A purely paternalistic approach does not always consider differences between short-term and longer-term hospitalization; risk of abuse of the system and risk of harm to the child from adverse effects of hospitalization may increase with longer-term hospitalization. This approach may fail to distinguish between parental admissions and admission of children in state custody. The latter may be more open to abuse; the neutral decision-maker and the person initiating hospitalization may both be state employees. The assumption that the responsible adult is acting in the best interests of the child may not apply when a child is in state custody rather than in the custody of his parents.

The joint subcommittee agreed to a statutory scheme which includes aspects of the libertarian and the paternalistic models. The joint subcommittee's recommended statutory procedure is based on HB 414 but incorporates changes which represent the consensus of persons and organizations participating in the study, when such consensus was possible, and includes changes agreed to by the joint subcommittee when broader consensus could not be reached. It addresses the following issues:

- Which cases should be decided entirely on parental and clinical decision-making and which should require judicial intervention? How should this decision be affected by the minor's age?

- What procedures should be included in the nonjudicial process?

- What commitment criteria should be applied in the judicial process?

- Should the statute apply only to hospitalization or should it also apply to other clinical interventions, such as outpatient treatment and day hospitalization?

- Should additional safeguards by provided in cases in which hospitalization exceeds a designated length of time?

RECOMMENDATIONS

The basic provisions of the joint subcommittee's recommendations are described below. They are included in HB 1780, introduced in the 1989 Session and included in the attachments to this report.

APPLICATION OF PARENTAL/CLINICAL OR JUDICIAL DECISION-MAKING

The joint subcommittee recommends that a nonjudicial process be applied in cases of (i) any minor younger than 14 whether he objects or not and (ii) any minor 14 or older who consents jointly with his parent or who is incapable of consenting but who does not object to hospitalization. This presumes that a minor under 14 is not competent to consent, but allows these minors to participate in the decision to the degree that they are capable of involvement. It also allows for some exercise of parental prerogatives with regard to their children's treatment. The joint subcommittee recommends that a judicial procedure, with additional due process safeguards, be provided for minors 14 or over who object to hospitalization, thus recognizing the enhanced decision-making capacity and legal claims to autonomy of older children.

Nonjudicial Process

If the proposed admission is to a state mental health facility or involves the admission of a child over 14 to a state or private mental health facility, the joint subcommittee recommends a nonjudicial admission procedure which requires an independent clinical opinion in addition to the parents' and admitting facility's decision that hospitalization is needed. Before a child may be admitted pursuant to this process, the independent evaluator must find that (i) the minor needs inpatient treatment for mental illness and is likely to benefit from it, (ii) that the treatment has been explained to the minor, (iii) that the rights of a minor 14 or older as set forth in the statute regarding consent and a judicial hearing have been protected, and (iv) that the treatment is the least restrictive alternative. Prescreening is required by the community services board prior to admission to a state facility. Such a determination is not essential for admissions to private facilities of children under 14 because insurance providers screen for medical necessity of hospitalization and is therefore not recommended.

A treatment plan for the child should be developed within 10 days after admission, with the participation of both the minor and his family.

Because the process is a "voluntary" one and any minor 14 or over who objects to admission is entitled to a judicial hearing, any minor 14 or over admitted pursuant to the nonjudicial process who objects to further treatment should be discharged within 48 hours to the custody of his parent or other responsible person unless a petition for involuntary admission is filed.

Current law does not limit the length of stay in a hospital following voluntary admission. The joint subcommittee recommends that inpatient treatment not exceed 90 days pursuant to this process unless authorized by appropriate hospital medical personnel based on written findings that criteria justifying initial admission continue to be met. This provides an additional inquiry into the need for hospitalization when it is long-term, defined by the American Psychiatric Association as hospitalization which exceeds 90 days.

Judicial Process

The judicial process recommended by the joint subcommittee applies to minors 14 or over who object to hospitalization. The process is begun by petition. Initial processing of the petition is handled by the intake officer of the juvenile court, to ensure that this threshold determination is made by a person available 24 hours a day and familiar with the needs and problems of children. The intake officer should investigate nonjudicial alternatives for procuring needed treatment prior to the filing of the petition to allow a consensual resolution of the problem whenever possible. Once a petition is filed, the hearing should take place between 24 and 72 hours after the filing, to allow time for preparation for the hearing but to expedite it. Counsel should be appointed no later than 12 hours before the hearing.

The process should include prescreening by the community services board regarding availability of less restrictive alternative treatment modalities and an assessment by an independent evaluator concerning whether the commitment criteria are met.

The responsibilities of the attorney for the minor should be specified, to include interviews and examination of records as appropriate to allow full representation of the minor. Compensation for appointed attorneys should be raised to $86 from the $25 now paid in commitment cases.

The joint subcommittee recommends criteria for commitment which are distinct from those applied to adults and which address a child's needs more specifically. Current law authorizes commitment of an individual when, because of mental illness, he (i) presents an imminent danger to himself or others or (ii) is unable to care for himself. The joint subcommittee recommends criteria which authorize commitment when

> [b]ecause of mental disorder or substance abuse, the minor either (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control.

The revised criteria do not use the word "imminent"; this change eliminates the need to show almost certain harm before needed treatment is available. What constitutes a serious danger is carefully defined. The criteria of "unable to care for self," ambiguous as applied to children, is eliminated. The criteria address the developmental problems which most frequently are responsible for children's need for mental health treatment, as opposed to the psychoses which are more often seen in adults and which are addressed by criteria in current law.

Prior to commitment, hospitalization should also be found to be the least restrictive alternative and the child should be found to be reasonably likely to benefit from the proposed treatment. The minor's parents should also approve the commitment unless the placement is necessary to protect the minor's life, health or normal development and the issuance of a removal order or protective order is authorized by law.

As in the nonjudicial process, the period of hospitalization should be shortened from 180 to 90 days to minimize the effects of a child's removal from his family and community.

Also, as with nonjudicial admissions, a treatment plan should be prepared for the child soon after admission. The child's status and condition should be reviewed, in writing, at least every 30 days to ensure that the commitment criteria are met and that the treatment plan continues to be appropriate. This review should be reported in writing to the court, which must terminate the commitment if the criteria are no longer met. Current law does not require any such periodic review of a patient involuntarily committed for mental health treatment. A child committed may consequently remain hospitalized involuntarily after he no longer meets the criteria for such hospitalization.

A predischarge plan, the contents of which should be specifically set forth in the statute, should be developed in all cases to ensure adequate follow up upon discharge.

The court should be authorized to order the child's parents to comply with reasonable conditions relating to the minor's treatment, in recognition of the important role parents must play in the mental health treatment of their children.

The community services boards should work with juvenile courts and inpatient service providers to ensure that the provisions of the statute are implemented.

The joint subcommittee considered whether the statutory procedure should apply to treatment modalities other than hospitalization and recommends that the issue be resolved by defining inpatient treatment to include hospitalization or treatment in any facility substantially similar to a psychiatric hospital with regard to its limitations on freedom and its therapeutic intrusiveness. The State Board of Mental Health, Mental Retardation and Substance Abuse Services should develop standards for determining whether a given treatment modality meets this definition.

EMERGENCY ADMISSIONS

Authority in current law for taking a child into custody in an emergency is unclear; some hospitals reportedly will not take children on temporary detention orders which are issued under current statutes. It is therefore recommended that an emergency admission procedure be established which allows treatment for up to 72 hours

without a judicial order when a parent, law-enforcement official or mental health provider believes that immediate treatment is needed. This may resolve a crisis to allow follow-up treatment without judicial intervention. If the situation is not stabilized and the minor wishes to leave, a petition must be filed and a hearing held. The procedure also allows immediate treatment pending a commitment hearing. Before admission pursuant to this procedure, an independent evaluator should determine that the minor appears to meet the criteria for commitment and that immediate inpatient treatment is needed to protect the safety of the minor or others.

QUALIFIED EVALUATOR

Current law requires an examination of persons who are the subject of involuntary commitment proceedings by a psychiatrist or clinical psychologist, or, if neither is available, by a physician or psychologist who is licensed in Virginia and qualified in the diagnosis of mental illness. In addition, the community services board screens all voluntary admissions to state hospitals and all involuntary admissions. The joint subcommittee's recommendations expand the role of the examiner--referred to as a "qualified evaluator"--by requiring that he perform a clinical screening function in all voluntary, involuntary or emergency admissions of minors and periodically review the appropriateness of the hospitalization. The evaluator should be independent, that is, he should have no involvement at the time of the evaluation or in the future with the treatment of the minor and derive no financial benefit from admission to a private facility. The qualifications of the evaluator track current language by specifying that he must be either a licensed psychiatrist or psychologist skilled in the diagnosis and treatment of mental disorder in minors. However, to address the problem of lack of availability of persons with such qualifications, the joint subcommittee recommends that if such professionals are unavailable, the community services board should be authorized to designate an evaluator who meets qualifications established by the MHMRSAS Board.

Respectfully submitted,

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Footnotes

[1] Pierce v. Society of Sisters, 268 U.S. 510 (1925); Wisconsin v. Yoder, 406 U.S. 205 (1972)

[2] Prince v. Massachusetts, 321 U.S. 158 (1944); Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

HOUSE JOINT RESOLUTION NO. 97

Establishing a joint subcommittee to study the commitment statutes as they relate to the admissions of minors to psychiatric hospitals.

Agreed to by the House of Delegates, February 16, 1988
Agreed to by the Senate, March 9, 1988

WHEREAS, the Code of Virginia does not differentiate between minors and adults in its statutes related to the voluntary and involuntary admissions of patients to psychiatric hospitals (§§ 37.1-65 and 37.1-67.3); and

WHEREAS, the statutes of Virginia accord the same rights to minors, regardless of their young age or stage of cognitive development, as to adults in consenting to or refusing psychiatric treatment; and

WHEREAS, the rights and responsibilities of a minor's parents or guardian are not adequately considered in the current commitment law; and

WHEREAS, a voluntary admissions law for minors should facilitate hospitals in planning and carrying out treatment in a manageable way; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study the laws relating to admissions to psychiatric hospitals. The study shall examine such topics as: (i) the effects of current commitment statutes on the rights of minors and parents; (ii) the efficacy of separate commitment laws for minors and adults; (iii) the relationship between accessible community services and the need for committing minors to facilities; and (iv) the development of proposed statutes, if necessary.

The joint subcommittee shall be composed of five members: one member from the House Courts of Justice Committee, and two members from the House Health, Welfare and Institutions Committee, to be appointed by the Speaker of the House; one member each from the Senate Courts of Justice Committee and the Senate Rehabilitation and Social Services Committee to be appointed by the Senate Committee on Privileges and Elections.

The joint subcommittee shall complete its work and make its recommendation to the 1989 Session of the General Assembly.

The indirect costs of this study are estimated to be $13,045; the direct cost of this study shall not exceed $6,300.

November 26, 1988

Here is an updated copy of the psychiatric hospitalization of minors survey results. The addition of six hospitals which sent late returns did not substantially change the general contours of the data. The two most significant changes, both of which were anticipated, were as follows:

1. With the addition of several private psychiatric hospitals which admit young children, the percentage of minors 11 years of age and younger who were hospitalized pursuant to some sort of judicial process dropped from 39% to 31%. In the preliminary data set, most of the children hospitalized pursuant to judicial process were in DMHMRSAS hospitals and consequently governed by Departmental Instruction #60.

2. The percentage of minors hospitalized pursuant to some sort of judicial process in DMHMRSAS hospitals saw an overall drop from 89% to 75%. A Northern Virginia facility which admits only older adolescents had no judicial admissions in its patient sample and was responsible for this drop.

Another potential downfall of the initial data was the underrepresentation of Tidewater psychiatric hospitals in the hospital sample. That fault was corrected with the addition of the late responding hospitals, only one of the Tidewater having ultimately failed to respond.

PSYCHIATRIC HOSPITALIZATION OF MINORS
A SURVEY OF POLICY AND PRACTICE IN VIRGINIA
Updated, November, 1988

Prepared for the legislative joint subcommittee studying admission of minors to psychiatric facilities by:

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SUMMARY

This study was undertaken in order to discover how hospitals in both the public and private sector understand and implement current civil commitment laws as they apply to minors. The data collected is descriptive in nature and not intended to prove or disprove any particular hypotheses. The Institute of Law, Psychiatry and Public Policy with assistance from the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Virginia Hospital Association developed three survey instruments which were directed to the chief operating officers of both psychiatric hospitals and general hospitals with psychiatric units. Forty hospitals responded, a response rate of 93%. Without the help and cooperation of the responding hospitals, it would have been impossible to gather this information. Responding hospitals are to be commended for their forthright and timely assistance.

Responding hospitals reported 546 psychiatric admissions of minors during the month of March, 1988. It is difficult to predict an annual figure from this number because of the variation from month to month in psychiatric admission rates, and because some hospitals did not respond to the survey. Based upon 1987 aggregate data provided by the hospitals and these March admissions, hopwever, an annual figure of 4500-5000 psychiatric admissions of minors is probably not too far off the mark.

A patient sample consisting of the first ten consecutive minors admitted for psychiatric treatment beginning March 1, 1988, in each hospital was isolated for study. The inquiry focused on information of particular importance to the civil commitment process such as the age of the minor patient, the length of his hospitalization, and various factors relating to patient consent and judicial intervention. No general demographic data (eg. race, sex, etc.) was gathered.

More than half of the patient sample, consisting of 324 children ranging in age from 6 to 17, were older adolescents, 15 -17 years of age.

Once admitted to the hospital, most of the sample patients (54%) remained hospitalized between 4 and 30 days. The mean length of stay was 21 days. DMHMRSAS hospitals reported the largest percentage of juveniles staying longer than 30 days, while general hospitals reported the largest percentage of minor psychiatric patients staying 3 days or less.

Affective disorders accounted for almost half of all primary admitting diagnoses in the patients sampled. Undifferentiated depression was the single most frequently cited primary admitting diagnosis.

About one-third of the sample had a recorded prior psychiatric hospitalization. Minors in DMHMRSAS hospitals were more likely than those in other types of hospitals to have a recorded prior hospitalization.

The vast majority of the patients sampled (87%) were reported to be in parental custody. With only two exceptions, hospitals articulated identical psychiatric admission policies for minors in state custody as for those in parental custody. Length of stay did not differ according to custody. As would be expected, minors in state custody were more likely to be hospitalized in DMHMRSAS hospitals. They were also twice as likely to be hospitalized pursuant to court process as minors in parental custody.

Within our patient sample, 64% of all minors were "voluntary" admissions; that is, there was no court involvement in their admission. Written consents had been signed by 54% of the minors in the sample. Among minors initially hospitalized as "voluntary" patients, fewer than 2%, experienced any judicial intervention during the course of the reported hospitalization. By contrast, nearly a third (29%) of minors initially admitted pursuant to court order experienced some sort of legal status change during the course of the reported

hospitalization. A "legal status change" for purposes of this survey was defined as any change from "voluntary" to court-ordered status, from court-ordered to "voluntary" status, or a chnage from one type of court-ordered status to another.

In addition to gathering patient information, the survey also sought to elicit hospital policies concerning the legal aspects of psychiatric admissions of minors. The clearest and perhaps single most important message of the survey responses is that there is enormous variation in the policies expressed by hospitals across the Commonwealth for making psychiatric admission decisions for minors. Not only do stated policies vary widely (see TABLE B), but actual practice, as measured by the patient sample, may vary from the stated policy. The likelihood of judicial involvement in a minor's hospitalization may depend upon such factors as the type of hospital making the admission decision, the age of the minor, whether the minor is objecting or assenting to hospitalizaiton and the geographic region of the state in which the hospital is located. Even when these variables are controlled, practice is by no means uniform, although some trends do emerge.

Hospitals operated by DMHMRSAS are both most likely to express a policy of invoking judicial process when admitting a minor to psychiatric hospitalization, and to follow such a practice, as evidenced by the very large proportion of their admissions which were judicially involved (75%). Conversely, responding general hospitals with psychiatric units were very unlikely either to express a policy of invoking the judicial process, or to follow such a practice. Only 25% of all juvenile psychiatric patients sampled in general hospitals had undergone some sort of judicial admission process. Private psychiatric hospitals expressed policy choices which supported the use of judicial process for minors who objected to hospitalization, and that

preference became stronger as the age of the minor increased. On the other hand, policy choices for assenting minors reflected a willingness to forego judical involvement. In practice, only 27% of all sampled minors in private psychiatric hospitals were admitted pursuant to judicial process.

Judicial involvement in the admission proces did not seem to vary significantly by age. 31% of children eleven yers of age and younger were admitted to the hospital pursuant to some sort of judicial process. The same percentage of 15-17 year olds in the patient sample had judicailly involved admisions. The percentage of 12-14 year olds who were admitted pursuant to judicial process was somewhat lower, 26%

Minors hospitalized in the Richmond/Petersburg area were somewhat more likely than those in other geographic areas to be hospitalized pursuant to some sort of court order. Thirty-five per cent of the minors sampled in the Richmond area hospitals were judicial admissions. This compares with 34% in the Western area, 28% in the Tidewater area and 23% in the Northern Virginia area.

Introduction

This is a study of hospital policy and practice with regard to the psychiatric hospitalization of minors. It was undertaken in an effort to inform the deliberations of the joint legislative sub-committee charged by the Virginia General Assembly with studying the impact of laws regulating the admission of minors to psychiatric facilities (House Joint Resolution No. 97). The goals of the study were two: 1) to determine how hospitals interpret current commitment law in making psychiatric admission decisions for minors; and, 2) to develop a picture of a sample of actual juvenile psychiatric patients, with particular attention to their legal status, that is whether or not there was any judicial involvement in their admission to the hospital and if so, what kind. It was the intent of the study to provide descriptive data

rather than to test any particular hypotheses with regard to the interrelationships among the many variables bearing upon this issue.

Methodology

Three survey instruments were prepared by the Institute of Law, Psychiatry and Public Policy with the assistance of DMHMRSAS and the Virginia Hospital Association. Responses were computerized in order to facilitate comparison of certain variables.

The first instrument, AGGREGATE DATA FOR CALENDAR YEAR 1987 (aggregate data), requested those hospitals with easily accessible data to provide information about the total number of juvenile psychiatric admissions for calendar year 1987, including a break down of total admissions by patient age, legal status, and diagnosis, as well as the average length of stay.

The second instrument, PSYCHIATRIC HOSPITAL ADMISSION QUESTIONNAIRE, was divided into three parts. The first part sought descriptive information about the responding hospital such as the number of psychiatric beds reserved for minors, the provision of outpatient psychiatric services, types and percentages of third party payment, admissions review practices and minimum age policies. The second part of the instrument requested those respondents which admitted minors 17 years of age or younger to respond to a series of ten hypothetical situations by choosing one of several statements which best reflected the hospital's admission policy. The hypotheticals presented admission and release decisions for minors of various ages, some of whom were actively protesting hospitalization, and others of whom were expressing no overt opinion on the matter ("assenting minors"). Possible responses included options ranging from exclusive reliance on parental consent to seeking various types of court involvement.

The third part asked for the total number of minors admitted to the respondent hospital for psychiatric treatment during the month of March, 1988. Respondent was then instructed to complete one copy of the third instrument, A SURVEY OF ADMISSIONS TO PSYCHIATRIC FACILITIES DURING MARCH, 1988 (survey), for each of the first ten minors so admitted. If fewer than ten minors were admitted during the month of March, respondent was asked to include admissions in subsequent months until a total of ten surveys had been completed. The survey instrument was to be completed by examining the minor patient's chart in order to gather such information as the age and admitting diagnosis of the patient, length of stay for this hospitalization, the patient's legal status, the patient's legal custodian, whether or not the patient had a history of prior psychiatric hospitalization, and who was responsible for the patient's bill.

Surveys were mailed to 47 hospitals, 40 of which had been identified by the Virginia Hospital Association as psychiatric hospitals or general hospitals with psychiatric units. The remaining 7 were hospitals operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. The surveys were directed to the chief operating officer of the hospital. Four hospitals were deleted from the survey because they did not admit minors for psychiatric treatment. Of the remaining 43 hospitals, 40 have responded, an overall response rate of 93%.

All but one of the responding hospitals completed the PSYCHIATRIC HOSPITAL ADMISSION QUESTIONNAIRE (questionnaire) thoroughly. With two exceptions, those hospitals which completed fewer than ten chart surveys were hospitals with very small numbers of minor psychiatric admissions. Such hospitals completed chart surveys for as many admissions as they had. A total of 324 chart survey responses were thus generated and compose the patient data set.

Because of varying record-keeping practices, the responses to the AGGREGATE DATA form were much less complete. Most hospitals were able to supply the total number of psychiatric admissions for 1987, the total number of minor psychiatric admissions for that year, and the average length of stay for minor psychiatric patients. Data describing ages of minor patients, their legal status, individual lengths of stay and admitting diagnoses for calendar year 1987 were frequently unavailable.

Respondent hospitals were given the name and phone number of a person to contact in the event that they had any questions or problems with the survey. Several hospitals took advantage of this opportunity. Extensive telephone follow-up was done to clarify any ambiguous or incomplete responses. Non-responding hospitals were contacted both by phone and by mail and encouraged to complete the survey so that a thorough and accurate report could be made to the joint subcommittee.

Respondent hospitals are to be commended for their generous cooperation in completing these instruments. While every effort was made to simplfy the response process, the necessity of getting patient data from individual patient charts made the survey time-consuming to complete. Hospital personnel were very gracious in providing telephone clarification when needed, and in expediting the return of the completed survey forms. Without the voluntary cooperation of the hospitals, it would have been impossible to gather the kind of data that the survey has made available to the joint subcommittee.

THE HOSPITAL SAMPLE

Our sample group of hospitals is comprised of 40 hospitals. Seven of these are operated by DMHMRSAS. Another 11 are private psychiatric hospitals. The remaining 22 are psychiatric units of general hospitals. Three hospitals failed to respond to the survey. They included 1 private psychiatric hospital

and 2 general hospitals. The response rate for all hospitals was 93%. The response rate for DMHMRSAS hospitals was 100%. The response rate for general hospitals with psychiaric units was 92%. The response rate for private psychiatric hospitals was 92%.

Respondent hospitals are fairly evenly distributed geographically: 7 are in the Tidewater area, 9 are in the Richmond/Petersburg area, 10 are in Northern Virginia, and the remaining 14 are in the western part of the state, stretching from Winchester to Bristol. The non-responding private psychiatric hospital is in Tidewater. The 2 non-responding general hospitals are in the Richmond area. Because of the high response rate and the variety of hospital type and location, responding hospitals provide a reasonably complete picture of hospital policy and practice with regard to the psychiatric hospitalization of minors in Virginia.

During calendar year 1987, responding hospitals reported a total of 32,613 psychiatric admissions for persons of all ages, of which 4,874 were minors. Of these minors, 70% (N=3429) were hospitalized in private psychiatric hospitals, 15% (N=730) were in hospitals run by DMHMRSAS, and another 15% (N=715) were patients in the psychiatric unit of a general hospital.

Responding hopspitals reported a total of 1681 psychiatric beds available for minor patients: 22% (N=378) of these are provided by DMHMRSAS, 43% (N=715) are in private psychiatric hospitals, and the remaining 35% (N=588) are on the psychiatric units of general hospitals. Only 660 of these beds are actually reserved for children and adolescents. The remaining beds are undesignated. The questionnaire did not inquire whether all of these beds would be made available to involuntary (eg. TDO's) as well as to "voluntary" patients.

Of the responding private psychiatric hospitals, 64% (N=7) offer outpatient psychiatric therapy as well as inpatient treatment, while 32% (N=7)of the responding general hospitals and only one (14%) of the DMHMRSAS

hospitals offer outpatient psychiatric treatment. In some cases the outpatient treatment is available only to former inpatients at the treating hospital.

Only 20% (N=8) of all responding hospitals required an in-house preadmission evaluation. However, 60% (N=22) of all responding hospitals routinely undertook post-admission reviews.

The following information is set out in Table A: Five hospitals stated that they had no minimum age policy for psychiatric admissions; 7 hospitals had a minimum age policy of 10 years of age or younger; 10 hospitals require a minor patient to be at least 12 years of age; 4 hospitals have set 13 as their minimum age; 8 hospitals have a minimum age policy of 14; 4 hospitals, all of which are general hospitals, had a minimum age policy of 16. Only 3 of the general hospitals (14%) accept children 10 years of age or younger, while more than half of the private psychiatric hospitals accept them (N=6) and 3 of the 7 DMHMRSAS hospitals (43%) will take young children.

Because the hospitals were assured that the survey results would not be reported in such a way as to identify a particular hospital, the responding hospitals in Table A are separated by type and identified by number only. Although there were 6 possible hospital types in the questionnaire (DMHMRSAS, psychiatric unit/general proprietary hospital, psychiatric unit/general voluntary hospital, proprietary psychiatric hospital, voluntary psychiatric hospital and university-affilitated hospital), the responses have been collapsed into 3 groups. DMHMRSAS remains the same, that is, those hospitals operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Proprietary and voluntary psychiatric hospitals were collapsed into "private psychiatric hospitals." With one exception, all of the responding hospitals in these two categories were proprietary. The remaining three groups were also collapsed. With three exceptions, responding general hospitals were all voluntary. One university-affiliated hospital responded.

Because it was most like a general hospital in its overall response pattern, especially in the small number of minor psychiatric admissions, it was included with the general hospitals.

It is important to note that only institutions licensed as hospitals were included in the survey. Other types of residential treatment facilities upon whose patients HB 414 might have an impact were not included in this survey.

THE PATIENT SAMPLE

From the total March admission census of 546 minors reported by responding hospitals, the survey identified a sample consisting of the first 10 minor psychiatric admissions in that month from each hospital for more detailed study. By examining patient charts, hospitals were to provide information concerning age, diagnosis, length of stay, legal status, prior hospitalization and insurance coverage for each patient in the sample. The total sample of patients thus obtained is 324. Hospitals with fewer than 10 March admissions were instructed to provide a sample of 10 patients by continuing with patient admissions in chronological order until a sample size of 10 was obtained. In some cases, particularly for some general hospitals, there were fewer than 10 minor psychiatric admissions from March 1 until the date the survey was completed. In those cases, individual hospital samples of fewer than 10 were obtained. In each case where there were fewer than 10 surveys returned, telephone follow-up was made to assure accuracy. In two cases smaller samples were returned because those particular respondent hospitals felt it too burdensome to complete the entire sample. We are nonetheless confident that this sample of 324 admissions is representative of minors admitted to hospitals for psychiatric treatment in 1988.

AGE

The ages of the patients within the sample break down as follows:

Age (in years)(sample)	Number	Percentage
11 or younger	30	9%
12	11	3%
13	23	7%
14	53	16%
15-17	207	64%

The aggregate data reflected a similar trend. A relatively small percentage of all admissions for calendar year 1987 were of children 11 or younger. Roughly one quarter of all admissions fell within the early adolescent years of 12-14. A disproportionately large percentage, nearly two-thirds, was comprised of minors in their later teenage years, ages 15-17. Among the 22 hospitals which were able to break down their 1987 admissions by age for the aggregate data form, the admissions were as follows:

Age (in years)(1987)	Number	Percentage
11 or younger	253	9%
12	146	5%
13	208	8%
14	385	11%
15-17	1717	63%

The younger patients in the sample exhibited more variation in primary diagnosis than their older counterparts. Among patients 11 years of age or younger, 27% had a primary admitting diagnosis in the group of conduct disorders; 20% fell within organic disorders; 27% fell within miscellaneous disorders of childhood; 20% were affective disorders, and 7% were pervasive developmental disorders. By comparison, almost 50% of the primary diagnoses i

both the 12-14 and the 15-17 age groups fell within the group of affective disorders. Miscellaneous disorders of childhood, which includes adjustment reaction/disorder, accounted for roughly 20% of the primary diagnoses in these older age groups. Conduct disorders accounted for 20% of the diagnoses in the 12-14 age group. Drug related diagnoses represented 10% of the diagnoses in the 15-17 age group.

Younger patients in the sample were more likely to be in private psychiatric hospitals than were older patients. Of sampled patients 11 years of age or younger, 67% were in private psychiatric hospitals; 27% were in DMHMRSAS hospitals, while only 6% were in psychiatric units of general hospitals. Older adolescents, by contrast, were more likely to be in general hospitals. Of the sample patients aged 15-17, 54% were in general hospitals; 27% were in private psychiatric hospitals and 18% were in DMHMRSAS hospitals. General hospitals also had the largest share of the 12-14 age group at 45%; 29% of these younger adolescents were in private psychiatric hospitals, while 26% were in DMHMRSAS hospitals.

LEGAL STATUS

Court Orders

If "voluntary psychiatric admissions" are defined as those which proceed without any judicial involvement, then the vast majority of minors in our sample are considered to be "voluntary psychiatric admissions." Among the patients sampled, 64% (N=206) were hospitalized without judicial involvement of any kind. Of the remaining 36% (N=116) who were admitted via judicial process, more than two thirds (69%, N=80) were brought to the hospital by someone other than a parent or came to the hospital unaccompanied. The police or an unrelated legal guardian (eg. social worker) was that "other than parent" in 62 of those 80 admissions. By contrast, when one or both parents brought the

minor to the hospital, 82% (N=168) were admitted without judicial process.

There is a range of possible judicial status for those minors hospitalized pursuant to court order. Like adults, minors may become "court-ordered voluntary" patients (Va. Code §37.1-67.2), civilly committed involuntary patients (Va. Code §37.1-67.3), or may be temporarily detained pursant to a TDO (Va. Code §37.1-65). Minors may also be hospitalized for court-ordered evaluations pursuant to Virginia Code §16.1-275. In our sample, TDO's accounted for not quite half of the judicial admissions (42%, N=49), while involuntary civil commitments accounted for about a third (30%, N=35).

Consent

This study was not designed to evaluate the nature and quality of the consents signed by minors or the circumstances under which consent was given. Rather it identified those sample patients whose records disclosed that a consent to hospitalization had been signed. By combining that information with the "court status" ("voluntary", TDO, civil commitment, etc.) information supplied in the survey, a combined variable, "summary status," was developed. The "summary status" variable was defined as follows: "recorded consent" describes those minors who were hospitalized without any judicial involvement and whose records indicated that they had signed a consent to the hospitalization; "non-judicial" describes those minors for whom there is no record of a signed consent, but who, nevertheless, were hospitalized without court order; finally, "judicial" describes those minors who were hospitalized pursuant to some sort of court order, whether or not their records disclosed a signed consent. The following table shows how this summary status variable applies to minors in various age groups in the patients sampled.

AGE	SUMMARY STATUS		
	RECORDED CONSENT	NONJUDICIAL	JUDICIAL
11 OR YOUNGER	41% (N=12)	28% (N=8)	31% (N=9)
12 -14	54% (N=41)	20% (N=15)	26% (N=20)
15 -17	49% (N=92)	20% (N=38)	31% (N=58)

These figures would suggest that hospitals do not treat children of different ages differently when seeking written consent to hospitalization. This is surprsing in view of the hospital responses to hypothetical policy questions in which they express deference to the stated opinions of older children, and greater willingness to invoke judicial process for those older children. The similarity of the figures calls into question the correspondence between stated policies and actual practice. The figures also call into question the nature and quality of the consents signed by the minor patients.

Status Change

About 121% of the patients in the sample underwent a change in legal status during the course of the reported hospitalization. For the most part, a legal status change involved a change from one court-ordered status to another (eg. from a TDO to an involuntary civil commitment). It sometimes involved a change from a court-ordered status to a "voluntary" status, and much less frequently a change from a "voluntary" status to some court-ordered status. Minors initially admitted without court involvement were highly unlikely to experience court involvement at any time during the course of the reported hospitalization. For these "voluntary admissions" fewer than 2% experienced subsequent judicial involvement during their reported hospitalization. By contrast, 29% (N=34) of those minors who were initially admitted to the hospital pursuant to some sort of court order experienced a change in legal status during their hospitalization. A small number of these (N=7) initially

admitted under a TDO became "voluntary" patients. The remainder (N=27) exchanged their initial court ordered status for a different court ordered status (eg. TDO to involuntary civil commitment).

Although minors in state custody and minors in parental custody were equally unlikely to have a change in legal status (88.15% as compared with 87.80%), it did seem to make a difference who brought the minor to the hospital. Only 7% (N=14) of the minors presented for hospitalizaiton by one or both of their parents experienced a change in legal status during their hospitalization. Twenty-six per cent (N=8) of the minors brought to the hospital by the police had a change in legal status. Seventeen per cent (N=8) of those brought by an unrelated guardian (eg. social worker) had some sort of legal status change.

CUSTODIAL STATUS

Within our sample, 87% (N=270) of the minors were reported to be in parental custody. Children in parental custody were more than twice as likely to be admitted as "voluntary patients" (that is, outside the judicial process) as those in state custody. Seventy per cent of children in parental custody were voluntary admissions compared with 37% of those in state custody. Because minors in state custody are more likely to be hospitalized in DMHMRSAS hospitals, the higher proportion of judicial admissions for children in state custody could well be a function of DMHMRSAS hospital policy rather than a consequence of custodial status per se.Children in parental custody were less likely to be hospitalized in a hospital operated by DMHMRSAS. Only 17% of the sample patients in parental custody went to DMHMRSAS hospitals, whereas 44% of those in state custody did so.

Children in state custody were more likely to have had a prior psychiatric hospitalization than were those in parental custody. Of the sampled patients

in parental custody 29% had a recorded prior hospitalization, while 60% of sample patients in state custody had a recorded prior hospitalization.

DIAGNOSIS AND PRIOR HOSPITALIZATION

Respondent hospitals were asked to provide a primary admitting diagnosis for each patient in the sample and to list any additional significant presenting diagnoses if applicable. The diagoses enumerated by respondents were grouped into 7 major categories: *affective disorders* (including undifferentiated depression, atypical depressive disorder, major depression/single episode, major depression/recurrent episode, major affective disorder, suicide attempt, suicidal ideation, dysthymic disorder, and bipolar disorder); *conduct disorders* (including oppositional disorder, undifferentiated conduct disorder, personality disorder, intermittent explosive disorder, solitary aggressive conduct disorder, and socialized conduct disorder); *stress/anxiety disorders* (including dissociative disorder, post traumatic stress disorder, and anxiety); *organic disorders* (including organic psychoses, attention deficit disorder, and hallucinogenosis); *pervasive developmental disorders* (including schizophrenia, autism, paranoid schizophrenia, schizotypal, schizoaffecitve and schizoid disorders); *drug related disorders* (including undifferentiated substance abuse, alcohol abuse/dependence, polysubstance abuse, and drug overodose); and *miscellaneous disorders of childhood* (including neurotic depression, emotional disturbances of childhood, eating disorders, adjustment disorders, adjustment reaction, mental retardation, developmental disorder, and parent-child problem).

Each chart surveyed listed a primary admitting diagnosis. About half (N=152) went on to list a second significant admitting diagnosis, while a much smaller number (N=36) listed as many as three. Affective disorders were cited as the priamry admitting diagnosis in nearly half of all of the patients in the

sample (47%, N=151). Major depression was the single most frequently cited diagnosis. About 21% of the primary diagnoses fell within the group called miscellaneeous disorders of childhood. Adjustment disorders/reactions were the most frequently cited in this category. Conduct disorders accounted for 16% of the primary diagnoses, while drug related disorders were cited in 8% of the cases as the primary admitting diagnosis. Drug related disorders accounted for larger percentages of the secondary and tertiary diagnoses (22% and 17% respectively).

About one third of the sampled patients had a recorded prior hospitalization (34%, N=110). Patients at DMHMRSAS hospitals were more likely to have a record of prior hospitalization than those at other types of hospitals: 69% (N=46) of DMHMRSAS patients in the sample had a record of prior psychiatric hospitalization as compared with 23% for general hospitals and 28% for private psychiatric hospitals. Slighly more than 7% of the surveys indicated that this information was unknown, but with a mobile society and the difficulty of insuring the completeness of medical histories, the possibility must be considered that a response of no prior hospitalization reflects the absence of any affirmative evidence to the contrary rather than any certainty that there was, in fact, no prior hospitalization.

LENGTH OF STAY

Length of stay for patients in this sample ranged from as short as one day to as long as 157 days. There were 6 patients within the sample who were still hospitalized at the time the chart surveys were completed. Without considering those six patients, the mean length of stay in the sample was 21.4 days. This compares with the reported 1987 aggregate data mean of 36 days. Obviously, the impossibility of including the 6 still hospitalized patients within the sample mean calculation causes it to be slightly lower than it otherwise would be.

Most of the patients in the sample were hospitalized between 3 and 30 days (54%, N=174). Twenty-three per cent (N=74) of the sample stayed in the hospital for 3 or fewer days, while another 23% (N=73) were hospitalized for more than 30 days. The longer hospitalizations break down as follows: 9% (N=29) 31-45 days, 9% (N=27) 46-90 days, and 5% (N=17) more than 90 days.

Length of stay did not seem to vary with the age of the patient or with the custodial status of the patient.

A larger percentage of the patients hospitalized at DMHMRSAS hospitals had stays longer than thirty days. Forty-eight per cent of the DMHMRSAS sampled patients had hospital stays of longer than 30 days. General hospitals had the largest percentage of patients with short stays. Thirty -six percent of general hospital patients were hospitalized three or fewer days. Another 58% had stays of 4 - 30 days, while only 7% stayed longer than 30 days. Private psychiatric hospitals resembled general hospitals in having a large percentage of patients staying 4-30 days (53%). Private psychiatric hospital sample patients were more likely than those at general hospitals to stay longer than 30 days (31%). 16% of the sample at the private psychiatric hospitals stayed 3 or fewer days.

PAYMENT SOURCE

For our patient sample, records indicated that 9% of the patients' bills would be paid by Medicare/Medicaid. About 20% would by paid by Blue Cross/ Blue Shield. Other commercial private health insurance accounted for 31% of the bills in this sample. Champus was 14%, HMO's 3%, and private pay, 8%. About 21% of the sample responded "other," most of which was explained as "written off" or paid by state funds. No patients in the sample were receiving funds for this hospitalization through their school district. Only one was recorded to be participating in a PPO. As would be expected, commercial

private health insurance and Blue Cross/Blue Shield are the primary third party payors for general hospitals and private psychiatric hospitals, while DMHMRSAS hospitals rely more heavily on public funds. This survey was not designed to identify specific coverage provisions relating to psychiatric services. It is noteworthy that the mean hospital stay within our sample (21.4 days) as well as the majority of individual stays (54% in the 4-30 day category) are within the 30 day mental health coverage mandated by state law.

PSYCHIATRIC ADMISSION POLICIES FOR MINORS

One of the two major goals of the survey was to determine how current civil commitment law is understood by hospitals in the Commonwealth which provide inpatient psychiatric treatment to minors. In order to do this, a series of hypothetical questions were posed to hospital administrators. They were instructed to choose the response which most closely represented their hospital's standing policy with regard to the psychiatric admission of minors. The possible repsonses forced them to consider the relevance, if any, of such factors as the age of the minor, the minor's expressed opinion, and the nature of the decision to be made (eg. whether to admit or to release the minor).

A set of three identical hypotheticals was posed for an 8 year old, an 11 year old and a 15 year old. The first involved a minor brought to the hospital by his parents, for whom hospitalization was appropriate, and who clearly objected to being hospitalized. Possible responses included relying on parental consent for a "voluntary" admission, seeking a TDO and commitment proceedings, seeking commitment proceedings, but holding the minor in the interim without a TDO, and denying admission or referring the minor to another hospital. If none of these choices was acceptable to the responding hospital, it was free to choose "other" and explain what procedure it would follow.

The second hypothetical was similar to the first except that the minor,

instead of objecting to being hospitalized, was merely silent on the subject, an "assenting" patient. Possible responses included admitting the minor based upon his presumed consent and his parents' consent, actively seeking the minor's informed consent, but ultimately relying on the parents' consent for a "voluntary" admission, instituting commitment proceedings if the minor was incapable of giving informed consent, and "other."

The third hypothetical looked at the release decision. Responses included looking solely to the parents for authority to release, honoring the minor's expressed decison to leave, instituting commitment proceedings and "other."

TABLE B sets out the simple frequencies of the responses to these policy hypotheticals. With an age neutral civil commitment statute such as the one currently in effect, it might have been expected that there would be no difference in response for the same hypothetical at different ages. One might also have expected that a clear understanding of the current law would have yielded substantially similar responses from hospital to hospital. Those who interpret the law as applying differently to private and public sector hospitals might have expected any differences in reposnses to fall roughly along public/private lines.

None of these expectations are reflected in the responses actually given. As TABLE B makes clear, there is a wide variation in policy choices for each of the hypothetical situations. While some generalizations can be drawn from the choices made, the clearest conclusion that can be reached from these responses is that there is no clear consensus as to what current law requires in the area of psychiatric hospitalization of minors.

Even though there is no overall agreement about what the law requires in this area, there are several interesting trends in the responses. Expressed policy, as reflected in the responses to the hypotheticals suggested that: 1) hospital type was a significant factor in a hospital's inclination to invoke

the judicial process when admitting a minor for psychiatric treatment; 2) some types of hospitals vary their policy according to the age of the patient to be admitted; and, 3) some types of hospitals vary their policy according to whether the minor is objecting to hospitalization or merely assenting.

TABLE C sets out the expressed policy choices when viewed as a function of hospital type. For all three ages and regardless of whether the minor is protesting or assenting, the DMHMRSAS hospitals express a strong policy in favor of seeking court involvement. General hospitals express an equally strong but opposing policy in favor of relying on parental consent and staying out of court. In those cases where general hospitals found court involvement to be appropriate, they were slightly more likely to invoke judicial process for objecting than for assenting patients. They were also more likely to accord older adolescents judicial process than younger ones. Private psychiatric hospitals were much more likely than general hospitals to express a policy of seeking court involvement, especially when the minor was objecting to hospitalization. Objecting older patients were even more likely than the younger ones to benefit from this expressed policy preference. Even though private psychiatric hospitals' expressed policies strongly favored judicial involvement for objecting minors, only 27% of the sample patients in private psychiatric hospitals were admitted pursuant to some sort of court process.

TABLE A

DMHMRSAS HOSPITALS	1987 TOTAL PSYCH *	1987 PSYCH MINORS	MARCH '88 MINORS	AVAIL BEDS MINORS	OUTPT SERV	MINIMUM AGE
#1	181	181	20	28	yes[1]	0
#2	156	156	14	60	no	2
#3	1846	151	16	40	no	7
#4	1874	95	13	25	no	14
#5	1341	97	10	15	no	14
#6	911	7	2	96	no	14
#7	1001	43	3	114	no	14
TOTALS	7310	730	78	378		
PRIVATE PSYCHIATRIC HOSPITALS						
#1	1665	368	n/a	n/a	n/a	n/a
#2	1388	470	50	108	yes[1]	0
#3	450	444	54	60	no	0
#4	2850	745	67	88	yes[1]	3
#5	357	341	45	84	yes[1]	4
#6	1736	365[3]	35	51	yes[2]	4
#7	1239	272	32	40	yes[1]	6
#8	455	148	23	48	yes[1]	12
#9	1683	n/a	1	75	no	12
#10	2086	276	32	134	yes[1]	12
#11	n/a	n/a	27	27	no	12
TOTALS	13,909	3,429	366	715		

* TOTAL PSYCH ADMISSIONS, 1987; TOTAL PSYCH ADMISSIONS OF MINORS, 1987; TOTAL PSYCH ADMISSIONS OF MINORS, MARCH, 1988, BEDS AVAILABLE TO (BUT NOT RESERVED FOR) MINORS

n/a Not available. Respondent hospital was unable to provide this information.

[1] Outpatient services are availabe to the general public.

[2] Outpatient services are available only to former inpatients.

[3] approximate

Table A continued

PSYCH UNITS/GENERAL HOSPITALS	1987 TOTAL PSYCH	1987 PSYCH MINORS	MARCH '88 MINORS	AVAIL BEDS MINORS	OUTPT SERV	MINIMUM AGE
#1	894	118	21	55	no	0
#2	575	25	2	28	no	0
#3	950	48	4	31	yes[1]	10
#4	373	31	6	25	no	12
#5	1488	152	15	13	no	12
#6	569	60	1	22	yes[2]	12
#7	1196	n/a	9	52	no	12
#8	210	55	5	12	no	12
#9	2110	99	12	n/a	yes[1]	12
#10	119	24	2	16	no	13
#11	n/a	n/a	2	28	no	13
#12	n/a	n/a	4	62	yes[1]	13
#13	352	18	3	18	no	13
#14	n/a	n/a	n/a	34	no	14
#15	n/a	n/a	7	12	no	14
#16	1151	56	1	40	yes[1]	14
#17	625	27	6	19	no	14
#18	n/a	n/a	0	23	yes[1]	15
#19	494	n/a	n/a	39	yes[1]	16
#20	n/a	n/a	2	12	no	16
#21	288	2	0	15	no	16
#22	n/a	n/a	0	32	no	16
TOTALS	11,394	715	102	588		
GRAND TOTALS	32,613	4,874	546	1,681*		

*While all of these beds are available for children and adolescents, depending upon the minimum age policy of the particular hospital, only a total of 525 beds are actually designated for this population among the responding hospitals.

TABLE B

Simple frequencies of response to admission policy hypotheticals

HYPOTHETICAL	PARENTAL CONSENT	JUDICIAL PROCESS	DENY-REFER	OTHER
1. objecting 8 year old	6	7	22	1
2. assenting 8 year old	9	3	23	1
3. objecting 11 year old	8	8	19	1
4. assenting 11 year old	11	4	19	2
5. objecting 15 year old	6	24	5	1
6. assenting 15 year old	18	9	4	6
7. 8 year old wants release	7	8	21	1
8. 11 year old wants release	8	9	19	1
9. 15 year old wants release	10	20	5	1

"Parental consent" indicates the number of hospitals which responded that they ultimately relied upon the parents' consent rather than that of the minor in making a voluntary psychiatric admission. The hospital may or may not have sought the consent of the minor or may have presumed it from his assent.

"Judicial Process" indicates the number of hospitals which responded that they felt it necessary to resort to court process, either involuntary civil commitment or temporary detention orders, in order to admit or to retain the minor in the hospital.

"Deny-Refer" indicates the number of hospitals which, because of their minimum age policy, did not accept minors of the age posed in the hypothetical.

"Other" responses were explained in a variety of ways. When they specified denying admission because of the minor's age, the response is charted here under "deny-refer." Some hospitals specified under "other" that they relied upon the local community service board to make any decsions with regard to the necessity for instituting judicial process. Many of the "other" responses on line 6 were explained by the hospitals as a requirement that the minor or the minor and his parents sign a consent to hospitalization.

The actual responses represent slightly more variation than what this table would indicate. Questions 1,3,and 5 included two different approaches to invoking judicial process which have been collapsed into 1 figure for this table. Similarly, questions 2, 4 and 6 contained two repsonses ultimately relying on parental authority and these responses have been collapsed into 1 figure for this table.

TABLE C

Policy hypothetical responses grouped by hospital type

HYPOTHETICAL	PARENTAL CONSENT	JUDICIAL PROCESS	OTHER
1. objecting 8 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	75% (N=3)	25% (N=1)	
Private Psych Hospitals	43% (N=3)	57% (N=4)	
2. assenting 8 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	100% (N=5)		
Private Psych Hospitals	80% (N=4)	20% (N=1)	
3. objecting 11 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	83% (N=5)	17% (N=1)	
Private Psych Hospitals	37% (N=3)	63% (N=5)	
4. assenting 11 year old			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	100% (N=7)		
Private Psych Hospitals	57% (N=4)	29% (N=2)	14% (N=1)
5. objecting 15 year old			
DMHMRSAS Hospitals	14% (N=1)	43% (N=3)	43% (N=3)
General Hospitals	25% (N=4)	75% (N=12)	
Private Psych Hospitals	10% (N=1)	90% (N=9)	
6. assenting 15 year old			
DMHMRSAS Hospitals	14% (N=1)	43%(N=3)	43% (N=3)
General Hospitals	74% (N=14)	5%(N=1)	21% (N=4)
Private Psych Hospitals	20% (N=2)	50% (N=5)	30% (N=3)

TABLE C continued

	PARENTAL CONSENT	JUDICIAL PROCESS	OTHER
7. 8 year old wants release			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	67% (N=4)	33% (N=2)	
Private Psych Hospitals	43% (N=3)	57% (N=4)	
8. 11 year old wants release			
DMHMRSAS Hospitals		66% (N=2)	33% (N=1)
General Hospitals	57% (N=4)	43% (N=3)	
Private Psych Hospitals	50% (N=4)	50% (N=4)	
9. 15 year old wants release			
DMHMRSAS Hospitals		83% (N=5)	17% (N=1)
General Hospitals	44% (N=7)	56% (N=9)	
Private Psych Hospitals	20% (N=2)	60% (N=6)	20% (N=2)

Percentages have been calculated based upon the number of hospitals which admit a minor of the age designated in the hypothetical. Those hospitals which responded "DENY/REFER" were omitted for the purposes of this calculation.

1989 SESSION

LD6317574

HOUSE BILL NO. 1780

Offered January 24, 1989

A BILL to amend and reenact §§ 16.1-241, 16.1-246, 16.1-280, 37.1-61 and 53.1-245 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 11 of Title 16.1 an article numbered 16, consisting of sections numbered 16.1-335 through 16.1-346, relating to mental health treatment of minors.

Patron—Stambaugh

Referred to the Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 16.1-241, 16.1-246, 16.1-280, 37.1-61 and 53.1-245 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 11 of Title 16.1 an article numbered 16, consisting of sections numbered 16.1-335 through 16.1-346, as follows:

§ 16.1-241. Jurisdiction.—The judges of the juvenile and domestic relations district court elected or appointed under this law shall be conservators of the peace within the corporate limits of the cities and the boundaries of the counties for which they are respectively chosen and within one mile beyond the limits of such cities and counties. Except as hereinafter provided, each juvenile and domestic relations district court shall have, within the limits of the territory for which it is created, exclusive original jurisdiction, and within one mile beyond the limits of said city or county, concurrent jurisdiction with the juvenile court or courts of the adjoining city or county over all cases, matters and proceedings involving:

A. The custody, visitation, support, control or disposition of a child:

1. Who is alleged to be abused, neglected, in need of services, in need of supervision, or delinquent;

2. Who is abandoned by his parent or other custodian or who by reason of the absence or physical or mental incapacity of his parents is without parental care and guardianship;

2a. Who is at risk of being abused or neglected by a parent or custodian who has been adjudicated as having abused or neglected another child in the care of the parent or custodian;

3. Whose custody, visitation or support is a subject of controversy or requires determination. In such cases jurisdiction shall be concurrent with and not exclusive of courts having equity jurisdiction, except as provided in § 16.1-244 hereof;

4. Who is the subject of an entrustment agreement entered into pursuant to § 63.1-56 or § 63.1-204 or whose parent or parents for good cause desire to be relieved of his care and custody;

5. Where the termination of residual parental rights and responsibilities is sought. In such cases jurisdiction shall be concurrent with and not exclusive of courts having equity jurisdiction, as provided in § 16.1-244 hereof;

6. Who is charged with a traffic infraction as defined in § 46.1-1 (40).

The authority of the juvenile court to adjudicate matters involving the custody, visitation, support, control or disposition of a child shall not be limited to the consideration of petitions filed by a mother, father or legal guardian but shall include petitions filed at any time by any party with a legitimate interest therein. A party with a legitimate interest shall be broadly construed and shall include, but not be limited to, grandparents and other blood relatives and family members. The authority of the juvenile court to consider a petition involving the custody of a child shall not be proscribed or limited where the child has previously been awarded to the custody of a local board of social services. In any decree involving visitation, the juvenile and domestic relations district court may provide in such decree for visitation privileges for grandparents, stepparents or other family members.

B. The *admission of minors for inpatient treatment in a mental health facility in*

accordance with the provisions of Article 16 (§ 16.1-335 et seq.) of this chapter and the commitment of a mentally ill person or judicial certification of eligibility for admission to a treatment facility of a mentally retarded person ~~. Such commitment and certification shall be~~ in accordance with the provisions of Chapters 1 (§ 37.1-1 et seq.) and 2 (§ 37.1-63 et seq.) of Title 37.1. Jurisdiction of the commitment and certification of adults shall be concurrent with the general district court.

C. Except as provided in ~~subdivision~~ *subsection* D hereof, judicial consent to such activities as may require parental consent may be given for a child , who has been separated from his or her parents, guardian, legal custodian or other person standing in loco parentis and is in the custody of the court when such consent is required by law.

D. Judicial consent for emergency surgical or medical treatment for a child , who is neither married nor has ever been married, when the consent of his or her parent, guardian, legal custodian or other person standing in loco parentis is unobtainable because such parent, guardian, legal custodian or other person standing in loco parentis (i) is not a resident of this Commonwealth, (ii) his or her whereabouts is unknown, (iii) he or she cannot be consulted with promptness, reasonable under the circumstances or (iv) fails to give such consent or provide such treatment when requested by the judge to do so.

~~D1. [Repealed.]~~

E. Any person charged with deserting, abandoning or failing to provide support for any person in violation of law.

F. Any parent, guardian, legal custodian or other person standing in loco parentis of a child:

1. Who has been abused or neglected;

2. Who is the subject of an entrustment agreement entered into pursuant to § 63.1-56 or § 63.1-204 or is otherwise before the court pursuant to subdivision A 4 of this section;

3. Who has been adjudicated in need of services, in need of supervision, or delinquent, if the court finds that such person has by overt act or omission induced, caused, encouraged or contributed to the conduct of the child complained of in the petition.

G. Petitions filed by or on behalf of a child or such child's parent, guardian, legal custodian or other person standing in loco parentis for the purpose of obtaining treatment, rehabilitation or other services which are required by law to be provided for that child or such child's parent, guardian, legal custodian or other person standing in loco parentis. Jurisdiction in such cases shall be concurrent with and not exclusive of that of courts having equity jurisdiction as provided in § 16.1-244 hereof.

H. In any case where a child is not qualified to obtain a work permit under other provisions of law.

I. The prosecution and punishment of persons charged with ill-treatment, abuse, abandonment or neglect of children or with any violation of law which causes or tends to cause a child to come within the purview of this law, or with any other offense against the person of a child. In prosecution for felonies over which the court shall have jurisdiction, such jurisdiction shall be limited to determining whether or not there is probable cause.

J. All offenses in which one family member is charged with an offense in which another family member is the victim. In prosecution for felonies over which the court shall have jurisdiction, said jurisdiction shall be limited to determining whether or not there is probable cause. The word "family" as herein used shall be construed to include husband and wife, parent and child, brothers and sisters, grandparent and grandchild, regardless of whether such persons reside in the same home.

K. Petitions filed by a natural parent , whose parental rights to a child have been voluntarily relinquished pursuant to a court proceeding, to seek a reversal of the court order terminating such parental rights. No such petition shall be accepted, however, after the child has been placed in the home of adoptive parents.

L. Any person who seeks spousal support after having separated from his or her spouse. A decision under this subdivision shall not be res judicata in any subsequent action for spousal support in a circuit court. A circuit court shall have concurrent original jurisdiction

in all causes of action under this subdivision.

M. Petitions filed by a spouse for the purpose of obtaining an order of protection pursuant to § 16.1-253.1 or § 16.1-279.1 as a result of spouse abuse.

N. Any person who escapes or remains away without proper authority from a residential care facility in which he had been placed by the court or as a result of his commitment to the Virginia Department of Corrections.

O. Petitions for emancipation of a minor pursuant to Article 15 (§ 16.1-331 et seq.) of this chapter.

P. Petitions for enforcement of administrative support orders entered pursuant to Chapter 13 of Title 63.1 (§ 63.1-249 et seq.), or by another state in the same manner as if the orders were entered by a juvenile and domestic relations district court upon the filing of a certified copy of such order in the juvenile and domestic relations district court.

The ages specified in this law refer to the age of the child at the time of the acts complained of in the petition.

§ 16.1-246. When and how child may be taken into immediate custody.—No child may be taken into immediate custody except:

A. With a detention order issued by the judge, the intake officer or the clerk, when authorized by the judge, of the juvenile and domestic relations district court in accordance with the provisions of this law or with a warrant issued by a magistrate; or

B. When a child is alleged to be in need of services and (i) there is a clear and substantial danger to the child's life or health or (ii) the assumption of custody is necessary to ~~insure~~ *ensure* the child's appearance before the court; or

C. When, in the presence of the officer who makes the arrest, a child has committed an act designated a crime under the law of this Commonwealth, or an ordinance of any city, county, town or service district, or under federal law and the officer believes that such is necessary for the protection of the public interest; or

C1. When a child has committed a misdemeanor offense involving shoplifting in violation of § 18.2-103 and, although the offense was not committed in the presence of the officer who makes the arrest, the arrest is based on probable cause on reasonable complaint of a person who observed the alleged offense; or

D. When there is probable cause to believe that a child has committed an offense which if committed by an adult would be a felony; or

E. When a law-enforcement officer has probable cause to believe that a person committed to the Department of Corrections as a child has run away or that a child has escaped from a jail or detention home; or

F. When a law-enforcement officer has probable cause to believe a child has run away from a residential, child-caring facility or home in which he had been placed by the court, the local department of public welfare or social services or a licensed child welfare agency; or

G. When a law-enforcement officer has probable cause to believe that a child (i) has run away from home or (ii) is without adult supervision at such hours of the night and under such circumstances that the law-enforcement officer reasonably concludes that there is a clear and substantial danger to the child's welfare; or

H. ~~With a temporary detention order issued in accordance with § 37.1-67.1 by a special justice appointed pursuant to § 37.1-88, who shall receive no fee, or by a magistrate.~~ *When a child is believed to be in need of inpatient treatment for mental illness or substance abuse as provided in § 16.1-339.*

§ 16.1-280. Commitment of mentally ill or mentally retarded children.—When any juvenile court has found a child to be in need of services or delinquent pursuant to the provisions of this law and reasonably believes such child is mentally ill or mentally retarded, the court may commit him ~~or her~~ to an appropriate hospital *, in accordance with the provisions of § 16.1-338 or §§ 16.1-340 through 16.1-344,* or *admit him to a* training center *, in accordance with the provisions of § 37.1-65.1,* for observation as to his ~~or her~~ mental condition ~~, whereupon the proceedings shall be in accordance with the~~

~~provisions of~~ § ~~37.1-65.1 or §§ 16.1-338 or 37.1-67.1 through 37.1-67.4~~ . No child shall be committed pursuant to this section ~~or~~ , § ~~37.1-67.1 through 37.1-67.4~~ *16.1-338 or §§ 16.1-340 through 16.1-344* to a maximum security unit within any state hospital where adults determined to be criminally insane reside. However, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services may place a child fifteen years of age or older who has been certified to the circuit court for trial as an adult pursuant to § 16.1-269 or § 16.1-270 or who has been convicted as an adult of a felony in the circuit court in a unit appropriate for the care and treatment of persons under a criminal charge when, in his discretion, such placement is necessary to protect the security or safety of other patients, staff or public. The Commissioner shall notify the committing court of any placement in such unit. The committing court shall review the placement at thirty-day intervals.

Article 16.

Mental Health Treatment of Minors Act.

§ 16.1-335. Short title.—A. The provisions of this act shall be known and may be cited as "The Mental Health Treatment of Minors Act."

§ 16.1-336. Definitions.—When used in this article, unless the context otherwise requires:

"Consent" means the voluntary, express, and informed agreement to treatment in a mental health facility by a minor fourteen or older or, when applicable, by a parent or other legally authorized custodian.

"Inpatient treatment" means placement, for observation, diagnosis, or treatment of mental illness or substance abuse, in a psychiatric hospital, or in any other type of mental health facility determined by the State Board of Mental Health, Mental Retardation and Substance Abuse Services to be substantially similar to a psychiatric hospital in relation to restrictions on freedom and therapeutic intrusiveness.

"Least restrictive alternative" means the treatment and conditions of treatment for a minor which, separately and in combination, (i) are no more restrictive of freedom or intrusive than necessary to achieve a substantial therapeutic benefit, and (ii) involve no restrictions on physical movement except as reasonably necessary for the administration of treatment or for the protection of the minor or others from physical injury.

"Mental illness" means a substantial disorder of the minor's cognitive, volitional, or emotional processes that demonstrably and significantly impairs judgment or capacity to recognize reality or to control behavior. "Mental illness" may include substance abuse, which is the use, without compelling medical reason, of any substance which results in psychological or physiological dependency as a function of continued use in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior. Mental retardation, head injury, a learning disability or a seizure disorder alone is sufficient neither to justify nor exclude a finding of "mental illness" within the meaning of this article.

"Mental health facility" means a public or private facility for treatment of mental illness operated or licensed by the Department of Mental Health and Mental Retardation and Substance Abuse Services.

"Minor" means a person less than eighteen years of age.

"Parent," unless otherwise indicated by the context, means (i) a biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint custody decree or agreement, (ii) a person judicially appointed as a legal guardian of the minor, or (iii) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. However, the term "parent" does not mean the local department of public welfare or social services or the Department of Corrections when it has assumed the status of legal guardian of the minor; nor does it include persons or agencies, including foster parents or others, who exercise custodial responsibilities upon delegation by the Commonwealth.

"Qualified evaluator" means a psychiatrist licensed in Virginia or a psychologist

licensed in Virginia by either the Board of Medicine or the Board of Psychology, skilled in the diagnosis and treatment of mental illness in minors and familiar with the provisions of this article, or, if such psychiatrist or psychologist is unavailable, a person designated by the community services board serving the jurisdiction where the child is located who meets the qualifications established by the State Board of Mental Health, Mental Retardation and Substance Abuse Services.

"Treatment" means any planned intervention intended to improve a minor's functioning in those areas which show impairment as a result of mental illness.

§ 16.1-337. Inpatient treatment of minors; general applicability.—A minor may only be admitted to a mental health facility for inpatient treatment pursuant to §§ 16.1-338, 16.1-339 or 53.1-245, or in accordance with an order of involuntary commitment entered pursuant to §§ 16.1-340 through 16.1-344.

§ 16.1-338. Inpatient treatment of minors younger than fourteen and nonobjecting minors fourteen or older.—A. A minor younger than fourteen years of age may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent with whom the minor resides.

A minor fourteen years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and a parent with whom the minor resides or, if the minor is in the custody of the local department of public welfare or social services, upon the joint application and consent of the minor and the department's director or the director's designee; however, any minor fourteen years of age or older who is unable to make an informed decision regarding treatment may be admitted upon such application as long as he does not object.

B. Except as hereinafter provided, admission of a minor under this section shall be approved by a qualified evaluator who is not and will not be treating the minor, and, if admission is sought to a private facility, who will not derive any significant financial benefit from such admission. Such evaluator shall have conducted a personal examination of the minor and have made the following written findings:

1. The minor appears to have a mental illness for which he is in need of the proposed inpatient treatment, and he is reasonably likely to benefit from the treatment;

2. The minor has been provided with an explanation of the nature and purpose of the proposed treatment to the extent that he can understand the nature and purpose of the treatment and will not be harmed by the explanation;

3. If the minor is fourteen or older, that the minor has been provided with an explanation of his rights under this Act and has consented to admission or, if the minor is unable to make an informed decision, that he does not object to admission; and

4. The treatment is the least restrictive alternative. If the facility to which admission is sought is a state facility, the community services board serving the area in which the minor resides must certify that it has examined the minor, has surveyed all modalities of treatment less restrictive than the program to which admission is sought, and has concluded that no available modality that is less restrictive would offer comparable benefits to the minor. This examination and certification may be provided simultaneously by the qualified evaluator who conducts the examination and makes the findings required above.

The evaluation required by this subsection shall not be required in cases of admission of a minor under fourteen years of age to a public mental health facility pursuant to this section.

C. Within ten days of the admission of a minor under this section, the director of the facility shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's desire for confidentiality and with his treatment needs. The plan shall include a preliminary plan for placement and

aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.

D. If a minor fourteen years of age or older admitted under this section objects at any time to further treatment, he shall be discharged within forty-eight hours to the custody of his parent or other legally responsible person, unless a petition for involuntary commitment is filed under § 16.1-345.

E. Inpatient treatment of a minor admitted under this section may not exceed ninety consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section have been met, after such persons have interviewed the minor and the parent or legal custodian and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than fourteen shall be informed orally and in writing by the director of the facility within five days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.

G. The community services board serving the political subdivision in which any minor admitted under this section resides shall ensure that the requirements of this section are met.

§ 16.1-339. Temporary admission of minors for evaluation and emergency treatment.—A. Whenever a parent, law-enforcement official, mental health provider, or other person exercising lawful custodial responsibility for a minor has reason to believe that the minor meets the criteria set forth in § 16.1-344 for involuntary commitment, and that immediate inpatient treatment is needed to protect the safety of the minor or others, the minor may be taken into custody and transported to a willing mental health facility or other appropriate location for immediate evaluation by a qualified evaluator. If the evaluator determines that the minor does not require inpatient treatment, the minor shall be discharged as soon as possible to the custody of his parent or other legally responsible person and, if appropriate, shall be referred for other appropriate mental health services. If the evaluator determines that the minor is in need of inpatient treatment and that the safety of the minor or others may be endangered if the minor is not detained, the minor may be retained and admitted to the facility or transported to another appropriate facility for emergency treatment. If a minor is retained and admitted to a facility for inpatient treatment under this paragraph, the director of the facility shall ensure that the minor's parent or other legal custodian is notified of the admission as soon as possible.

B. If the minor is not already being lawfully detained in a mental health facility for evaluation and treatment under subsection A at the time that a petition for involuntary commitment is filed pursuant to § 16.1-340, a juvenile and domestic relations court judge may issue an order requiring the minor to be brought before the court for the purpose of deciding whether an emergency treatment order shall be issued pending disposition of the petition. Such an order shall be issued if the judge finds, after interviewing the minor and at least one mental health professional familiar with the minor's condition, that there are reasonable grounds to believe that the minor needs inpatient treatment and that the safety of the minor or others will be endangered if the minor is not detained.

C. A minor taken into custody and detained in a mental health facility for evaluation and emergency treatment pursuant to subsections A or B of this section shall be discharged within seventy-two hours of the time he was initially taken into custody unless the minor is (i) admitted pursuant to § 16.1-338, or (ii) involuntarily committed pursuant to § 16.1-344. However, if a continuance is granted pursuant to § 16.1-344 D, the court may enter an order permitting the minor to be retained in the facility until the hearing is held.

D. Any mental health facility to which a minor is admitted for emergency treatment under this section is authorized to provide medical and psychiatric services within its capabilities when the minor's parent or legal guardian determines that such services are in the best interests of the minor. The costs incurred in providing such services shall be paid

and recovered as provided in § 37.1-89. The maximum costs reimbursable by the Commonwealth pursuant to this section shall be established by the State Board of Health based upon reasonable criteria. Where coverage by a third-party payor exists, the facility seeking reimbursement under this section shall first seek reimbursement from the third-party payor. The Commonwealth shall reimburse the providers only for the balance of costs remaining after the allowances covered by the third-party payor have been received.

E. Whenever transportation of a minor for evaluation, treatment or appearance before the court is authorized by this section, and no other suitable mode of transportation is available, the sheriff shall provide such transportation in an expeditious and humane manner.

§ 16.1-340. Involuntary commitment; who may petition; contents of petition; processing of petition; notice and appointment of counsel.—A. A petition for the involuntary commitment of a minor may be filed with the juvenile and domestic relations district court by a parent or other lawful custodian, or, if the parent or custodian is not available or is unable or unwilling to file a petition, by any responsible adult.

B. The petition for involuntary commitment shall include the name and address of the petitioner and the minor and shall set forth in general terms why the petitioner believes the minor meets the criteria specified in § 16.1-344 for involuntary commitment. The petition shall be under oath.

C. The initial processing of petitions shall be the responsibility of the intake officer. Prior to the filing of any petition under this section, the intake officer shall interview the petitioner, shall contact the appropriate community services board, and shall conduct such other investigations as he deems appropriate, for the purpose of achieving a consensual resolution under which needed treatment or other services are provided without judicial intervention. The intake officer shall refer the petitioner to the community services board prior to the filing of any petition under this section if it is determined that the minor has not been interviewed or evaluated by the community services board. If the intake officer's efforts to avoid judicial intervention are not successful, the petition shall be filed.

D. After any petition is filed with the juvenile and domestic relations district court, a hearing shall be scheduled no sooner than twenty-four hours and no later than seventy-two hours after the petition is filed. Copies of the petition, together with a notice of the hearing, shall be served immediately upon the minor and the minor's parents, if they are not petitioners. No less than twelve hours before the hearing, the court shall appoint counsel to represent the minor, unless it has determined that the minor has retained counsel. Upon the request of minor's counsel, for good cause shown, and after notice to the petitioner and all other persons receiving notice of the hearing, the court may continue the hearing once for a period not to exceed seventy-two hours.

§ 16.1-341. Involuntary commitment; prescreening report; independent evaluations.—A. Upon the filing of a petition for involuntary commitment, the juvenile and domestic relations district court shall direct the community services board serving the area in which the minor is located to provide, before the time of the scheduled hearing, a prescreening report describing available placement alternatives and including recommendations regarding the most suitable placement. The community services board shall complete the prescreening report in all cases, whether admission is sought to a state or private facility. The prescreening report shall indicate specifically whether any available modality of treatment less restrictive than inpatient treatment would be appropriate to the minor's needs. The court shall also appoint a qualified evaluator who is not and will not be treating the minor and, if admission is sought to a private facility, who will not derive any significant financial benefit from such admission, to perform a personal evaluation of the minor. The evaluator so appointed shall report to the petitioner, the minor's attorney, and the court the findings of the evaluation before the time of the scheduled hearing. The prescreening report and the report of the qualified evaluator may be combined. The evaluator shall state in writing, to the extent that he is able to do so, an opinion

regarding whether the criteria for involuntary commitment specified in § 16.1-344 are met. If requested by the petitioner, the minor's attorney, or the court, the evaluator shall attend the involuntary commitment hearing as a witness.

B. The petitioner, all public agencies, and all providers or programs which have treated or who are treating the minor, shall cooperate with the provider conducting the evaluation and shall promptly deliver to him, without charge, all records of treatment or education of the minor.

§ 16.1-342. Involuntary commitment; duties of attorney for the child.—As far as possible in advance of a hearing conducted under § 16.1-343 or an appeal from such a hearing, the minor's attorney shall interview the minor; the minor's parent or guardian, if available; the petitioner; and the qualified evaluator. He shall interview all other material witnesses, and examine all relevant diagnostic and other reports. The obligation of the minor's attorney during the hearing or appeal is to interview witnesses, obtain independent experts when possible, cross-examine adverse witnesses, present witnesses on behalf of the minor, and otherwise fully represent the minor in the proceeding. Counsel appointed by the court shall be compensated in accordance with the provisions of § 16.1-267 of this title.

§ 16.1-343. Involuntary commitment; hearing.—The court shall summon to the hearing all material witnesses requested by either the minor or the petitioner. All testimony shall be under oath. The rules of evidence shall apply; however, the evaluator's report required by § 16.1-341 shall be admissible into evidence by stipulation of the parties. The petitioner, minor and, with leave of court for good cause shown, any other person shall be given the opportunity to present evidence and cross-examine witnesses. The hearing shall be closed to the public unless the minor and petitioner request that it be open. Within thirty days of any final order committing the minor or dismissing the petition, the minor or petitioner shall have the right to appeal de novo to the circuit court serving the jurisdiction in which the minor was committed or in which the minor is hospitalized pursuant to the commitment order. The juvenile and domestic relations district court shall appoint an attorney to represent any minor desiring to appeal who does not appear to be already represented.

§ 16.1-344. Involuntary commitment; criteria.—A. The court shall order the involuntary commitment of the minor to a mental health facility for treatment for a period not to exceed ninety days if it finds by clear and convincing evidence that:

1. Because of mental illness, the minor either (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats; or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment;

3. If inpatient treatment is ordered, such treatment is the least restrictive alternative. This finding shall be made only after the court has given specific consideration to the prescreening report prepared by the community services board pursuant to subsection A of § 16.1-341; and

4. In cases involving a minor who is in parental custody, that a parent approves the proposed commitment or, if the parent is unable or unwilling to approve the proposed commitment, that the proposed commitment is necessary to protect the minor's life, health or normal development, and that issuance of a removal order or protective order is authorized by § 16.1-252 or § 16.1-253. Upon further finding that the best interests of the minor so require, the court may also enter an appropriate order directing either or both of the minor's parents to comply with reasonable conditions relating to the minor's treatment.

§ 16.1-345. Treatment plans; discharge; perdiodic review of status.—A. Within ten days of commitment ordered under § 16.1-344, the director of the facility to which the minor

was committed shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and, if applicable, has been communicated to the parent. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's desire for confidentiality and with his treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured.

B. A qualified evaluator shall review the status and current condition of each minor no less frequently than every thirty days to ensure that the commitment criteria currently are met and that the individualized treatment plan is responsive to the minor's current treatment needs and is no more restrictive than is necessary to meet those treatment needs. The evaluator shall submit his findings in writing to the court, which shall terminate the commitment if the criteria are no longer met.

C. Prior to discharge of any minor, a predischarge plan shall be formulated and explained to the minor, and copies thereof shall be sent to the court and to the minor's parent or, if the minor is in the custody of the local department of public welfare or social services, to the department's director or the director's designee. If the minor was committed to a state facility, the predischarge plan shall be prepared and implemented in accordance with § 37.1-98.2. The plan shall, at a minimum, (i) specify the services required by the released patient in the community to meet the minor's needs for treatment, housing, nutrition, physical care and safety; (ii) specify any income subsidies for which the minor is eligible; (iii) identify all local and state agencies which will be involved in providing treatment and support to the minor; and (iv) specify services which would be appropriate for the minor's treatment and support in the community but which are currently unavailable.

§ 16.1-346. Cooperative plans; fees and expenses for independent evaluators.—A. Each community services board shall enter into a cooperative plan with all juvenile and domestic relations district courts and all providers of inpatient mental health services to minors in the area served by the community services board to ensure that the provisions of this article are implemented fairly and efficiently. The plan shall be publicly disseminated. The plan shall address the provision by the community services board of prescreening, evaluative, training, and other services to the court and compensation for these services.

B. Every qualified evaluator appointed by the court to conduct an evaluation pursuant to § 16.1-341 who is not regularly employed by the Commonwealth shall be compensated for fees and expenses as provided in § 37.1-89. The cost of an evaluation conducted pursuant to § 16.1-338 shall be considered for all purposes a cost of treatment and shall be compensated accordingly.

§ 37.1-61. Admissions and transfers.– ~~(a.)~~ *A.* Only mentally ill or emotionally disturbed children under sixteen years of age shall be admitted or transferred to a treatment center.

~~(b)~~ *B.* Voluntary admissions may be made, in the discretion of the director, upon signed application *, as provided in § 16.1-338 of the Code* .

~~(c)~~ *C.* Transfers to the centers may be made as provided in § 37.1-48 with respect to transfers between other facilities operated by the Department. Upon application made by any state department, institution or agency having custody of any child who is mentally ill or emotionally disturbed, such child may, with the approval of the Commissioner and subject to §§ ~~37.1-67.1 through 37.1-67.4~~ *§§ 16.1-338 or 16.1-340 through 16.1-344* , be admitted for study, care and treatment at the center.

§ 53.1-245. Observation and treatment of mentally ill and mentally retarded children.– After commitment of any child to the Department, if the Department finds, as a result of psychiatric examinations and case study, that such child is mentally ill or mentally retarded, it shall be the duty of the Department to obtain treatment for the child's mental

condition. If the Department determines that transfer to a state hospital, training center, or other appropriate treatment facility is required to further diagnose or treat the child's mental condition, the proceedings shall be in accordance with the provisions of § *§* 37.1-65.1 or §§ ~~37.1-67.1 through 37.1-67.4~~ *16.1-340 through 16.1-344, except that provisions requiring consent of the child's parent or guardian for treatment shall not apply in such cases* . No child transferred to a state hospital pursuant to this section or the provisions of Title *16.1 or* 37.1 shall ~~, however,~~ be held or cared for in any maximum security unit where adults determined to be criminally insane reside, but such child shall be kept separate ~~and apart~~ from such adults.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
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Clerk of the House of Delegates	Clerk of the Senate