REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Minor Consent for Voluntary Inpatient Psychiatric Treatment

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 522

COMMONWEALTH OF VIRGINIA
RICHMOND
2015

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

This study was requested in a policy option included in the 2014 JCHC study, *Minor Consent Requirement for Voluntary Inpatient Psychiatric Treatment*. The policy option, added at the suggestion of Senator Barker, requested:

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under Code § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment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

Under the current Virginia statutes the parent(s) and the minor aged 14 through 17 must apply jointly in order for a minor to be admitted voluntarily into an inpatient psychiatric treatment center. In instances in which the minor child (aged 14 through 17) consents but the parent does not consent, a range of actions may be taken including the parent taking custody of the child and returning home, a request for an emergency custody order or temporary detention order, and a report to child protective services for medical neglect on the part of the parent.

A variety of perspectives were expressed regarding the need to change admission requirements. These perspectives ranged from community services board (CSB) staff members who indicated that they were never involved in a case or situation where the child wanted to be in an inpatient setting and the parents objected, to the private practice clinicians who reported that parental objection disagreements over treatment occur on a regular basis in both the admission stage as well as the continuation of treatment stage of the treatment plan.

A review of other state statutes found that 19 states explicitly authorized voluntary admission for inpatient psychiatric treatment of a minor without the consent of the parent. Most of the authorizing statutes include provisions that balance the minor's rights to voluntary admission with language that protects the minor, clinicians and providers from abuses of the authorization.

Finally, data provided by the Office of the Chief Clerk of the Supreme Court and the Institute of Law, Psychiatry and Public Policy at the University of Virginia (UVA) combined with national data suggests that parental objection of the recommendation for inpatient psychiatric treatment may occur in Virginia 120 times a year. Hospital financial data provided by the Virginia Health Information organization indicates that the average annual cost to treat minors aged 14 through 17 in an inpatient psychiatric treatment setting was $6,372 per discharge between 2009 and 2011. The estimated annual cost to treat minors that consent to inpatient psychiatric treatment without parental consent is approximately $764,600, of which private insurance represents 43.7 percent and Medicaid 38.7 percent.

Six policy options were offered for JCHC consideration; after considering the study findings and public comments, Joint Commission members voted to take no action.

Joint Commission members and staff would like to thank the individuals who assisted in this study, including representatives of American Civil Liberties Union of Virginia; Department of Behavioral Health and Developmental Services; Professor Richard Bonnie and associates from the Institute of Law, Psychiatry and Public Policy at UVA; Department of Education and the Secretary of Education; Department of Medical Assistance Services; disABILITY Law Center of

Virginia; Hospital Corporation of America; Just-Children Program at the Legal Aid Justice Center; Ms. Jacquelin McKisson; National Alliance for the Mentally Ill of Virginia; Office of the Attorney General; Office of the Executive Secretary of the Supreme Court of Virginia; Mr. John Oliver, Deputy City Attorney at City of Chesapeake; Dr. Bela Sood, Senior Professor of Psychiatry and Pediatrics at Virginia Commonwealth University; Virginia Association of Community Service Boards; Virginia Health Information; Virginia Hospital and Healthcare Association; Voices for Virginia's Children.

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Minor Consent for Voluntary Inpatient Psychiatric Treatment

A Joint Commission on Health Care report, *Minor Consent Requirement for Voluntary Inpatient Psychiatric Treatment*, RD No. 459 (2014) included the JCHC-member approved policy option:

> Include in the 2015 JCHC work plan, a staff review of the implications of allowing a minor to consent for inpatient treatment at a mental health facility without the consent of the minor's parent. The review shall include consideration of 1) amending *Code* § 16.1-338 to allow a minor 14 years of age or older to consent for voluntary inpatient mental health treatment without the consent of the minor's parent, 2) creating a judicial review regarding release under *Code* § 16.1-339 when the minor desires to continue inpatient treatment and consent for continued admission is withdrawn by the parent who consented to the minor's admission, and 3) reimbursement issues for services provided when a minor receives inpatient mental health treatment without the consent of the minor's parent.

Background on Virginia's Current System

Under the current Virginia statutes both the parent(s) and the minor aged 14 through 17 must apply jointly in order for a minor to be admitted voluntarily into an inpatient psychiatric treatment center. [1]

Parents who do not consent to inpatient mental health treatment for their consenting minor child often take custody of the child which means the minor will not receive inpatient treatment. If the situation warrants, however, other more coercive actions may be taken to overrule the parent(s) objection, such as:

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

If the parent revokes consent to treatment while the minor is already in a psychiatric facility the minor may be discharged to the parent within 48 hours or the minor may be compelled to remain inpatient through a petition to the courts for involuntary commitment or a temporary detention order requested by the treating clinician.[2]
The available options for overruling parental objections to consent to treatment for a minor are coercive and can be perceived as adversarial by the parent, the minor child, and the clinicians that are providing treatment.

Advantages, Disadvantages and Perspectives

Research and court decisions since the 1970s have discussed the benefits of voluntary admission over involuntary admission for inpatient psychiatric care. The research also discusses the advantages and disadvantages of a process that while beneficial also has disadvantages and can be subject to abuse. [3, 4]

Table 1 on the next page displays some of the advantages and disadvantages of allowing a minor to consent to inpatient psychiatric treatment without parental consent.

Table 1

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

Community Service Boards in Virginia – A Perspective on Parental Objection. There are a total of 40 community services boards/behavioral health authorities (CSB/BHAs) in Virginia. The CSBs are on the front line of community mental health in the Commonwealth. CSB evaluators provide emergency psychiatric services and are required by law to evaluate all minors during an inpatient commitment to State facilities and to designate inpatient mental health facilities in the community where the minor is being evaluated. [5]

CSB staff, participating in a conference call through the Virginia Association of Community Services Boards (VACSB), indicated that they were never involved in a case or situation where the child wanted to be in an inpatient setting and the parents objected. "It is usually the other way around." [6]

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

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

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

Provider, Clinician, and Counselors - A Perspective on Parental Objection. Hospital administrators, during a conference call through the Virginia Hospital and Healthcare Association (VHHA), indicated that hospitals experience parental disagreements with evaluators and clinicians over recommendations for inpatient treatment for minors once or twice every few months.[7] Clinicians indicated that parental disagreements over treatment occur on a regular basis and occur in both the admission stage as well as the continuation of treatment stage of the treatment plan. The disagreements may involve denial by the parents of a problem with their child and/or the costs involved with inpatient treatment.

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

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

Finally, it was reported that some parents get tired and frustrated waiting in a hospital emergency-room and simply walk out with the minor child. The wait for an evaluation in the emergency room can last "up to 12 hours." [8]

During conversations with clinicians different scenarios were presented that illustrate when minor consent for inpatient psychiatric treatment without parental consent would have been helpful. The following table summarizes three of the scenarios.

Table 2

Clinician-Reported Situations in Which Minor Consent Without Parental Consent Would Have Been Helpful		
A girl in high school is involved in multiple activities and is very popular with her peers and teachers. She is viewed as friendly, outgoing and very intelligent. In her senior year at age 16 the girl had a break down in the school counselor's office. The counselor learned that the girl was raising her younger siblings and had taken on the role of "parent" in the household. Both parents were working through their own issues and resisted consent to treatment for their daughter. They did not want the neighbors to know that there was something wrong in the household.	A child was already in an inpatient setting. The clinical team determined that the child needed additional inpatient care. The child agrees and consents. The parents, however, do not. The clinical team began the TDO but was concerned about how the court process might interfere with the treatment plan. The child volunteers to say whatever is needed in order to continue treatment.	A child was taken from school to the emergency room. The parents were notified and showed up in the ER. The examination indicated that the child needed to be in an inpatient setting. The parents objected. The CSB evaluator began a discussion with the parents about involuntary commitment through TDO. The parents were given a choice: consent to treatment or face involuntary treatment, having the child removed from the home and the possibility of an investigation by Child Protective Services for medical neglect.

Perceived Barriers and Prevalence. A literature review, reported in *BMC Psychiatry* in 2010 examined 22 studies on the perceived barriers for adolescents seeking mental health treatment. The review's thematic analysis found: "Young people perceived stigma and embarrassment, problems recognizing symptoms, and a preference for self-reliance as the most important barriers to help-seeking." [9]

In a well-cited study from 1993, a survey of high school students found that 58 percent had health concerns that they wished to keep private from their parents, and 69 percent from friends and classmates; 25 percent reported that they would forgo health care in some situations if their parents might find out.[10]

According to a study that appeared in the Archives of General Psychiatry in 2005, half of all lifetime cases of psychiatric disorders, including substance abuse disorders, begin by age 14.[11]

Prevalence of Psychiatric Disorders in Minors. Estimating the number of minors who may need inpatient treatment but are not receiving it is difficult. The Congressional Research Service (CRS) reported in 2015, that the estimated number of adolescents with mental health disorders ranges from 8.0 percent to as high as 42.6 percent depending on the methodology used by the study's authors. The studies that found the lowest prevalence rates sought to only identify the seriously mentally ill while the studies that found the highest prevalence rates typically sought to identify every minor who had a mental disorder regardless of severity.[12]

CRS also cited a 2012 study on severity (from the Archives of General Psychiatry) to make the point that most adolescents with mental disorders do not necessarily need treatment. [13]

Identifying Minors In Need of Inpatient Mental Health Treatment. A National Institute of Mental Health (NIMH) study found that approximately 36.2 percent of adolescents identified with mental health disorders received services for their illness.[14]

According to a 2012 SAMHSA survey of youth that has been completed since 1971 and is updated regularly: 12.7 percent of youths reported receiving "Specialty Mental Health" services (defined as inpatient and/or outpatient services and does not include school counselors or family physicians); 2.5 percent of that number reported receiving their Specialty Mental Health services in an inpatient mental health setting. [15]

Table 3 includes estimates of the number of minors age 14 through 17 in Virginia who may be in need of inpatient psychiatric care but are not receiving it. The estimate is based on census data and findings from the NIMH and SAMHSA studies.

Table 3

Estimated Number of Minors Who Need But May Not Be Receiving Inpatient Mental Health Services	
Description	**Applying SAMHSA Survey Results**
Virginia Population of Minors Ages 14 through 17 (U.S. Census)	459,000
multiplied by prevalence percentage	x 12.7%
Resulting Estimate of Virginia Minors with a Diagnosable MH Disorder	58,293
multiplied by percentage who are not receiving services	x 63.8%
Resulting Estimate of Minors Not Receiving Services	37,191
multiplied by percentage who need but not receiving inpatient MH services	x 2.5%
Number of Minors Who Need but May Not Be Receiving Inpatient Mental Health Services	**930**

Other State Statutes

A review of other state-statutes found that 19 states explicitly authorized voluntary admission for inpatient psychiatric treatment of a minor without the consent of the parent. Most of the authorizing statutes include provisions that balance the minor's rights to voluntary admission with language that protects the minor, clinicians and providers from abuses of the authorization.[16] The statutory references for these 19 states are shown in Table 4; as also indicated: 10 states set the minor's age to consent at 16, seven states at 14, one state at 15 and one at 13. (Additional descriptions of these 19 state-statutes are included as an attachment.)

Table 4

Statutory References for 19 States that Authorize Voluntary Admission for Minors Without Parental Consent		
State	**Age**	**Authorizing State Statutes**
Alabama	14	Alabama Code § 22-8-4
Colorado	15	Colorado Rev. Stat. § 27-65-103 [Formerly 27-10-103]
Idaho	14	Idaho Code § 66-318
Illinois	16	Illinois 405 ILCS Sec. 5/3-400, 3-405, 3-502; 3-507.
Kansas	14	Kansas Revised Statutes § 59-2949
Louisiana	16	Louisiana Children Code CH 11. Art. 1464 & 1467, 1468
Maryland	16	Maryland Code Ann., Health-Gen. §10-609 and §20-104
Massachusetts	16	Massachusetts Ann. Laws Part 1 Title XVII CH. 123; section 10
Michigan	14	Michigan Compiled Laws 330.1498d; e; j.
Minnesota	16	Minnesota Stat. § 253b .03 & .04 c. Subdiv. 6(d); Minn. Stat. § 144.343-347
Montana	16	Montana Code Ann. § 53-21-112
New Jersey	14	New Jersey stat. Ann. § 4:74-7a. (c)
New York	16	New York MHY. Law § 9.13
Oklahoma	16	Oklahoma Stat. Ann. Tit. 43a § 5-503
Pennsylvania	14	Pennsylvania 50 P.S. § 7201-7204; Pennsylvania 35 P.S. § 10101.1-10105
Tennessee	16	Tennessee Code Ann. § 33-6-201 - 203
Texas	16	Texas Health and Safety Code. § 572.001; Tex. Fam. Code ann. § 32.004
Vermont	14	Vermont Stat. Ann. Tit. 18, § 7503
Washington	13	Washington Rev. Code ann. § 71.34.500; Wash. Rev. Code ann. § 71.34.520

While one state made minors adults for purposes of inpatient mental health treatment thereby affording them all of the rights and authorizations that an adult has for voluntary admission, most states explicitly addressed other issues related to inpatient treatment, such as:

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

Table 5 provides brief examples of some of the issues addressed in state statutes and the states in which the examples are found:

Table 5

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

Cost and Reimbursement Issues

As explained in this section of the report, an attempt was made to estimate the number of minors that may be impacted by a change in Virginia law and what the financial implications may be.[17]

How many times does a parent object under the current Virginia system? Staff of UVA's Institute of Law, Psychiatry and Public Policy (ILPPP) surveyed CSB evaluators during the month of April 2013. According to the survey, 387 emergency evaluations of juveniles aged 14 through 17 were completed with 165 (42.6%) recommended for inpatient mental health treatment during the month.

The survey included three questions related to whether a parent was consulted and whether he/she was willing to approve the proposed admission of the minor to inpatient psychiatric treatment. In 10 (6.1%) cases the parent did not approve of the evaluator's recommendation to admit the minor into an inpatient mental health facility; of the 10 minors, seven were eventually admitted while two were not admitted due in part to insurance issues, and one due to other medical conditions.[18]

Assuming that April 2013 was a typical month for juvenile evaluations, the information from the survey may be used to estimate the annual number of parental objections to recommended inpatient treatment. Table 6 annualizes the UVA survey findings:

Table 6

Estimates Based on ILPPP Survey of CSB Evaluators in April 2013	
Estimated Number of Emergency Evaluations in a Year (n=387 x 12) multiplied by percentage recommended for inpatient admission	4,644.0 42.6%
Resulting Estimate of Annual Number of Inpatient Admission Recommendations multiplied by percentage of parental objections	1,978.3 6.1%
Estimated Number of Parental Objections in a Year	**120.7**

Another way to develop an estimate of parental objections is to review court data displaying the number of involuntary commitment petitions not granted for 2014 as shown in Table 7.

Table 7

Final Disposition of Petitions Not Granted for Involuntary Commitment by Age in 2014				
Age of Juvenile	Dismissed	Withdrawn	Released to Parents	Total Not Granted
14	52	6	11	69
15	35	6	13	54
16	41	5	18	64
17	61	5	16	82
Total	**189**	**22**	**58**	**269**
Source: Office of the Executive Secretary, Supreme Court of Virginia as reported by court clerks.				

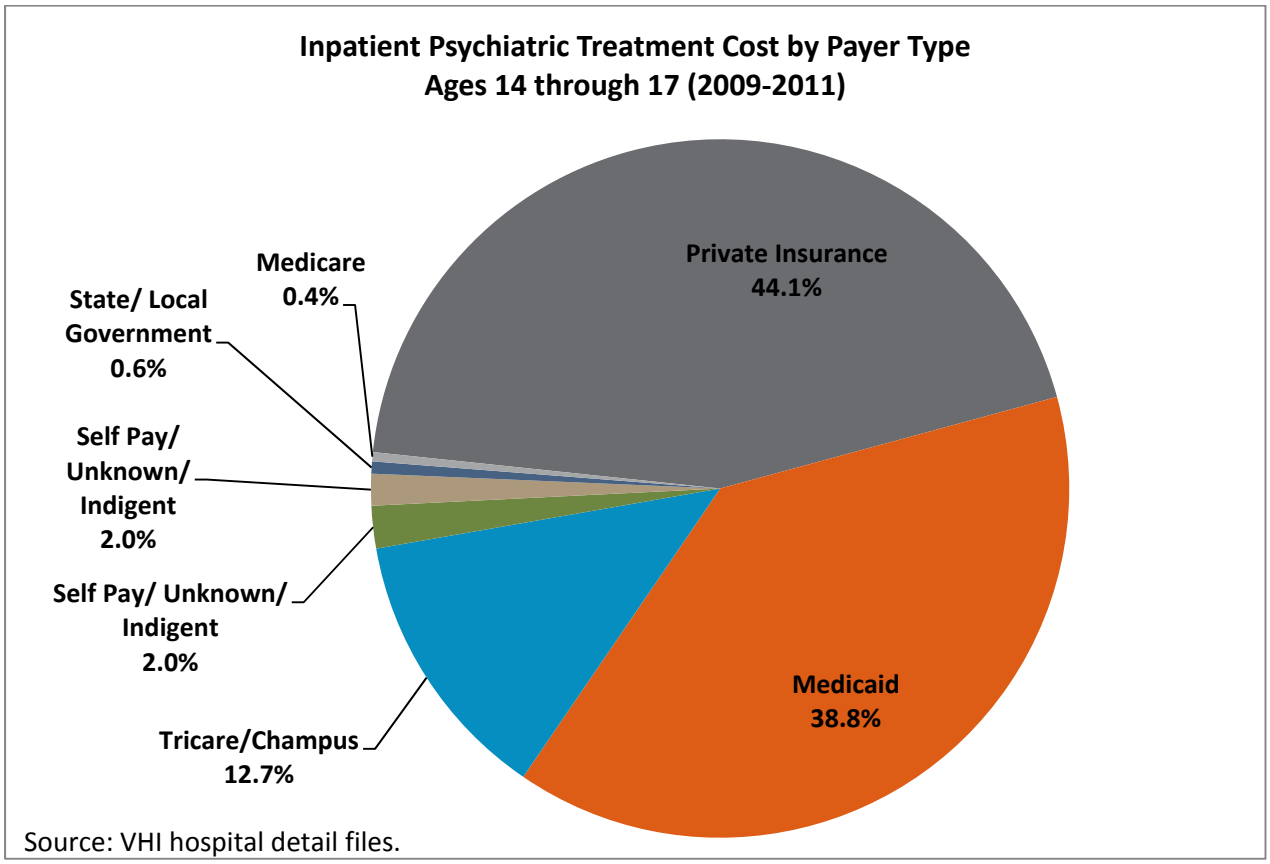
It is unknown how many of the 269 petitions were not granted because of parental objection or because they became voluntary admissions. However, the UVA study suggests that some of the recorded "not-granted" petitions were the result of parental objection.

Financial Implications.[A] A review, of the financial data reported by hospitals to Virginia Health Information (VHI), indicates that from 2009 through 2011 the overall total cost-of-care for inpatient treatment for minors aged of 14 through 17 in a private psychiatric hospital or a mental health unit of a general hospital was $85.2 million with an average cost-per-discharge of $6,372.

The graph in Figure 1 displays the payer-mix based for inpatient psychiatric care for minors between the ages of 14 through 17. Private insurance and Medicaid made up 82.9 percent of the payments for this age group (44.1% and 38.8% respectively).

[A] Minor adjustments were made to the financial data after the initial presentation was made to the Commission with the assistance of VHI, DMAS, and VHHA staff.

Figure 1



The estimated cost to treat the 120 minors identified above was $762,630 and breaks down by payer type as shown in Table 8.

Table 8

Inpatient Psychiatric Treatment for Consenting Minors Aged 14 through 17 Estimated Annual Cost by Payer Type			
Payer Type	**Number of Minors 14 - 17**	**Cost Per Discharge**	**Annual Cost**
Private Insurance	65	$5,140	$334,120
Medicaid *	37	$7,994	$295,782
Tricare/CHAMPUS	11	$8,883	$97,712
Self-Pay/Unknown/Indigent	2	$6,490	$12,980
Other Government	3	$4,118	$12,354
State/Local Government	1	$6,920	$6,920
Medicare	1	$2,763	$2,763
Total	**120**	**$6,372**	**$762,630**
***** *The Virginia Medicaid State match is 50 percent of the total cost or $147,891 of the estimate.* Source: Virginia Health Information.			

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

Policy Options and Public Comment

Six policy options, addressing the expansion of the authority for minors to consent to their inpatient mental health treatment, were presented for JCHC-member consideration. Public comments regarding the policy options were submitted by:

- Mr. Richard J. Bonnie, Ph.D., Director
  Institute of Law, Psychiatry and Public Policy at the University of Virginia
- Ms. Jacquelin McKisson, Parent
- Ms. Claire Guthrie Gastanaga, Executive Director
  American Civil Liberties Union of Virginia (ACLU-VA)
- Ms. Colleen Miller, Executive Director
  disABILITY Law Center of Virginia (dLCV)
- Ms. Mira Signer, Executive Director
  National Alliance for the Mentally Ill of Virginia (NAMI-VA)
- Ms. Jennifer Faison, Executive Director
  Virginia Association of Community Services Boards (VACSB)

Policy Options		**Comments**
1	Take no action.	NAMI-VA primary option supported. VACSB primary option supported.
2	Introduce legislation to amend *Code of Virginia* Title 16.1 to provide minors with the same rights and responsibilities as an adult in terms of consenting to voluntary inpatient mental health treatment beginning at age: ▪ 14 years ▪ 16 years ▪ 15 years ▪ 17 years	Ms. McKisson at age 16 with provisions similar to Maryland's current law; most importantly that the parent is not responsible for the cost of treatment. ACLU-VA at age 14 dLCV at age of 14
3	Introduce legislation to amend *Code of Virginia* Title 16.1 to establish a process by which a minor, whose parent(s)/guardian(s) will not consent to his/her voluntary inpatient mental health treatment, may request and receive such treatment with the approval of a clinician and/or evaluator who has examined and found the minor to be in need of and likely to benefit from the requested treatment.	Mr. Bonnie reported that his review of civil commitment of juveniles led him to the conclusion that self-admission requests by minors "occur frequently enough (~125/year) to warrant statutory guidance." NAMI-VA is open to option "as long as parents' input is solicited and included in the process." VACSB, if action is to be taken, may support option if an "independent" clinician and/or evaluator must examine the minor and approve of his/her treatment.
4	Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to access the evaluation process of the local community services board in order to receive approval for voluntary inpatient mental health treatment.	NAMI-VA is open to option "as long as parents' input is solicited and included in the process."
5	Introduce legislation to amend *Code of Virginia* Title 16.1 to allow, when consent by his/her parent(s)/guardian(s) is not given, a minor to petition the juvenile court in order to be examined and receive authorization for voluntary inpatient mental health treatment.	

Policy Options		Comments
6	Include the following provisions in introduced legislation to amend *Code of Virginia* Title 16.1 to address: A. Parental Objection – provide opportunity to consider objections, by the parent(s)/ guardian(s), to the minor's voluntary inpatient mental health treatment. B. Admission criteria – establish the clinical criteria, for allowing the minor's admission for voluntary inpatient mental health treatment without the consent by his/her parent(s)/ guardian(s), to be the current inpatient admission standards such as those established by the American Academy of Child and Adolescent Psychiatry. C. Other evaluation criteria – establish criteria to determine that minor has the capacity to consent and is clinically suitable for the voluntary mental health treatment that will be provided. D. Liability Relief – add language that providers are not liable for damages if a minor misrepresents himself except for damages resulting from negligence or willful misconduct. E. Limitations on inpatient stays – establish limitations on the number of days a minor may be treated in the inpatient facility on a voluntary basis and/or the number of times the minor may be admitted without the consent of the parent(s)/guardian(s). F. Financial responsibility – as needed, add language regarding mental health parity provisions, financial liability of parent(s)/ guardian(s), and other payment guidelines. G. Confidentiality – determine and denote requirements in order to comply with Health Insurance Portability and Accountability Act (HIPAA) privacy provisions, such as sharing of treatment or health-insurance payment information with parent(s)/guardian(s).	Mr. Bonnie commented: • 6A – The facility should endeavor to notify the parents within 24 hours after the minor's admission and provide for judicial review if the parent objects to continued hospitalization. • 6C – A qualified evaluator as defined in *Code* § 16.1-336 finds the minor meets admission criteria "under some adaptation of" *Code* § 16.1-338.B. • 6F – "As a matter of policy, I think that parents should remain liable for medically necessary expenses to the same extents as they would be responsible if they had admitted the minor. I fear that any other arrangement would encourage parents to refuse to consent to medically necessary care that they would otherwise seek in the absence of a provision allowing self-admission of the minor." Ms. McKisson recommends that 6F include that the "parent is not liable for any costs of the treatment of the minor….There needs to be some financial provision in the law….Either the local CSB needs to step-in and make payment, the hospital has to voluntarily agree to waive the payment, VA Medicaid rules for long-term care need to be modified to accept children with a 'higher' income or without respect to income, and/or some state budget line needs to be added to provide 'gap'/financial coverage."

Action by the Joint Commission on Health Care. After considering the study findings and public comments, Joint Commission members voted to take no action.

JCHC Staff for this Report
Stephen Weiss
Senior Health Policy Analyst

Philip Z. Van Keuren
Health Policy Extern

End Notes

[1] § 16.1-338 of the Code of Virginia.
[2] § 16.1-339; § 16.1-340.1, §16.1-345 of the Code of Virginia.
[3] Stone, Donald H., The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality? (Fall 1999). Boston University Public Interest Law Journal, Vol. 9, p. 25, 1999.
[4] Shields, John M. and Alf Johnson., Collision Between Law and Ethics: Consent for Treatment with Adolescents. The Bulletin of the American Academy of Psychiatry and the Law (Bull Am Acad Psychiatr Law), Vol. 20, No. 3, 1992
[5] §16.1-345 of the Code of Virginia.
[6] Conference call with CSB Association members; April 21, 2015.
[7] VHHA Hospital Administrator Conference Call, May 22, 2015.
[8] Summary of Personal Communications with the following clinicians: Mr. John Oliver, Deputy City Attorney at City of Chesapeake, VA; April 1, 2015. Jo Ann Burkholder – Director, Office of Student Services, Virginia Department of Education; April 14, 2015. Dr. Bela Sood, Bela Sood, MD MSHA, Senior professor of Child Mental Health Policy, Psychiatry and Pediatrics; VCU. April 17, 2015. Odean Baker, Preadmission Screening Supervisor Chesapeake Virginia, CSB; May 6, 2015. Matt Ours, CEO, Kempsville Center for Behavioral Health Professor; May 6, 2015. Stephanie Sammarco, Mental Health Counselor, MA, LPC, NCC; May 5, 2015. Dr. Michael Chiglinsky, Ph.D., Licensed Clinical Psychologist; June 25, 2015.
[9] Gulliver, Amelia. Et al. "Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review." BMC Psychiatry 2010, Gulliver et al. 10:113.
[10] Cheng, Tina L. MD, MPH., et al. "Confidentiality in Health Care A Survey of Knowledge, Perceptions, and Attitudes Among High School Students." JAMA. 1993;269(11):1404-1407. March 17, 1993.
[11] Kessler, RC., et al. "Lifetime Prevalence and age-of-onset distributions of DSM-IV disorders in National Comorbidity Survey Replication." Archive of General Psychiatry. June 6, 2005; pages 593-602.
[12] Bagalman, Erin et al. "Prevalence of Mental Illness in the United States: Data Sources and Estimates." Congressional Research Service; 7-5700, R43047. March 9, 2015. Page 6.
[13] CRS study cited: Ronald C. Kessler et al., "Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement," Archives of General Psychiatry, vol. 69, no. 4 (April 2012).
[14] Merikangas, Kathleen, et al. "Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey Adolescents Supplement (NCS-A)." Journal American Academic Child Adolescent Psychiatry. January 2011; 50(1): 32-45.
[15] Substance Abuse and Mental Health Services Administration (SAMHSA), Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings, NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Pages 37 and 39 (Figure 4.5).
[16] The statutes of all fifty states and the District of Columbia were searched and reviewed using internet searches through:

- Justia Law (http://law.justia.com/)
- Socratek Law Reference (http://www.socratek.com/), and
- Cornell's Legal Information Institute (https://www.law.cornell.edu/statutes.html).

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

- Minor Consent to Medical Treatment Laws; Updated January 2013. The National District Attorney Association.
- English, Abigail, et al. State Minor Consent Laws: A Summary 3rd Edition; January 2010. Center for Adolescent Health & the Law, Chapel Hill, North Carolina (www.cahl.org). ISBN: 0974410829.
- Assisted Psychiatric Treatment: Inpatient and Outpatient Standards by State; June 2011. Treatment Advocacy Center. Treatment Advocacy Center (www.TreatmentAdvocacyCenter.org)

[17] A follow up report to this one is being conducted by UVA's Institute of Law, Psychiatry and Public Policy in an effort to obtain better data on the admission process of minors to inpatient mental health treatment and provide a more complete review of the financial implications.
[18] Bonnie, Richard J., LL.B. et al. A Study of Face-to-face Emergency Evaluations Conducted By Community Services Boards in April 2013. Institute of Law, Psychiatry, and Public Policy at the University of Virginia. December 2013.

ATTACHMENTS

State Statutes that Authorize Voluntary Admission for Minors
Without Parental Consent

June 17, 2015 Presentation to the Joint Commission on Health Care

State Statutes that Authorize
Voluntary Admission for Minors Without Parental Consent

State	Age	Statute	Brief Description
Alabama	14	Ala. Code § 22-8-4: Mental health services.	• 14 years of age or older, consent to any legally authorized mental health services; consent of no other person shall be necessary.
Colorado	15	Colo. Rev. Stat. § 27-65-103 [Formerly 27-10-103] Mental health.	• Minors 15 or older can consent to mental health services rendered by a facility or a professional person without consent of parents. • Consent shall not be subject to disaffirmance because of minority. The professional person may advise the parents with or without consent from the minor. • An independent professional person shall interview the minor and conduct a careful investigation into the minor's background so that prior to admitting a minor: the minor has a mental illness and is in need of hospitalization; that a less restrictive treatment alternative is inappropriate or unavailable; and that hospitalization is likely to be beneficial.
Idaho	14	Idaho Code § 66-318. Mental health.	• Any individual fourteen (14) to eighteen (18) years of age may apply to be admitted to a mental health facility for observation, diagnosis, evaluation, care or treatment. • Facility director is required to notify the parent of the admission to a mental health facility for observation, diagnosis, evaluation, care or treatment. The parent may apply for release.
Illinois	16	Ill. 405 ILCS Sec. 5/3-502. Mental health. Ill 405 ILCS 5/3-400 Clinically suitable. Ill 405 ILCS 5/3-405 review of denial by person seeking admission. 405 ILCS 5/3-507 Objection to admission.	• Any minor may be admitted to a mental health facility voluntarily if the minor executes the application and shall be treated as an adult. • The minor's parent shall be immediately informed of the admission. • Minor must be found clinically suitable and have the capacity to consent. • If the facility director of a Department mental health facility declines to admit a person seeking admission, a review of the denial may be requested by the person seeking admission. • Objection may be made to the admission of a minor and the minor shall be discharged at the earliest appropriate time, not to exceed 15 days, unless the objection is withdrawn in writing or unless, within that time, a petition for review of the admission and certificates of examination by both a licensed mental health provider and a psychiatrist are filed with the court.

State	Age	Statute	Brief Description
Kansas	14	KS Revised Statutes § 59-2949 Mental health.	• Minor may make written application without the consent of parent for admission to a psychiatric treatment facility as a voluntary patient; the head of the treatment facility determines need of treatment and that the person has the capacity to consent. • The head of the treatment facility shall promptly notify the child's parent of the admittance of child.
Louisiana	16	LA Children Code CH 11. Art. 1464 & 1468. Mental health LA Children Code CH 11. Art. 1467. Capacity to consent.	• Minor may apply for voluntary admission to a mental health or substance abuse treatment facility. • A minor so admitted shall have the same rights as an adult patient. • The admitting physician may admit the person on either a formal or informal basis. • No admission may be deemed voluntary unless the admitting physician determines that the minor has the capacity to make a knowing and voluntary consent to the admission.
Maryland	16	Md. Code Ann., Health—Gen. §10-609 Mental health. Md. Code Ann., Health—Gen. §20–104. Capacity as an adult to consent.	• Application for voluntary admission of an individual to a facility may be made if the individual is 16 years old or older. • The individual must understand the nature of the request; is able to give continuous assent to retention by the facility; and is able to ask for release. • A minor has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or a clinic. • The capacity of a minor to consent to treatment does not include the capacity to refuse treatment for which a parent has given consent. • The physician heading the treatment team decides whether a parent of the minor should receive information about treatment. • The parent is not liable for any costs of the treatment of the minor.
Massachusetts	16	Mass. Ann. Laws Part 1 Title XVII CH. 123; section 10. Mental health.	• The superintendent of a mental health facility may accept an application for voluntary admission by any person 16 years or older that is in need of care and treatment. • The parent shall not be liable for the payment of any care.
Michigan	14	MCL 330.1498d; e; j. Mental health, parental consent.	• A minor of 14 years or older may request, and if found suitable, be hospitalized. Once hospitalized, the hospital director is required to obtain parental consent or proceed to court process.

State	Age	Statute	Brief Description
Minnesota	16	Minn. Stat. § 253b.04 Mental health. Minn. Stat. § 253b.03 c. Subdiv. 6(d) consent Minn. Stat. § 144.343 Mental and other health services to treat alcohol and other drug abuse. Minn. Stat. § 144.345 services provided in good faith. Minn. Stat. § 144.346 provider may inform parents. Minn. Stat. § 144.347 financial responsibility.	• Any person 16 years or older may request informal admission to a treatment facility for observation or treatment of mental illness, chemical dependency, or mental retardation and may give valid consent for hospitalization, routine diagnostic evaluation, and emergency or short-term acute care. • Facility to admit must be based on clinical admission criteria consistent with the most current inpatient admission standards established by the American Psychiatric Association or the American Academy of Child and Adolescent Psychiatry. • Minor may consent for mental and other health services to determine the presence of or to treat alcohol and other drug abuse; the consent of no other person is required. • Consent of a minor shall be deemed effective for the purposes of providing services in good faith. • Provider may inform parents if they determine it is in best interest of minor. • A minor consenting for health services shall assume financial responsibility for the cost of services.
Montana	16	Mont. Code Ann. § 53-21-112 Mental health.	• A minor is at least 16 years of age may, without the consent of a parent, receive mental health services. • Voluntary admission terminates at the expiration of 1 year. • Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. • Minors consenting assume financial responsibility unless proven to be unable to pay and who receive the services in public institutions. If the minor is covered by health insurance, payment may be applied for services rendered.
New Jersey	14	N.J. stat. Ann. § 4:74-7a. (c) Mental health.	• Any minor 14 years of age or over may request admission to a psychiatric facility and be admitted provided that the court finds the minor's request informed and voluntary.
New York	16	N.Y. MHY. Law § 9.13 Mental health.	• A person over 16 and under 18 years of age is authorized to apply for voluntary inpatient admission to a hospital; application accepted at the discretion of the hospital director.
Oklahoma	16	Okla. Stat. Ann. Tit. 43a § 5-503 Mental health.	• A minor 16 years of age or older may consent to voluntary admission for inpatient mental health or substance abuse treatment. • A minor who revokes consent must be discharged within 48 hours unless the district attorney files opposition to the discharge with the court.

State	Age	Statute	Brief Description
Pennsylvania	14	Pennsylvania 50 P.S. § 7201 Mental health. Pennsylvania 50 P.S. § 7204. Parent notification, right to object. Pennsylvania 35 P.S. § 10101.1. mental health treatment. Pennsylvania 35 P.S. § 10101.2 Records controlled by minor. Pennsylvania 35 P.S. § 10105 Providers not liable.	• Any person 14 years of age or over may submit himself to mental health examination and treatment provided that the decision to do so is made voluntarily. • Upon the acceptance of an application for examination and treatment by a minor 14 years or over but less than 18 years of age, the director of the facility shall promptly notify the minor's parents and shall inform them of the right to be heard upon the filing of an objection. • Any minor who is 14 years of age or older may consent to outpatient mental health examination and treatment and voluntary inpatient mental health treatment. • The minor shall control the release of the minor's mental health treatment records and information to the extent allowed by law. • Providers not liable if minor misrepresent themselves.
Tennessee	16	Tenn. Code Ann. § 33-6-201 Mental health. Tenn. Code Ann. § 33-6-203 Admission limit.	• A person who is sixteen (16) years of age or over may apply for voluntary admission. • Admission of an un-emancipated child limited to one (1) six-month period in any twelve-month period unless the admission is reviewed and approved for further hospitalization.
Texas	16	Tex. Health and Safety Code. § 572.001. Mental health inpatient or outpatient. Tex. Fam. Code ann. § 32.004 Provider not	• The administrator of an inpatient or outpatient mental health facility may admit a minor who is 16 years of age or older to an inpatient or outpatient mental health facility as a voluntary patient without the consent of the parent, managing conservator, or guardian. • A physician, psychologist, counselor, or social worker is not liable for damages if a child misrepresents themselves except for damages resulting from negligence or willful misconduct. • Parent not consenting to counseling treatment is not obligated to compensate providers.
Vermont	14	Vt. Stat. Ann. Tit. 18, § 7503 Mental health.	• Any person 14 years of age or over may apply for voluntary admission to a designated hospital for mental health examination and treatment provided that consent is given in writing.
Washington	13	Wash. Rev. Code ann. § 71.34.500 Mental health. Wash. Rev. Code ann. § 71.34.520 Notice of intent to leave.	• A minor 13 years of age or older may admit himself or herself to an evaluation and treatment facility for inpatient mental treatment, without parental consent based on professional person consent. • May give notice of intent to leave at any time.

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

Joint Commission on Health Care
June 17, 2015

Stephen Weiss
Senior Health Policy Analyst

Genesis and Purpose of the Study

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

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

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

Issues to Consider and Review

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

3

Virginia's Current System

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

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

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

4

Allowing Minors to Consent to Inpatient Mental Health Treatment

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

5

Part 1
The Current Virginia System

6

Community Services Board Perspective

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

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

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

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

7

Provider, Clinician, and Counselor Perspectives

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

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

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

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

8

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

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

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

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

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

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

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

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

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

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

9

Part 2
Other State Statutes

10

Other State Statutes

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

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

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

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

11

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

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

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

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

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

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

12

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

13

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

Part 3
Estimating the Number of Impacted Minors

15

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

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

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

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

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

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

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

16

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

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

17

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

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

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

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

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

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

18

Perceived Barriers to Adolescent Mental Health Treatment

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

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

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

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

19

Prevalence of Psychiatric Disorders in Minors

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

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

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

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

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

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

20

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

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

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

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

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

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

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

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

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

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

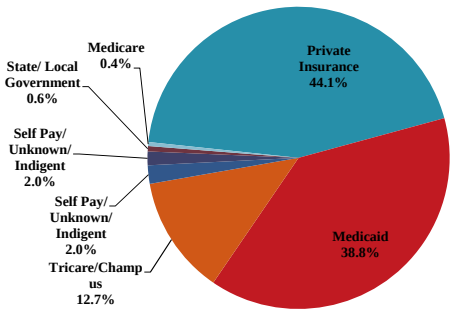
There is no reason to believe that the children that may need inpatient mental health treatment will have a different "payer-mix" than those already in the system.

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

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

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

Inpatient Psychiatric Treatment Cost by Payer Type Ages 14 through 17 (2009-2011)



Source: VHI hospital detail files.

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Policy Options

Option 1: Take no action.

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

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

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Policy Options

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

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

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

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Policy Options

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

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

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

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Policy Options

Option 6 continued:

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

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Policy Options

Option 6 continued:

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

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

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Public Comments

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

Comments may be submitted via:

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

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX I

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

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APPENDIX II

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

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

Source: Virginia Health Information (VHI)

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

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APPENDIX II

Overall Total of Cost per Discharge by Year

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

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

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APPENDIX II

Overall Total of Cost per Discharge by Year

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

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

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Public Comments

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

Comments may be submitted via:

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

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

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