ISSUE DATE:	EFFECTIVE DATE:	NUMBER:

SUBJECT:	BY:	
CONSENT TO MENTAL HEALTH TREATMENT FOR MINOR CHILDREN	Teresa Miller Secretary of Human Services	Dr. Rachel Levine Secretaty of Health

SCOPE:

County MH/ID Programs
County Human Services Administrators
Licensed Mental Health Facilities
Licensed Health Providers

PURPOSE:

Act 147 of 2004 ("Act 147"), 35 P.S. §§ 10101.1-10101.2, addresses who can provide consent to voluntary mental health treatment for minors ages 14 and less than 18 years of age in both inpatient and outpatient settings. Act 147 should be read and implemented in conjunction with the Mental Health Procedures Act ("MHPA"), which is mentioned in Act 147 and which applies to involuntary and inpatient treatment. See 50 P.S. § 7103, 55 Pa. Code § 5100.4(a).

CONSENT TO TREATMENT FAQS

Outpatient Treatment

- **Who can consent to outpatient care?** A minor can consent to outpatient mental health examinations and treatment for themselves without parental consent.

  A parent or legal guardian of a minor can also provide consent to outpatient treatment without the minor's consent.

- **Can the non-consenting person revoke consent of the other?** No. The consent of one is sufficient without the consent of the other. A minor cannot abrogate consent that has been provided by a parent or guardian and, likewise, the parent or guardian cannot revoke consent that a minor has provided.

- **Can a parent or guardian object to outpatient treatment for which a minor has provided consent?** No. Neither Act 147 nor the MHPA provides a procedure through which a parent or guardian can object to voluntary outpatient treatment for which a minor has provided consent.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Office of Mental Health and Substance Abuse Services, Bureau of Policy, Planning & Program Development, P.O. Box 2675, Harrisburg, PA 17105. General Office Number 717-772-7900.

- **Can a minor object to outpatient treatment for which a parent or guardian has provided consent?** No. Neither Act 147 nor the MHPA provides a procedure through which a minor can object to voluntary outpatient treatment for which a parent or guardian has provided consent.

Inpatient Treatment

- **Who can consent to inpatient care?** Minors can consent to inpatient mental health care for themselves without parental consent.

  A parent or legal guardian of a minor can also provide consent without the minor consent on the recommendation of a physician who has examined the minor, without the need to initiate involuntary treatment process pursuant to the MHPA.

- **Can the non-consenting person revoke consent of the other?** No. The consent of one is sufficient without the consent of the other. A minor cannot abrogate consent that has been provided by a parent or guardian and, likewise, the parent or guardian cannot abrogate consent that a minor has provided.

- **Can a parent or guardian object to inpatient treatment for which a minor has provided consent?** Yes. Act 147 does not restrict or alter the right of a parent or guardians to object to inpatient treatment initiated by the minor. Under the MHPA, a parent or legal guardian may file a written objection with the facility or the county administrator, who will arrange for a hearing to determine whether the treatment is in the best interest of the minor. See 50 P.S. § 7204, 55 Pa. Code § 5100.74.

- **What happens if the consenting person revokes consent?** If the person who has provided consent revokes it, the revocation is effective unless the other person provides consent to continued inpatient treatment.

- **Can a minor object to inpatient treatment for which a parent or guardian has provided consent?** Yes. When a minor is admitted on the consent of a parent or guardian, the facility director must provide to the minor an explanation of the treatment and a statement of rights, including the right to object to treatment by filing a petition in court. If the minor wishes to object to treatment, the facility must provide a form for the minor to request withdrawal from or modification of treatment. The facility director must file the signed petition in court of common pleas where the facility is located. Act 147 does not specify a time frame but it should be filed promptly.

- **Can a parent object to inpatient treatment consented to by another parent?** Yes. If one parent provides consent to treatment, the other parent, if they have legal custody rights, can object to inpatient treatment by filing a petition in the court of common pleas where the minor resides.

CONTROL OF CONFIDENTIALITY OF MEDICAL RECORDS, INPATIENT AND OUTPATIENT SETTINGS

General Rules

- **Who controls release of medical records?** Control over the release of medical records generally resides with the person who has provided the consent to treatment. Under Act 147, when the minor has provided consent to treatment and understands the nature of the records and the purpose of releasing them, they control release of the records. See also 55 Pa. Code § 5100.33(a). When a parent or guardian has provided consent to treatment, the parent or guardian has the right to receive information necessary to consent to specific treatment options, including symptoms, conditions to be treated, medications, treatments, risks, benefits, and expected results. A parent or guardian who has provided consent to treatment may also consent to release of records to the current mental health treatment provider and, if it would not be detrimental to the minor, to the minor primary care provider. If deemed pertinent by the minor's mental health treatment provider, information regarding prior mental health treatment, for which the minor had provided consent, may also be released to other mental health treatment and primary care providers.

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Accomplishments

County administrative and clinical managers, managed care organizations, and local service providers have continually collaborated on innovative solutions to meet the needs of Behavioral HealthChoices members and their families. Quality standards have been continually measured, strengthened, and improved throughout the program's history. In addition, accountability and efficiency practices have been built to provide greater control of public funds. These practices ensure the services that are need by members are provided in an efficient yet responsive manner. Through this management approach, counties can make appropriate and wise use of reinvestment dollars that are made available through the residual capitation. The Pennsylvania model provides a foundation for continued development of programs to manage mental health and substance use disorder programs.

- **Strategic Health System Innovation** - it was not until Behavioral HealthChoices was launched that a unified and integrated approach to leverage all the publicly funded behavioral health programs in an aligned fashion was established. Savings were achieved by utilizing less expensive and less restrictive community services.
- **Specialized Health Care** – it has proven to be very nimble and flexible, quickly able to respond to members' needs as well as larger systemic needs. Community behavioral health services are very specialized, and would present a unique challenge for traditional carved-in managed care insurers.
- **Improved Member Health** – successfully led to the development of new approaches to improve member health and reduce the cost of care. New consumer inventories and assessment tools helped to identify the health care needs of people with serious mental illness. Member Health Profiles and data exchange processes have been developed which gave both behavioral health and physical health providers a more complete clinical picture of the member.
- **Integrating Social Determinants of Health** - consistently delivered over its 20-year lifespan services that are mindful of the member's social determinants of health such as income, access to food and housing, employment, transportation and physical health management. County administration of Behavioral HealthChoices also benefits from a close alignment with a broad array of other human services resources including: child welfare, aging services, intellectual disability and early intervention programs, housing and homeless services, veterans' services, court / criminal justice system diversion programs, and local school districts.
- **Expanded Member Access** - member-months (the measure of individuals participating in Behavioral HealthChoices each month) has grown by an average of 10% per year from 1997 to 2017, indicating that many more people are on Medicaid as a percent of the general population, and more of those on Medicaid are accessing services. At the same time, while more members are eligible to receive services, the average cost per person per month has remained constant from 2007 (the year Behavioral HealthChoices was state-wide) to 2017.

1997 2007 2017

The County Commissioners Association of Pennsylvania and the COMCARE Board commissioned this report to provide policymakers with a review of the Behavioral HealthChoices Program's history, an analysis of the positive impact the program has had on consumers and their families, on every taxpayer and on the state's overall health care delivery system

The County Commissioner's Association of Pennsylvania / COMCARE fully supports the Pennsylvania Behavioral HealthChoices Carve-Out service model, and will continue to provide support to help Pennsylvania build upon this strong foundation.

This report comes as many states in the nation continue to grapple with the challenges regarding the delivery of behavioral health managed care services. In addition, every state, including Pennsylvania, is experiencing an unprecedented number of opioid and substance use deaths. Behavioral HealthChoices has proven to be an invaluable resource in the Commonwealth's on-going response to this public health crisis. In 2017, Behavioral HealthChoices marked 20 years of delivering valuable services to Pennsylvania's most vulnerable citizens and their families.

Overwhelming Success

- The decision to carve-out behavioral health managed care is among the most significant decisions impacting the financing and delivery of mental health and substance use treatment services since the passage of the Mental Health Act of 1966. The model creates a set of unique partnerships between the state, counties, and their Behavioral Health Managed Care Organizations
- Behavioral HealthChoices has demonstrated improved access and increased quality to critical services, at a cost savings estimated from $11 to $14 billion statewide through 2016. Counties, their BHMCOs, and community providers have developed a structure that assures a broad array of services for over 2.9 Million Pennsylvanians.

Innovative Change

- Behavioral HealthChoices was created in response to systematic challenges and shortcomings in the behavioral health system that led to poor results for consumers and significant, unnecessary costs for the state.
- National experience suggests that such blended or "carve-in" systems are primarily financial arrangements that have no bearing on care coordination. Most Managed Care Organizations (MCOs) use a "downstream risk" approach and contract behavioral health services to yet another managed care organization. These arrangements create barriers to care and strip needed dollars from care for administrative overhead or profit margins. In fact, in these models, MCOs have been shown to spend less than half of capitated mental health funds on mental health care.
- The wisdom and forethought of many individuals during the Ridge, Rendell, Corbett, and Wolf administrations with input from state officials at what was then the Department of Welfare (now the Department of Human Services) and locally at the county level has been realized not only by the significant cost savings, but in the increased access of valuable services not previously part of the service continuum as well as dramatic measurable increases in quality.

- **Billions of Dollars in Savings** - provides a structure to contain behavioral health costs and bend the long-term cost curve. Segregating behavioral health Medical Assistance dollars allows state and county governments to monitor program revenues to ensure that funds are being allocated to the behavioral health service delivery system. Behavioral HealthChoices has a long history of promoting the use of taxpayer dollars to go directly to the public good.
- **Controls for Quality Assurance, Accountability, and Efficiency** - a model of quality, accountability, and efficiency. The regulations, coupled with the leadership of OMHSAS, provide an operating structure and support for the BHMCOs and their networks of service providers.
- **Quality Provider Service Network** - a catalyst to attract a network of highly qualified service providers. The provider network has grown in number as well as their respective service array. Service providers have been very supportive and constructive innovation partners from the beginning of the Behavioral HealthChoices Program.
- **Battling the Opioid Epidemic** - Behavioral HealthChoices, along with the local Single County Authority (SCA) for substance use disorders have provided badly-needed and targeted resources to battle the opioid crisis. Behavioral Health MCO's showed initiation and engagement rates more than double of that of the physical health MCO's for both measurement year 2013 and 2014. The performance of Behavioral HealthChoices for the initiation and engagement of those battling opioid addiction exceeds that of the HealthChoices physical health plan, providing a successful model moving forward.
- **Reinvestment Expanding Service** - reinvestment funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill gaps in the service system, test new innovative treatment approaches, and develop cost-effective alternatives to traditional services that have created cost savings for state plans. Reinvestment funds have allowed counties to provide supplemental services that go far beyond the in-plan service array. Over the first 20 years $844 Million was dedicated to reinvestment plans. Reinvestment is capped at 3%.

> The wisdom and forethought of lawmakers with bi-partisan support from the state legislature during the Ridge, Rendell, Corbett, and Wolf administrations, and locally at the County administration and legislative levels has been proven not only by the significant cost savings, but in the increased access of valuable services not previously part of the service continuum as well as dramatic measurable increases in quality.

- **Integrated Care** - expertise within Behavioral HealthChoices is taking the lead by exploring new effective methods to provide integration of behavioral and physical heath in ways that treat the whole person's needs. Clinical integration of behavioral and physical health has included comprehensive physical and behavioral health screenings, member engagement, shared development of care plans and care coordination and navigator support. System integration includes identifying areas where the health systems can work together, such as the integration of real-time information-sharing, multi-disciplinary teams that coordinate care, the development of provider networks, and mechanisms for assessing and rewarding high-quality care. Behavioral / physical health collaborations include behavioral health medical integration, behavioral health homes, primary care teams using nurse navigators, wellness coaches, certified peer specialists and certified recovery specialists, integrated care with Federally Qualified Health Centers (FQHCs), Centers of Excellence (COEs) for substance abuse, Certified Community Behavioral Health Clinics (CCBHCs), and joint behavioral health and physical health performance plans (i.e. integrated care plans).