Youth.

Families.

Community

Health.

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To: Vermont House of Representatives, Committee on Health Care
Rep. William J. Lippert Jr., Chair, Rep. Anne B. Donahue, Vice Chair, Rep. Timothy Briglin, Ranking Member, Rep. Annmarie Christensen, Rep. Brian Cina, Rep. Sarah Copeland-Hanzas, Rep. Elizabeth "Betsy" Dunn, Rep. Douglas Gage, Rep. Michael Hebert, Rep. Lori Houghton, Clerk, Rep. Benjamin Jickling

From: Mitchell Barron, LICSW LADC

Re: An act relating to consent by minors for mental health treatment related to sexual orientation and gender identity

Date: March 14, 2017

Thank you for the opportunity to provide testimony on H.230, an act relating to consent by minors for mental health treatment related to sexual orientation and gender identity.

By way of introduction, my name is Mitch Barron – a resident of Hinesburg since 1992, and a resident of Vermont since 1988. I'm trained as a Clinical Social Worker and Addictions Counselor, licensed as both, and have worked with young people and families for almost 30 years. For the past 20 years, I've been the Director of *Centerpoint*, Vermont's largest provider of fully integrated mental health, substance abuse, and specialized educational services designed specifically for teens, young adults, and families (www.CenterpointServices.org). I'm on the Boards of, and have previously Chaired, two Chittenden County substance abuse prevention and health promotion coalitions – the *Burlington Partnership for a Healthy Community* - and - *Connecting Youth*, serving the 5 towns in the Chittenden South School District. I have also been the Chair of the *Vermont Alcohol and Drug Abuse Advisory Council* (with statute change, now the *Vermont Alcohol and Drug Abuse Council*) and am currently the Vice President of the *Vermont Association of Addiction Treatment Providers* (www.VTAddictionServices.org). Perhaps most importantly, I am a husband and father raising a 16 year old son.

At Centerpoint, we see approximately 750 young people and families each year, with services and supports ranging from prevention and early intervention to specialized, intensive treatment and recovery support. About half of these folks come to us to address some type of social, emotional, or mental health challenge – with the balance of folks facing very similar challenges with additional obstacles resulting from and contributing to substance abuse or addiction. For many, these issues are being addressed within the context of adolescent and young adult identity development – with an increasing number of young people seeking our services and working through issues related to their sexual orientation and gender identity.

H.230 is highly relevant for many that we see, however, I understand the request for my testimony is related to our experience with similar, parallel legislation, regulation, and statute regarding minors' access to substance abuse treatment. My comments on the following pages will be limited to this request, and will consider application and implication in substance abuse treatment with minors.

Originating with Federal confidentiality regulations (42 CFR Part 2) and codified in Vermont statute (18 V.S.A. § 4226), Vermonters under the age of 18 identified with a substance use disorder (current diagnostic terminology and criteria) are indeed able to access substance abuse treatment without the parental consent typically required for accessing general medical care. And this minor-consent access has been vital to many, many young people – and families – as I have seen them address their substance abuse issues and achieve health, over my 20 year career at Centerpoint.

Within this testimony, I'll defer to your committee's counsel regarding further legal detail and definition. From the clinical/practical perspective, I do have thoughts and to share:

First off, at Centerpoint, we often see the best outcomes for young people when we are able to work with the family as a whole – and when *resourced, skilled, and committed* parents are able to *support* their child/children *through the growth and healing* that we all hope to see through treatment:

1. For some young people who access services, parents are remarkable in their ability to support their child/children through their difficulties. These parents are truly able to provide, and their kids truly appreciate the support. For this group, statutes such as 18 V.S.A. § 4226 and the proposed H.230 may not be necessary.
2. For many more, these parent/family qualities, abilities, and skills may be an *outcome* of effective treatment, but are not evident or yet developed *upon treatment admission*. In these situations, a minor's ability to access treatment without parental consent is *quite important* to the minor's engagement with treatment and support – and this treatment participation would often *not occur* if protected information, including the need for treatment, was shared with the parent(s) prematurely.
3. And in some cases, the parent and family situation is a *primary contributor to the difficulties* of substance abuse and addiction. In these cases, parent consent would be a significant obstacle to a minor's access to treatment, and a minor's attempt to get help could place them at even greater risks. For kids in this situation, the protections afforded through 18 V.S.A. § 4226 and the proposed legislation *are essential*.

For those families who would be best defined by (1) above, our ability to work with the family as a whole is not impeded by statute, and by addressing issues of protected information, confidentiality, and treatment consent, we take the opportunity to reinforce the value of *healthy* and open communication.

For the many families that are better described in (2) above, we may initially be working with a young person independent of any *focused family therapy*, while also providing *parent support* if requested. This parent support in no way violates the protection of the minor as afforded by 42 CFR Part 2 and 18 V.S.A. § 4226. Rather, it is often very effective to help build – or rebuild – safe and trusting communication between child and parent(s) that can be so helpful in long-term health and recovery.

And for those described in (3) above, we find that we are helping young people get healthy 'in spite' of the parent or family situation, rather than with the support of it. This is our 'perspective of last resort,' though this is the absolute reality for some that we see.

As suggested, 42 CFR Part 2 and 18 V.S.A. § 4226 are critical for many of our clients, and important for most.

Some common scenarios, challenges, and misinterpretations:

- We – understandably – work with parents who say some version of "Are you kidding me?!? My 16 year old daughter can get counseling without me knowing what's going on?" As a parent of a 16 year old son, I can certainly appreciate this question. I also know that parents ask this question for many different reasons (ranging from care & concern about their child – to – control & fear that their own actions or behaviors may be disclosed). Responses require a skillful and nuanced clinical approach to insure that health is promoted and harm is avoided. While responses to these understandable inquiries range from *support* to more *strategic intervention*, they must always maintain the perspective that helping families get healthy is a primary mechanism to support a young person's health and well-being.

- We also work with kids who say some version of "I didn't sign a release, so *you can't talk to my parents*." For some teens, this legal right to consent may be the first time they are able to legally say "NO," and the power that comes from exercising this legal right may – at times - not be in their best interest. This, too, requires a skillful and nuanced clinical approach, recognizing that as families get healthy, more open communication is typically a part of the solution and closed communication may part of the problem. As noted above in (2), improved and open communication (with consent to communicate) may not be present at the outset of treatment but may be an outcome of an effective treatment experience. It is something we work towards, rather than begin with.

- We see providers and others who misinterpret and misapply the statutes, believing that they can't say "anything to anyone about anything" without authorized consent. The Federal and State Statutes regarding a minor's consent to treatment are relatively limited, though the Federal code language of "*any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program*" does broaden the application. Practically speaking?
    - If you were to call up Centerpoint and say "my son is in counseling there, can you tell me how he's doing?"… without authorized consent, we would not even be able to acknowledge that we know your son… even if you drive him to and from Centerpoint!
    - However, if you call up Centerpoint and say "I'm really concerned about my daughter," we will ask what is concerning you… we will offer ideas, supports, and strategies based on what *you* share, and we will invite you to take advantage of parent support services and parent skill building opportunities. These services would be no different that the types of services that we provide to many parents whose kids are no longer – or have never been – in treatment with us.

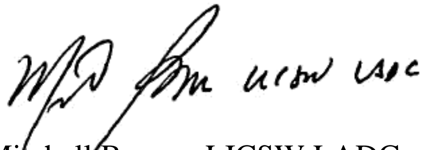
- It is also important to note that the protections offered through these statutes are further reinforced through their 'limited application' within a *program approved by the Agency of Human Services* and with treatment needs as diagnostically *verified by a licensed physician* (text in italics taken directly from statute). As an example, Centerpoint is a program approved preferred provider through VDH/ADAP with a Board Certified Medical Director reviewing all diagnostic assessments. While the minor's consent to treatment can be essential to protecting them from family *risks or obstacles to accessing treatment*, these additional 'consumer protections' help to insure that no harm occurs *within* treatment. Practically speaking?
    - This aspect of the statute – and the application of this within approved treatment settings with medical oversight – does help to reduce the concern expressed by parents *who would like to be involved* but whose child is *not willing or not yet ready* to have their parents involved.

- I'm aware that aspects of 18 V.S.A. § 4226 may be applied by some practicing outside of this 'limited application,' based on their non-AHS (VDH/ADAP) approved treatment setting or the absence of physician verification.

In summary, when applied as intended – including setting, oversight, and clinical skill necessary to insure safe and effective treatment services for the complex needs of a vulnerable population:

- 42 CFR Part 2 and 18 V.S.A. § 4226 have been essential to assisting many *in need* to actually *access and engage* in the services to address these needs.
- Issues of sexual orientation and gender identity may be no less powerful than issues of substance abuse and dependence within childhood and adolescence.
- The risks associated with unmet needs for these issues may be no less grave.
- I applaud this committee in your efforts to rigorously consider this proposed legislation, and I certainly support its adoption.

If I can be of further assistance, to clarify any points highlighted in this written testimony, or on any related matters, please feel free to reach me at phone or email below. Thanks for your continued commitment to the health and wellbeing of Vermonters, and particularly for your attention to the needs of young people, families, and those most vulnerable.



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