Testimony on H.230
Senate Health & Welfare
Jessica Oski

Thank you for the opportunity to speak with you today about H.230.

A little bit about me and why I am here. I am a parent of a 13 year old, a 13yo who has gained tremendous confidence, insight and the ability to communicate difficult personal concepts with her and father and me as the result of a few weeks of mental health treatment. I am also lawyer and have spent time working as an Assistant Attorney General with the Department of Mental Health and at Planned Parenthood, so I have some experience with these issues. I am also a lobbyist and have spent a lot of time in this building working on a wide variety of large and small statutory changes.

Although I have great respect for Commissioners Schatz and Bailey, I believe the time to act is now. This bill simply adds "mental health treatment" to the list of treatments to which minors are allowed to consent. This doesn't require any minor to seek treatment or require any provider to provide treatment.

I want to briefly review current law, federal law and then address a few of the problems I have heard raised.

Current Vermont Law
Currently under Vermont law an unemancipated minor may give informed consent to their own health care for a number of reasons:

- A minor 12 years or older may give informed consent to treatment for sexually transmitted diseases (including HIV and AIDS), drug dependence, and alcoholism. 18 V.S.A. § 4226. But if a minor requires immediate hospitalization for treatment of any of these conditions, the parents must be notified of the hospitalization. *Id.* This was added in 1971.

- A Minors 14 years or older may also voluntarily admit themselves to a hospital for mental health related treatment if they give informed consent in writing. Minors under 14 may admit themselves to a hospital for mental health related treatment by providing their own written informed consent and a written application from a parent or guardian. 18 V.S.A. § 7503. This provision was added in the 1960's, last amended in the 1970's.

- Minors of any age may give informed consent to medical treatment associated with rape, incest, or sexual abuse. Health care providers are required to report such incidents to the Department of Children and Families ("DCF") within 24 hours. 33 V.S.A. § 4911 et seq.

Under currently law, we have decided that the public health and individual health needs of minors to receive treatment for substance abuse and sexually transmitted diseases outweighs the state's desire to promote family focused care. This bill extends that balancing to mental health treatment. If the option is to force a minor to suffer because they don't feel that they can talk with their parents, or allow that minor to access potentially lifesaving treatment, treatment that could also possibly lead to family engagement, the state should err on the side of protecting the minor.

Federal law
HIPAA also anticipates minor's consent to treatment
From HHS: https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/

With respect to general treatment situations, a parent, guardian, or other person acting in loco parentis usually is the personal representative of the minor child, and a health care provider is permitted to share patient information with a patient's personal representative under the Privacy Rule. However, section 164.502(g) of the Privacy Rule contains several important exceptions to this general rule. A parent is not treated as a minor child's personal representative when: (1) State or other law does not require the consent of a parent or other person before a minor can obtain a particular health care service, the minor consents to the health care service, and the minor child has not requested the parent be treated as a personal representative;… For example, if State law provides an adolescent the right to obtain mental health treatment without parental consent, and the adolescent consents to such treatment, the parent would not be the personal representative of the adolescent with respect to that mental health treatment information.
The Rule goes on to provide more specific guidance to providers

Other State Laws
The laws that authorize minors to give their own consent for health care are mostly state laws. Beginning in the middle of the 20th century, states began to enact specific statutes to enable minors to obtain care without parental consent. Over the next half century, every state enacted some of these statutes, which vary in approach and coverage. See Chart from 2010. See also story from NJ re Gov Christie signing NJ law in 2016.

Consent by Minors Based on Services They Are Seeking
Every state has enacted one or more statutes allowing minors to consent for specific types of health care. The most common categories of care for which states have laws expressly allowing minors to consent are: emergency care; general medical care; family planning services or contraceptive care; pregnancy related care; STD/VD care; reportable disease care; HIV/AIDS care; drug or alcohol care; and outpatient mental health services. Also, a small number of states allow minors to consent for other categories of services, such as care related to a sexual assault, bone marrow transplantation, or "do not resuscitate" orders.
At least 35 states allow minors to consent for ***outpatient mental health services.*** Data I have is from 2010 and we know that at least one state, NJ, has signed law since 2010. These statutes contain a variety of limitations with respect to the age of minors who may consent, the type of

care that may be provided, the health care professionals who are covered, and the number of visits for which a minor may be seen without the involvement of a parent.

Payment

Questions about how these services are paid for have been raised. I am not an expert in this area, but I believe that this is not an insurmountable problem. Many adolescents are covered by Medicaid. I have been told that there are no barriers to a provider billing Medicaid for a covered minor receiving treatment. For minors covered by private insurance, it can be more difficult for a minor to access that coverage without their parents knowing, but it is not impossible. This committee heard testimony from carriers that they are able to send EOB to a different address when patient safety or confidentiality are critical. There was anecdotal testimony in the other body that some providers may be willing to provide treatment at no cost until the kid is able to involve their parents. There is also some free and low cost care available.

Age

Questions have been raised about age, and what is a minor? Some states do set an age, ex: 11 or older, others do not. The legal right to consent should not be confused with the capacity to provide informed consent. If the law allows a minor to consent to treatment, a health care provider must still determine whether the minor has the capacity for informed consent. Generally, informed consent requires that the patient understands the risks and benefits of the treatment, voluntarily agrees to treatment and participate meaningfully in treatment decision-making. At what age a patient is able to provide informed consent will vary from person to person and will vary depending on the treatment sought.

Need and Access

Approximately 20 percent of adolescents have mental health disorders; however, only a small number receive treatment.[1]

Knopf, D. K., Park, J., & Mulye, T. P. (2008). The mental health of adolescents: A national profile, 2008. Retrieved November 9, 2012, from http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf

Evidence-based interventions— before adolescents develop a mental health disorder— offer the best opportunity to reduce the economic and health costs associated with these disorders.2,3

[2] Schwarz, S. W. (2009). Adolescent mental health in the United States: Facts for Policymakers .Retrieved November 9, 2012, from http://nccp.org/publications/pdf/text_878.pdf

[3] Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., et al. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry, 40(10), 980-989.

Groups with the greatest need for mental health services include lesbian, gay, bisexual, and transgender adolescents; adolescents overseen by the child welfare and juvenile justice systems; and homeless adolescents.

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youth. American Journal of Public Health, 100(12), 2426-2432.

[9] Morrow, S., & Howell, E. (2010). State mental health systems for children. Washington, DC: Urban Institute.

[10] United States Interagency Council on Homelessness. (2010). Opening doors: Federal strategic plan to prevent and end homelessness. Executive Summary. Retrieved February 16, 2011, from http://www.ich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf

There is no doubt that multiple challenges exist in trying to connect adolescents with mental health needs to the services and treatments that can help them attain a better quality of life. We know that similar challenges exist even for adults to seek mental health care, challenges like: fear, shame, lack of insight, distrust, hopelessness…
Let's not have consent be one of those challenges. If a kid has the wherewithall to ask for help, but they feel they can't talk to their parents, let's not miss the opportunity to get that kid the help they need.

I think it is great that DCF and DMH want to tackle this problem. Passing this law will be the impetus that is needed to move forward with removing barriers to treatment.

As I said the last time I was here, as a parent, my number one goal for my child is that she survives, and hopefully thrives and finds happiness. For some kids, this is about survival.

Thank-you.