Center for American Progress

Providing a Lifeline for LGBT Youth

Mental Health Services and the Age of Consent

Carlos Maza December 2010

Lesbian, gay, bisexual, and transgender teenagers are some of the most vulnerable of people in the United States today. They face discrimination and harassment from a variety of different sources: bullying and harassment in schools, rejection at home, and condemnation from media and religious organizations. A fear of persecution encourages many LGBT teens to keep their real identities hidden.

Living with the stress of a marginalized identity has clear and negative effects on the mental health of LGBT youth. They are consistently reported as having higher rates of depression and anxiety than their non-LGBT peers.[1] Even more troubling, studies have demonstrated that these young adults are more likely than non-LGBT teenagers to engage in self-harm, have suicidal thoughts, and attempt suicide.[2]

Providing LGBT adolescents with access to mental health services is essential to helping them cope with the extreme pressures that have led many of them to consider suicide. Numerous studies have already demonstrated the benefits of mental health treatment for people suffering from depression and other mood disorders. Mental health counseling and therapy have a high probability of improving the mental health and wellbeing of teens, even when unaccompanied by medication.

State age-of-consent laws

A majority of states require minors to obtain consent from a parent or guardian before receiving outpatient mental health treatment. This requirement too often forces LGBT adolescents into a painful catch-22—they must choose to either forgo critically needed professional help or seek treatment while risking revealing their LGBT status to their families prematurely and without a support network, which can significantly aggravate existing mental health problems.[3]

LGBT youth are likely to avoid using public mental health services if they believe that doing so will cause them to have to reveal their LGBT status to their parents or peers.[4] That's why young adults with mental health issues wait an average of seven and a half years after first experiencing symptoms before seeking professional help despite the effectiveness of mental health services.[5]

When LGBT teens are fortunate enough to obtain parental consent, they may still be reluctant to fully disclose the extent or severity of their mental health issues. Many LGBT teens worry about the confidentiality of their treatment sessions, fearing that their parents will access their medical records and discover their LGBT status. A few of the states that allow minors to consent to outpatient mental health care still allow doctors to reveal minors' personal medical information to their parents without their permission. Concerns about patient-provider confidentiality undermine the effectiveness of mental health treatment by dissuading LGBT teens to withhold important information during the treatment process.[6]

State age-of-consent laws for accessing mental health care vary widely.[7] A third of the states do not allow patients under the age of 18 to access outpatient mental health services without a parent's consent. Only 16 states allow minors to receive outpatient mental health care without parental consent at that age despite research demonstrating that half of all lifetime cases of mental illnesses develop by age 14.[8]

Several of the states that allow minors to access outpatient mental health care maintain restrictions on providing minors with medication. These restrictions significantly alter the quality of mental health care available to them. Studies have demonstrated that the effectiveness of counseling and therapy is greatly increased when coupled with antidepressants and other psychiatric medications.[9]

Fully understanding state statutes governing age of consent for outpatient mental health treatment can be frustrating. Many of these regulations include a range of caveats, requirements, and vaguely defined exceptions. Some states require parental consent after a certain number of treatment sessions. Others require that a court deems a minor to be mature and fit to consent before receiving treatment. Still others allow minors to consent only in emergency situations, when a parent or guardian is not available to consent on his or her behalf.

And nearly every state that allows minors to access mental health services without parental consent (Connecticut and Washington, D.C. are the exceptions) gives practitioners discretion about whether to inform the minor's parents about his

or her treatment. Some states allow medical practitioners to inform parents of a minor's condition only when the minor's health is at serious risk. But others establish no guidelines for when to involve a patient's parents, putting LGBT youth at risk of having their true sexual orientation or gender identity revealed to their families without good reason.

These wildly different standards for mental health treatment and confidentiality serve as major hurdles for LGBT teens looking for safe and supportive places to receive treatment for their mental health concerns. It is likely that LGBT youth will avoid seeking help altogether if they do not believe they can receive respectful and effective treatment without having to "out" themselves to their families. Establishing clear and youth-friendly standards for administering mental health services is essential to ensuring that America's most vulnerable teens are not forced to struggle alone with devastating effects of depression and other mental illnesses.

The California model—The Mental Health Services for At-Risk Youth Act

California Gov. Arnold Schwarzenegger signed the Mental Health Services for At-Risk Youth Act (SB 543) into law on September 30, 2010. The law expands minors' access to mental health services by relaxing the state's consent requirement and is a useful model for state or federal legislation to address mental illness among LGBT youth.

The new law will go into effect on January 1, 2011, significantly expanding the scope of minors qualified to access mental health services without parental consent. Minors seeking mental health care previously needed to be (1) at least 12 years old, (2) mature enough to participate intelligently in the treatment, and (3) either in danger of serious physical or mental harm to himself or herself, or to others, without treatment, or a victim of incest or child abuse.

The new law eliminates the third requirement for accessing treatment, allowing LGBT minors who are not yet in serious danger to receive outpatient mental care. This shift in policy is tremendously important; instead of focusing on crisis management once a mental health situation has *already* become life threatening, the new law emphasizes prevention and early detection, which are more effective and less costly for health care providers.[10]

SB 543 includes several restrictions on the kind of mental health treatment that minors can receive. The previous law and SB 543 both allow minors to only consent to outpatient mental health treatment and counseling. They are not allowed to consent to inpatient mental health treatment, psychotropic drug therapies, convulsive therapy (electroshock), or psychosurgery (surgery intended to alter brain performance).

The new law does not eliminate a care provider's ability to bring a minor's parents into the care process. In fact, the law encourages caregivers to involve parents—unless the provider, after consulting with the minor, determines that their involvement would be inappropriate. Parental involvement, however, does not require that parents be able to access their child's mental health records. Under current law and SB 543, a care provider can only share related mental health records with parents or guardians after the provider has received written authorization from the minor. This provision is significant for LGBT teens because it eliminates their fears that seeking mental health services will result in having their LGBT status revealed to potentially unsupportive or even hostile family members.

Policy recommendations

Other states and the federal government should use the California legislation as a guide for drafting their own legislation that will enable LGBT youth to access mental health services without fear. Yet any federal legislation will have to consider and resolve a number of important issues including who will be eligible for treatment, what types of treatment they should be eligible for, and how to ensure confidentiality.

Eligibility for treatment

Federal legislation should strive to allow minors to be able to consent to outpatient mental health treatment by that age, considering a large percentage of lifetime mental illnesses develop by age 14.[11] Professional health practitioners should follow the California model by retaining the ability to determine if "the minor is mature enough to participate intelligently in the mental health treatment or counseling services," even if the minor is not immediately at risk of causing harm to himself or herself, or others. This would establish a reasonable balance between excluding frivolous or unnecessary requests for treatment and providing help before mental health problems develop into crises situations.

Types of treatment

Medication can be an important and necessary part of mental health treatment in many cases. Yet many parents would be understandably uncomfortable with their child receiving treatment without their knowledge or consent. Medication should therefore only be provided to minors without parental consent if (1) the health care provider determines that the medication is necessary for treatment and (2) the provider determines that requiring parental consent would damage the minor's course of treatment—especially if the minor won't seek treatment if parental consent is required. More extreme treatments such as psychosurgery should still require parental consent. This approach balances a concern for parental rights and the need to ensure that the mental health of LGBT teens is not held hostage by unsupportive or hostile parents.

Patient confidentiality

California's youth mental health law provides an excellent middle ground for determining parental involvement in the mental health treatment process. Care providers should be encouraged to involve parents only when deemed appropriate and after discussing such involvement with the minor. Care providers should make a conscious effort to protect the privacy of the minor, especially when revealing his or her LGBT status would prompt a negative reaction from family members. Caregivers should not hand over medical records to a minor's parents without first obtaining the minor's written consent.

Legislators will inevitably have to debate and resolve other issues concerning the age of consent for outpatient mental health care. What is most important, however, is that Congress acts to deal with the gaping hole in mental health services for LGBT youth. Providing these vulnerable teens with the knowledge that they can safely and privately seek help for their mental health problems may mean the difference between finally stopping the trend of LGBT mental illness and suicide, and allowing it to continue indefinitely.

State age of consent for outpatient mental health services

State	Age of consent (general health)	Age of consent (mental health)	Parents can be informed
Alabama	14	14	X
Alaska	18	18	
Arizona	18	18	
Arkansas	MM*	MM	X
California	18	12	X
Colorado	18	15	X
Connecticut	18	14	
Delaware	18	18	
District of Columbia	18	MM	
Florida	18	13	X
Georgia	18	18	
Hawaii	18	18	
Idaho	MM	MM	X
Illinois	18	12	X
Indiana	18	18	
Iowa	18	18	
Kansas	18	14	X
Kentucky	18	16	X
Louisiana	MM	MM	X
Maine	18	18	X
Maryland	18	16	X
Massachusetts	18	16	X
Michigan	18	14	X
Minnesota	18	16	X
Mississippi	18	15	X
Missouri	18	18	
Montana	18	16	
Nebraska	19	19	
Nevada	MM	MM	X
New Hampshire	MM	MM	X
New Jersey	18	14	X
New Mexico	18	14	X
New York	18	16	X
North Carolina	18	MM	X
North Dakota	18	14	X
Ohio	18	14	X
Oklahoma	18	18	
Oregon	15	14	X
Pennsylvania	18	14	X
Rhode Island	16	16	X
South Carolina	16	16	X
South Dakota	18	18	
Tennessee	18	16	X
Texas	18	16	X
Utah	18	18	
Vermont	18	18	
Virginia	18	14	X
Washington	18	13	X
West Virginia	18	18	
Wisconsin	18	14	X
Wyoming	18	18	

Note: MM is a "mature minor"—allows any person to consent that is capable of intelligently participating in treatment and comprehending the need for, nature of, and significant risks of treatment.

Endnotes

1 Wendy B. Bostwick, "Mental Health Risk Factors Among GLBT youth" (Arlington: National Alliance on Mental Illness, 2007), available at http://www.nami.org/TextTemplate.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=48112.

2 Christopher Bagley and PierreTremblay, "Suicidal Behaviors in Homosexual and Bisexual Males," Journal of Crisis Intervention and Suicide Prevention, 18 (1) (1997): 24-34; National Institute of Mental Health, "Treatment of Children with Mental Illness" (2009), available at http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml.

3 Equality California , "Mental Health Services for At-Risk Youth" (2010), available at http://www.eqca.org/site/pp.asp?c=kuLRJ9MRKrH&b=5027751.

4 J.M. Poirier and others "Practice Brief 1: Providing Services and Supports for Youth Who Are Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, or Two-Spirit" (Washington: National Center for Cultural Competence, Georgetown University Center for Child and Human Development, 2008), p. 2-4.

5 Lesley Russell, "Mental Health Services in Primary Care" (Washington: Center for American Progress, 2010), available at http://www.americanprogress.org/issues/2010/10/pdf/mentalhealth.pdf, p.26.

6 K.R. Ginsburg and others, "How to reach sexual minority youth in the health care setting: the teens offer guidance," *Journal of Adolescent Health* (31) (2002): 407-416..

7 For the purposes of this section, any reference to "state laws" will also include Washington, D.C.

8 National Institute of Mental Health, "Treatment of Children with Mental Illness" (2009), available at http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml.

9 American Psychiatric Association and American Academy of Child and Adolescent Psychiatry, "The Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families" (2010), available at http://www.psych.org/Share/Parents-Med-Guide/Medication-Guides/ParentsMedGuide-Depression-English.aspx, p. 3.

10 Equality California , "Mental Health Services for At-Risk Youth."

11 Legislation should set a "ceiling" and not a "floor" for the age of consent for mental health care. States that wish to set their age of consent *below* 14 (like California) should retain the right to do so.