MCEDV.
The Maine Coalition
to End Domestic Violence

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Testimony of Andrea Mancuso on behalf of the Maine Coalition to End Domestic Violence
LD 1439 "An Act to Promote Family-centered Interventions for Substance Use Disorder Treatment"
Before the Joint Standing Committee on Health and Human Services
Wednesday, May 3, 2023

Senator Baldacci, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, I am writing on behalf of the Maine Coalition to End Domestic Violence (MCEDV)[1] to raise concerns with LD 1439, "An Act to Promote Family-centered Interventions for Substance Use Disorder Treatment."

MCEDV deeply appreciates the intention behind this proposal. However, where abusive people can use systems and community responses against their partner, they will find a way to do so, and this bill does not provide any of the guard rails that would be necessary to prevent that. While many family members might be sincerely seeking substance use intervention services for their loved one with the best of intentions, and they may be an appropriate and positive source of support for that loved one, we cannot write that assumption into our laws given the high prevalence of domestic abuse and violence in our state – abuse that is perpetrated by family members or others who may fall under the "authorized person" category. While certainly positive social and family support is associated with successful recovery, negative social and family involvement, to specifically include interpersonal conflict, is related to *increased* risk of substance use. Without proper screening and assessment, the requirements on health care facilities outlined in the draft of LD 1439 risk causing great harm.

[1] MCEDV serves a membership of the eight regional domestic violence resource centers (DVRCs) across the state, as well as the Immigrant Resource Center of Maine. Last year, these programs together served more than 12,000 Maine survivors of domestic abuse and violence and their children.

As drafted, LD 1439 does not provide any way for either health care facilities or the person affected to identify or account for whether the family member or friend seeking to get involved is a positive or negative support. An "authorized person," under the bill, means any family member or friend who requests an intervention, regardless of the nature, quality or context of their relationship with the affected person or how the affected person feels about their involvement. This is in direct contrast to the recommendations from the Substance Abuse and Mental Health Services Administration Advisory around involving family in any sort of intervention or counseling from the advisory that was provided to the Committee in support of the bill. The SAMHSA recommendations call for fairly comprehensive screening for circumstances in which family-based interventions would be "inadvisable, inappropriate, or counterproductive," and specifically cite domestic violence and abuse dynamics as concerns. The recommendations further note the importance of giving the impacted person "choice" over who participates and of honoring that person's choices. There are clearly many factors to be thoughtfully explored and accounted for before a third party is involved in the treatment of a patient; none of those factors appear to be accounted for in this proposal.

It also appears that a "person in need" means any person hospitalized for any reason, as the only place where the hospitalization is specifically limited to hospitalization for treatment of substance use disorder is in section 1, subparagraph 4. Therefore, under the current proposal, could a woman who is hospitalized to give birth be faced with an "intervention" and two compulsory substance use evaluations based on substance use disorder allegations made by the child's father who, unbeknownst to the health care facility, has a history of domestic abuse and violence towards this person?

The language of LD 1439 would permit any family member or friend of a person hospitalized for any reason to "request an intervention." It is unclear if the intervention that must then be offered by the facility can be refused by the patient. Can the patient decline to have the facility move forward with the intervention? If not, how will this forced intervention be paid for? We understand from our colleagues at the Office of Behavioral Health and the Maine Hospital Association that such practices are not covered by health insurance. Will the patient be responsible for the cost of an intervention they had no option to refuse? The proposal further directs that the facility is compelled to include in the intervention the "authorized person" who requested it and other family members or friends. Again, we note that this would not seem to allow for any structure or process to determine whether the authorized person or other participants is not a positive source of support. Such a determination is also likely to be difficult for providers to be expected to accurately make in

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the context of an emergency room response, where providers have not yet established a relationship of trust with the patient, such that disclosures about abuse could be reasonably expected from a person who is already in a vulnerable place.

Section 3 of the bill directs two substance use evaluations, in which all of the patient's medical history must be provided and reviewed and through which the authorized person and any other family or friend would be able to give whatever information they want. The bill is unclear what launches this requirement. Is it the request for intervention by an authorized person? The fact of hospitalization of a person for substance use treatment? Can the patient refuse these examinations? There is no process referenced in the bill language for the patient to contest the need for such compulsory evaluations or to seek to limit who is appropriate to provide information to the evaluators. In the context of domestic abuse and violence, we would expect to see abusive family members manipulating this process and later seeking to use these medical records for harm – for example in an ongoing or subsequent family court or child welfare proceeding.

Lastly, section 4 of the bill requires any discharge plans developed to "include the authorized person and family members," without any opportunity for the patient to have input into whether that authorized person or other family members are positive supports or would be inappropriate to be participating in any recovery plans. It is unclear what it means for a discharge plan to be "include[d]." Does it mean that the discharge plan, with potentially confidential medical/health information, is shared with these 3rd parties? Does it require the person in need to work with or share information with these interested parties? How would facilities screen and account for whether someone who qualifies as an authorized person has a history of sabotaging the patient's prior attempts at sobriety? The language in this bill does not provide flexibility to facilities to fully consider and respond to the individual circumstances of the patient in front of them.

It is not uncommon for perpetrators of domestic abuse and violence to be the reason the victim is using substances in the first place – whether that be due to coerced use or where the use is

a means to cope with abuse. And it is not uncommon for a perpetrator to then manipulate that substance use against the victim, to impair credibility, to gain leverage around child custody, to use state systems like the child welfare system to advance their own agendas, etc. This proposal risks codifying a health care response that facilitates such abuse, and it goes further – seemingly compelling certain actions and information sharing before the subject person is even determined to be a person in need of substance use treatment.

Giving family members or close associates power to compel health care interventions (and their own involvement with them) without substantial guard rails and off ramps would be very dangerous to victims of domestic abuse and violence. This is especially true for those victims who have additional vulnerabilities, including those who may already have a harder time than an "authorized person" communicating with health care professionals in these situations. MCEDV asks this Committee to deeply consider the complex nature of family dynamics and ensure that any requirements around family involvement in health care responses have appropriate protections to guard against abuse.

Thank you for the opportunity to provide our perspective. MCEDV is happy to work with the Committee and any interested parties as your work on this proposal continues.

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