Sen. Gelser, Vice-Chair Anderson and members of the committee,

Thank you for the hearing and opportunity to testify on HB 3139A, the bill to clarify when it is appropriate to notify parents or engage trusted adults in suicide prevention safety planning. We very much appreciate the opportunity to discuss this important issue and acknowledge the vast complexities of balancing youth autonomy with safety. With the topic of youth suicide prevention often comes anxiety and we find ourselves asking many "what ifs" (e.g., what if the provider discloses too much, what if they do not disclose when they need to do so, or what if the law is misapplied?). I do not think that any version of this or any bill regarding youth suicide will fully address our anxieties, but it is our hope that HB 3139 will be a step in the right direction.

To summarize, HIPAA allows for the notifications and engagement outlined in HB 3139A but as committee members noted, the federal regulations can be vague and confusing to mental health providers. This bill does not change current practices, which require clinical judgment in determining when it is appropriate to engage parents and other trusted adults and what information to disclose. The intent is to provide clarity to mental health providers, youth, and families that providing safety planning and coordinating support in high-risk situations saves lives.

Questions raised by the committee:
What about kids (e.g., LBGTQ+ community) who may be harmed by parental notification? When this law rolls out, how will providers be intentional about who is notified or not?

Under HIPAA, mental health providers "when using or disclosing protected health information… must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose…" (known as the HIPAA Minimum Necessary Rule). If appropriate, a mental health provider could safety plan with the youth and parents while discussing the risk of suicide without disclosing that the youth identifies as a member of the LGBTQ+ community. Alternatively, the mental health provider and youth could safety plan with another trusted individual with whom the youth feels more comfortable or a local LGBTQ+ support organization. This bill seeks to make explicit to mental health providers the available options and tools, so that they can balance disclosing necessary information while also considering the youth's individual circumstances, beliefs, and values. This is a responsibility that mental health providers are currently navigating, sometimes with an incomplete understanding of HIPAA and Oregon Statutes as written.

Will youth be informed? The language in HB 3139 is not explicit that other organizations may be included without the consent of the youth.
There is no language that I am aware of in HB 3139, current Oregon Statutes, or HIPAA specifically addressing notifying youth that information was disclosed during an emergency. Yet, the process of safety planning can only be successful if the youth and the mental health provider collaborate (i.e., the youth would be involved every step of the way). If this is not successful, the risk for suicide increases further and, in most situations, the youth would be taken to an emergency department for further assessment and treatment.

Involving other organizations is allowed under HIPAA and HB 3139 but not required. The HIPAA Minimum Necessary referenced above would apply and other organizations would only be involved if necessary. A common example when this would be important is when youths have a psychiatrist/PMHNP, therapist, and primary care provider. If the high-risk assessment is made by the primary care provider, it is likely that they would reach out to the other professionals involved in the youth's care to schedule additional appointments, make medication adjustments, or increase the youth's level of services.

What happens if the youth objects to disclosure? What's confidential and what is not?
Under HIPAA, disclosures can only be made when the mental health provider believes that doing so is in the best interest of the youth. If the mental health provider makes a disclosure, then they would also need to follow the HIPAA Minimum Necessary Rule referenced above. Any disclosure that is not in the best interest of the youth (e.g., identifies as a member of the LGBTQ+ community or disclosing information carries the risk of stigmatization), would remain confidential.

What are the HIPAA regulations in regard to the age to get mental health treatment without parental consent?
HIPAA is silent regarding the age of consent, so this is left up to the discretion of the state. In Oregon, the age is 14. HIPAA does outline rules for youth and adults where information can be disclosed in emergent and non-emergent situations.

What is the process for what information is shared and when, what are the circumstances and what tools do providers need in order to keep kids safe?
In my experience, when youths disclose that they are having suicidal thoughts and are worried that they will act on them, they want help but often are too scared and

do not know how to ask for it. When they hear that the mental health system and their support network care about them and need to be involved, they are typically relieved and agree to safety plan. In the instances where youth object to the disclosure, mental health providers would engage the youth in a discussion of reasonable alternatives (e.g., Can we just tell your parents that you are struggling right now, have them lock up the firearms and medications, and ask them to keep a close eye on you until our next appointment. We can keep everything else between you and me for now.). If all attempts at safety planning fail, the parents would be notified of information relevant to the suicide risk with the recommendation to take their child to the emergency department.

The most important evidence-based tool in safety planning with youths is bringing in additional support, ideally loving parents. There is nothing that I can do in my office that will have a comparable effect. We strongly recommend avoiding situations where a youth who is assessed to be a serious and imminent risk of suicide leaves the provider's office with parents who are unaware of the danger to a home where medications and firearms are not secured.

What is the risk if it does not pass? What happens if this bill passes?
If the bill does not pass, most mental health providers will continue to follow the best practices and standards of care in compliance with current federal regulations and Oregon statutes. A significant minority of providers will likely continue to practice with the misnomer that even youth at serious and imminent risk of suicide have an absolute right to privacy and even in emergencies, they will be sent home without following evidenced based practices that would reduce their risk of suicide.

If the bill passes, the hope is that by taking language directly from and consistent with HIPAA, it will make it clear to more mental health providers that in mental health emergencies, steps must be taken to safety plan and collaborate with the youth, family, and if indicated, other professionals or trusted adults.

Please let us know if you have any other questions. Dr. Daniel Nicoli will be available at the hearing on May 20 to be a resource to the committee.

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