

Julie Magers Testimony – March 11, 2015

Hello Chairperson Greenlick, Vice-Chairs Hayden and Nosse and esteemed members of the committee. My name is Julie Magers. I work as a family advocate and educator at NAMI Multnomah, serve on several Children’s Mental Health advisory councils and the new Oregon Young Adult Suicide Prevention Steering Committee. I’m a mother with two kids ages 20 and 24 who are entering their adulthoods as contributing and productive members of our community.

I urge you to move toward passing HB 2948, 2022, and 2023. My personal experiences advocating for my daughter will describe to you why they are critically important to saving lives.

In a report¹ titled “Continuity of Care for Suicide Prevention & Research” it is stated: “For patients at risk for suicide, discharge from an emergency room or psychiatric inpatient facility is all too often the beginning of a difficult ... journey across the landscape of a disarrayed mental health care system... Once patients are discharged, the complexity of coordinating and continuing mental health care ... is confounded by existing fragmentations and gaps in services among service providers.”

Please let me describe to you how my experiences reflected this grim assessment.

In 2011, my daughter was 16 years old and in desperate moments of her darkest days, she attempted suicide two times in less than 30 days. At the first ED, after swallowing 3 bottles of OTC medication, workers performed what the attending doctor told me was their protocol in such situations: tend to the medical crisis, medically clear her, ask her if she actively wanted to hurt herself, and then send her back home just 12 hours later. I was certain this wasn’t enough to address the conditions that brought us there that night and I pushed back strongly enough that they admitted her to the next available bed in an adolescent psychiatric unit. I thought naively that she would be fully evaluated and we would be given long overdue answers and medical recommendations for how to address her unmanageable struggles.

What we actually experienced upon discharge was the following:

1. an assessment that fell short of revealing what we were dealing with by way of a diagnosis and was based on a physician having read her file and visiting with her for 2 ten minute sessions;
2. a treatment plan that fell dramatically short of addressing her illness – the plan entailed following up with her outpatient therapists, appts they did help us to schedule, and to be placed on a waiting list for a treatment program that she may or may not get access into;

¹ Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2010) *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit*. Newton, MA: Education Development Center, Inc.

and perhaps most importantly,

3. a failure to inform me of the severity of her condition from a clinical perspective, her increased risk of suicide, and the critical importance of getting a qualified team of practitioners to do a more thorough evaluation and create a treatment plan to meet her needs (in other words, educating me and her on her conditions);

All of this led to a second suicide attempt less than two weeks after her discharge, and a costly re-hospitalization, although luckily not a completed suicide. That second hospitalization was so predictable that the attending psychiatrist told me that mine was the “kind of kid who would likely experience recurring hospitalizations before he would be able to diagnose her” and then he went on to predict a diagnosis at age 18 that he couldn’t make given her age at the time. **Not once did he suggest that with intensive and consistent care then and over the course of the following 2 years that we might intercept that future prognosis.**

What I learned as a parent in that indescribably traumatic month, was that I would have to fight hard in a system that seemed to have practices designed to move patients out of its facilities but isn’t designed well to help them with a plan to address their needs out in the community.

At the time of my daughter’s second discharge, armed with a skilled advocate by my side, we insisted on a plan that would better place us onto a path of effective treatment and recovery. This included:

(1) a clinically appropriate step down in care, (2) a thorough evaluation that revealed what a treatment plan should include for her, (3) transition from a residential placement back to home that put in place a longer term plan to meet her clinical, educational, and social needs, and (4) a better informed parent with the supports I needed to help her follow her treatment plans over the long haul. **These all led us through the hardest parts of her recovery and a smooth transition to adulthood, where she continues to be supported in ways that help her to incrementally take on more responsibilities for herself.** In fact she’s here today to bravely share with you her own perspectives of these experiences.

We present a success story of what is possible when we as a community get it right - And I am so very grateful for this. It is heartbreaking that too many other families have not been so fortunate and I wish that we would all find this unacceptable. I firmly believe that the content of these 3 bills will save lives. What they describe are many of the evidence-based and best practices that saved my daughter’s life. Oregon has one of the highest suicide rates in the nation. These are preventable losses. Riley and I are here today revealing what is possible so that you may help the many other families who are desperately seeking care and support for their children.

Thank your time and thoughtful attention.