Testimony for Coordination of Care Act (HB 3091)

Chair Gelser, Vice-chair Olsen, Members of the Committee

My name is Jerry Gabay. I am on the board of NAMI Oregon and am a member of the Alliance to Prevent Youth Suicide; however I am testifying on my own behalf today. Many of you may remember me from 2015, when I drafted the initial concepts for HB 2948 and 2023, both of which later became law. As you may remember my story, I'll be brief…which usually draws a smile from the Chair.

My daughter Susanna was 21 when she had a psychotic breakdown while a student at Clark Honors College at the U of O. She was held at Sacred Heart Hospital on a 48 hour police hold, then admitted to the secure psychiatric unit for 8 days. The first days she was on suicide watch, but the hospital did not tell us that. They told us almost nothing. The psychiatrist said blithely that she had had a psychotic episode. She might have others, she might never have another. That was it. You passed the Susanna Blake Gabay Act in 2015 to help address such failures in communication – for which her mother and I are deeply grateful.

Susanna did have a written discharge plan when the hospital released her. It did document an appointment 5 days later with a counselor at the University Health Center, and an appointment with a private psychiatrist whom Susanna had never seen before, 30 days after discharge. The entire remainder of the 3 page plan were things Susanna came up with that she could do if she felt increased mental illness or suicidal tendencies. There were no follow up calls to check in with her, no contact by someone to help her navigate the plan; she was left alone to navigate on

her own, and her parents were neither counseled on how to help nor warned by any of the medical providers of her suicide risk. I want to re-emphasize almost the entire plan depended upon my child taking actions necessary to save her own life. I maintain that if she had the legal or mental capacity to have done so, she would not have been in the hospital to begin with.

Currently in many situations, it is parents who are implicitly the coordinator of their children's mental health care. No one trains these parents, no one even tells them they must perform that role. It is not their proper role to do so, but few in the medical profession are currently doing that coordination. With tragic results.

My child was released from Sacred Heart Secure Psychiatric Unit on April 5, 2010. She died on May 6, 31 days later. When Sacred Heart discharged my daughter the day after Easter Sunday 2010, without any followup, without any transition other than those 2 appointments, without any support after discharge, without counseling her parents, they gave Susanna a death sentence. My precious child deserved better than that.

You have it in your power today to save the lives of other precious children. I deeply believe this act, HB 3091, requiring coordination of care and case management, will save lives. Please think of those children – and my child – when you vote. Thank you.