May 16, 2017

To: Oregon House Health Committee
Chair Greenlick, Vice-Chairs Hayden and Nosse and Members of the Committee

RE: Testimony in support of SB48 - continuing education related to suicide risk assessment, treatment and management for health care providers.

My name is Julie Magers. I work as a family support specialist, health system navigator and educator for families who have children living with mental and emotional health challenges, including those at heightened risk of suicide. I serve on Oregon Health Authority's *Children's System Advisory Council* (CSAC), I was one of many committed members of our state's suicide prevention community who developed the *Youth Suicide Intervention & Prevention Plan*, and I am now a member of the *Oregon Alliance for Youth Suicide Prevention*.

My comments today are from the perspective of family members and our experiences trying to get professional help for our loved ones at immediate risk of suicide, or worse, what happens once they've painfully made a suicide attempt.

As I understand it, Senate Bill 48 addresses licensing boards to accommodate voluntary continuing education in suicide risk assessment, treatment and management for certain health care providers and allowing the providers to report their voluntary coursework and have the credits apply toward their overall licensing requirements. SB 48 also requires the licensing boards to provide their training statistics to Oregon Health Authority, which is required to report progress to the Legislature each year as part of OHA's requirements described in the annual suicide intervention and prevention report.

I think we can all agree that adequate training is essential in any field, and most critically in health care and safety. I'd like to share one brief story about a time my daughter turned to a crisis walk-in center, whose website states, "all who seek help at the Urgent Walk-In Clinic will meet with a mental health clinician." My daughter was struggling and she turned to a place where she believed she would find help. She described to the mental health clinician her history of hospitalizations, her present state and symptoms, and she asked for his help. She was told her only options were to ride it out or go to an emergency department. She left the clinic in a friend's car to go to the E.D. The clinician did call the E.D. to see that she made it (although I'm not certain what would have been done had she not) and he also followed up with her private practice therapist. He shared that he was surprised that she could really be at a heightened risk for suicide due to her ability to articulate herself and her keen self-awareness.

I'm sharing this story because it is an example of my experiences seeing personal bias among health care workers getting in the way of best and safe practices when responding to people struggling with suicidal ideation. Families turning to professionals to help them with their children who are expressing suicidal thoughts and plans to act on those thoughts expect the professionals to be trained to evaluate, treat and manage the presenting condition. When we encounter health care providers who don't have adequate training in how to assess risk and provide appropriate information and follow up treatment guidance, our loved ones are underserved and are often left in a high-risk state without appropriate next steps to follow.

I believe that training and practice render us more competent in any field. When preconceived ideas of what suicidal "looks" like or "speaks" like are not informed by current research and quality training, biases and misinformation can and often do lead to less (or more) care than is needed. Training and practice not only build knowledge, they also check our biases.

Today, my daughter is doing very well in life, due in large part to the knowledge and skill level of her mental health providers and how they have helped her and her family learn about risk factors, warning signs and protective factors. I see many families turning to emergency or other urgent care settings and even mental health specialists who are not as informed or skilled in these areas.

Having our health care workers adequately educated and trained in how to detect and respond to our loved ones presenting with symptoms of risk of dying by suicide is a basic expectation that families hold.

I would like to see training in suicide detection, assessment, treatment and management be mandatory for any health care worker who is likely to be responsible for patients who present with suicide risk and warning signs. If industry associations are so strongly opposed to mandatory training, the very least that should be compromised is for trainings to be available, providers encouraged to participate, and to collect and report the data on what is being done under this voluntary option so that it can be determined if training will make a difference in providing effective care to stem the tide of the numbers of suicides taking place in Oregon.

Thank you for your time in reading my input.