Concerns / Opposition for HB 3139 – Requires parental disclosure when minor receives suicide risk assessment, intervention, treatment, or support services.

18 May 2021

TO: Chair Senator Sara Gelser
Vice Chair Senator Dick Anderson
Members of the Senate Committee On Human Services, Mental Health and Recovery

FROM: Jennifer Fraga, CSWA

SUBJECT: Concerns / Opposition for HB 3139 – Requires parental disclosure when minor receives suicide risk assessment, intervention, treatment, or support services.

My name is Jennifer Fraga and I am currently pursuing my CSWA in order to become a LCSW. In my professional background, I have provided direct care for youth and young adults experiencing a mental / behavioral healthcare crisis such as an increase in suicidal ideation or a suicide attempt. Part of this work has included working with families of the youth and young adults in crisis. In my personal life, I am an attempt survivor and live with chronic ideation and mental health diagnoses.

I want to share my concerns about HB 3139 and why I do not think this is the right action to pursue at this time. While I understand the desire and intent behind HB 3139, I do not think this will meet that need. I think that this requires more groundwork to be done, especially connecting with youth and young adults on what *they* think would help. I also believe other changes can be made to meet the need, such as focusing on the passage and implementation of HB 2315.

My fist concern is that while different agencies, including youth serving agencies, have come together to work on the language for needed amendments to HB 3139, I did not hear any youth or young adult specific people / community members mentioned on this workgroup. I think it is easy to forget that youth and young adults have great insight into what they need. They know their story best and what helps / does not help them. Because this bill will directly impact them if passed, we are creating a gap in the process by not including them. I understand that family members and youth serving agencies were included. That is one important piece of the puzzle. However, youth and young adults are the ones *directly* experiencing the suicidality and know what helps them. I also recognize that the ones who have died cannot speak to what could have helped them. I am not trying to diminish their lives and the loss their loved ones have experienced. I am saying that there are many youth and young adults experiencing suicidality now and we would be completely remiss if we did not seek out and listen to their voices. Their voice is extremely important and should not be left out of this process.

My second concern is that this type of requirement of notification currently exists. If we want behavioral healthcare professionals to follow best care and life saving practices, we need to teach them that these standards exists and why they are important to follow. I worry that, if this were to pass, we may think that the issue is fixed because we have put something into

statute and the gap has been closed. I think this will instead lead to unintended consequences if we don't work with and educate professionals which brings me to my third concern for HB 3139.

Behavioral healthcare professionals are not taught about suicide. Currently, courses in suicide prevention, management, assessment, and intervention are not required and many graduate their master's level programs without having ever talked about suicide. Many go on to receive their professional licenses without ever having to learn how to safely manage suicidality or safely treat the suicidal crisis.

Because of this, I have a concern about the existing language in the bill "imminent and serious risk." When professionals do not understand suicide, there are gaps in care, one of which being an incorrect response to someone when they express suicidal ideation. When professionals hear the word "suicide" or that someone is thinking about suicide or having suicidal thoughts, many automatically think that the risk is serious and imminent. Professionals do not always know that there is a difference between passive and active ideation. I am one example that simply thinking about suicide and having suicidal thoughts does not constitute a serious and imminent risk as this is my baseline and my normal. Living with chronic ideation means that these thoughts are part of my daily life.

My experience is not the only one like this. Many are fearful of sharing their ideation with providers because of how the provider will respond. For those who are not trained correctly, a poor response from the professional can cause additional trauma and distrust of the system making it difficult for the person to seek help again. I think that education for providers is an important first step before putting something like this into statute.

If we first focused on making sure our workforce is educated and competent in working with suicidality, I would not have as much of a concern surrounding this language. It is important to notify necessary parties when the risk is serious and imminent. It can be lifesaving. Professionals also need to be able to differentiate between serious and imminent situations and situations that are not. Over reactions and under reactions can cause additional trauma distrust and this can happen more often when our workforce is not trained in how to work with someone experiencing suicidal ideation.

Along with training professionals about assessing folks experiencing a suicidal crisis, professionals also need to be trained in treatment and management. Involving parents and family members in a youth or young adults safety planning process is sometimes the right course of action and can be vital in their treatment. There are also times when involving parents will exacerbate the issue. In my work experience, I have seen a parent's indifference to their child's state, complete denial of any concern, and parents who treat their child worse after learning that they are contemplating suicide. During each of these situations, the youth's crisis increased, leaving them more isolated which increases their risk for a suicide attempt. I wish I could say that these situations only happened once or twice, but they happen regularly.

For clinicians to make the right decision in knowing when and how to involve parents, guardians, family members, they need to be trained. They need to learn about suicide

prevention, intervention, assessment, and management. Without this training or education, this can make so many situations worse for the youth already in crisis.

Due to all of these concerns, I truly think that passing HB 2315 is a vital first step to take before this passes into statute. When I looked at other testimony provided to the House of Representative Behavioral Health Committee, I see that I am not the only one with similar concerns.

To summarize, I really think that we need to connect with and hear from youth and young adults to hear what they say will help them and their thoughts on this legislation. I also believe that we need to educate our workforce to become a competent workforce when it comes to suicide assessment, intervention, treatment, and management. This means our social workers, counselors, psychiatrists, peer support specialists, therapists, and also primary care providers, emergency department staff, doctors, nurses, emergency department security officers, pediatricians, dentists, and others. Education will help people to know how to work with folks, it will help to decrease stigma, and it will increase help seeking from those in crisis. We know how to ask for help. We just do not necessarily feel safe to do so.

Thank you for your time.

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