DRO | Disability Rights Oregon

February 21, 2021

Tawna Sanchez, Chair
Raquel Moore-Green, Vice-Chair
Rob Nosse, Vice-Chair
House Committee on Behavioral Health
Oregon Legislature
900 Court St. NE,
Salem, Oregon 97301

RE: Disability Rights Oregon Testimony on HB 3139

Dear Chair Sanchez, Vice-Chair Moore-Green, and Vice Chair Nosse:

Disability Rights Oregon submits this testimony in opposition to HB 3139. Disability Rights Oregon is the federally-designated Protection and Advocacy organization for the state of Oregon. Our mission is to protect the rights of people with disabilities, including the rights of people with mental illnesses. 42 USC 10801 *et seq*.

Youth suicide is a terrible problem across the nation and especially in Oregon, where youth often struggle to find accessible mental health resources in an overtaxed and underfunded mental health system. Death by suicide is the most common cause of death among Oregon youth between 10 and 24. Each youth who contemplates suicide has their own story and different factors that have contributed to a sense of suicidality. Those factors may include family disruption and poor family relationships, abuse or neglect, underlying mental illness, substance abuse, and difficulties at school or with the criminal legal system. Suicide rates are especially high among youth who identify as LGBTQ+.

Large numbers of youth have suicidal thoughts to one degree or another. A 2013 survey reported that 17% percent of eighth and eleventh graders reported having seriously considered suicide at some point in the past 12 months.[1] For this reason, some pediatric groups and psychiatric groups recommend that *all* youth be routinely screened for suicidality at least yearly.[2] Routine suicide screening can be normal, rather than a sign of concern.

[1] Oregon Health Auth., *Youth Suicide Intervention and Prevention Plan, 2016-2020*, at 42, *available at* https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/5-year-youth-suicide-prevention-plan.pdf.
[2] Matthew B. Wintersteen, *Standardized Screening for Suicidal Adolescents in Primary Care*, 125 PEDIATRICS 938 (2010) (detection of suicidality increased 219% when a brief suicide screening was added to the routine assessment of youth 12 years old and older).

Legally Requiring Parental Disclosure Will Deter the Vast Majority of Suicidal Adolescents from Confiding in Anyone at All, Making It Less Likely Parents Can Assist Their Children

Providers seeking to gain the trust of adolescents to discuss any suicidal thoughts must be able to promise the youth confidentiality. "[W]hen confidentiality is assured, adolescents are more likely to access health care, have a more favorable attitude about their clinicians, and share sensitive information."[3] Youth who feel suicidal or who experience other risk factors for suicide need *more* protection for their confidentiality, not *less*, because they are more likely to cite confidentiality concerns as a reason for not seeking help at all.[4]

Clinicians have specifically studied how the guarantee of confidentiality encourages adolescents to report frankly on whether they have recently felt suicidal. Youth filling out a survey form that guarantees complete confidentiality reported suicidal thoughts 8% of the time, while those filling out the same survey with a preface that allowed only conditional confidentiality reported suicidal thoughts only 1% of the time.[5] Guaranteeing confidentiality makes it *eight times more likely* that a youth will confide in a provider about suicidal thoughts.

While all of us share the goal to halt suicide, the proposed bill will make it more likely that adolescents with suicidal thoughts will confide in no one at all. If offered the choice between a teen who is too scared to report feelings of suicidality to anyone, and a teen who confides in a trusted provider, we would all choose the latter.

A thoughtful mental health provider who learns of suicidal thoughts from a youth will engage in a careful review of their concerns. The provider will likely be able to discuss how the youth is feeling, what their interactions with their family are like, assess the degree of risk, determine whether the youth has an active plan to harm themselves, and determine what the youth's fears about disclosure are. Once the provider has gained the trust of the youth, the provider can discuss with the youth how to include parents as part of the partnership to keep the youth safe. In most cases, the provider will be able to talk down the teen patient and convince them of the need to engage the parents. However, if the teen never confides at all in the provider, neither the provider nor the parents may ever know about those thoughts.

Providers who receive confidential information about suicidality will attempt to engage parents

---

[3] Klein et al., *Screening and Counseling Adolescents and Young Adults: A Framework for Comprehensive Care*, 101 AMERICAN FAMILY PHYSICIAN 147 (2020) *available at* https://www.aafp.org/afp/2020/0201/p147.html.

[4] Lehrer et al., Foregone Health Care Among U.S. Adolescents: Associations Between Risk Characteristics and Confidentiality Concern, 40 J. of Adolescent Health 218 (2007) (among boys "high depressive symptoms, suicidal ideation, and suicide attempt were each associated with increased odds of reporting confidentiality concern as a reason for forgone health care").

[5] Kline et al., *Truth and Consequences: Ethics, Confidentiality, and Disclosure in Adolescent Longitudinal Prevention Research*, 33 J. of Adolesc. HEALTH 385 (2003), *available at* https://pubmed.ncbi.nlm.nih.gov/14596960/.

wherever possible, because parents play a vital role in the response to suicidality in young people. Parents can identify many of the stressors and risk factors in the youth's life. Direct parental engagement in family therapy and indirect support for their child's participation in therapy can assist youth. Parents can also take active steps to remove firearms, prescription medications, and other potential instruments of self-harm from a youth's control. But for parental engagement in this process to happen in the first place, a teen must feel enough trust in someone to disclose how they are feeling.

No one can legislate trust. Gaining the confidence of an adolescent who feels like few if any people care about them is a difficult job. The law is a clumsy instrument to interpose between a mental health care provider and a vulnerable youth. We know from the science that youth who get confidentiality protections are eight times more likely to confide in a provider, and that youth who get little privacy protection will suffer in silence. We can and should trust mental health providers to determine how and when to engage parents in the process of treating a youth with suicidal thoughts, rather than trying to legislate how a delicate, difficult process happens.

The Bill Inappropriately Lacks Opt-Out for Abusive, Neglectful, or Dangerous Parents, in Violation of Federal Law

Most parents who learn that their child has experienced suicidal thoughts would be desperate to do anything to help their child. For the reasons stated above, a supportive, engaged parent is one of the most important aids for a youth experiencing suicidality.

Unfortunately, not all parents are supportive and engaged. Some parents are abusive and neglectful. In some cases, part of the root cause of the youth's suicidality is physical abuse, sexual abuse, or neglect by the parent, or by one of the parent's partners or relatives. In one study, more than one in every three youths being treated for suicidality had been sexually and physically abused.[6] Three in every five youths in that survey had been physically neglected.[7]

In other cases, other concerns may make immediate and mandatory disclosure to a parent of any reported suicidality challenging, dangerous, or inappropriate. Some parents are overtly hostile to psychiatric treatment and view treatment as something for people who are weak. Some youth who identify as LGBTQ+ experience suicidal thoughts for reasons that specifically include their parents' intolerance of and rejection of them because of their LGBTQ+ status.

Compelling disclosure of a youth's suicidality to a parent who may abuse, neglect, or otherwise

[6] Lipschitz et al., *Perceived Abuse and Neglect as Risk Factors for Suicidal Behavior in Adolescent Inpatients*, 187 J. NERV. MENT. DIS. 32 (1999).
[7] *Id.*

pose a threat to the youth is both unwise and violates federal law. Under HIPAA rules, a child's medical records are confidential and cannot be disclosed except to a "personal representative." 45 C.F.R. § 164.502(g). A parent of a child is typically a "personal representative" under the law, except where a provider determines that the youth has been "subjected to domestic violence abuse or neglect" by the parent or that allowing disclosure to the parent "could endanger the child. . . ." 45 C.F.R. § 164.502(g)(5). Contrary state law would be unenforceable but would likely confuse providers and wrongly induce providers to disclose medical information to abusers.

The Scope of the Proposed Reporting Requirement is Overbroad

The text of the bill requires disclosure any time a minor receives a "suicide risk assessment, intervention, treatment or support services." Those terms are not defined and could be interpreted broadly. For instance, a pediatrician may routinely ask adolescents about suicidality at annual checkups, even without any individual reason (beyond the youth's age) to suspect suicidality. This bill would force such a pediatrician to report that they had made such an inquiry, even if the pediatrician's assessment was negative for suicidality.

The current status of ORS 109.680 already allows providers to make "clinically appropriate" judgments about when to include parents in any discussion of a youth's condition, including when a "minor's condition has deteriorated" or suicidality has increased substantially. These protections have been adequate to preserve confidentiality while not constraining a provider from taking action when the risk to the youth is high.

Conclusion

For a long time, Oregon has relied on the sound judgment of providers to encourage youth to agree to discuss suicidality concerns with parents, to exercise judgment about the severity and acuity of any suicidal thoughts of the youth, and to make independent judgments about the risk of abuse, neglect, or other danger to the youth by disclosing information about suicidality. Little if any evidence has been produced to show that providers in Oregon are routinely refusing or failing to disclose suicide risk to parents in an unreasonable way, or that confidentiality concerns are leaving suicidal youth without supports. Instead, robust medical evidence shows that sweeping and mandatory disclosure rules endanger children, discourage reporting of suicidality, and jeopardize the frank conversation between a provider and a patient.

//

//

I am happy to discuss these matters by telephone at 503-243-2081 x223 or by email at tstenson@droregon.org.

Sincerely,

Thomas Stenson
Deputy Legal Director