Dear Chair Sanchez and members of the committee,

My name is Carol Greenough. I live in Tualatin Oregon and am a retired clinical psychologist. I have worked in the past as a program administrator for Alaska's twenty five mental health centers, for decades as a consulting psychologist in K-12 schools throughout the region, as policy person for the Alaska Mental Health Board where I chaired monthly teleconferences with families who had children in residential treatment, as a suicide crisis center volunteer and trainer, and as a teacher/psychologist in a middle school for 6 years. I currently serve on the Washington County Behavioral Health Council.

While I strongly support the involvement of families and other community supports when a young person is suicidal, I am testifying in favor of making revisions to HB 3139. I will briefly list my concerns below:

1. I agree with the prior testimony that mandatory reporting for suicide risk assessment would have a chilling effect on an essential practice that is finally becoming more frequent. It should not be required.

2. I have some concerns that the current bill does not address many mental health professionals in the schools, where many of these problems arise. I realize that there are differing privacy rules in schools, but think this is an important link in the chain of communication and needs to be highlighted in some way. Many schools have developed excellent protocols including alternatives if parents cannot be contacted. (https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/SUICIDEPREVENTION/Documents/Oregon-School-Suicide-Protocol-Toolkit.pdf)

3. If we don't have mandatory reporting, Section 1(a) as currently written is actually too narrow, limiting the possibility of parental notice to quite extreme circumstances. I would like

to see revised language that allows, but does not mandate, earlier parental involvement such as:

> May advise the parent or parents or legal guardian of a minor described in ORS 109.675 of the diagnosis or treatment whenever the disclosure is clinically appropriate and will serve the best interests of the minor's treatment because the minor's condition has deteriorated, **there is a risk of a suicide attempt, or the minor has made a suicide attempt.** [*has become such that inpatient treatment is necessary]*

4. In spite of my concerns stated above about mandatory reporting, I am worried that the range of clinical practice is great. Appropriate family notification doesn't always happen. Even as a licensed clinical psychologist working within a school system, I would sometimes have difficulty getting information from an outside therapist about the danger a student faced from suicide. Any reporting requirement must both:

   - honor the importance of the client/therapist privilege, and
   - acknowledge that each minor exists in a social system and that the best therapeutic work usually engages parts of that system.

   The complexity of this dichotomy was reflected in today's testimony. One resolution might be to require that if "suicide intervention, treatment or support services" are provided:

   - A decision not to notify parents is clearly documented in the case file with the reasons, and
   - Attempts are made with the minor to identify an alternative support person who will be notified of the risk and a plan for that person to stay engaged with the minor is documented in the case file.

An adjunct to laws that mandate action is involving professionals in training about how to bestaddress suicide risk, how to engage

appropriate supports, and how to assess the risks and rewards of parental involvement. I believe many on the front line, such as primary care physicians, would benefit from this. My thanks to all who are grappling with this difficult subject.

Carol Greenough, Ph.D.
Retired Clinical Psychologist
Tualatin, Oregon