FAQ New Oregon Law and Best Practices
Involving Parents and Trusted Adults in Youth Suicide Prevention

The Oregon Legislature passed HB 3139 in 2021 to clarify when it is appropriate to notify parents or to engage trusted adults in suicide prevention safety planning. The FAQ below will help providers to better understand the complexities of balancing youth autonomy with safety. This includes when to involve a parent, guardian or trusted adult in youth suicide prevention and safety planning to prevent or lessen the risk of a suicide attempt.

What does this law do?
The law requires licensed medical and mental health care providers to disclose information about a minor's treatment and diagnosis as clinically appropriate regarding a serious and imminent risk of suicide.

What are the privacy laws around disclosure of this information?
HIPAA allows for the notifications and engagement outlined in HB 3139, but the federal regulations can be vague and confusing to mental health providers. This law does not change current practices, which require clinical judgment in determining when it is appropriate to engage parents and other trusted adults and what information to disclose to them. The intent of the law is to provide clarity to mental health providers, youths, and families, that providing safety planning and coordinating support in high-risk situations saves lives.

Isn't this already the standard of care?
Most mental health providers will continue to follow the best practices and standards of care in compliance with current federal regulations and Oregon statutes. A significant minority of providers likely will continue to practice with the misconception that even youths at serious and imminent risk of suicide have an absolute right to privacy and even in emergencies, they will be sent home without following evidenced-based practices that would reduce their risk of suicide. This bill is intended to increase understanding of best practices and the standard of care by allowing for notifications and engagement.

What about kids (e.g., LBGTQI+ community) who may be harmed by parental notification? When this law rolls out, how will providers be intentional about who is notified or not?
Under HIPAA, mental health providers "when using or disclosing protected health information … must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose…" (Known as the

HIPAA Minimum Necessary Rule.) If appropriate, a mental health provider could safety plan with the youth and parents while discussing the risk of suicide without disclosing that the youth identifies as a member of the LGBTQI+ community. Alternatively, the mental health provider and youth could safety plan with another trusted individual with whom the youth feels more comfortable or a local LGBTQI+ support organization. This bill seeks to make explicit to mental health providers the available options and tools, so that they can balance disclosing necessary information while also considering the youth's individual circumstances, beliefs, and values. This is a responsibility that mental health providers currently are navigating, sometimes with an incomplete understanding of HIPAA and Oregon statutes as written.

What are other exceptions to the disclosure requirement?
Providers should not disclose this information in the following circumstances:

- Reasonable belief of abuse or domestic violence against youth
- Youth would be endangered by sharing info
- Against the youth's best interests
- Legal emancipation or 90-day separation from family

Will youths be informed? The language in HB 3139 is not explicit that other organizations may be included without the consent of the youths.
There is no language in HB 3139, current Oregon statutes, or HIPAA specifically addressing the practice of notifying youth that information was disclosed during an emergency. Yet, the process of safety planning can be successful only if the youth and the mental health provider collaborate (i.e., the youths would be involved every step of the way). If this is not successful, the risk for suicide increases further and, in most situations, the youth would be taken to an emergency department for further assessment and treatment.

Involving other organizations is allowed under HIPAA and HB 3139 but not required. The HIPAA Minimum Necessary referenced above would apply and other organizations would be involved only if necessary. A common example when this would be important is when youths have a psychiatrist/PMHNP, therapist, and primary care provider. If the high-risk assessment is made by the primary care provider, it is likely that they would reach out to the other professionals involved in the youth's care to schedule additional appointments, make medication adjustments, or increase the youth's level of services.

What happens if the youth objects to disclosure? What's confidential and what is not?

Under HIPAA, disclosures can be made only when the mental health provider believes that doing so is in the best interest of the youth. If the mental health provider makes a disclosure, then they also would need to follow the HIPAA Minimum Necessary Rule referenced above. Any disclosure that is not in the best interest of the youths (e.g., identifies as a member of the LGBTQI+ community or disclosing information carries the risk of stigmatization), would remain confidential.

What are the HIPAA regulations in regard to the age to get mental health treatment without parental consent?
HIPAA is silent regarding the age of consent, so this is left up to the discretion of the state. In Oregon, the age is 14. HIPAA does outline rules for youth and adults where information can be disclosed in emergent and non-emergent situations.

What is the process for what information is shared and when, what are the circumstances and what tools do providers need in order to keep kids safe?
Often when youths disclose that they are having suicidal thoughts and are worried that they will act on them, they want help but are too scared and do not know how to ask for it. When they hear that the mental health system and their support network care about them and need to be involved, they are typically relieved and agree to safety plan. In the instances where a youth objects to the disclosure, mental health providers would engage the youth in a discussion of reasonable alternatives (e.g., "Can we just tell your parents that you are struggling right now, have them lock up the firearms and medications, and ask them to keep a close eye on you until our next appointment? We can keep everything else between you and me for now."). If all attempts at safety planning fail, the parents would be notified of information relevant to the suicide risk with the recommendation to take their child to the emergency department of a local hospital.

The most important evidence-based tool in safety planning with youths is bringing in additional support, which is, ideally, loving parents or other primary caregivers. There is nothing that providers can do in their offices that will have a comparable effect. We strongly recommend avoiding situations where a youth who is assessed to be a serious and imminent risk of suicide leaves the provider's office with parents who are unaware of the danger to a home where medications and firearms are not secured.

Dr. Daniel Nicoli
Oregon Psychiatric Physicians Association
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