COMMITMENT TO CHANGE WORKGROUP

November 18, 2022

AGENDA

- Welcome – Chris Thomas, Workgroup Facilitator
- Introductions – Workgroup Membership
  - -Who
  - -Representing
  - -Share something interesting from the reading
- October Highest Hopes and Worst Fears Recap
- Constituent Input/Plan/Survey Findings
- Core Principles: Role of Government in Behavioral Health
- Incorporating Science
- Developing Effective Legal Structures
- System Reforms
- Mural Exercise – Something Learned or Opinion Changed
- Homework

WORKGROUP MEMBERSHIP

Oregon Health Authority- William Osborne

Oregon State Hospital- Dr. Katherine Tacker

Oregon Department of Human Services- Chelas Kronenberg

Disability Rights Oregon- KC Lewis

Mental Health and Addiction Association of Oregon- Janie Gullickson

Oregon Family Support Network- Sandy Bumpus

NAMI Oregon- Chris Bouneff

Oregon House- Rep. Jason Kropf (D); Rep. Christine Goodwin (R)

Oregon Senate- Sen. Floyd Prozanski (D); Justin Brecht for Sen. Kim Thatcher (R)

WORKGROUP MEMBERSHIP—CONT.

Oregon Criminal Defense Lawyers Association- Allison Knight

Oregon District Attorneys Association- Amanda Dalton for Scott Healy

Association of Oregon Community Mental Health Providers- Ann-Marie Bandfield for Cherryl Ramirez (10-12)

Association of Oregon Counties- Michael Burdick for Gina Nikkel

League of Oregon Cities- Dakotah Thompson

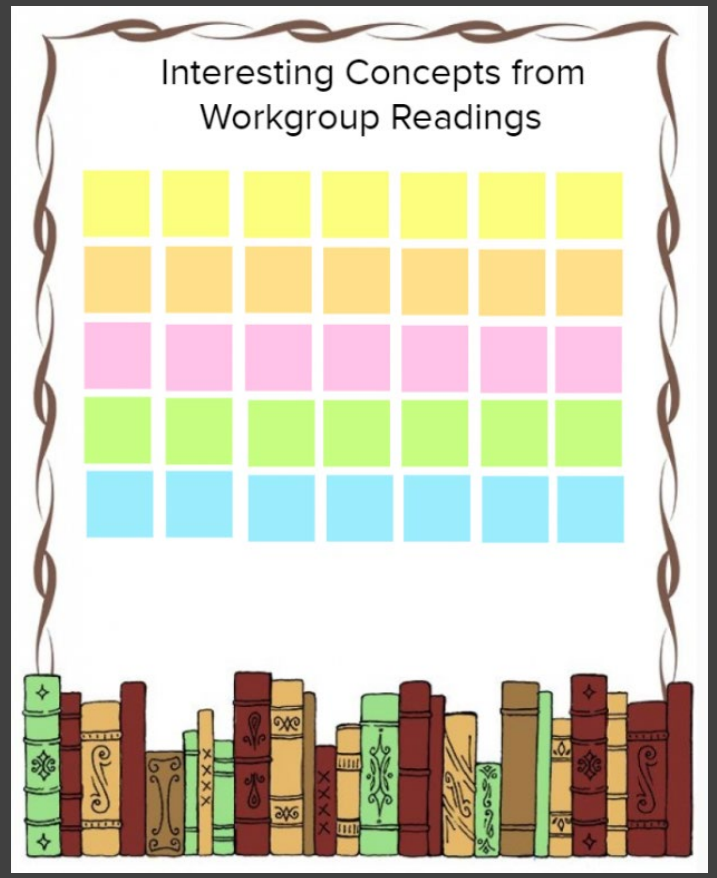
Oregon State Sheriffs' Association- Sheriff Matt Phillips

Oregon Association Chiefs of Police- Kevin Campbell

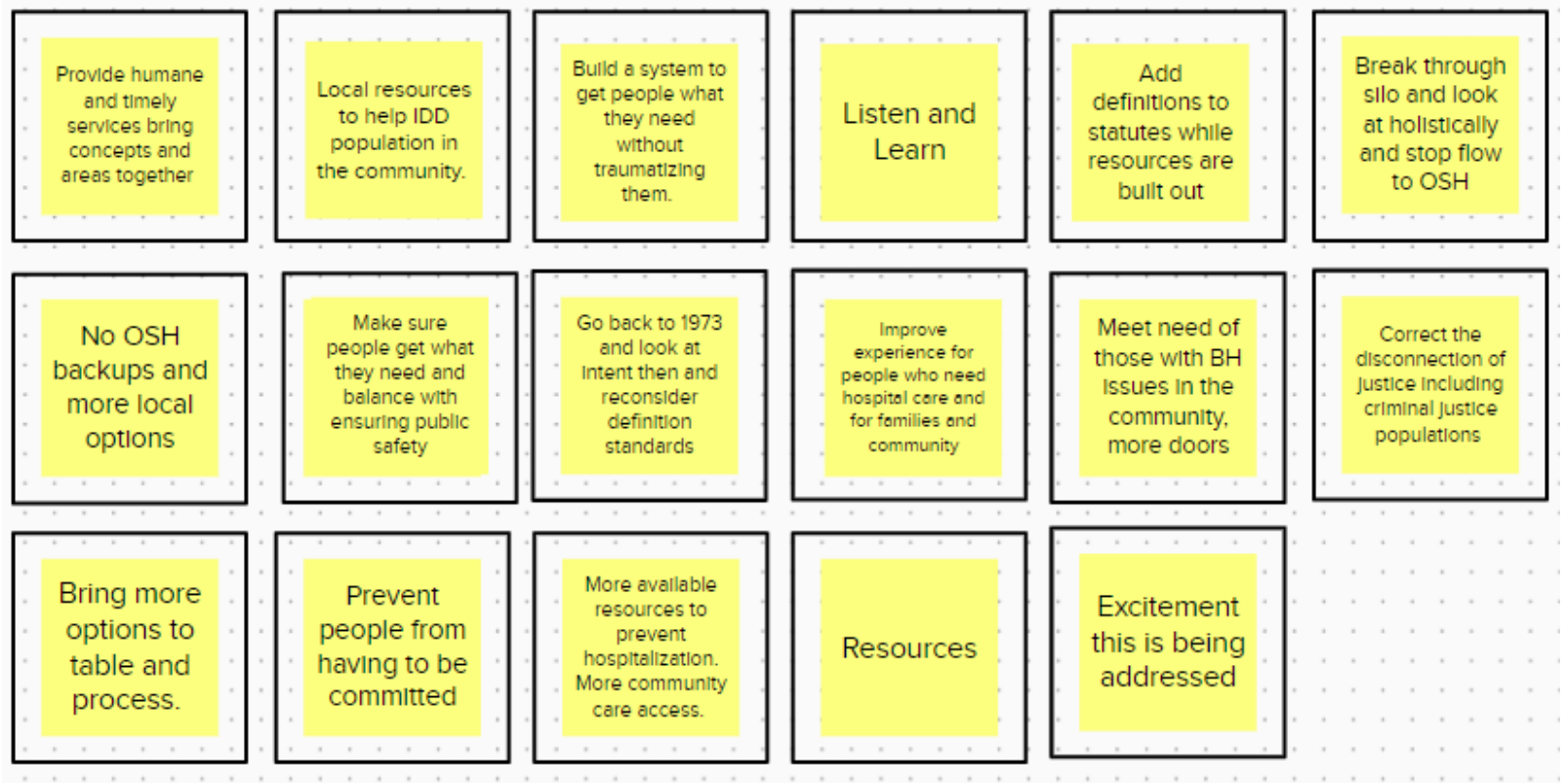
Oregon Association of Hospitals and Health Systems- Danielle Meyer for Meghan Slotemaker (10-12)

Oregon Judicial Department- Hon. Cindee Matyas; Hon. Jonathan Hill for Hon. Nan Waller; Hon. Matt Donohue

READING REFLECTION MURAL



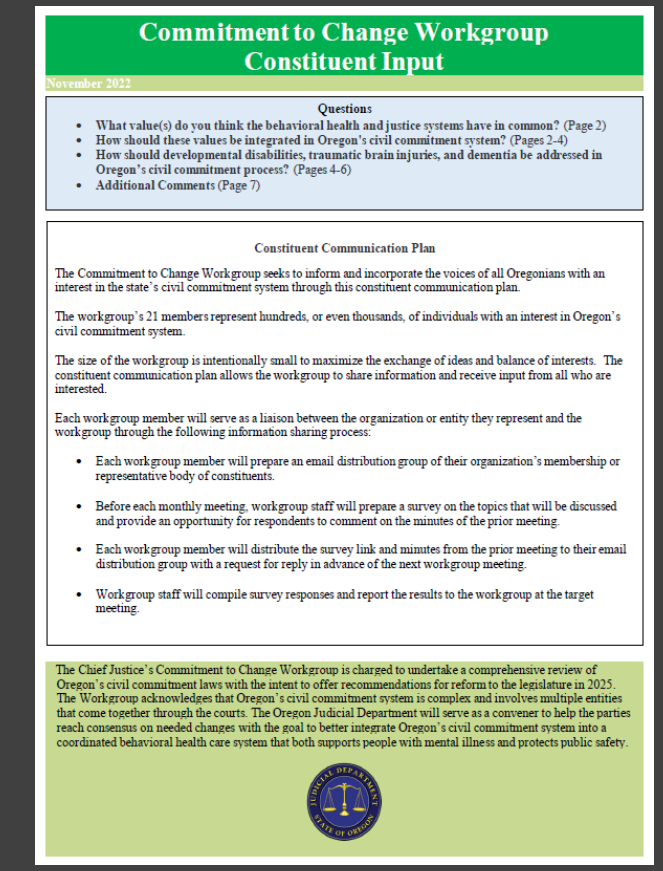
OCTOBER HIGHEST HOPES



OCTOBER WORST FEARS

CONSTITUENT FEEDBACK

- 51 responses through 11/15/2022
- Allows feedback and opportunity for all voices to be heard
- Opportunity to review Monthly Workgroup Meeting Minutes
- Constituent Input document
- Incorporate feedback in meetings
- Include “represented by” on the next survey



Commitment to Change Workgroup
Constituent Input

November 2022

Questions

- What value(s) do you think the behavioral health and justice systems have in common? (Page 2)
- How should these values be integrated in Oregon's civil commitment system? (Pages 2-4)
- How should developmental disabilities, traumatic brain injuries, and dementia be addressed in Oregon's civil commitment process? (Pages 4-6)
- Additional Comments (Page 7)

Constituent Communication Plan

The Commitment to Change Workgroup seeks to inform and incorporate the voices of all Oregonians with an interest in the state's civil commitment system through this constituent communication plan.

The workgroup's 21 members represent hundreds, or even thousands, of individuals with an interest in Oregon's civil commitment system.

The size of the workgroup is intentionally small to maximize the exchange of ideas and balance of interests. The constituent communication plan allows the workgroup to share information and receive input from all who are interested.

Each workgroup member will serve as a liaison between the organization or entity they represent and the workgroup through the following information sharing process:

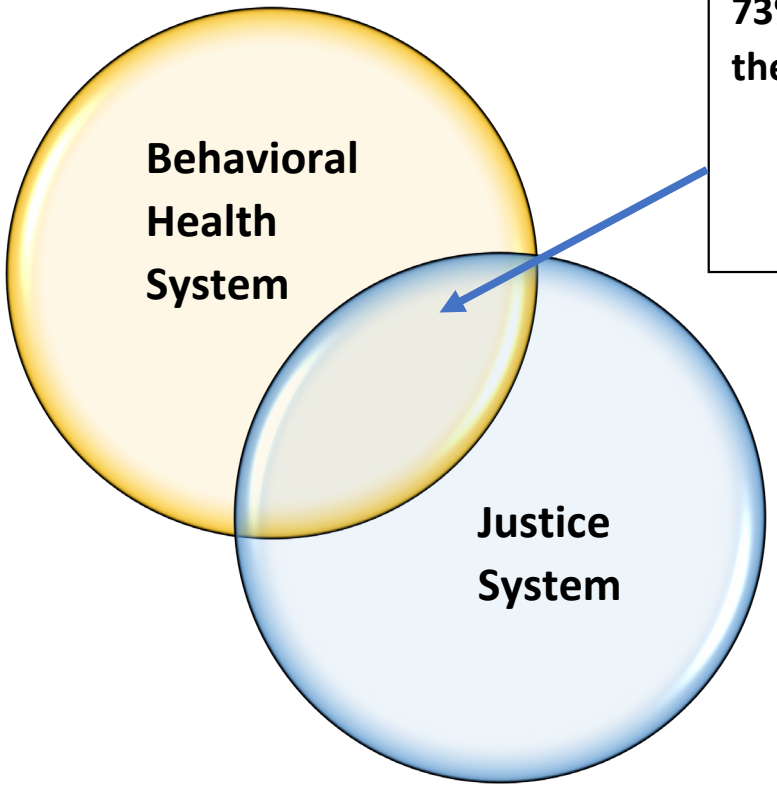
- Each workgroup member will prepare an email distribution group of their organization's membership or representative body of constituents.
- Before each monthly meeting, workgroup staff will prepare a survey on the topics that will be discussed and provide an opportunity for respondents to comment on the minutes of the prior meeting.
- Each workgroup member will distribute the survey link and minutes from the prior meeting to their email distribution group with a request for reply in advance of the next workgroup meeting.
- Workgroup staff will compile survey responses and report the results to the workgroup at the target meeting.

The Chief Justice's Commitment to Change Workgroup is charged to undertake a comprehensive review of Oregon's civil commitment laws with the intent to offer recommendations for reform to the legislature in 2025. The Workgroup acknowledges that Oregon's civil commitment system is complex and involves multiple entities that come together through the courts. The Oregon Judicial Department will serve as a convener to help the parties reach consensus on needed changes with the goal to better integrate Oregon's civil commitment system into a coordinated behavioral health care system that both supports people with mental illness and protects public safety.

CORE PRINCIPLES: ROLE OF GOVERNMENT IN BEHAVIORAL HEALTH

Food for Thought

- There is a difference in purpose between the justice and behavioral health systems. How do we maximize individual autonomy when restricted by the justice system?
- Acknowledging systemic concerns, what do we need to consider when thinking about policy and statute to avoid class-based and raced-based inequities in the civil commitment system?
- Within our Workgroup, how will we navigate knowing that neither the views nor the experiences of individuals with behavioral health conditions are monolithic?



73% or more of survey respondents identified these values as common to both systems:

- Public safety (84%)
- Protection of civil rights & liberties (76%)
- Individual safety (73%)

60% or fewer of survey respondents identified these values as common to both systems:

- Due process of law (60%)
- Equal protection under the law (56%)
- Accountability for risky & dangerous behavior (56%)
- Access to justice (53%)
- Access to appropriate and available community-based care (53%)
- Personal choice to make health care decisions (22%)

DIFFERENT SYSTEM VALUES

DIGNIFYING MADNESS

Civil commitment is based on two powers of modern state:

1. *Parens Patriae* - power to protect residents against death or injury when they become disabled and are unable to care for themselves and their affairs
2. Police Power - power to protect residents against violent assaults from others

Concept	Explanation
Parens Patriae	Protection from Self (including basic needs)
Police Power/Public Safety	Protection from Others

DIGNIFYING MADNESS (CONT.)

Interest in protecting human dignity should **inform**, but not replace, the traditional police power and *parens patriae* bases for intervention:

1. **Narrative Autonomy** – when procedures give people an opportunity to exercise voice, their words are given respect, and decisions are explained to them, they substantively feel less coercion
2. **Minimization of Incarceration** – flexible and realistic standard that requires courts to consider local conditions, law enforcement and incarceration practices, and the views and understandings of the person facing incarceration for treatment
3. **Progressivity** – minimize length of incarceration and emphasize preparedness to return to community

CORE PRINCIPLES: ROLE OF GOVERNMENT IN BEHAVIORAL HEALTH

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AMERICAN BAR ASSOCIATION CRIMINAL JUSTICE MENTAL HEALTH STANDARDS

- Criminal justice system officials should recognize that people with mental disorders have special needs that must be reconciled with the goals of ensuring accountability for conduct, respect for civil liberties, and public safety
- Attorneys who represent defendants with mental disorders should be familiar with local providers and programs that offer mental health and related services to which clients might be referred in lieu of incarceration
- Courts and prosecutor offices should facilitate meetings among community organizations interested in assuring that services are provided to justice-involved persons with mental disorders
- Appropriate professional organizations and governmental agencies should establish programs and evidence-based practices for monitoring the performance of mental health professionals participating in the criminal process

CORE PRINCIPLES: ROLE OF GOVERNMENT IN BEHAVIORAL HEALTH

- Acknowledging systemic concerns, what do we need to consider when thinking about policy and statute to avoid class-based and raced-based inequities in the civil commitment system?

- Within our Workgroup, how will we navigate knowing that neither the views nor the experiences of individuals with behavioral health conditions are monolithic?

INCORPORATING SCIENCE INTO THE CIVIL COMMITMENT SYSTEM

Food for Thought

- How are current civil commitment statutes inconsistent with current evidence-based knowledge regarding behavioral health and public safety?
- In what ways could current science be incorporated in civil commitment statute to improve behavioral health services and improve public safety?
- How do intellectual and developmental disabilities, traumatic brain injuries, and dementia fit into the civil commitment system?

BUILDING BRIDGES BETWEEN EVIDENCE AND POLICY IN MENTAL HEALTH SERVICES RESEARCH

- Evidence-based policy research focuses on producing knowledge and the best evidence regarding health policies that are most likely to improve the quality of health care and create conditions for effective, safe, equitable, efficient, timely, and patient-centered care.
- Evidence-based policy research can inform how laws and regulations affect the delivery of evidence-based practices and how policies can either counteract or perpetuate structural racism and health disparities, including disparities in health care.
- New data sources, such as large electronic health record databases, are increasingly making it possible to use real-time data to promote the development of learning health systems that both facilitate quality improvement and produce generalizable findings that can be applied more broadly.

PRINCIPLES OF COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

SAMHSA's eight principles are based on the most current and relevant research:

- **Principle 1:** Community providers are knowledgeable about the criminal justice system. This includes the sequence of events, terminology, and processes of the criminal justice system, as well as the practices of criminal justice professionals.
- **Principle 2:** Community providers collaborate with criminal justice professionals to improve public health, public safety, and individual behavioral health outcomes.
- **Principle 3:** Evidence-based and promising programs and practices in behavioral health treatment services are used to provide high quality clinical care for justice-involved individuals.
- **Principle 4:** Community providers understand and address criminogenic risk and need factors as part of a comprehensive treatment plan for justice-involved individuals

PRINCIPLES OF COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS (CONT.)

- **Principle 5:** Integrated physical and behavioral health care is part of a comprehensive treatment plan for justice-involved individuals.
- **Principle 6:** Services and workplaces are trauma-informed to support the health and safety of both justice-involved individuals and community providers.
- **Principle 7:** Case management for justice-involved individuals incorporates treatment, social services, and social supports that address prior and current involvement with the criminal justice system and reduce the likelihood of recidivism.
- **Principle 8:** Community providers recognize and address issues that may contribute to disparities in both behavioral health care and the criminal justice system.

INCORPORATING SCIENCE INTO THE CIVIL COMMITMENT SYSTEM

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DEVELOPING EFFECTIVE LEGAL STRUCTURES FOR CIVIL COMMITMENT

Food for Thought

1. How have we learned from our civil commitment past and how can we use that history to guide our future?

2. How can legal processes for civil commitment be most effectively integrated with other legal processes that involve individuals with mental illness?

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW & PRACTICE

Historical shift away from large state hospitals: Before the mid to late 20th century, public mental health services in the U.S. were provided almost exclusively in large state hospitals. Today, all but about two percent of care is provided in other settings, including other inpatient settings.

Key U.S. Supreme Court Decisions

- *O'Conner v Donaldson,* 422 U.S. 563 (1975): "a State cannot constitutionally confine, without more, a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."
- *Addington v Texas*, 441 U.S. 418 (1978): clear and convincing evidence standard "strikes a fair balance between the rights of the individual and the legitimate concerns of the state"

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

In 1982, the American Psychiatric Association endorsed the following five criteria for civil commitment:

1. Reliable diagnosis of severe mental illness;
2. Without treatment, a short-term prognosis of major distress, including "profound anxiety, depression or other painful affects, deterioration of the personality, and the proliferation or intensification of symptoms;"
3. The availability of treatment that is likely to be effective;
4. Incompetency to consent to or refuse treatment; and
5. That a reasonable person would accept the treatment being offered

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

Deinstitutionalization, 1955-1975, was shaped by many forces:

- Advent of effective medications
- Community Mental Health Act of 1963 (endorsing community-based care as alternative to hospitalization)
- Changes in Medicaid laws denying financial coverage for inpatient services
- Advances in treatment of conditions that accounted for large swaths of psychiatric inpatient population (epilepsy, neurosyphilis, developmental and intellectual disabilities, geriatric dementia)
- Establishment of managed care with strict medical necessity criteria for insurance reimbursement for hospitalization
- Federal disability laws and regulations imploring states to use community alternatives to inpatient care

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

Component parts of inpatient commitment law today:

- **Mental illness**—required in every state; generally defined in terms suggesting serious mental illness, usually excluding substance use disorders, intellectual disabilities, and dementia;
- **Dangerousness to self or others**—appearing in the law in nearly every state, although no longer as an exclusive criterion in most; defined in various ways;
- **Grave disability**—part of the law in most states; generally defined as inability to provide for basic personal needs, as discussed above;
- **Need for treatment**—required in nearly every state,; no longer an exclusive criterion for commitment in any state, except where defined to encompass risk of harm or some other commitment criterion;
- **Deterioration**—beginning to appear as a distinct criterion in some states' laws, or as part of the definition of grave disability; never an exclusive criterion; and
- **Incompetence**—part of the law in a few states; never an exclusive criterion.

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

Procedural Protections - At least since the 1970's, every state's inpatient commitment law has provided procedural protections for persons facing commitment:

- Right to notice of hearings;
- Right to the assistance of counsel;
- Right to appear, to testify, and to present witnesses and other evidence contesting commitment; and
- Right to confront witnesses appearing "against" them (*i.e.*, in support of commitment)
- Individual may be committed only if found to meet commitment criteria by, at a minimum, clear and convincing evidence.

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

Court-Mandated Community Treatment & Programs emerged beginning in the 1980s:

- When outpatient commitment laws first appeared, they were used most often as a step down for inpatients upon their discharge, or for individuals with extensive histories of admission and release, to bring an end to what was perceived as a "revolving door" cycle of hospitalization.
- In more recent decades, as the locus of care has shifted more and more into community care settings, and fewer patients are hospitalized in the first instance, outpatient commitment may be initiated in the community for persons without a history of multiple hospitalizations.
- There remains considerable variability in outpatient commitment laws and policies, implementation models, and practices. Some may not work as effectively as others.

CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

The American Psychiatric Association position paper on outpatient commitment in 2015 reflects prevailing views:

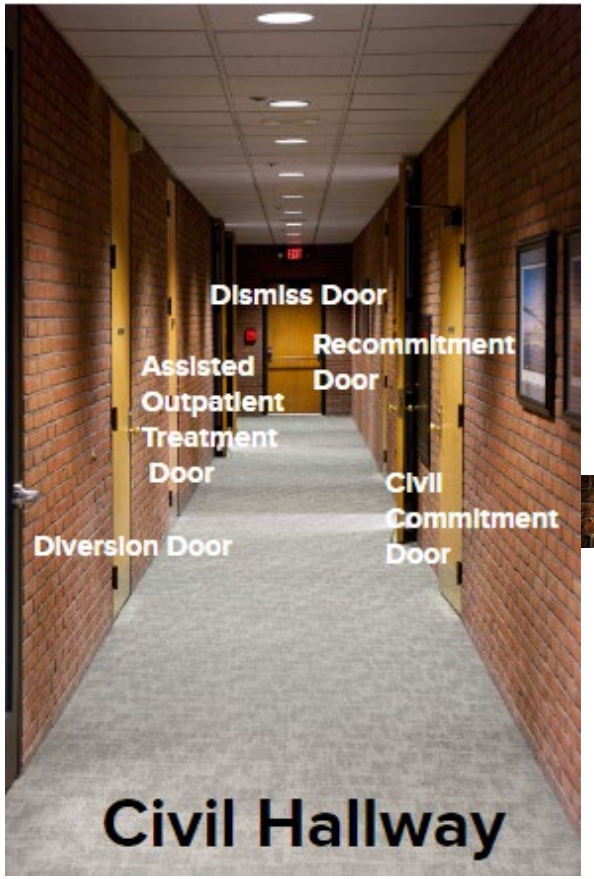
1. Involuntary outpatient commitment, if systematically implemented and resourced, can be a useful tool to promote recovery through a program of intensive outpatient services designed to improve treatment adherence, reduce relapse and re-hospitalization and decrease the likelihood of dangerous behavior or severe deterioration among a subpopulation of patients with severe mental illness.
2. The goal of involuntary outpatient commitment is to mobilize appropriate treatment resources, enhance their effectiveness and improve an individual's adherence to the treatment plan. It should not be considered as a primary tool to prevent acts of violence.

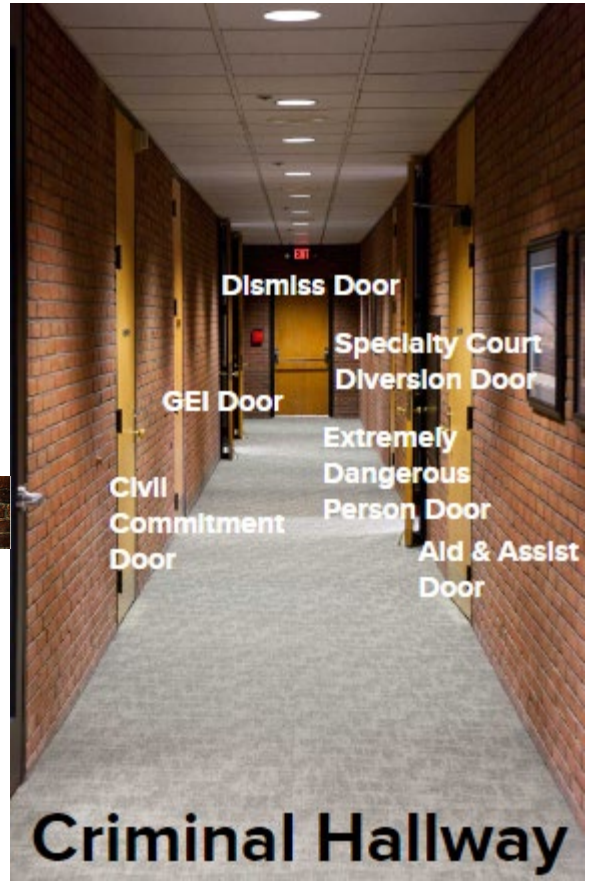
CIVIL COMMITMENT & MENTAL HEALTH CARE CONTINUUM (CONT.)

3. Some of the research studies have shown that involuntary outpatient commitment is most effective when it includes a range of medication management and psychosocial services, equivalent in intensity to those provided in Assertive Community Treatment or intensive case management.
4. States adopting involuntary outpatient commitment statutes should assure that adequate resources are available to provide such intensive treatment to those under commitment."

DEVELOPING EFFECTIVE LEGAL STRUCTURES FOR CIVIL COMMITMENT

1. How have we learned from our civil commitment past and how can we use that history to guide our future?

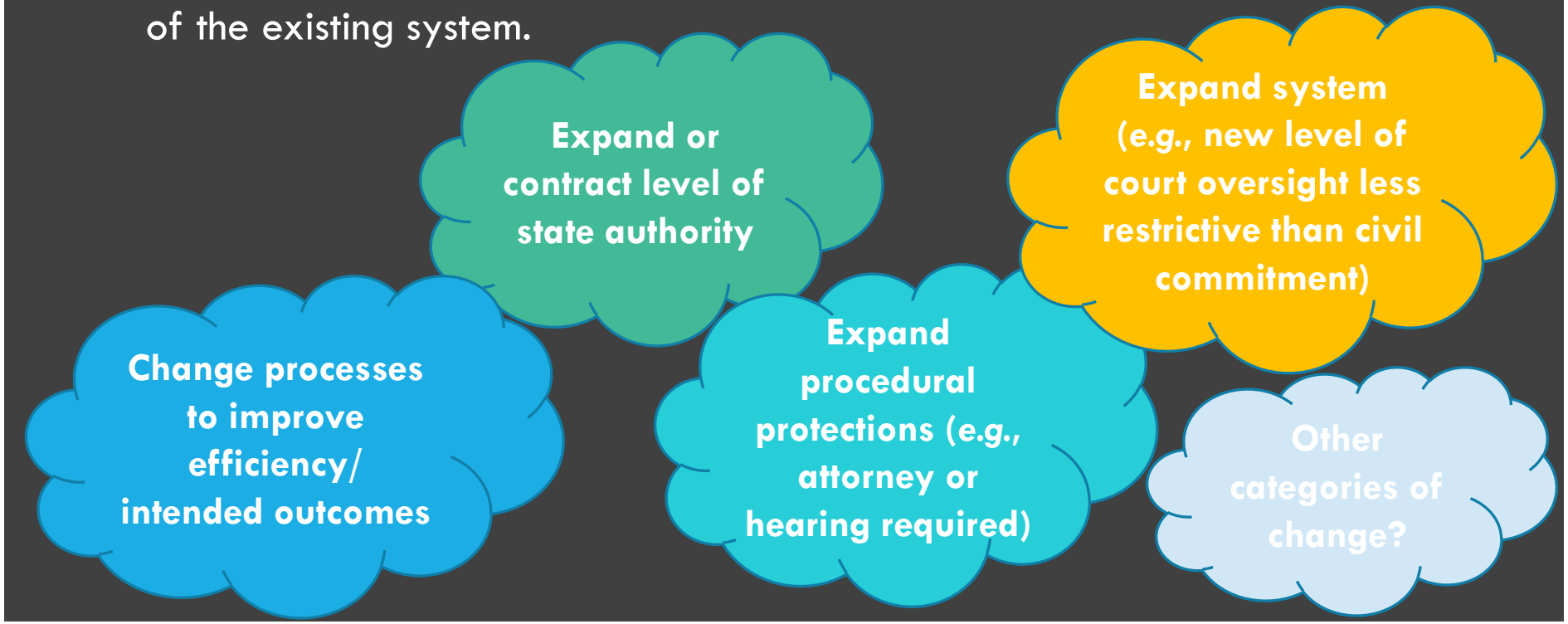




2. HOW CAN LEGAL PROCESSES FOR CIVIL COMMITMENT BE MOST EFFECTIVELY INTEGRATED WITH OTHER LEGAL PROCESSES THAT INVOLVE INDIVIDUALS WITH MENTAL ILLNESS?

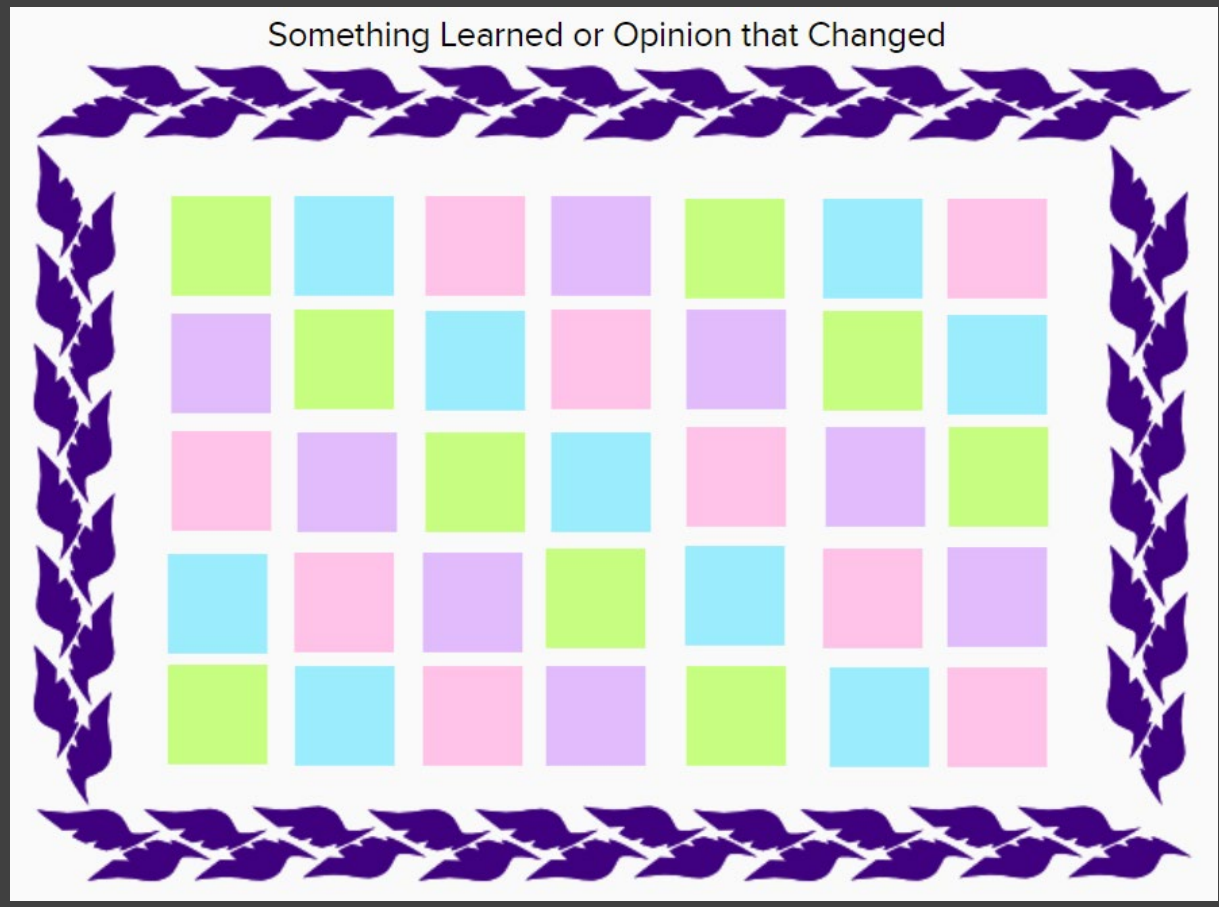
SYSTEMIC VS. INCREMENTAL CHANGE

- **Incremental change** makes discrete changes to the existing system.
- **Systemic change** is fundamental change that is beyond the capacity of the existing system.



SYSTEM REFORMS

MURAL EXERCISE



NEW UNDERSTANDING DISCUSSION

HOMEWORK

- Distribute December survey to your constituents
- Read ALL materials provided in advance of the next meeting

NEXT MONTH

Date	Subjects

December 2022	• Overview of Current Civil Commitment Process
	  ○ Initiation
	  ○ Investigation
	  ○ Examination
	  ○ Hearing
	  ○ Commitment
	  ○ Continued Commitment
	• Initiation of Civil Commitment (Holds, Notice of Mental Illness, Court Case)

STAFF CONTACTS

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