Building Consensus Survey Results (also showing Recommendations Survey results)

1. Which stakeholder group were you appointed to represent on the Commitment to Change Workgroup?

Respondents:

- Families of Individuals with Lived Experience (Mothers of the Mentally Ill)
- Individuals with Lived Experience and their Families (NAMI Oregon)
- Advocates of People with Mental Illness (Disability Rights Oregon)
- Oregon Judicial Department
- Oregon Health Authority
- Oregon State Hospital
- Oregon Department of Human Services
- Coordinated Care Organizations
- Oregon Association of Hospitals and Health Systems
- Oregon Criminal Defense Lawyers Association (Public Defenders)
- Oregon State Sheriffs' Association

Non-Respondents:

- Oregon Tribes
- Legislature (House Democrats)
- Legislature (House Republicans)
- Legislature (Senate Democrats)
- Legislature (Senate Republicans)
- Governor's Office
- Association of Oregon Community Mental Health Programs
- League of Oregon Cities
- Association of Oregon Counties
- Oregon District Attorneys Association
- Oregon Association of Chiefs of Police

I. Community-Based Behavioral Health Services

2. Provide education and training to behavioral health and substance use disorder providers about the criminal justice system and how to address criminogenic risk and need factors

Recommendations Idea #: 3

Recommend this idea as currently drafted (3):
OJD, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OAHHS, ODHS, DRO

Would recommend this idea with specific changes to its wording (specify) (2):
OSH, MOMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

(OHA skipped)

Consensus Survey Comments
OSH: consider adding language that would emphasize the importance of this education/training curriculum being developed via an evidence-based, ***collaborative*** process including OHA, relevant Oregon healthcare providers/ experts, existing training programs, patient/family/advocate representatives, and external experts.

MOMI: Provide education and training to behavioral health and substance use disorder providers about the criminal legal system and how to improve services upstream in order to prevent criminalization. (replace justice with legal as there is not a "justice" system and remove unhelpful use of jargon: criminogenic)

OHA: For example, #47, #100, #109, #110 are some of the remaining 10+ recommendations on training standards. Formulating one recommendation for statutory expectations for training and then recommendations to agencies for contracts/agreements could be more useful.

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, MOMI, OAHHS, OCDLA, ODHS, OJD, OSSA, Tribes

No (0)

It Depends (5):
OSH, LOC, DRO, OHA, ODAA

Recommendations Survey Comments
OSH: This recommendation seems most directly relevant for consideration re: Competency Restoration, (i.e., population awaiting standing trial for criminal charges) and/or mitigating risk for recidivism for those found Guilty Except for Insanity. Even though this is an important issue in its own right and patients at risk for civil commitment also likely have an increased risk of receiving criminal charges at some point in time, this issue certainly extends well beyond the civil commitment system. If this education/training is provided, it will be important to be thoughtful in approach so that it yields added knowledge/benefit and does not inadvertently replicate the training already being provided within psychiatric training programs on this topic

LOC: This is unnecessary. The role of those providers in this context is already addressing the criminogenic factors because the untreated and acute mental illness has reached the stage of pathological severity leading to the criminal system being involved. It's unfair to heap the responsibility set of a reentry social worker onto the providers acting in this sliver of the system.

DRO: It depends on what the education/curriculum is and who is providing it.

OHA: Depends on who will be providing it and what enforcement looks like.

ODAA: Education shouldn't be provided as a means of "gaming" the system (examples, symptoms for purposes of malingering, agreeing to a civil commitment in hopes of charges dismissed, etc). But education for the purpose of addressing and preventing underlying problematic behavior is supported.

Abstain (1):
NAMI

3. Require STATE to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care (TOP 5 IDEAS OF OJD, AOC, OAHHS, OSSA)

Recommendations Idea #: 4

Recommend this idea as currently drafted (2):
OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OSH, OAHHS, OHA, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (2):
NAMI, MOMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (1):
OCDLA

Consensus Survey Comments
OSH: Unsure if the language itself needs to specify intended population(s) who would be eligible for receiving those services (perhaps not specifying this grants greater adaptability of the services being provided as needed). But given the incredible challenges Oregon is facing (and negative impacts for various subgroups of patients who have dramatically lost access to state services in recent years due to legal and political pressures), the lack of clarity re: how these services would or would not be designed to help specific subgroups is a looming critical question. If this item is included in the recommendations, it is likely important to also provide the reader with an expanded explanation of the risks/downsides of the state potentially owning and/or operating facilities outside of OSH (as mentioned in NAMI response comments).

NAMI: Remove requirement that state "build, own, operate" from recommendations. Alter recommendation so that it clearly recommends that Oregon continue to make investments in community-based treatment facilities, recognizing historic investments the Legislature has made thus far. Also, the recommendation should mention the recent report from Public Consulting Group as being one place to start in terms of prioritizing Oregon's investments.

ODHS: the 'or' in the statement changes the intent significantly. Either it's the state owning the facilities or they are passing funds through to community based facilities. I am unaware of the PCG report referenced by NAMI in the Recommendations document. It would be useful to understand what is in that report. Ultimately, short-term behavioral health inpatient care appears to be necessary and needed in Oregon, but i'm unable to make a recommendation at this time.

MOMI: replace "shorter term" with acute. Families don't want to shorter and shorter stays but we recognize the need for more acute care beds.

OHA: While the language currently drafted is acceptable, and could drive funding in the right direction, it could use more narrowing. For example: "require the State to ensure each region of the state has at least one operational subacute facilities with adequate secure transport services" or "require the state to oversee and fund the development of x number of regional acute care psychiatric facilities with capacity to provide inpatient-equivalent care, subacute treatment, and respite care."

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, ODAA, ODHS, OHA, OJD, OSSA, Tribes

No (1):
NAMI

NAMI: The state is making significant investments in facility-based care. Additional investments should be guided by the Public Consulting Group report that will be finalized in June. There may be a role for underwriting some of the cost of developing additional hospital inpatient care. Under no circumstances should the state own any additional facilities outside of state hospital level of care.

It Depends (1):
OSH

OSH: Conceptually there appears to be a significant interest in this being part of a broader solution for Oregon’s distressed mental healthcare system. That being said, achieving it would obviously require incredible amounts of funding, time, and additional resources. If pursued, it is imperative that Oregon recognize the futility of hyperfocusing on one patient subpopulation/statute when ultimately a resource system is required that must be flexible and adaptive in meeting the needs of all citizens under various legal parameters and who require differing durations and levels of care.

Abstain (1):
OCDLA

OCDLA: In general I am in favor of this recommendation, I assume "STATE" is in caps because it's differentiating between the state and the county as the funder. I don't know enough about the implications for state vs. county funding to give an educated opinion about how my organization would land on that question

II. Psychiatric Emergency Holds

4. Require the state to develop programs to expand the number of providers who have training, expertise, and willingness to support people with intellectual and developmental disabilities, including people with autism and people affected by drugs and alcohol in utero (TOP 5 IDEAS OF ODHS)

Recommendations Idea #: 5

Recommend this idea as currently drafted (7):
OCDLA, NAMI, ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3)
OSH, OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1)
OHA

Consensus Survey Comments
ODHS: In the Recommendations report, OHA comments that there are other workforce development efforts that could absorb this request. it would be helpful to understand what these efforts are. ODDS often hears about client challenges in finding providers with the willingness and expertise to provide treatment and therapy or counseling to them.

OHA: Specifying which agency within the state would be essential to this (ODHS, DOC, etc.)

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODHS, OJD, OSH, OSSA, Tribes

No (1):
OHA

OHA: Other workforce development efforts could absorb this request.

It Depends (1):
ODAA

ODAA: This support could not be at the expense of appropriate prosecution or involvement of the criminal justice system when necessary.

Abstain (0)

5. Create a state funding mechanism to reimburse community case managers for outreach efforts to individuals in need of behavioral health care

Recommendations Idea #: 6

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (2):
OSH, NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments

OSH: Increasing outreach and other avenues for developing supportive relationships between patients and local services is a vital need across the state. While building outreach services is undoubtedly a necessary component of a more effective mental healthcare system and may contribute to earlier intervention/more consistent engagement in treatment/potentially reducing need for civil commitment, the necessary resources along these lines likely extends beyond the parameters of the civil commitment system, and if developed, is deserving of a more comprehensive and inclusive approach than solely through the lens of civil commitment. Frankly, creation of salaried positions is likely more appropriate than playing catch-up with a reimbursement system among personnel who are already stretched too thin.

NAMI: As drafted, this recommendation doesn't account for the obligations some payers have to provide this exact service. Also, what population is this focused on? All people who need behavioral health, even for those with mild to moderate needs? Only people with high acuity? Only people without coverage? How does this comport with engagement models being developed around mobile crisis? A CCO is responsible for doing this for people with exceptional needs? So are they relieved of this? It's too hard to recommend specific language here because this concept is so broad. But maybe limit to people without coverage or without coverage for case management who have exceptional needs or high acuity. Or be clear about this being in addition to, and not duplicative of, what's already expected in our system via statute or contract.

ODHS: i wonder if this is a reimbursement or claims issue in how the contracts are written or what is included in the State plan or other federal agreement with CMS to deliver case management?

OHA: The CFAA theoretically does this for multiple programs -- civil commitment, PSRB, and Aid and Assist included. It could be more impactful to direct this to CCOs.

Recommendations Survey Results

Yes (13)

AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSSA

No (0)

It Depends (3):

OSH, Tribes, NAMI

Tribes: is this person already getting an hourly wage? or salary? or does this mean create a way for them to bill Medicaid?

NAMI: For OHP, some of this is/should be included in the CCO contracts. Thereafter, it largely depends on the model intended here and whether what is intended is Medicaid reimbursable. One of the more intriguing models around is the case management that Washington County is employing with help from the special Metro tax. What is clear is that a code alone isn't sufficient to sustain the type of case management that would be helpful.

Abstain (0)

6. Establish a fee schedule/funding code for billing Medicaid for behavioral health preventative care, such as 23-hour crisis and respite (TOP 5 IDEAS OF OHA)

Recommendations Idea #: 7

Recommend this idea as currently drafted (3):
MOMI, OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OAHHS, ODHS, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OCDLA, OSSA

Consensus Survey Comments
OSH: Important to ensure evidence-based respite models are utilized.

NAMI: OHA is already proposing Oregon Administrative Rules for Crisis Stabilization Centers that address this. The word "preventative" also isn't commonly used in context

of providing crisis services, which are an intervention. We also already have rules for Psychiatric Emergency Services that's for care for 23 hours or fewer. Revisiting those rules and/or adapting them so that such services can be more widely available would be prudent. Maybe recasting the recommendation to recognize rules that exist (PES) and rules under development (CSC) would achieve the aim here and also meet NAMI's concern.

ODHS: It is still unclear if establishing a fee schedule is the same as a funding code. Overall the concept is supported.

Recommendations Survey Results

Yes (12)
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, OHA, OJD, OSSA, Tribes

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No (0)

It Depends (3)
OSH, ODHS, NAMI

ODHS: t's unclear if this is a two part question or not. Establishing a fee schedule is separate from a funding code. Respite is available in some programs

NAMI: We already have a code and rules for Psychiatric Emergency Services. A better option would be to look at whether loosening those rules so they aren't so restrictive can address what's intended here.

Abstain (1)
ODAA

ODAA: My organization does not know enough about this issue to take a position.

7. Require state to build and fund more mental health crisis centers so emergency rooms are not the only option (TOP 5 IDEAS OF OHA, HOUSE REPUBLICANS)

Recommendations Idea #: 8

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (6):
OCDLA, OSH, OAHHS, DRO, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
NAMI

Abstain (0)

Consensus Survey Comments
ODHS: I support the Recommendation comments from DRO and OJD and would need more details on implications for this to be fully recommended. Conceptually i support offering non-ED/ER crisis centers but they would need to receive long term/ongoing funding for stabilization and success.

OHA: Specifying 'crisis stabilization centers' or 'urgent walk-in clinics' or 'street outreach' would be helpful here.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OSH OSSA, Tribes

OACMHP: We are assuming these are crisis stabilization or receiving centers, which would be the appropriate alternative to EDs.

No (1):
NAMI

NAMI: You can't require something that has no ongoing funding source for operations. Doing this entirely on the back of state general funds will divert funding from other services. This one is going to take a ton of work to figure out. Also, one of the easier options is to encourage existing emergency departments to adapt their infrastructure to accommodate behavioral health crises. The reimbursement path is there, but it also likely will require revisiting the rule around Psychiatrict Emergency Services.

It Depends (2):
DRO, OJD

DRO: There are many models... some are better than others. Voluntary or involuntary? We support the Deschutes County model but not in favor of a model that simply increases the likelihood of commitment.

OJD: For this to be successful there must also be a network of community treatment and housing so that people can be stepped down after being stabalized

Abstain (0)

8. Require first responder training on use of mental health crisis centers as an alternative to emergency rooms

Recommendations Idea #: 9

Recommend this idea as currently drafted (4):
MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OAHHS, ODHS

Would recommend this idea with specific changes to its wording (specify) (3):
OSH, OHA, OSSA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
NAMI

Abstain (0)

Consensus Survey Comments
OSH: This training would need to be closely coordinated to collaborate well with the available services (many of which still need to be designed and built within Oregon) and then have those service providers help create the curriculum to ensure alignment in decision-making and appropriate use of resources.

NAMI: This idea is just too vague to suggest wording changes that would gain NAMI's full support. There would need to be much more discussion around this to understand

what training would be, who would be trained, why are they being trained, and what do you do for the vast majority of communities that don't have such crisis centers. Our experience is that this is best done voluntarily in those communities where such crisis services have or are being developed. As such, we've moved from "it depends" to "cannot recommend."

ODHS: all education and training to first responders on community resources will be useful. However, if the training is not developed and will be community focused, this will take a lot of resources if the community availability isn't standard across the state

OHA: Would combine with other training recommendations -- condense into one.

OSSA: Strike "Require" and change to make available.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD

No (0)

It Depends (3):
OSH, NAMI, OSSA

OSH: Do enough of these types of alternative crisis resources currently exist so that trained first responders will reliably have the option to utilize them across the state? If not, such resource development would certainly be a necessary priority before investing in training. (As an aside, might also consider for what circumstances it could be advantageous to have mental health consultant accompanying police on calls as a team).

NAMI: How do you compel, say, law enforcement to participate? In communities where we see this working, it's a cooperative relationship that fosters the greatest success.

OSSA: I don't think training is available, this is a resource law enforcement officers would love to have. If it is built, we will bring people to the center, I don't think training will be necessary. Additionally, we don't have bandwidth for more trainings.

Abstain (1):
Tribes

9. Educate providers on when an individual may be released from a psychiatric hold following submission of an NMI to the court

Recommendations Idea #: 10

Recommend this idea as currently drafted (4):
OCDLA, OJD, MOMI, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
OSH, ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OHA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
MOMI

Abstain (1):
NAMI

Consensus Survey Comments
OSH: consider thinking creatively beyond standard "training" module or session and aim for a more efficient/reliable strategy -- may be more effectively and efficiently integrated into the specific point of service when it is most relevant and needed (e.g. prompted information in the electronic health record when the NMI is placed). Clinicians are already drowning in recurring trainings filled with information they transiently retain. If EHR's can offer a more streamlined, consistent, reliable approach, that would be preferable.

ODHS: it isn't training that providers need. The release date needs to be identified by the court and clearly documented in an electronic system and on the commitment document.

MOMI: Providers do not need "training" to encourage more patient dumping.

OHA: Combine with other training recommendations.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSSA, Tribes

No (1):
ODHS

ODHS: Recommend the court identifies this on the psychiatric hold paperwork so that providers are not the ones trying to figure it out

It Depends (1):
OSH

OSH: This is important information to have ready access to but also may be more effectively and efficiently integrated into the specific point of service when it is most relevant and needed (e.g. prompted information in the electronic health record when the NMI is placed instead of additional trainings that may or may not be effectively retained). Clinicians are already drowning in recurring trainings filled with information they may only transiently retain. If the EHR can offer a more streamlined approach, that would be preferable.

Abstain (1):
NAMI

III. Notice of Mental Illness/Initiation of Civil Commitment Process

10. Require state to create a centralized repository of civil commitment investigation reports for investigators to access for subsequent civil commitment investigations of the same individual (TOP 5 IDEAS OF OHA)

Recommendations Idea #: 11

Recommend this idea as currently drafted (2):
MOMI, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
OCDLA, OSH, ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
DRO

Abstain (1):
NAMI

(OJD skipped)

Consensus Survey Comments
OCDLA: I could support this recommendation if there were very clear restrictions on who could access that repository, and there were restrictions on how long a report could be accessed. I would propose only attorneys, investigators, and examiners have access and the reports expire from the repository after 5 years.

OSH: Identifying patterns and gaining deeper understanding of unique longitudinal context can greatly help inform a more tailored and accurate assessment of an individual's situation and thereby inform appropriate treatment. That being said, the potential for bias based on historical data even under circumstances where that data may not be entirely relevant to a current situation is certainly a risk. There should be some mechanism (not sure if appropriate for the statute itself vs other means) to help

raise awareness of and mitigate against inappropriate impact of biases generated from access to such information.

ODHS: Agree with OSH Recommendation report comment around the risk of bias. Also agree the knowledge could be useful in reviewing trends and history of the person. Would recommend with caution about what information is available, maybe not the full report but only specific details that would be entered by an investigator and then seen by only the other investigators across the state.

OJD: Require State to develop a secure centralized repository of civil investigation reports that can be accessed only by investigators, the defense, prosecution and Mental Health Examiner in a subsequent civil commitment proceeding. The State shall provide training on the how to appropriately use historical data and how to mitigate risk of implicit bias.

OHA: Funding for the centralized system is essential.

Recommendations Survey Results

Yes (10):
AOC, CCO, LOC, MOMI, OAHHS, ODAA, ODHS, OHA, OSSA, Tribes

No (1):
DRO

DRO: This prejudices people who have a history of mental health interactions. Will also have a greater impact on marginalized communities more likely to interact with law enforcement, etc. However, if this requirement happens, it should include defense attorney and P&A access.

It Depends (4):
OSH, AOCMHP, OCDLA, OJD

OSH: Having historical data available is an important tool when assessing a situation involving clinical pathology. Identifying patterns and gaining deeper understanding of unique longitudinal context can help inform a more tailored and accurate assessment of an individual's situation. That being said, the potential for bias based on historical data even under circumstances where that data may not be entirely relevant to a current situation is certainly a risk. Clear and specific guidance should be developed/provided to investigators as to how to most appropriately make use of such historical data and how to mitigate risk of implicit bias, where possible. (This is a situation where there exists a trade-off -- risks with a repository and risks without one).

AOCMHP: A database like this could be useful for history, however may not be useable in current case depending on timeline. A database that Counties could use to look up history of commitments for PAMIs would be helpful as there may be people who meet

extended criteria that the investigator is unaware of. A database of historical commitment information could also inform whether the current behavior is part of a pattern of behavior that leads to dangerousness for self or others. Would the state input this data, or would the CMHP have to do more data reporting?

OCLDA: I could support this recommendation if there were very clear restrictions on who could access that repository, and there were restrictions on how long a report could be accessed (for example, the reports are automatically deleted after a period of time).

OJD: Lots of questions would need to be answered to assure that the information is adequately protected and that the privacy rights of individuals are addressed.

Abstain (1):
NAMI

IV. Warrant of Detention

11. Require Oregon Judicial Department to collect data on the factual findings in which judges issue warrants of detention

Recommendations Idea #: 13

Recommend this idea as currently drafted (5):
OCDLA, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (1):
OSH

Would recommend this idea with specific changes to its wording (specify) (0)
OSH,

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
ODHS

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (4):
OAHHS, NAMI, OHA, OSSA

Consensus Survey Comments
ODHS: this would still be challenging to collect and likely require workload by the courts to enter data. There also needs to be outcomes intended with the data. What is the purpose of the data collection? More discussion on purpose and intent would be needed

DRO: With appropriate privacy protections and made available to the public.

OHA: There is only one reason a warrant of detention should be issued so I am not sure the utility of this. #125 and #126, both around education for judges. A warrant of detention really is allowed for one reason statutorily: probable cause to believe the person is a serious risk of danger to self or others. It is unclear where this recommendation would add enough benefit to push through this process.

Recommendations Survey Results

Yes (7):
AOC, DRO, MOMI, OCDLA, ODAA, OHA, OSH

DRO: With adequate privacy protections and made available to the public.

No (0)

It Depends (7):
OAHHS, LOC, AOCMHP, Tribes, OJD, ODHS, OSSA

OAHHS: We would like additional information on this proposal.

LOC: This is an enormous financial investment. It would be easier to require the court to state on the record the basis of its findings and have that included in the minutes.

AOCMHP: Depends on who would be responsible for collecting this data and what it would be used for.

Tribes: I'd need more information, how the data would be used and what examples of factual findings are??

OJD: Not sure what the goal is collecting this information

ODHS: only if there is a plan to evaluate trends for consistency and future changes

OSSA: I think this will be cumbersome and am unsure of the story this data will tell. I would like to know more.

Abstain (2):
CCO, NAMI

V. Investigation

12. Educate investigators that statute requires the submission of an investigation report regardless of whether the investigator believes that the person would be willing to participate in treatment on a voluntary basis

Recommendations Idea #: 14

Recommend this idea as currently drafted (6):
OCDLA, ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OSH, OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OHA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OHA: Combine with other investigator education. I would recommend adding language that recommended a rule change to enforce the no hearing report. Possibly change the colloquial name form "hearing report" to "recommendation report" so that it is clearer the report is about the recommendation and not simply a hearing (especially because if initiated under 426.070, the judge does not really have to use the report).

Recommendations Survey Results

Yes (13):
AOC, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA

No (0)

It Depends (1):
AOCMHP

AOCMHP: They should already know this.

Abstain (2):
Tribes, NAMI

13. Amend statutes or rules to require that civil commitment investigators provide all information specified in OAR 309-033-0920 or explain why missing information cannot be obtained

Recommendations Idea #: 15

Recommend this idea as currently drafted (6):
OSH, ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (1)
OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OCDLA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OCDLA: I agree with the substance of this idea but also agree with other comments that this OAR is not relevant to that concept and shouldn't be added to that provision specifically.

OAHHS: We are open to learning more about this idea. Should the citation be to a different rule?

OHA: It is already in the CFAA that investigations are supposed to be in accordance with the applicable rule. Since rules are generally more pliable than statute, it is not advised to change statute with this direction. Emphasis in CFAA could considered.

Recommendations Survey Results

Yes (10):
CCO, DRO, LOC, MOMI, OCDLA, ODHS, OJD, OSH, OSSA, Tribes

No (0)

It Depends (4):
OAHHS, AOC, AOCMHP, ODAA

OAHHS: This concept is unclear. Should the citation be to a different rule?

AOC: Civil Commitment investigator already have a difficult workload. More information may not be required in these situations

AOCHMP: If the State was willing to increase our budget for unfunded individuals who are in the hospital systems. We would also need more information about the criteria.

OHA: Making this decision unilaterally would be unhelpful. More would need to be studied/agreed to between OJD, OHA, providers around what should be in the report. Also if this were to be a recommendation, the rule would need to be pared down to only the essentials

ODAA: This OAR is on the certification of investigators. It reads that individuals have to be certified and particular things are needed for certification. I'm not sure this is necessary and as a general matter, OARs should not be made into statute except in very limited circumstances given their manipulatable nature.

Abstain (1):
NAMI

(OHA skipped)

14. Require civil commitment investigators to participate in continuing education following initial certification that includes updates on relevant legal and clinical information

Recommendations Idea #: 16

Recommend this idea as currently drafted (7):
OCDLA, NAMI, ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OHA

Consensus Survey Comments
OSH: (possibly OAR or statute?) Recommend continuing education include key topics re: anosognosia and medical dangers as a result of psychiatric or cognitive impairments (e.g., eating disorders, dangerously mis-managed diabetes, etc.)

OHA: This is already required by OAR 309-033-0920(5).

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSSA, Tribes

AOCMHP: If these trainings are offered by the State for free many times a year, yes, this should be included in the investigator recertification.

OHA: This is already required in rule for certification and recertification.

No (0)

It Depends (2):
OSH, ODHS

OSH: Recommend continuing education include key topics re: anosognosia and medical dangers as a result of psychiatric or cognitive impairments (e.g., eating disorders, dangerously mis-managed diabetes, etc.) Uncertain if this is specifically warranted in statute vs perhaps OAR.

ODHS: only if there is also a quality assurance review of random investigations to evaluate consistency and trends for education

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Abstain (0)

VI. 14-Day Voluntary Diversion

15. Amend statute to increase the maximum period of voluntary diversion from 14 days to a longer duration (workgroup to recommend the specific duration allowable) (TOP 5 IDEAS OF OJD, HOUSE REPUBLICANS)

Recommendations Idea #: 17

Recommend this idea as currently drafted (4):
MOMI, OJD, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
ODHS, DRO

Would recommend this idea with specific changes to its wording (specify) (4):
OCDLA, OSH, OAHHS, OHA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1)
NAMI

Abstain (0)

Consensus Survey Comments
OCDLA: I could support this if the timeframe to accept a diversion also changed (for example, so the parties could agree to a diversion at any time during the pre-hearing hold).

OSH: Until the ideas around duration of various treatment requirements are more fleshed out and specific, would not want this idea to preclude also exploring the possibility of shorter duration civil commitment. (Although, the question then would be what would determine appropriateness for longer diversion vs short civil commitment).

OAHHS: We support additional conversation to develop this concept. We suggest the workgroup consider allowing for voluntary diversion to last for a longer period (e.g., up to 21 days), with the duration of treatment based on the clinical judgment of the LIP.

ODHS: Many of the Recommendations indicate 'it depends' and related it to more criteria around when and for whom an extension could be allowed. This would need to be worked out in a RAC I supposed and i'd support it as long as there was clear criteria on who and when an person could stay longer

OJD: We agree with OCDLA's suggestion

DRO: Basically, this is way too open-ended, but I do not object to the principle. DRO would support additional diversion options for those of whom 14 days is not appropriate. Perhaps that would be the default with an opportunity for the ICP team to offer more or less time based on individual needs and with advice of counsel.

OHA: If it encouraged community placement.

Recommendations Survey Results

Yes (9):
CCO, LOC, MOMI, ODAA, ODHS, OHA, OJD, OSSA, Tribes

OHA: Coupling this with the tiering proposal would be beneficial, especially if including diversions and AOT.

No (1):
NAMI

NAMI: NAMI Oregon has considered this in depth as part of its recent deliberations and cannot support a longer period at this time.

It Depends (6):
OSH, OAHHS, AOC, AOCMHP, DRO, OCDLA

OSH: Greater flexibility in duration of commitment or diversion is important if we are to truly achieve a system in which individually appropriate, least restrictive care is to be reliably provided. One possible avenue is to have the option for a longer diversion period (especially if there is a history to indicate a longer period is likely necessary) which may ultimately help avoid eventual civil commitment and some of commitment's less desirable consequences, such as subsequent stigma. Additional possibility (although more restrictive) may be creating mechanisms to foster more tailored civil commitment orders (when appropriate) for shorter durations than the max default of 180 days. (Even though under current statute, civil commitment can be ended sooner than an original for "up to 180 days" maximum, the patients do not always understand this early on, which heightens their distress, and, unfortunately, despite best intentions, systems of care could be at risk of adapting to time allotted).

OAHHS: If this concept is adopted, we request that hospitals be included in the development of the new standard. Some concepts would be important to incorporate such as a medication override and patient engagement.

AOC: Depends on ability of local hospitals and resources to manage these longer stays.

AOCMHP: In many cases the 14 day period seems sufficient to either increase stabilization, engage in full voluntary treatment or to determine if the person will not willingly comply and a hearing needs to be requested. Most treating physicians do not keep the person admitted longer than 5-7 days.

DRO: This would be entirely dependent on how the new guidelines would work. Would it give additional options or just a longer period for diversions? Maybe the ICP worker could submit a treatment plan or more documentation showing why a diversion needs to be longer than the default 14 days? Or an option to extend with advice of counsel? Maybe shorter diversions as well, like 7 days?

OCDLA: I could support this if the timeframe to accept a diversion also changed (so the parties could agree to the diversion at the time of hearing, for example, rather than prior to the hearing being brought).

Abstain (0)

VII. Probable Cause Determination

16. Amend statute to require that peer support services are provided to an individual upon completion of diversion treatment

Recommendations Idea #: 19

Recommend this idea as currently drafted (0)

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
MOMI, CCO

Would recommend this idea with specific changes to its wording (specify) (4):
OSH, OAHHS, OJD, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (3):
OCDLA, NAMI, ODHS

Cannot recommend this idea, even with specific wording changes or combined with other ideas (2):
OHA, OSSA

Abstain (0)

Consensus Survey Comments
OCDLA: I would like transitional services of all kinds to be required for individuals ending diversion, peer support being just one of those services.

OSH: specify the purpose(s) (as commented previously -- Would this be for the purpose of ongoing clinical support? Or to reassess clinical status/success of the diversion treatment? Or to assess whether follow up care arranged at discharge was utilized? If detecting decompensation warranting re-hospitalization, would mechanisms for expedited access to inpatient care be in place? Transitions are highly vulnerable time periods and continued engagement/safety net may have value in that regard but would certainly require ample funding and logistical support. Gathering outcomes data on diversions past the point of discharge may also be highly valuable in determining how often diversion is, in fact, succeeding in ultimately reducing the need for civil commitment vs. delaying it and/or detect (based on outcomes) if there are identifiable ways to improve the diversion process.)

OAHHS: Peer support services should be offered to an individual as an option and not a requirement. If this is mandated it is important that it is not an unfunded mandate.

NAMI: There's just too many facets unaddressed by this recommendation, such as who is being required, how is it paid for, what's the role of a CCO or PCPCH or CCBHC. And amending statute for this vs. rule vs. contract is problematic. We can probably get to yes if the recommendation is softened to recommend that CCOs and other payers be required to reimburse peer services for those who have completed 14-day diversions.

ODHS: tying this into the concept about billing for case management outreach may work. There are a lot of unresolved comments in the Recommendations report that could benefit from discussion

MOMI: This presumes that peer services would exist in all circumstances, and I'd hate to see an unintended consequence of someone being abandoned by the system (not being offered the diversion services) in anticipation of not being able to meet this criteria later in the process.

OJD: Amend statute to require that peer services are offered as a voluntary service upon completion of diversion treatment and fund peer services

DRO: Offered and provided if the individual desires.

OHA: Cannot require a service like this during workforce shortage and when forcing a service is against the service philosophy. Requiring certain services as such is unrealistic in workforce shortages, and requiring peer intervention is against the peer approach. Requiring peer services be offered may be a better approach, though it would make more sense to transition diversion clients to AOT following the diversion period.

OSSA: Peer support is fantastic, but few counties have the resources to provide peer support. This appears to be an unfunded mandate.

Recommendations Survey Results

Yes (3):
MOMI, ODAA, Tribes

No (1)
OHA

OHA: It is against peer philosophy to force a service like peer support on clients. And it is unreasonable to require this during the workforce issues the state is experiencing.

It Depends (12)
OSH, OAHHS, AOC, LOC, AOCMHP, DRO, OCDLA, OJD, CCO, ODHS, NAMI, OSSA

OSH: This would presumably be quite challenging to achieve without a greatly increased number of peer support specialists, (even impossible in some counties without significant additional effort and supports to put into place). Attention to implementing this with evidence-based approaches will be imperative.

OAHHS: Peer support services should be offered to an individual as an option and not a requirement. If this is mandated it is important that it is not an unfunded mandate.

AOC: Okay if resource allocation meets the demand this would create.

LOC: Increasing the community health resources already achieves these ends.

AOCMHP: These are voluntary services. No one is under any legal obligation to follow up with treatment. See 18. Who would be responsible for funding and providing peer support?

DRO: Offered and provided if the individual desires.

OCDLA: I'd like transitional services of all kinds to be required for individuals ending diversion, peer support being just one part of those services.

OJD: Peer support should be offered but there should not be a requirement that they are provided - it should be up to the individual as to whether they want peer services. There also funding issues and capacity issues in some parts of the state that would need to be addressed.

CCO: Again, if the statute will also require the individual to engage with peer support then I would support this but if it just requiring peers to attempt to engage with someone who does not want services then I would not, as peers already attempt to engage following a 14 day diversion.

NAMI: As long as the individual has a choice to accept such services. Another variable, what's the payment mechanism?

OSSA: I would re-word to "...peer support services are available to..."

Abstain (0)

17. Require OHA to compare civil commitment diversion programs among Oregon counties and identify best practices, including accountability mechanisms for community treatment providers

Recommendations Idea #: 20

Recommend this idea as currently drafted (3):
OCDLA, MOMI, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OAHHS, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
OJD

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OSH

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (2):
NAMI, OHA

Consensus Survey Comments
OSH: Comparing county-based diversion programs may yield very helpful information. Hopefully this would help inform ultimately developing a state-level, centralized system to improve program development, accountability, monitoring, and funding across the state vs the separate programs that currently exist in highly varied formats (based primarily on available resources and not necessarily in a way that is tailored to the specific needs of the local community).

ODHS: As I understand it, OHA does not manage civil commitment diversion programs. Unless there is an intent for OHA to manage this, the comparison process appears impossible and would likely result in removing the community autonomy in the programs

OJD: change best practices to evidence based practices

OHA: This indicates diversions happen in the community; they do not. The way this recommendation is written suggests that diversion occur in the community where CMHPs or CBOs could be held accountable to providing services. As it is right now, diversions are overwhelmingly if not entirely completed in the inpatient hospital/ nonhospital setting (i.e. hold rooms), so it is unclear what treatment they are held to referenced here.

Recommendations Survey Results

Yes (10):
AOC, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OSSA, Tribes

LOC: This is frankly self-evident. Any organization administering such a large project should obviously be assessing its efficacy by comparing it to others. Having to specify this hints at a bigger issue of incompetence.

No (0)

It Depends (4):
OSH, AOCMHP, OJD, CCO

OSH: There appears to be strong support for this idea. However, there is even stronger support for ultimately shifting to a more centralized process of programming, accountability, monitoring, and funding from a state (OHA) level vs continuing to use the current format in which counties are so varied and isolated in their mental health systems.

AOCMHP: Good idea, but workforce shortage is backdrop for the ability to effectively implement identified practices.

OJD: This should be an exercise between local communities and OHA. There should be an evidence determination of what is best practice.

CCO: I would support if there were two sets of "best practices" one for rural and frontier regions and one for urban and metro regions, as resources, landscape, staff and logistics are very different depending on the region.

Abstain (1):
NAMI

(OHA skipped): Diversions currently all happen on inpatient units or in hospitals. It could be beneficial to require a substantial restructure of the NMI hold process, diversions, and AOT as diversion programming.

VIII. Citation and Service

18. Amend statute to require that citations include information about eligibility for 14-day intensive treatment option (diversion)

Recommendations Idea #: 21

Recommend this idea as currently drafted (2):
OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OSH, OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OCDLA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (2:)
ODHS, MOMI

Abstain (3):
NAMI, OHA, CCO

Consensus Survey Comments
OCDLA: I initially said yes to this idea but agree with the comments raised which note that citations are served after it is already deemed a person is ineligible for diversion. I previously responded to a question regarding diversion length and noted that it would be helpful to expand the timeframe in which a person can accept a diversion. If the timeframe was expanded, this recommendation would make more sense.

ODHS: From comments on the Recommendations document, if this concept were to move forward there may be negative consequences to other timelines. Support providing the information about eligibility but this should be done at the very beginning of an investigation, not with a citation

MOMI: A citation such as this is being served to someone who is extremely unwell. There is no need to complicate the person's "options" at this point in the process, when they are most likely too incapacitated to make reasonable choices in their own best interests. After evaluation is a better time for providers to decide how best to explain the

diversion into intensive treatment for a person who might be capable enough to choose that option.

OHA: citations are provided after the three day window to offer the diversion. A citation is, procedurally, provided to a person after the third day in the timeline, and therefore diversions should no longer, statutorily, be on the table by the time a citation is provided.

Recommendations Survey Results

Yes (11):
AOC, CCO, DRO, MOMI, OAHHS, OCDLA, ODHS, OJD, OSH, OSSA, Tribes

OJD: We are assuming that this is simply notice that diversion may be an option.

No (1):
OHA

OHA: Generally speaking, the citation is served after the 3rd day of a hold, which means the diversion option is no longer available.

It Depends (2):
AOCMHP, ODAA

AOCMHP: Ideally investigators are going over this option with the person. If they do not receive the citation until day three, and then agree to 14DD after receiving citation it could result in last minute scramble to get notified and 14DD signed.

ODAA: Citations should be short and to the point conveying exactly what needs to be noticed. Adding a lengthy section about diversion isn't helpful and probably doesn't belong here.

Abstain (2):
LOC, NAMI

IX. Appointment of Counsel

19. Amend statute to clarify when in the civil commitment process the court must appoint legal counsel to financially eligible individuals (TOP 5 IDEAS OF DRO)

Recommendations Idea #: 22

Recommend this idea as currently drafted (4):
MOMI, OJD, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OSH, OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (3):
OCDLA, ODHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OCDLA: I support this and would also like language to make clear appointing counsel is the default even if financial eligibility cannot be established (for example: if the court is unable to determine financial eligibility by the end of the first day of the hold, counsel will be appointed regardless of financial eligibility).

ODHS: Support this and including that legal counsel should be a default in the process

DRO: Agree with OCDLA that there should be some language regarding a default appointment of counsel if eligibility cannot be determined.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, ODAA, ODHS, OHA, OJD, OSSA, Tribes

No (0)

It Depends (2):
OSH, OCDLA

OSH: Ensuring clarity on this point is ideal but also completely dependent on greatly expanding the public defender workforce in order to adhere to. Unsure if this is necessary in statute vs OAR?

OCDLA: I support this, but there should also be language regarding appointment of counsel being the default even if it can't be established whether they person is financially eligible (something like if the court is unable to determine eligibility by the end of the first day of the hold, counsel will be appointed).

Abstain (1):
NAMI

20. Amend statute to require continuity of appointed legal counsel throughout process when feasible

Recommendations Idea #: 23

Recommend this idea as currently drafted (3):
MOMI, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
ODHS, OJD, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (2):
OCDLA, OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OAHHS, NAMI

Consensus Survey Comments
OCDLA: The statute should clarify one lawyer or lawyers within the same firm.

OSH: currently unclear what would appropriately qualify a situation as "feasible" vs "not feasible." Under what circumstances will patient preference for different counsel be honored?

ODHS: 'when feasible' should be clarified

OJD: This needs more specificity as to what continuity means. We think that it will be hard to require continuity of the same lawyer throughout the process.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, AHHS, ODAA, ODHS, OHA, OSSA, Tribes

No (1):
OJD

OJD: In the ideal yes but not sure throughout the state how feasible this is.

It Depends (2):
OSH, OCDLA

OSH: What would the criteria be to qualify a situation as “feasible” vs "not feasible"? Would this requirement override even a patient’s preference to have a different attorney? Would this be more appropriate in OAR vs statute?

OCDLA: I would need to know what continuity meant - one law firm, or one lawyer specifically? It may not be feasible for one lawyer to see patients immediately and also represent them in their hearing, but lawyers from the same firm are able to communicate and share information such that two separate people might not cause any lack of continuity.

Abstain (1):
NAMI

21. Amend statute to require that public defenders appointed for representation in civil commitment cases have specialized knowledge and experience in civil commitment law and practice

Recommendations Idea #: 24

Recommend this idea as currently drafted (3):
MOMI, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OSH

Would recommend this idea with specific changes to its wording (specify) (3):
ODHS, OJD, OHA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OSSA

Abstain (2):
OAHHS, NAMI

Consensus Survey Comments
OCDLA: After reading the comments I wanted to offer: There are already OPDS requirements for who can be certified to take civil commitment cases, but it does not require any specific training in mental illness or working with individuals who have mental illness. This practice area is very niche within public defense and frankly kind of neglected in terms of providing training and accountability to those standards.

OSH: in context of current limited numbers of public defenders, these training requirements may further exacerbate lack of available personnel. Assuming this item will only have the full impact desired if there is first additional problem-solving and major funding to remedy the lack of p.d.'s.

ODHS: OJD commented that all public defenders should have adequate training. While there may be adequate training, the fact that public defenders may not defend a person going through civil commitment more than once a year or ever few years is high. The knowledge gets lost of things change. Public defenders need to have identified 'experts' in their office for civil commitments would be my recommendation.

OJD: Require all lawyers (defense and prosecution) who may participate in the civil commitment process to have training/education in the civil commitment process

OHA: allow for training/associate period given workforce shortage/crisis. Or be in a period of training, fellowship, apprenticeship, etc.

OSSA: This is an excellent idea, but we have too few public defenders right now as it is. This requirement may create a situation where no public defender is available.

Recommendations Survey Results

Yes (9):
AOC, AOCMHP, CCO, DRO, MOMI, OCDLA, ODHS, OSSA, Tribes

No (1):
OJD

OJD: All public defenders should have adequate training on mental health and the civil commitment process.

It Depends (4):
OAHHS, LOC, OHA, ODAA

OAHHS: It depends on the requirement. Generally, yes, it is a good idea for public defenders appointed for representation in civil commitment cases to have specialized knowledge and experience in civil commitment law and practice. However, the details of the new standard will be important. What will it take to meet that standard? If the statutory standard for specialized knowledge and experience is set too high than an unintended consequence could be that individuals are left without representation even when appropriate lawyers are available and willing to serve this role.

LOC: It's unclear what this means and that lack of clarity could potentially contribute to the struggles in hiring public defenders. If an attorney has chosen to represent people in that capacity then they already care a great deal and will do the learning necessary to provide constitutionally firm legal representation. Would this prevent brand new attorneys who want to practice this type of law from getting in the door? CLE and on the job training will do the trick.

OHA: Caveat being that new attorneys should have a timeframe to acquire the training. With the workforce shortage and public defense crisis, seems there would need to be a grace period on this.

ODAA: It is beneficial to have someone with understanding but given the workload in numerous jurisdictions and the burden on public defenders, it may not be feasible to require this expertise and could result in scarce supply of defenders.

Abstain (1):
NAMI

(OSH skipped): This will require extensive resources and logistical planning. Public defenders are already limited in both availability and time to prepare and build relationships with clients under complex circumstances. Adding such a requirement could exacerbate these limitations even further unless other concurrent changes ensure adequate numbers of defenders are available (and receive training). If pursued, appropriate for statute vs OAR?

X. Access to Medical Records

22. Amend statute to require hospitals to share pertinent documentation from electronic health record with defense attorneys for civil commitment hearings (TOP 5 IDEAS OF OCDLA)

Recommendations Idea #: 26

Recommend this idea as currently drafted (3):
OSH, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (0)

Would recommend this idea with specific changes to its wording (specify) (3):
OCDLA, NAMI, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OAHHS

Abstain (4):
ODHS, OHA, OSSA, CCO

Consensus Survey Comments
OCDLA: Defense counsel should have access more than 24 hours before the hearing. I appreciate the comments that OHA does not own the medical record, so perhaps an adjustment could be made to the wording that directs the entity with the records to respond to requests more promptly, and specify a remedy if they fail to do that (hospitals routinely fail to respond to requests for records before the 24 hour deadline, even with the statute being as it currently is).

OAHHS: It would be helpful to hear what problem this is trying to solve. Hospitals already provide documentation.

NAMI: A repeat from the previous survey: Is this not already required? Is there an exception in statute for EHRs that doesn't exist for written records? How are records currently provided and/or what is required?

ODHS: this should fall under attorney rights or client treatment/HIPPA

OJD: We do think pertinent should be defined and a time limit should be specified as to when the records need to be provided.

DRO: More than 24 hours would be enormously helpful in actually being able to go through the medical records. Not sure why the hospitals should bear the burden of producing this documentation... it seems like OHA or the County should???

OHA: already in statute. If this is to be required of hospitals, suggested language change would be to extend to any hospital, nonhospital, community, or independent provider who would have records relevant to the current period of investigation.

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, ODAA, OJD, OSSA, Tribes

DRO: Including outpatient records and VA records.

OJD: Pertinent should be defined.

No (1)
ODHS

It Depends (4)
OSH, OAHHS, OCDLA, NAMI

OSH: Appropriate for statute vs OAR?

OAHHS: How would this proposal differ from current legal requirements?

OCDLA: Yes absolutely, but the language should also include a timeframe (immediately upon request).

NAMI: If there is some clear barrier by which this information is not routinely provided or if hospitals claim information is excluded from disclosure, such a clarification in statute may be necessary.

Abstain (1)
OHA

OHA: This is already in existence.

XI. Examination

23. Require the state to implement a plan to expand the number of mental health examiners for civil commitment cases (e.g. through the Oregon Behavioral Health Workforce Initiative (BHWI))

Recommendations Idea #: 27

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5)
OCDLA, OSH, DRO, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OAHHS

Consensus Survey Comments
OCDLA: As long as expansion did not reduce the qualification to be an examiner.

NAMI: Add wording that this should be distinct from, or in addition to, other workforce investments that the Legislature has made.

DRO: Additional information is needed: Who is supervising the examiners? How are they chosen? How are they paid? To whom do they report? Is there oversight of their methods and findings?

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, ODAA, ODHS, OJD, OSH, OSSA, Tribes

DRO: Additional information needed: who is supervising examiners, how are they chosen, how are they paid, to whom do they report/oversight of methods and findings?

No (1):
OAHHS

OAHHS: Is there a shortage of mental health examiners for civil commitment cases? Funding should focus on the areas of known need. There are many other areas of known shortages within the behavioral health workforce.

It Depends (2):
OCDLA, NAMI

OCDLA: I would not want expansion to reduce the qualifications to be an examiner, but as long as those were kept in place I would support this.

NAMI: NAMI Oregon is sensitive to imposing additional conditions on this funding source. A large impetus for this specific funding is around growing the workforce so that it reflects the racial, ethnic, identity demographics of Oregon with focus on building BIPOC workforce.

Abstain (1):
OHA

24. Require state to create a centralized database of mental health examiners that is available to courts and CMHPs

Recommendations Idea #: 28

Recommend this idea as currently drafted (6):
NAMI, ODHS, MOMI, OJD, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OSH, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OCDLA: Yes, and make clear the courts can appoint any examiner, not just those used locally. I'd also like defense counsel to be able to request a specific examiner for the court to appoint.

DRO: Add "and to defense counsel"

OHA: While we don't have a formal 'database' available, as written this recommendation is already realized. It would be a modification to the current situation to add that examiners are a statewide resource rather than a county resource.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, ODAA, OHA, OJD, OSH, OSSA, Tribes

DRO: And available to defense.

No (1)
ODHS

ODHS: courts will use people they know. Statewide data base won't change practices. examiners aren't likely to travel either.

It Depends (1)
OCDLA

OCDLA: Yes, and make clear courts can appoint any examiner, not just those used locally. I'd also like counsel to be able to request a specific examiner for the court to appoint.

Abstain (0)

25. Amend statute to expand training requirements for mental health examiners in civil commitment cases

Recommendations Idea #: 29

Recommend this idea as currently drafted (4):
ODHS, OJD, CRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OSH

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OHA

Abstain (3):
NAMI, OHA, OSSA

Consensus Survey Comments
OAHHS: Would this proposal expand what is required for initial training? Would this proposal add requirements for ongoing or periodic training? We would like more information on what problem this proposal intends to solve.

MOMI: I have no awareness of whether they are already properly trained and whether this is a good use of funding

OHA: The training/experience requirements are already greater than those of the investigators. It remains unclear what benefit this recommendation provides.

Recommendations Survey Results

Yes (12):
AOC, CCO, DRO, MOMI, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (1):
AOCMHP

AOCHMP: Examiners already have training requirements for their licenses.

It Depends (2):
OAHHS, LOC

OAHHS: Would this proposal expand what is required for initial training? Would this proposal add requirements for ongoing or periodic training? We would like more information on what problem this proposal intends to solve.

LOC: It is precisely the intersection of law and medical expertise that is so problematic. Medical experts contort their clinical decisions to the framework of a statute not aimed at treatment, but at avoiding curtailing civil liberties that the person is often unable to appreciate in the first place.

Abstain (1):
NAMI

26. Amend statue to clarify mental health examiners are appointed as neutral experts for the benefit of the court and are independent from counties and CMHPs

Idea #: 30

Recommendations Idea #: 30

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OAHHS, NAMI

Consensus Survey Comments
OHA: This alone is not possible without modifications to components of the statute and rule that ae outside the recommendations included in this survey. For example, an examiner must be recommended by a CMHP director

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OCDLA, ODHS, OHA, OJD, OSH, OSSA

AOCMHP: Does this also mean you will clarify who PAYS the examiner as that practice differs from County to County?

No (0)

It Depends (2):
OAHHS, ODAA

OAHHS: We would like more information on what problem this proposal intends to solve.

ODAA: This would need to be carefully worded so not to create a situation of further scarcity.

Abstain (2):
Tribes, NAMI

27. Amend statute to clarify that only one examination report is required per examiner. (Statute currently refers to examination reports in the plural.)

Recommendations Idea #: 31

Recommend this idea as currently drafted (6):
OSH, OAHHS, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
DRO, OHA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OCDLA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OSSA

Consensus Survey Comments
OCDLA: The statute currently allows for a second examiner to be appointed if the AMIP requests one. Rather than clarify only one is required, I'd like the barriers to a second examiner to be removed (the statewide database would help with this).

ODHS: Just caution not to limit it to only one evaluation as there may be reasons that more than one is needed

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, ODAA, OHA, OJD, OSH, OSSA

DRO: Examiners should not get to examine witnesses (in contravention of current statute), or the PAMI during the hearing on the record? PRIOR to hearing can examine PAMI and talk to treatment providers (only, not other witnesses) per statutory authority. DURING hearing, can listen to evidence and write report.

No (1):
ODHS

ODHS: there may be reasons more than one report is required and beneficial.

It Depends (1):
OCDLA

OCDLA: The statute currently allows for a second examiner to be appointed if the AMIP requests one. Rather than clarify only one is required, I'd like the barriers to a second examiner to be removed (the statewide database would help with this).

Abstain (2):
Tribes, NAMI

XII. Court Determination of Mental Illness

28. Amend statute to add a definition of “mental disorder” for purposes of determining whether an individual is a "person with mental illness"

Recommendations Idea #: 33

Recommend this idea as currently drafted (2):
MOMI, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OJD, DRO, OSSA

Would recommend this idea with specific changes to its wording (specify) (2):
OCDLA, NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OAHHS, ODHS

(OHA skipped)

Consensus Survey Comments
OCDLA: Some clarification would be helpful (whether or not neurocognitive disorder or TBI should be included) but absolutely would not support this change if substance abuse disorder was added to the definition.

OAHHS: What problem is this idea trying to solve? We need more information.

NAMI: This is too vague. How about recommending that a select workgroup discuss the merits of a definition and possible definitions? The lack of a definition of "metal disorder" isn't the major barrier, in our experience.

ODHS: Conflicted - i would recommend not restricting statute too much. What about people with TBI or dementia. Same could be said for people with developmental disabilities. What is the behavior that is risky and where the person must have their rights removed in order to keep themselves and others safe?

OJD: We agree with many of the comments that there is a need for more discussion on this given the comments made by those who indicated it depends

DRO: It depends on whether or not this is a clarification of current law as defined by appellate caselaw, or an expansion of the currently accepted bases for commitment. We are NOT in favor of expanding civil commitment for things like SUD, TBI, Alzheimer's, Autism, etc.

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, LOC, MOMI, ODHS, OJD, OSH, OSSA, Tribes

AOCMHP: If the definition is too limiting in nature (ex: SPMI) those who need the safety of a commitment may not qualify. A distinction between mental disorder and medical conditions such as dementia would be useful, along with a consideration for substance use impacts on the diagnosis and where that puts recommendations legally.

No (0)

It Depends (6):
OAHHS, DRO, OHA, OCDLA, ODAA, NAMI

OAHHS: What problem is this trying to solve? Is the concept to require that the individual have a diagnosed mental disorder?

DRO: It depends on whether or not this is a clarification of disorder as defined through appellate caselaw, or an expansion of the currently accepted bases for commitment.

OHA: This would take a great deal of study. The definition is necessary, and 2025 might be too early to rally for it. this could inadvertently exclude people, restrict services and options, have implications on OSH admissions, for example. More research is needed and more consensus is required to move it forward.

OCDLA: I absolutely do not support substance use disorder being added to the definition of mental disorder for purposes of 426 civil commitment, but it would be helpful to clarify whether neurocognitive disorders (dementia, TBI) are intended to be covered.

ODAA: This is really tricky. Psychiatry is an evolving field and adding a definition of what it is, rather than what it is not, is something that will age and become antiquated. Already, it feels like we spend so much time arguing about whether the person has a mental illness and it leads to absurd situations. Even within our group, without hours of conversation with experts, we could not come to an agreement on what a mental illness

is or is not. While my organization may support having clear lines, it will cut both ways in cases and in the end, some people who need care won't receive it. This is a big issue.

NAMI: Specifics matter here. Generally speaking, the lack of a definition for "mental disorder" isn't the major barrier, in our experience.

Abstain (0)

XIII. Court Options Following Determination of Mental Illness

29. Provide dedicated funding to CMHPs to support 14-day intensive treatment (diversion from civil commitment) (TOP 5 IDEAS OF HOUSE REPUBLICANS)

Recommendations Idea #: 37

Recommend this idea as currently drafted (4):
MOMI, OJS, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OSH, ODHS

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (3):
OCDLA, OHA, OSSA

Consensus Survey Comments
OSH: Would not want this idea to preclude exploring the possibility of a more centralized, state-level system. But if system remains county-based, this type of financial support would be a helpful and a potentially vital resource. If this concept is referring to 14 day intensive treatment in the community in order to divert hospitalization and civil commitment, then we are supportive of this concept.

OAHHS: If this concept is about 14 day intensive treatment in the hospital, then we would not support additional funding going to CMHPs for that treatment.

NAMI: There are multiple payers involved in reimbursing care. Key questions here revolved around ensuring we're not spending general fund dollars when other payers should be at financial risk for inpatient level services, particularly considering these are voluntary services where the care should be based on medical necessity and generally accepted standards of care.

NAMI could possibly get to yes if other payers were held accountable for payment for services and level of placement based on well-recognized instruments, such as the LOCUS. This should not be solely done on the back of general fund dollars.

ODHS: from the comments in the Recommendations, it seems more conversation is needed.

OHA: Already provided in CFAA

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OCDLA, ODHS, OJD, OSSA, Tribes

No (0)

It Depends (3):
OSH, OAHHS, NAMI

OSH: There appears to be significant support for utilizing diversion wherever possible and ensuring resources to enable this. However, there again is even greater support for restructuring the system to be centralized and accountable at the state vs county level.

OAHHS: This concept is unclear. If this concept is referring to 14 day intensive treatment in the community in order to divert hospitalization and civil commitment, then we are supportive of this concept.

NAMI: There are multiple payers involved in reimbursing care. Key questions here revolved around ensuring we're not spending general fund dollars when other payers should be at financial risk for inpatient level services, particularly considering these are voluntary services where the care should be based on medical necessity.

Abstain (2):
OHA, ODAA

ODAA: My organization is not well versed in the funding mechanisms involved here.

30. Require OHA and OJD to collect data on AOT outcomes, such as participant experience, community safety, effectiveness of different intervention levels, and effect on later criminal justice system involvement

Recommendations Idea #: 38

Recommend this idea as currently drafted (6):
OCDLA, NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
ODHS: Recommend identify the how/why this data will be used before the collection would begin

DRO: We are in favor of collecting aggregate (anonymized) data that is subsequently made available to the public.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OSH, OSSA, Tribes

No (0)

It Depends (2):
DRO, OJD

DRO: We are in favor of gathering aggregate (anonymized) data that is subsequently made available to the public.

OJD: We have questions about how the information on participant experience is collected. This will also require funding.

Abstain (0)

XIV. Conditional Release

31. Amend statute to clarify the kinds of support that OHA must provide to persons ordered to conditional release

Recommendations Idea #: 39

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OHA

Consensus Survey Comments
NAMI: Could possibly get to yes if altered to require OHA to develop by rule the suite of supports that OHA must provide (and fund) to individuals.

ODHS: could this also be support provided by a CMHP pending funds/positions?

OJD: We think that there should be a general statement with the particulars then be listed in the OARs - this will allow for easier amendment

Recommendations Survey Results

Yes (11):
AOC, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODHS, OJD, OSSA, Tribes

No (0)

It Depends (4)
OSH, AOCMHP, ODAA, NAMI

OSH: Would this be more appropriate for OAR vs statute?

AOCMHP: We would need a full definition of what conditional release actually entails.

ODAA: We do not support lengthy lists of evolving services in statute that have to be amended regularly-that belongs in OARs. But a general statement can likely be supported.

NAMI: There's tension here between should be in statute and what should be in rule, among other factors.

Abstain (1)
OHA

XV. Inpatient Commitment

32. Require OHA to establish an intensive care case management service that can identify and place individuals who need a higher level of care but are ineligible for the Oregon State Hospital (TOP 5 IDEAS OF OSH)

Recommendations Idea #: 41

Recommend this idea as currently drafted (3):
OSH, MOMI, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (6):
OCDLA, OAHHS, ODHS, DRO, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OHA

Consensus Survey Comments
NAMI: This recommendation should be further examined in context of how people are placed now given that OSH is almost exclusively a forensic facility and unavailable for patients under civil commitment. If there's nowhere for people to go, as there is now, then having intensive care case managers is worthless. Nor is it valuable if there isn't any accountability for OHA's current practice of abandoning patients under civil commitment. I think NAMI could get to a yes if tied to a recommendation to invest in community-based treatment facilities and services and to have some accountability for case managers, whether housed at OHA or elsewhere.

ODHS: where would people be 'placed' if they had intensive case management. Yes, in support of intensive case management as it has proven successful in other programs. However, if there are no residential resources then it may not matter

DRO: We need further clarification on this. Is this not being done under current case management? How are individual needs currently being assessed? What are the factors that make someone ineligible for OSH?

OHA: Exists with Choice and ICC from CCOs

Recommendations Survey Results

Yes (11):
AOC, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH, OSSA, Tribes

Tribes: this team should also be accessible to the 9 federally recognized tribal BH programs

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No (1):
CCO

It Depends (3):
AOCMHP, DRO, NAMI

AOCMHP: Who would be responsible for this? Would it be OHA or delegated to CMHPs?

DRO: Need further clarification. Is this not being done under case management currently? How are individual needs being currently assessed? Why is someone ineligible for OSH?

NAMI: NAMI likely would favor this but would wish to couple this by better holding OHA accountable for serving individuals under civil commitment. Right now, OHA is able to abdicate this responsibility. Adding care management without an obligation is pretty much the system we have today. There are plenty of care managers right now. Just not places to go.

Abstain (1):
OHA

XVI. Outpatient Commitment

33. Amend statute to require peer support and wrap-around services for individuals on outpatient commitment

Recommendations Idea #: 44

Recommend this idea as currently drafted (3):
ODHS, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, CCO

Would recommend this idea with specific changes to its wording (specify) (4):
OSH, OAHHS, NAMI, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OHA

Abstain (1):
OSSA

Consensus Survey Comments
OSH: If pursued, should emphasize evidence-based peer interventions and perhaps focus on a requirement for offering individualized approach to peer support services (vs requiring the patient to use peer support services - as OHA has commented, involuntary peer support does not align with that service model).

OAHHS: Peer support services should be offered to an individual as an option and not a requirement. If this is mandated it is important that it is not an unfunded mandate.

NAMI: NAMI could support if it's clear that such services are voluntary. Peer services should never be forced on someone. Wraparound is more of a multi-disciplinary team concept and not necessarily a specific service. Care that is coordinated with other efforts, such as housing, personal services, employment, community engagement -- that should be offered in any type of commitment.

OJD: If it is clear that participation with peer services is voluntary and funding is provided.

DRO: We would be in favor of amending the statute to OFFER peer support and wrap-around services.

Recommendations Survey Results

Yes (9):
AOC, CCO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OSH

No (1):
OHA

OHA: Requiring peer support is against the peer model.

It Depends (6):
AOCMHP, DRO, Tribes, OJD, NAMI, OSSA

AOCMHP: This would depend on funding made available for CMHPs to hire the workforce needed for such a requirement.

DRO: We generally oppose outpatient commitment (see earlier answers). However, we would be in favor of amending the statute to OFFER peer support and wraparound services.

Tribes: I would say yes, however, what if the individual doesn't want the "required service" are there consequences?

OJD: If adequate funding is provided to develop or expand peer services and wraparound serv

NAMI: If voluntary, ensuring access to peer supports adds value.

OSSA: Peer support is fantastic, but I don't know if every community has peer support resources available, making this a tough requirement.

Abstain (0)

34. Require OHA to amend its County Financial Assistance Agreements to require and fund CMHP outreach services for civilly committed individuals placed in outpatient treatment

Recommendations Idea #: 46

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (1):
NAMI

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (2):
OSH, NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (3):
OCDLA, OHA, OSSA

Consensus Survey Comments
OSH: if remaining separate county based system, would be in favor. But do not want this idea to preclude exploring a more centralized state level system that may be able to better support/ensure available resources for Oregonians regardless of county.

NAMI: NAMI could only get to a "yes" if there is a true obligation to fully fund CMHPs to do this. To our knowledge, much of what's contained in CFAAs isn't adequately funded.

DRO: No, if it is increased supervision. Yes, if it is case management for voluntary services to get someone out of commitment.

OHA: Exists already

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, ODHS, OJD, OSSA, Tribes

No (0)

It Depends (3):
OSH, DRO, NAMI

OSH: Lots of support for the intention of the idea but again would take this a step further and argue for an overall more centralized accountability and coordination led at a state-level (OHA) to help ensure care for citizens regardless of county of residence.

DRO: No, if it is increased supervision. Yes, if it is case management for voluntary services to get them out of commitment.

NAMI: How would this be different to requiring the necessary services and supports for someone on outpatient commitment? Couldn't peer supports achieve this, per an earlier question?

Abstain (3):
OHA, OCDLA, ODAA

OCDLA: In general I think this is a good idea but my organization has nothing to do with funding of this type.

ODAA: Again, my organization is not versed in the financial configurations enough to give an adequate response.

35. Establish mechanisms to certify, monitor, and measure the performance of facilities where civilly committed individuals are placed to provide trauma-informed care

Recommendations Idea #: 47

Recommend this idea as currently drafted (2):
MOMI, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OJD, CCO

Would recommend this idea with specific changes to its wording (specify) (2):
OSH, NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OAHHS

Abstain (2):
OHA, OSSA

(ODHS skipped)

Consensus Survey Comments
OSH: due to current restrictions to populations being served at OSH, community-based facilities unexpectedly found themselves in a situation of attempting to serve a civil commit population they were not designed to serve for extended periods. Although the state may need to certify, monitor, and evaluate such sites, it will likely be overall more successful if there is some effort for the state to back up a step and invest energy and resources in supporting, helping fund training, and helping facilities adapt to meet the needs of this population (vs solely holding them accountable for something they were not originally intended to provide).

OAHHS: We are not recommending this idea at this time. We have many questions. Significant oversight already applies to hospitals.

NAMI: This is lacking in the type of specificity necessary to determine whether this would be helpful. How are facilities licensed now? Is those reviews, is this not an expectation when licensing and re-licensing? Facilities are already drowning in data reporting. If this is added, could it be coupled with a reduction elsewhere in data collection?

OJD: We think that there needs to be a consensus on what is trauma informed case

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, DRO, MOMI, OCDLA, ODAA, ODHS, OSSA, Tribes

No (1):
OHA

OHA: We would need to come up with a statewide understanding of what trauma-informed care is before imposing that on hospital systems. Various interpretations continue to exist and we'd all need to be on the same page.

It Depends (4):
OSH, OAHHS, OJD, NAMI

OSH: Oregon’s current circumstances (ie, court mandated use of OSH beds in a manner which prioritizes capacity restoration patients) leaves many civilly committed patients ultimately spending a significant amount of time during their commitment receiving care in settings that were never specifically designed or intended to meet the longer term needs of civilly committed patients. Although certifying, monitoring, and evaluating sites for trauma informed approaches to civil commitment care could have potential value, focusing on provision of support, training, and funding for adaptive implementation of evidence based, trauma informed care may yield more desirable outcomes.

OAHHS: We would like more information on this proposal.

OJD: Again, this will funding and a determination of who is responsible for each task.

NAMI: The state requires submission of a ton of data from providers already. This data may exist but are not being utilized. If such data aren't being collected, given the admin burden already on providers, any mechanisms should be potentially offset by loosening data requirements elsewhere.

Abstain (1):
LOC

XVII. Changes in Placement

36. Require OHA to develop more transitional care options to enable transfers of civilly committed individuals from inpatient treatment to a lower level of care when appropriate (e.g., licensed treatment homes, secured residential treatment facilities, and foster homes) (TOP 5 IDEAS OF CCO, OSSA)

Recommendations Idea #: 49

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, DRO, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OHA

Consensus Survey Comments
NAMI: Recommendation should recognize the historic investments already in the works and the Public Consulting Group report on treatment facility bed needs for behavioral health. Essentially, this recommendation as drafted is saying "need more," which is already a widely accepted position.

ODHS: pending funding, resources and capacity

DRO: This should already be done as part of discharge planning. Also, depends on whether there is advice of counsel (automatic rather than only upon request) for recertification, and whether or not the treatment would be voluntary.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH, OSSA, Tribes

No (1):
OHA

OHA: Seems that some energy could be directed at non-residential based transitional care options like IOP or PHP

It Depends (2):
DRO, NAMI

DRO: This should already be done as part of discharge planning. Also, depends on whether or not the treatment would be voluntary and predicated on advice of counsel prior to any recertification.

NAMI: Oregon is already trying to do this with the huge influx of new funding to develop capacity. What more can realistically be required? The Public Consulting Group analysis that will be issued in June should serve as the blueprint for what Oregon needs to invest in.

Abstain (0)

XVIII. Trial Visits

37. Revise statutes and rules to change the term "trial visits" to something that more clearly describes its function (e.g., less restrictive placement)

Recommendations Idea #: 50

Recommend this idea as currently drafted (6):
OSH, NAMI, MOMI, OJD, DRO, OSSA

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (0):

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OCDLA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (1):
CCO

Consensus Survey Comments
OCDLA: The trial visit process needs more clarification than just a name change. I would like clarification on when a trial visit should be offered (vs. the CMHP dismissing the commitment as soon as an AMIP is discharged from the hospital) and remedies and opportunities to challenge the decision to place an AMIP on a trial visit.

ODHS: am unclear the need to change the term. From the text in survey and in reviewing the Recommendations i still do not understand how this is not a trial visit that may be revoked. what is this trying to change or fix?

Recommendations Survey Results

Yes (12):
AOC, DRO, LOC, MOMI, NAMI, OAHHS, ODAA, OHA, OJD, OSH, OSSA, Tribes

ODAA: We're ambivalent about this and wonder if it is necessary. If others support it, then we'd be willing to have a discussion on what term to use.

No (1):
OHDS

ODHS: seems like it is a 'trial visit' in a less restrictive setting that could be removed if not successful. If it's a term that is well known and used, changing it to terms that are longer in phrase and don't accurately capture that it is truly a 'trial' may make communication and expectations more confusing. This can also be done without ORS changes as OARs can be amended to reflect 'trial visit means... xxx'

It Depends (2):
AOCMHP, OCDLA

AOCMHP: Trial visits are a known term and there is no need for disruptive change. Familiarity and recognition across systems are established and key with our high volume.

Abstain (1):
CCO

38. Amend statute to clarify the entity responsible for a civilly committed individual during a trial visit

Recommendations Idea #: 51

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OCDLA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)
0

Consensus Survey Comments
OCLDA: I generally do not support this idea, however it's possible that I could be brought on board with a lot of specifications and limitations on how the courts would be used. Certainly the providers and treatment teams should be having regular meetings, but given this is not a criminal justice tool a patient should not be regularly required to appear in court (which in of itself has no clinical benefit). The court could be used for changes in levels of care or as a last resort if there are issues with compliance and revocation is possible.

NAMI: NAMI could get to "yes" with clarity that this, indeed, is a problem that should be fixed.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH, OSSA, Tribes

No (0)

It Depends (2):
OHA, NAMI

OHA: It depends on what responsibility is being called out here -- payment, care coordination, Choice, placement, etc.?

NAMI: This is presuming such ambiguity exists. To the degree confusion exists, making it clear who is responsible would be a benefit.

Abstain (0)

XIX. Medication

39. Require providers to include the individual under civil commitment as much as possible in developing treatment plans, including medication options

Recommendations Idea #: 55

Recommend this idea as currently drafted (7):
OSH, NAMI, ODHS, OJD, DRO, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, MOMI, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
OAHHS: In hospitals, this is already occurring. If this idea does not apply to hospitals and is focused on settings outside of hospitals, we are open to considering the idea.

MOMI: Of course patient voice should always be heard, but it seems like this could create unnecessary barriers to appropriate treatment when a person is clearly no connected to reality and needs the provider to help them back to sanity. I'd hate to see this creating another excuse for the medical system to abandon people to "die with their rights on"

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, DRO, NAMI, OCDLA, ODAA, ODHS, OJD, OSH, OSSA

OSH: FYI: Steps to include the patient in the decision-making process around treatment (including fundamental elements of the capacity assessment that are derived directly from treatment planning discussion with the patient soliciting extensive detail about the patient's perspective and preferences) are already integrated into the involuntary treatment informed consent authorization process (at least within OSH process templates).

No (0)

It Depends (3):
OAHHS, LOC, MOMI

OAHHS: How would this proposal differ from current requirements?

LOC: Again, providers already do this. The implicit accusation that medical providers are defaulting to a traumatic paternalism is misguided.

MOMI: Well of course this seems logical...but the rationale behind this recommendation seems to be provider shaming and a denial of the realities of severe mental illness. The American Psychiatric Association provides best-practice guidelines for the provision of care to individuals with schizophrenia, including recommendations for whole-person care. Requiring providers to follow those guidelines seems like a great idea. It also seems like a great idea to require providers to have training in motivational interviewing to ensure they know HOW to try to collaborate with their patients who lack insight. The way this recommendation is written could create barriers to good medical care, in the opinion of families whose loved ones have died and/or gone to jail because doctors were too afraid to use evidence-based treatment options because the psychotic person "didn't want it."

Abstain (2):
Tribes, OHA

OHA: This is already a part of services and routinely reviewed at certifications.

40. Require providers, when possible, to consider alternative treatment options when a committed individual has valid reasons not to want an ordered medication

Recommendations Idea #: 56

Recommend this idea as currently drafted (5):
OSH, NAMI, OJD, DRO, OSSA

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (2):
ODHS, MOMI

Abstain (0)

Consensus Survey Comments
OAHHS: In hospitals, this is already occurring. If this idea does not apply to hospitals and is focused on settings outside of hospitals, we are open to considering the idea.

ODHS: I would expect providers to do this already... from the Recommendations it seems more conversation or a more detailed statement is needed before moving forward.

MOMI: This idea seems designed to handcuff providers from using evidence-based treatment.

OJD: We like the idea of training in motivation interviewing to ensure that providers know how to effectively collaborate with patients

Recommendations Survey Results

Yes (8):
AOC, AOCMHP, DRO, NAMI, OCDLA, OSH, OSSA, Tribes

OSH: FYI: This is already explicitly required and documented per the involuntary treatment informed consent authorization process (at least within OSH process templates)

No (1):
LOC

LOC: Same as above. The providers already do this.

It Depends (5):
OAHHS, ODAA, CCO, ODHS, MOMI

OAHHS: How would this proposal differ from current requirements?

ODAA: This requirement has the potential to require providers to justify their medical decision making with persons subject to civil commitment and would result in documentation on whether a person's reasons were valid. That would lead to litigation on the issue. We support having as much autonomy, engagement, and choice for individuals as possible but we should not require providers to explain their reasoning at length and to document their understanding of whether a person's reasons are valid.

CCO: The word "valid" is relative and would be very difficult to define, especially when someone is experiencing delusions and hallucinations...their perception of valid is different than the provider's perception.

ODHS: this is the same (in my interpretation) as item number 54.

MOMI: I'm not sure what a "valid reason" might be. If the individual has had good results with ECT, for example, and wants that instead of a generically prescribed anti-psychotic, then okay maybe. If the individual has a psychiatric advance directive describing alternative treatment modalities that work well for them, then maybe. However, this recommendation does not seem necessary to improve patient care. Instead, it feels like an attempt to shame doctors and make them avoid medicating a person at all costs. Laws and rules that make doctors afraid to treat is causing death for our loved ones.

Abstain (2):
OHA, OJD

OJD: We did not have the expertise to know what a 'valid' reason for an individual not wanting to take medication

XX. Recertification for Continued Commitment

41. Require OJD to collect data on individuals who are recertified more than once to identify that population's unique needs

Recommendations Idea #: 57

Recommend this idea as currently drafted (5):
OCDLA, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
ODHS: need to define the purpose and outcome intent of the data collection prior to collecting it

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OSH, OSSA, Tribes

DRO: We are in favor of gathering aggregate (anonymized) data that is subsequently made available to the public.

No (0)

It Depends (1):
OJD

OJD: We are not certain of the purpose of collecting this data is. If it is to develop better services/treatment for this population than we would agree.

Abstain (1):
NAMI

42. Amend statute to require court to appoint defense counsel as soon as possible in the recertification process (TOP 5 IDEAS OF OCDLA)

Recommendations Idea #: 59

Recommend this idea as currently drafted (5):
NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
OCDLA, OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
DRO

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

Consensus Survey Comments
OCDLA: Counsel should be appointed every time re-certification is sought, whether the AMIP protests or not.

OSH: Who/what determines how to define "as soon as possible"? What will qualify as a valid delay?

ODHS: seems similar to question #22 and making this the default response rather than 'as soon as possible' - they should have counsel immediately

DRO: Appointment of counsel should be automatic instead of predicated on whether or not the individual specifically requests counsel. Combine with #60.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, ODAA, ODHS, OHA, OJD, OSSA

DRO: Should be automatic. Should not be predicated on the individual having the wherewithal to request that counsel be appointed.

No (0)

It Depends (2):
OSH, OCDLA

OSH: How is "as soon as possible" defined? What qualifies as valid delays?

OCDLA: Counsel should be appointed every time recertification is sought, whether the AMIP protests or not. It wasn't clear if that was what was meant by "amend statute" but that's what I would support.

Abstain (1):
Tribes

43. Amend statute or rule to require that OHA notifies defense counsel and an ombudsperson when recertification is pursued (TOP 5 IDEAS OF DRO, OCDLA)

Recommendations Idea #: 60

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OSH, OAHHS

Would recommend this idea with specific changes to its wording (specify) (3):
ODHS, DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OHA

Abstain (1):
OSSA

Consensus Survey Comments
NAMI: NAMI could move to "abstain" or "yes" with greater clarity with how this compares with what is required currently.

ODHS: notice must be made immediately upon petition

DRO: Combine with #59 and also include the state P&A in notification requirements.

OHA: Ombuds not necessary to be notified

CCO: Unclear who is best to notify...the court or OHA but notification is a good thing.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, DRO, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH

DRO: ... and notify Disability Rights Oregon as the state P&A.

No (1):
OHA

OHA: OHA does not receive notice until a placement order is submitted. That would be far too late.

It Depends (3):
LOC, NAMI, OSSA

LOC: Defense counsel has to be appointed first. This is putting the horse before the cart.

NAMI: For recertification, is it required or expected that notification be made of the original defense counsel? If so, then it should be required. If not, what value does this add to the process if the person is going to be assigned another attorney?

OSSA: I would like to know more about the role of the ombudsman and their qualifications.

Abstain (1):
Tribes

XXI. Discharge and Dismissal

44. Require providers or treatment facility to include and involve individuals under civil commitment in discharge planning

Recommendations Idea #: 63

Recommend this idea as currently drafted (5):
NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
OSH, OAHHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
OSH: How would this monitoring occur and how would it be different from what is already standard practice? To what degree is the patient permitted to limit their own involvement should that be their preference?

OAHHS: Hospitals already do this. There are times when a patient who is civilly committed will refuse all placements. There should be a solution to that. An ombudsman or advocate may be able to assist the patient under civil commitment with discharge planning.

ODHS: this should allow the guardian of a person as well as any other officially appointed person to act in the best interest of the committed person if that person is unable to participate for any reason other than due to the MI

DRO: If the individual chooses to participate. However, discharge planning should not be dependent on the individual's participation (so failure to participate does not delay or disrupt discharge). Failure to consent to involuntary treatment should not be grounds to

decline housing services. Individuals should be advised of and assessed for all pertinent Medicaid programs prior to discharge.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, MOMI, NAMI, OCDLA, ODAA, ODHS, OJD, OSH, OSSA

OSH: FYI: What would monitoring process be that would enhance or ensure this beyond what already occurs as standard practice?

ODAA: "to the extent possible"

No (1):
LOC

LOC: This already happens. By definition the people being treated in this context are ill equipped to plan all alone.

It Depends (3):
OAHHS, DRO, OHA

OAHHS: Hospitals already do this. There are times when a patient who is civilly committed will refuse all placements. There should be a solution to that. An ombudsman or advocate may be able to assist the patient who is civilly committed with discharge planning.

DRO: If the individual chooses to participate. However, discharge planning should not be dependent on the individual's participation. Failure to consent to involuntary treatment should not be grounds to decline housing services. Individuals should be advised of and assessed for all pertinent Medicaid programs prior to discharge.

OHA: Sometimes an individual is unable to participate due to a variety of reasons, and clarity around that would be needed.

Abstain (1):
Tribes

45. Require state to create a funding stream to establish and maintain long-term and intensive treatment options for individuals upon dismissal of a civil commitment case (TOP 5 IDEAS OF OAHHS)

Recommendations Idea #: 64

Recommend this idea as currently drafted (5):
OCDLA, ODHS, MOMI, OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OHA

Consensus Survey Comments
NAMI: We already have the architecture for this, but it's underfunded and doesn't work even close to seamlessly. Placing a new "requirement" to do things the state is already supposed to be doing isn't going to address the actual problem. Alternate wording that recognizes this architecture (ie CCOs, CMHPs) and recommending contract enforcement (CCOs) and actual funding (CMHPs) would allow NAMI to likely move to "yes."

DRO: Isn't this Medicaid (assuming the services are voluntary)?

OHA: Choice covers this

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH, OSSA, Tribes

DRO: This is Medicaid (assuming the services are voluntary).

No (1):
NAMI

NAMI: We already have the architecture for this, but it's underfunded and doesn't work even close to seamlessly. Placing a new "requirement" to do things the state is already supposed to be doing isn't going to address the actual problem.

It Depends (0)

Abstain (1):
OHA

46. Require CCOs and counties to allocate, provide, and prioritize continuing support services after the civil commitment is dismissed, including robust community outreach, an accessible service network, and individualized treatment options that go beyond psychotropic medications

Recommendations Idea #: 65

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (3):
NAMI, DRO, OSSA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)
AOC,

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (0)

Consensus Survey Comments
NAMI: This already is in CCO contracts and in rule. So what more should be "required" when entities aren't doing what's already required? Instead, contracts should be enforced.

ODHS: if this were a voluntary option and the CCOs/CMHPs had funding for intensive case management and funding for resources that are needed then yes. That needs to be first; legislature allocating funding to meet this demand. AOCMPH also says they do this already so it's unclear what this is intending to accomplish

DRO: If voluntary.

OHA: Choice exists

OSAA: Strike "Counties" Counties aren't funded for this work.

Recommendations Survey Results

Yes (11):
AOCMHP, CCO, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSH, OSSA, Tribes

AOCMHP: We already do this.

OJD: with adequate funding

No (1):
AOC

AOC: Will require development of entirely new systems and would be very cumbersome to manage.

It Depends (4):
LOC, DRO, ODHS, NAMI

LOC: Sometimes psychotropic medications are the answer. Implying they are a reflex that necessarily does harm to the patient is misguided. That said, the constellation of services posited are obviously necessary.

DRO: If voluntary.

ODHS: with funding specifically allocated to this population

NAMI: This already is in CCO contracts and in rule. So what more should be "required" when entities aren't doing what's already required?

Abstain (0)

47. Amend statute or rule to designate which entity will re-enroll Individuals in the Oregon Health Plan immediately after discharge from civil commitment at OSH

Recommendations Idea #: 66

Recommend this idea as currently drafted (5):
OCDLA, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, ODHS, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
NAMI, OSSA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
NAMI: NAMI can get to "yet" if limited to amending rules, which would maximize flexibility to make changes as circumstances or best practices change.

ODHS: This should be permitted 90 days prior to release now. This suggests it will fall on OSH?

OSSA: Require OSH to re-enroll individuals as part of discharge.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSH, OSSA, Tribes

OAHHS: We answered yes, however, the timing for re-enrollment should be discussed. In our view, the statute or rule should be amended to designate which entity will enroll or

re-enroll an individual into the Oregon Health Plan prior to the patient being discharged from civil commitment at OSH.

AOCMHP: If this lands on the CMHP will there be resources provided to do this and easy access to the system through which this is done?

OHA: Rule.

No (1):
ODHS

ODHS: this doesn't need rule to implement and should already be in existence

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It Depends (1):
NAMI

NAMI: If by rule, this would be extremely helpful. If by statute, it may be too prescriptive. To change process if circumstances change would require passing a law.

Abstain (0)

48. Require state to fund support for non-Medicaid covered outreach services to individuals after dismissal of civil commitment case

Recommendations Idea #: 67

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, DRO

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (2):
OHA, OSSA

Consensus Survey Comments
NAMI: It's the Legislature's role to allocate funding, so the state cannot be "required" to do this. However, the recommendation can be targeted to the state investing in such services, which would permit such services to roll up in future budgets. This may be an appropriate "safety net" service that should fall on responsibility of CMHPs for individuals who don't have coverage or who have Medicare. It's questionable as to whether the state should underwrite such services for someone with commercial coverage.

ODHS: could this be an intent for working with CMS to get Medicaid funding for this if the person doesn't have private insurance? OHA indicates this is possible already. More discussion seems necessary

OJD: outreach services should be defined and the services should be voluntary

DRO: If voluntary. Try to utilize Medicaid - they will cover voluntary case management and outreach.

OHA: CFAA

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, OJD, OSH, OSSA, Tribes

DRO: If voluntary. Try to utilize Medicaid - they will cover (voluntary) case management and outreach.

OJD: outreach services needs to be defined

No (0)

It Depends (2):
ODHS, NAMI

ODHS: if a person has private insurance, why should general funds be used. Could ORS or federal rules be passed to require all insurance companies to provide this outreach?

NAMI: How do you "require" the state to do something that's a legislative function? If the recommendation is to invest in such services, then we do have examples where this is helpful and would benefit the state.

Abstain (2):
OHA, ODAA

OHA: Already possible.

49. Require OSH to notify the local CMHP when discharging an individual from civil commitment

Recommendations Idea #: 68

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
OSH, NAMI, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (1):
OHA

Consensus Survey Comments
OSH: Since currently the majority of civil commitment patients are not being treated at OSH, language should be modified to acknowledge the broader scope of potential treatment sites in the state that may be discharging a patient under CC.

NAMI: NAMI seeks more clarity on what is required currently and whether that is occurring, which would indicate that this is an OHA problem and not a statutory problem. With clarity, NAMI may be able to move to "yes" or "abstain."

ODHS: From Recommendations there seem to be several variables that require conversation.

DRO: If it is for voluntary follow-up services then we are in favor.

OHA: This is required

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSSA, Tribes

OAHHS: We answered yes, however, the timing should be discussed. In our view, OSH should be required to notify the local CMHP as soon as the patient is admitted to OSH to begin discharge planning. Discharge planning should be a collaborative process between OSH and the CMHP.

No (0)

It Depends (4):
OSH, DRO, ODHS, NAMI

OSH: Many civil commitment patients are discharging from other institutions (not OSH). So may need to modify language to reflect the array of relevant institutions.

DRO: Why? If it is for voluntary follow-up services then we are in favor.

ODHS: I am not following all of the communication threads between OJD, CMHP and OHA. Whomever is the 'record holder' of civil commitment data should be notified when a person is being discharged from OSH when they were under civil commitment. That entity should then help to coordinate any further communications

NAMI: Is this not already required? Shouldn't the CMHP be involved in the discharge planning? Or is the issue of involving the CMHP in a different community than the one in which the individual is committed?

Abstain (0)

50. Require OHA or CMHPs to track and report community-based supports provided to individuals following discharge and dismissal of commitment cases

Recommendations Idea #: 69

Recommend this idea as currently drafted (3):
OCDLA, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OSH, OAHHS, ODHS, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

Consensus Survey Comments
NAMI: NAMI could move to "yes" or "abstain" if it was clear as to which populations this applies. For Medicaid-covered individuals, doesn't this fall under the obligation of the CCO, for example?

ODHS: need to define intent/purpose of the data and have a consistent way to report and staff to analyze

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

Recommendations Survey Results

Yes (10):
AOC, DRO, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSH, Tribes

DRO: We are in favor of gathering aggregate (anonymized) data that is subsequently made available to the public.

No (1):
CCO

It Depends (4):
LOC, AOCMHP, ODHS, NAMI

LOC: This should already be accomplished by the EHR system. By enrolling the patients in medical coverage this information will necessarily be collected.

AOCMHP: Unclear how we would do this or who would do it - we have no involvement after discharge; more reporting burden, and what would the data be used for?

ODHS: Ideally this is the CMHP. But there then needs to be coordination between CMHP for people who move between QMHP catchment areas for aiding in transferring and communication

NAMI: Again, if discharged from commitment, services and the risk rest with the payer and their provider network. How is the state or CMHP to do this without impinging on the privacy of the individual? Why not put the onus on CCOs, for example, which bear some responsibility in contract for adults at risk of commitment?

Abstain (1):
OSSA

51. Require OHA or CMHP to provide notice of discharge from commitment to the individual's legal counsel

Recommendations Idea #: 70

Recommend this idea as currently drafted (5):
OCDLA, MOMI, OJD, DRO, OSSA

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OSH, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (2):
NAMI, ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OAHHS

Consensus Survey Comments
NAMI: NAMI can move to "yes" or "abstain" if notice required the permission of the individual. Absent some compelling reason, being discharged from civil commitment

doesn't require legal representation, so notice should be at the patient's discretion outside of medically necessary communications and transition planning.

ODHS: only if there continues to be an existing attorney unless the law offices of every attorney wants this data

Recommendations Survey Results

Yes (10):
AOC, CCO, DRO, LOC, MOMI, ODAA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (5):
OAHHS, OHA, OCDLA, ODHS, NAMI

OAHHS: We would like information on the problem this proposal intends to address.

OHA: If an attorney were still assigned, sure. But many times attorneys have dropped off by the end.

OCDLA: Yes, and an opportunity to contest the discharge should be made available.

ODHS: only if there is an existing legal counsel

NAMI: What purpose does this serve? Unless there's a responsibility of legal counsel to ensure services post-commitment, there isn't a clear compelling interest to notify counsel.

Abstain (1):
OACMHP

52. Require OHA to amend County Financial Assistance Agreements to require and fund outreach services to individuals (and to their families and natural supports) who have been subject to multiple notices of mental illness without a commitment

Recommendations Idea #: 72

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OSSA

Would recommend this idea with specific changes to its wording (specify) (1)
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OSH

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
NAMI

Abstain (3):
OCDLA, ODHS, OHA

Consensus Survey Comments
OSH: support this if remaining a county-based set of systems. But again do not want this to preclude the exploration of a more centralized state-level system which may be positioned to better support/fund outreach, etc., even within lower resource areas of the state.

NAMI: This idea isn't suitable without much greater discussion and more elaboration on how and when this would apply.

DRO: Families and "natural supports" are not entitled to legal and/or medical information. For some individuals, releasing this information could be traumatic, dangerous, or damaging to natural support relationships. Outreach services could be overly intrusive and possibly triggering to individuals experiencing mental health issues (and PTSD or similar from involuntary treatment/holds). We are in favor of OFFERING voluntary services at the initial point of contact. Resources should be offered to the individual directly as needed.

OHA: Already covered in CFAA

Recommendations Survey Results

Yes (9):
AOC, CCO, LOC, MOMI, OAHHS, ODHS, OJD, OSSA, Tribes

No (1):
DRO

DRO: Families and "natural supports" are not entitled to legal and/or medical information. For some individuals, releasing this information could be traumatic or dangerous or damaging to natural support relationships. Outreach services would be overly intrusive at this point for individuals and possibly triggering to individuals experiencing mental health issues. Could OFFER services at initial point of contact. Resources should be offered to the person directly as needed.

It Depends (1):
OSH, AOCMHP, NAMI

OSH: Again, recommend going a step further with this and restructuring to a state level (OHA) centralized system vs piecemeal distributions to individual counties with limited accountability.

AOCMHP: This system of care doesn't exist yet. Unclear what outreach would occur in this situation. A person who is not civilly committed has a right to autonomy.

NAMI: Again, when other payers bear the financial risk and responsibility to provide and pay for similar services, why create yet another mandate? If the only purpose is to create another mandate because the current one isn't working, then this isn't helpful. If it's to provide similar services to individuals without coverage, then this should be "invest" and not "require." There's a ton "required" in CFAAs; yet, most of those requirements aren't funded.

Abstain (3):
OHA, OCDLA, ODAA

OHA: Already in CFAA

53. Require OHA to collaborate with tribes before discharging a tribal member from commitment with adequate time to plan for care coordination

Recommendations Idea #: 73

Recommend this idea as currently drafted (5):
NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OAHHS

Would recommend this idea with specific changes to its wording (specify) (2):
OSH, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OHA, OSSA

Consensus Survey Comments
OSH: what mechanisms determine if an individual's relationship with the tribe warrants this level of formal tribal involvement and information disclosure?

DRO: If desired by the individual, could notify the tribal mental health authority.

OHA: Already in rule

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSSA, Tribes

AOCMHP: We would also reach out to the tribes to collaborate. Tribes should be involved in discharge planning for their tribal members

No (0)

It Depends (2):
OSH, DRO

OSH: How/who determines if the individual's relationship with a tribe warrants this level of involvement?

DRO: If voluntary, could notify tribal mental health authority.

Abstain (1):
OHA

54. Require OHA or CMHP to provide all notices of discharge from commitment with enough time to coordinate care

Recommendations Idea #: 74

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OSH, OAHHS, OHA, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (3):
OCDLA, ODHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
The AMIP should have an opportunity to contest the discharge.

OSH: who will decide how long is reasonable to continue holding a "discharge-ready" patient in a highly restrictive setting when resources (outpatient care, appropriate housing, etc) are not available for an unpredictable length of time? If this requirement is in place, what happens on the occasion that the court does not renew a civil commitment and the facility is expected to immediately discharge the person?

ODHS: support this concept but there are a lot of comments that it seems like need additional discussion

OJD: We agree with many of the comments that this be done in such a way as to slow down the discharge process

DRO: No, if "enough time to coordinate care" slows down the discharge process. Yes, if it is requiring more and timely communication and planning.

Recommendations Survey Results

Yes (8):
AOC, LOC, MOMI, OAHHS, ODHS, OJD, OSSA, Tribes

No (1):
OHA

OHA: Many clients do not want after care. This could also hold up bottlenecks getting into facilities.

It Depends (7):
OSH, AOCMHP, DRO, OCDLA, ODAA, CCO, NAMI

OSH: How is the amount of adequate time determined? It may be unpredictable/ variable depending on individual patient and county. If care resources are limited or unavailable, for what duration is it reasonable to continue holding a “discharge-ready” patient? Although perhaps not frequent, there can be cases where a court dismisses the commitment and legally the patient must be immediately discharged.

AOCMHP: This question does not make clear who is being required to provide information and to whom.

DRO: No, if "enough time to coordinate care" slows down the discharge process. This would only be acceptable if it requires more and timely communication.

OCDLA: An opportunity to contest the discharge should be provided.

ODAA: This timeline could vary significantly from case to case. Mandating a timeline might not work.

CCO: These notices would also require hospitals to coordinate with either OHA and CMHPs to allow for time to coordinate care.

NAMI: Coordination of care should happen well before a notice of discharge occurs. Notice alone won't fully address the concern that's trying to be addressed here. What would be helpful is ensuring coordination of care occurs well before notices.

Abstain (0)

55. Amend OHA contracts to specify who should be notified and when they should be notified of an individual’s discharge from civil commitment

Recommendations Idea #: 75

Recommend this idea as currently drafted (3):
ODHS, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
DRO, CCO

Consensus Survey Comments
OAHHS: This concept is not clear. What is the role of OHA contracts in accomplishing this objective? Should OHA be making the notifications or the counties?

NAMI: NAMI would move to "yes" if this was also established in rule, which requires a public process and public input.

DRO: I don't understand what exactly the contracts are and who the contracts are with and what is currently contained in them. I don't think we oppose this, but not sure what it entails. Without further clarification I would need to abstain.

Recommendations Survey Results

Yes (11):
AOC, CCO, LOC, MOMI, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (4):
OAHHS, AOCMHP, DRO, NAMI

OAHHS: This concept is not clear. What is the role of OHA contracts in accomplishing this objective? Should OHA be making the notifications or the counties?

AOCMHP: Question is unclear.

NAMI: This should encompass both rules and contracts.

Abstain (1):
OCDLA

XXII. Data Sharing and Confidentiality (Case Management)

56. Establish or expand mandatory training on HIPAA for investigators and treatment teams that focuses on what can be shared and when (rather than just what cannot be shared) with family members, natural supports, courts, and others with an interest in the civil commitment case

Recommendations Idea #: 77

Recommend this idea as currently drafted (6):
NAMI, ODHS, MOMI, OJD, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, DRO, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
OAHHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OSH

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
OSH: Ideally this would be a component of a more comprehensive, consistently taught curriculum re: civil commitment (including for investigators).

OAHHS: This idea is focused on training. Would training solve the problem? Does the idea include changing Oregon law to adjust the standard of what can be shared and who can receive the information? Federal law will also apply.

DRO: Who is doing the training? What are the goals of disclosure and to whom are they being made? This would need to be a balanced training on HIPAA by legal professionals, with an emphasis on both what can AND cannot be shared.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

OSH: Ideally this should be a component of a more comprehensive, consistently taught curriculum re: civil commitment in Oregon for investigators.

No (0)

It Depends (2):
OAHHS, DRO

OAHHS: How would this proposal change current law?

DRO: Who is doing the training? What are the goals of the disclosures and to whom are they being made? Should be a balanced training on HIPAA by legal professionals.

Abstain (0)

57. Establish a statewide system for tracking civil commitment to improve data sharing and standardization of care across counties

Recommendations Idea #: 79

Recommend this idea as currently drafted (4):
NAMI, ODHS, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (7):
OCDLA, OSH, OAHHS, DRO, OHA, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
DRO: There is a great risk that this becomes overly prejudicial and of disparate impact with individuals from marginalized communities. Would it only be for actual commitments? Who would have access to this system? Including defense counsel?

Recommendations Survey Results

Yes (15):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (1):
DRO

DRO: This is overly prejudicial (see answer 78).

It Depends (0)

Abstain (0)

58. Explore use of psychiatric advance directives to facilitate needed information exchange and storage

Recommendations Idea #: 80

Recommend this idea as currently drafted (4):
NAMI, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (6):
OCDLA, OSH, OAHHS, ODHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
OSH: warrants discussion/exploration but currently unclear exactly how this would be utilized under circumstances where patient revokes it in the moment.

ODHS: May need language on when/how these can be revoked especially when a person is experiencing a MI

DRO: Explore the use of psychiatric advance directives to increase the voices and power of individuals with lived experience. (In other words... I do not understand what "information exchange and storage" entails, but focus should be on individual expressing their preferences for care.)

Recommendations Survey Results

Yes (12):
AOC, CCO, MOMI, NAMI, OAHHS, OCDLA, ODHS, OHA, OJD, OSH, OSSA, Tribes

OSH: Agreement primarily due to term "explore" in the idea (otherwise a lot of debate around exactly what the potential is for psych adv directive to have a viable, durable role under such circumstances as civil commitment)

No (0)

It Depends (3):
AOCMHP, DRO, ODAA

AOCMHP: This procedure would not result in better care. Individuals in psychiatric states tend to rescind their advanced directives.

DRO: Yes, explore the use of psychiatric advance directives to increase the voices and power of people with lived experience.

ODAA: These documents are very easy for an individual to revoke. That needs to be addressed before they can be effective.

Abstain (1):
LOC

XXIII. Data Collection, Analysis, and Reporting (Policy)

59. Collect and analyze socioeconomic data about individuals in the civil commitment process

Recommendations Idea #: 83

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OSSA

Consensus Survey Comments
ODHS: all data comments need intent and outcomes to be defined first

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

Recommendations Survey Results

Yes (13):
AOC, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

OJD: same questions as to who collects and whether there is funding

No (0)

It Depends (3):
AOCMHP, CCO, NAMI

AOCMHP: Who will collect this data? Some of this data already exists for OHP clients.

CCO: Who would be collecting and analyzing this data and would it cause more admin burden for the CMHPs?

NAMI: Again, we are awash in data. Where responsibility resides is just as important as the idea, which has merit.

Abstain (0)

60. Collect and analyze data on individuals who have engaged in the civil commitment process more than once, including the number of individuals with multiple engagements, the period of time between engagements, the number of times those individuals were engaged in the civil commitment system, and the reasons for the repeat engagements

Recommendations Idea #: 84

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (6):
OCDLA, OSH, OAHHS, ODHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
NAMI, DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
OCDLA: It should also include individuals who have been involved in the .370 system in addition to commitment.

NAMI: NAMI would like clarity as to whether this data already exists. Presumedly, OHA was collecting this when interacting with the U.S. DoJ during the Olmstead agreement period.

ODHS: need to define purpose and outcome of data and how/how this will be collected. Data is always good as long as there is intent and purpose

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

CCO: Not sure WHO would be doing this based on how it is written but the concept is good.

Recommendations Survey Results

Yes (13):
AOC, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

OCDLA: It should also include individuals who have been involved in the .370 system in addition to civil commitment.

No (0)

It Depends (3):
AOCMHP, CCO, NAMI

AOCMHP: Yes, as long as OHA is using the reports we are already submitting to analyze the data and providing information back to the CMHPs about this. No, if this is another report the CMHP is required to submit on top of MOTS and other reporting requirements. It also depends on what will be done with the data.

CCO: I am pretty sure OHA has this data now so would this be different than what exists already?

NAMI: Presumedly, OHA was monitoring this under its Olmstead agreement with the U.S. DoJ. Are they still doing so? Per previous comments, where this responsibility resides is critical to judge whether this is a good idea.

Abstain (0)

61. Collect and analyze quantitative and qualitative data on individuals with traumatic brain injuries and dementia that were subject to NMIs, including the number of NMIs and number committed under ORS chapter 426 or 427 (TOP 5 IDEAS OF ODHS)

Recommendations Idea #: 86

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (2):
DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
OAHHS, NAMI

(ODHS skipped)

Consensus Survey Comments
ODHS: data is good. What is purpose and intent? for ORS427 there will not be data regarding TBI/AQI, dementia, autism etc. as only people with IDD could be committed. Unclear if the data will align across 427 and 426

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

CCO: Again, not sure WHO would be doing this, so that would need to be specific. Good concept.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, OSH, OSSA, Tribes

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

No (0)

It Depends (5):
OHA, OJD, CCO, ODHS, NAMI

OHA: Depends on which entity is tasked with this -- APD, BH, IDD?

OJD: What are we analyzing the data for - if it is to determine and increase appropriate treatment then it is a good idea.

CCO: Is this different than the data we have now on 426 and 427? If so then what would it be used to accomplish?

ODHS: ORS427 likely won't provide good data as it is only for people with intellectual disabilities not necessarily those with TBI/AQI

NAMI: Nice data to have. Where responsibility resides is just as important as the idea.

Abstain (0)

62. Collect data to compare and report the types, quantity, and outcomes of treatment and services provided by counties to civilly committed individuals

Recommendations Idea #: 87

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, ODHS, OHA

Would recommend this idea with specific changes to its wording (specify) (3):
NAMI, DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

Consensus Survey Comments
NAMI: NAMI seeks clarity as to whether this data is already collected.

ODHS: data is good - need intent and purpose. how will data be used and who is doing the analysis?

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

CCO: Again, specify the WHO that would be doing this. Concept is good.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

OJD: If this is being used to identify and fill in treatment gaps in local communities it will be helpful

No (1):
CCO

It Depends (2):
NAMI, OSSA

NAMI: s this not collected already? Is the issue the data aren't retrievable in a manner that's actionable?

OSSA: Similar to question 82. Rural counties have the same needs as metro, but do not receive the funding to provide the same programs.

Abstain (1):
Tribes

63. Research civil commitment systems in other states and other parts of the world

Recommendations Idea #: 88

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (3):
OSH, DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)
AOC,

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (1):
NAMI

Consensus Survey Comments
OSH: this has been done on multiple occasions by multiple groups over the past decade. Would recommend including a requirement for current data to be collected in a transparent manner and centrally stored and made publicly accessible for shared use.

ODHS: for what purpose? who would do this?

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

CCO: Specify the WHO that would be doing this. Excellent concept.

Recommendations Survey Results

Yes (10):
AOC, AOCMHP, CCO, DRO, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

No (0)

It Depends (4):
LOC, ODHS, OSH, OSSA

LOC: We should always try to assess best practices being used elsewhere. Oregon has a bad track record of getting stuck in the let's study phase and we should be wary of falling into that trap again.

ODSH: only if there is a position offered for this work. otherwise Oregon can do what Oregon feels is appropriate and is voted upon by legislators and Oregonians

OSH: This has already reportedly been done multiple times over recent years during various iterations of efforts to improve the civil commitment system. So perhaps the task here is to ensure the results of the investigation be compiled in a formal report and made readily accessible to avoid needing to start from scratch.

OSSA: Other states, yes, the rest of the world might be troubling. The rights of Americans are likely more robust than those of citizens of other countries.

Abstain (2):
Tribes, NAMI

64. Analyze CCO claims data to determine if individuals with co-occurring mental illness and intellectual disabilities are placed in emergency departments for longer than average period of time

Recommendations Idea #: 89

Recommend this idea as currently drafted (3):
NAMI, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
DRO, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (3):
OSH, OAHHS, OSSA

(ODHS skipped)

Consensus Survey Comments
ODHS: agree with NAMI's comment on Recommendations - if this is a one-time exercise, what would we do with the data? this is also a capacity issue with access to long term care services for IDD rather than a need for ER tx. The variables seem risky but a one time analysis would be interesting. again though, what would we do with the data?

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

CCO: Specify the WHO.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, DRO, LOC, MOMI, NAMI, OCDLA, ODAA, OHA, OJD, OSSA

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

OJD: We would need clarification the purpose of the data collection and ionfomation on who will collect it

NAMI: This should be a one-time exercise with updates on some regular cycle.

No (1):
ODHS

ODHS: This is not dependent on civil commitments... it is most likely a capacity issue. In ICD-10 data discussions, it's clear that there are not clear codes in claims that indicate if

a person has an intellectual disability. the outcome for this research seems very far away from civil commitments - although it would still be interesting.

It Depends (2):
OAHHS, CCO

OAHHS: What is the objective of the analysis? A robust continuum of care outside of hospitals needs to be created.

CCO: I am pretty sure we already know that this is true so what would be the reason to analyze this data? for the sake of funding? if so then yes

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Abstain (2):
OSH, Tribes

XXIV. Rights of Individuals in Civil Commitment System

65. Require Oregon Public Defense Services to educate defense lawyers on effective representative of person with mental illness who do not want to be committed

Recommendations Idea #: 90

Recommend this idea as currently drafted (4):
NAMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OSH, OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
ODHS, OSSA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OCDLA

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
MOMI

Abstain (0)

Consensus Survey Comments
ODHS: I can get to a yes if there is discussion on intent behind this and if it would be a continuous education or continuing ed expectation. A one-time training does not seem useful or beneficial over time

MOMO: Defense lawyers are already doing way too good a job at getting people out of care and back onto the streets to die with their rights intact. There is not a lack of "training" about how to ensure the voice of a psychotic person wins their "freedom" to fail and die.

OSSA: I have real concerns about the ability to achieve this right now. The defense attorney shortage is real. Suggest change to "provide" training and not require, at least for now.

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, MOMI, NAMI, OAHHS, OCDLA, ODAA, OHA, OSH, OSSA, Tribes

NAMI: If this isn't already a requirement of someone doing civil commitment defense, it should be.

No (1):
ODHS

ODHS: This would require ongoing and consistent training/education for all DA's. the benefit is not identified here. thus a no

It Depends (2):
LOC, OJD

LOC: That is already occurring. The attorneys who represent these patients/clients are required to educate themselves to a constitutionally firm standard.

OJD: This sounds like something that could be provided through OSB and should be part of a broader training on how to incorporate the principles of procedural justice into representation

Abstain (0)

66. Amend rules to establish a process that supports individuals and families to access advocates, including patient advocacy organizations, legal advocates, and peers

Recommendations Idea #: 93

Recommend this idea as currently drafted (4):
NAMI, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, ODHS

Would recommend this idea with specific changes to its wording (specify) (2):
DRO, OHA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

Consensus Survey Comments
ODHS: Recommend the concept pending privacy concerns are addressed and clarification on who is responsible is provided.

DRO: Resources for individuals would be great, but serious privacy concerns exist if including families without the consent of the individual.

OHA: Remove families

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODAA, OHA, OJD, OSH, OSSA, Tribes

AOCMHP: Who would be responsible? Court or CMHP?

No (0)

It Depends (3):
DRO, ODHS, NAMI

DRO: Resources for the individuals are great, but serious privacy concerns exist if including families without the consent of the individual.

ODHS: I am not following why this needs to be a rule

NAMI: It's hard to see where this responsibility would reside. But in concept, it would be helpful. We get a significant number of queries from family members for whom the commitment process is a mystery and typically cuts them out of the investigation, treatment planning, discharge planning, and other activities where family input and participation could be helpful.

Abstain (0)

XXV. Funding System

67. Amend statute to require state agencies and counties to track and report the use and outcomes of designated behavioral health funding

Recommendations Idea #: 94

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
OSSA

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
ODHS: would recommend much more discussion on all of the data is kept locally at CMHPs, at courts and at OHA

OSSA: Strike "counties"

Recommendations Survey Results

Yes (13):
AOCMHP, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (1):
AOC

AOC: Depends on way it is provided for. Excess reporting requirements can be a drain on resources unless careful.

Abstain (2):
CCO, NAMI

68. Create a funding structure for civil commitment that incentivizes communities to apply best practices and evidence-based interventions for justice-involved individuals, including an outreach component

Recommendations Idea #: 95

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (6):
OSH, OAHHS, DRO, OHA, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (1):
OCLDS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
ODHS

Abstain (1):
NAMI

Consensus Survey Comments
OCDLA: It's not clear what this means. Evidence based practices should be incentivized for all people in the civil commitment system, justice involved or not.

ODHS: Support an incentive-based concept for communities figuring out how to support people effectively in their communities.

DRO: Unclear what this means... is it a backdoor monitoring tool for tracking people after the term of civil commitment ends?

OSSA: A funding structure that appropriately supports the needs of communities would in itself lead to best practices and evidence-based interventions. The way this reads makes me think of how unfair it is to dangle a carrot in front of someone who is already starving.

Recommendations Survey Results

Yes (10):
AOC, CCO, LOC, MOMI, OAHHS, OCDLA, ODHS, OJD, OSH, OSSA

No (1):
DRO

DRO: Unclear what this means... is it a backdoor monitoring tool for tracking people after the term of civil commitment?

It Depends (3):
AOCMHP, OHA, ODAA

AOCMHP: Unsure what the mechanism would be and certainly skeptical of a market-driven solution, but appreciate the goal.

OHA: Civil commitment is primarily not about the criminal legal system. Incentives should be provided for community-based civil commitment before looking elsewhere.

ODAA: Any model here would need to be efficient and structured to support the system, adhering to evidence based practices, not as a tool for advocacy or innovation.

Abstain (2):
Tribes, NAMI

69. Research creative ways that other states have used Medicaid for housing and other needs of civilly committed individuals

Recommendations Idea #: 96

Recommend this idea as currently drafted (3):
MOMI, OJD, OSSA

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (2):
ODHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)
AOC,

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
ODHS: Civil commitments violates HCBS services (not voluntary if civilly committed). Recommend researching creative ways that other states have FUNDED housing and other needs of civilly committed individuals

DRO: This violates Medicaid under the "Settings Rule" -- doesn't make sense to research it if it is in violation of federal law. However, could agree if it was researching the types of funding other states have utilized to provide housing and other services to civilly committed individuals.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, Tribes

No (1):
DRO

DRO: No, this violates Medicaid under the "Settings Rule."

It Depends (1):
LOC

LOC: Again, let's not get caught standing flat on our feet by studying and never doing anything.

Abstain (2):
NAMI, OSSA

XXVI. Transportation

70. Clarify in statute or rule who is responsible to pay for secure transport of individuals in the civil commitment process and the amount of reasonable compensation for that service

Recommendations Idea #: 97

Recommend this idea as currently drafted (6):
OSH, ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)

Consensus Survey Comments
NAMI: NAMI can support if the recommendation is clear that the individual cannot be charged in any way for transport. We're currently running into issues where people transported by ambulance on a hold are being charged for the ambulance service, and their bills are being sent to debt collection. We would recommend statute be amended to address that circumstance, as well.

Recommendations Survey Results

Yes (15):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (1):
NAMI

NAMI: For someone who is committed, the state via OHA should be responsible for all costs. That could be through CFAAs or directly. But, ultimately, the person is committed to state care. The state must figure out ways to provide that care, including transportation, unless it's a service that's also reimbursable.

Abstain (0)

XXVII. Liability

71. Assess the types and level of concern about different areas of liability in the civil commitment system

Recommendations Idea #: 98

Recommend this idea as currently drafted (4):
OCDLA, NAMI, ODHS, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OSH, OAHHS, OJD, OHA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (2):
MOMI, DRO

Abstain (1):
OSSA

Consensus Survey Comments
MOMI: too vague and broad, should not be a priority recommendation

OJD: we think that this is going to require a bigger discussion, but it does need to be addressed at some point

DRO: Counties should already be assessing their own liabilities, so it seems like a waste of time and resources. We are not in favor of an increase in additional immunity. Current statutory protections are adequate.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, OHA, OSH, OSSA

No (1):
DRO

DRO: Counties should already be assessing their own liabilities, and we are not in favor of additional immunity.

It Depends (2):
ODAA, ODHS

ODAA: This is a discussion that would require a lengthy focused discussion. We need providers to feel safe to talk about their specific issues and for individuals to bring forward concerns that they sense. From ODAA perspective, we don't participate in many liability related discussions the current protections in statute are adequate for us and our law enforcement partners.

ODHS: it's not clear what existing challenges or gaps there are in the current ORS protections. Examples and discussion would help with this yes/no vote.

Abstain (1):
Tribes

(OJD skipped): We need more information but think that the issue of liability needs to be directly addressed

72. Require institutions caring for individuals under civil commitment to hold regular morbidity conferences and encourage learning from mistakes instead of withholding information because of liability concerns

Recommendations Idea #: 99

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OCDLA, OSH, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
ODHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OSSA

(OAHHS skipped)

Consensus Survey Comments
OAHHS: We are not recommending this concept at this time as currently drafted. Hospitals already review cases to learn from them and have processes that are followed to do so.

ODHS: this is a slippery slope but i can support a 'yes' with more planning and discussion of how the negative outcomes and data would improve care/services

DRO: We would want this to be public information (after anonymization). What is the oversight mechanism to ensure compliance? How frequent? Monitoring? Consequences of non-compliance?

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OCDLA, ODAA, OSH, OSSA, Tribes

OSH: In most institutions is being implemented due to Joint Commission requirements.

DRO: Would this be public information (after anonymization)? What is the oversight mechanism to ensure that policies and incidents are actually reviewed and responded to with regularity?

No (1):
ODHS

ODHS: Let's focus on what's working well and how to duplicate those efforts rather than spending time and money continuing to discuss what is not working

It Depends (3):
OAHHS, OHA, OJD

OAHHS: Hospitals already review cases to learn from them and have processes that are followed to do so.

OHA: who is responsible for organizing, coordinating these?

OJD: Yes with institutions having confidentiality or something that doesn't allow the results of the morbidity conference from being used to establish liability

Abstain (1):
NAMI

XXVIII. Provider Safety

73. Provide training and education on vicarious trauma to staff of residential treatment facilities, acute hospitals, and OSH

Recommendations Idea #: 100

Recommend this idea as currently drafted (4):
MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OAHHS

Would recommend this idea with specific changes to its wording (specify) (1):
ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
OSH

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (3):
NAMI, OHA, OSSA

Consensus Survey Comments
OSH: centralize the process at a state-level (while also collaborating with counties to help ensure unique population factors are covered) to help provide more consistency in quality and content of training across counties.

ODHS: Concept is well intended. Need clarification on who is responsible for this, who is evaluating effectiveness of training and if there's an allegation or complaint who and how it is determined that the person was appropriately trained. Could benefit from being written similar to next item; (Idea 101)

OHA: can go into contract

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, DRO, MOMI, OAHHS, OCDLA, ODAA, OJD, OSSA, Tribes

No (1):
OHA

OHA: This should be a part of the certification/license process

It Depends (2):
OSH, ODHS

OSH: If done, would centralize the process at state-level so that there is consistency in quality and content across all counties.

ODHS: The expectation needs to be on residential treatment facilities, hospitals and OSH to incorporate the education and training

Abstain (2):
LOC, NAMI

74. Require residential treatment facilities, acute hospitals, and OSH to provide situational training for staff to recognize when a situation is becoming unsafe

Recommendations Idea #: 101

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OCDLA, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OSSA

(OAHHS skipped)

Consensus Survey Comments
OSH: can the language clarify if this is simply something the state will monitor that institutions are doing via the institution's own programming? vs. the state providing criteria as to what the training must include? vs. the state providing a standardized training?

OAHHS: How would this change current legal requirements?

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

OSH: Would this be additional standardized training from the state to complement what institutions already do individually? Or simply having a mechanism facilities and institutions to confirm to the state they are providing institution-specific safety training?

No (0)

It Depends (1):
OAHHS

OAHHS: How would this change current legal requirements?

Abstain (1):
NAMI

XXIX. Collaboration with Oregon Tribes

75. Require the state to seek input from tribal governments and treatment providers on the civil commitment system, including AOT

Recommendations Idea #: 103

Recommend this idea as currently drafted (8):
OCDLA, OSH, ODHS, MOMI, OJD, DRO, OSSA, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (2):
OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
ODHS: Following the tribal consultation guidelines may be useful

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (1):
ODAA

ODAA: At what level? Policy making, or individual treatment plans?

Abstain (1):
NAMI

76. Amend statute to require OHA and OJD to consult with the tribe of a tribal member who becomes subject to civil commitment proceedings to ensure compliance with relevant laws and coordination of resources

Recommendations Idea #: 104

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OSH: Would this effectively be analogous to the type of communication that occurs between OHA/OJD and a county when a county's resident is subject to civil commitment proceedings? Or are there unique questions/collaborations that are being pursued within this consultation process?

ODHS: Need to consult with the tribes on this item. What would the tribes want and how involved would they want family members to be if it isn't the alleged person with MI asking for a family member to be included. likely this is a good thing but more discussion with the tribes is needed

DRO: With sufficient privacy protections, and with individual agreement to tribal involvement and notification.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, LOC, MOMI, OAHHS, OCDLA, ODHS, OJD, OSH, OSSA, Tribes

OSH: Would this effectively be analogous to the type of communication that occurs between OHA/OJD and a county when a county's resident is subject to civil commitment proceedings? Or are there unique questions/collaborations that are being pursued within this tribal consultation process?

No (1):
OHA

OHA: the process moves too quickly for this. investigators are already required to coordinate with tribes in the investigation period

It Depends (3):
DRO, ODAA, CCO

DRO: With sufficient privacy protections, and with individual agreement to tribal involvement and notification.

ODAA: If there is time and the tribe can respond. But a CC can't be delayed because a tribe needs more time unless the individual agrees and good cause set over is still allowed.

Abstain (1):
NAMI

77. Amend rules to require CMHP directors to consult with the Oregon Tribe of a tribal member in the civil commitment system to improve compliance with existing rules concerning collaboration and information-sharing with tribes

Recommendations Idea #: 106

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (4):
OCDLA, OSH, OAHHS, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OSSA

Consensus Survey Comments
ODHS: Same comment as in 77

DRO: If agreed to by the individual.

Recommendations Survey Results

Yes (10):
AOCMHP, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSSA, Tribes

No (1):
OHA

OHA: If it is required it should be between tribes and a statewide agency or organization.

It Depends (4):
OSH, AOC, DRO, CCO

AOC: Needs to be implemented in a way where these can be streamlined conversations. But support if that can be done.

DRO: If agreed to by the individual.

CCO: If the CMHP has a database to look at to determine if a person is enrolled in a tribe, then yes. Otherwise, it is very difficult to know and often based on whether the person can articulate this themself or not.

Abstain (1):
NAMI

78. Amend rules to allow tribes to participate in civil commitment proceedings involving tribal members, similar to a child welfare case

Recommendations Idea #: 107

Recommend this idea as currently drafted (5):
NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (1):
OSH

Would recommend this idea with specific changes to its wording (specify) (2):
OSH, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (3):
NAMI, OHA, OSSA

Consensus Survey Comments
OSH: To what degree might an individual have a say in who from the tribe is involved or does it default to a specific tribal member position? (Is this analogous to how county personnel may be involved in non-tribal adult cases?) Either needs further explanation as to why this is appropriate or a different analogy than child/minor should be used for why an adult tribal member is essentially being granted the rights of a minor vs an adult.

DRO: If agreed to or requested by the individual.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODHS, OJD, OSSA, Tribes

No (1):
ODAA

ODAA: It's not clear to me that the tribe has standing. Adding another entity in the hearing will create an additional layer of complexity and would require some direction for the tribe. Is it there to advocate for the tribe? For the person? To act as an examiner? To answer questions to the court? Without tribes asking for this, we shouldnt take it up.

It Depends (2):
OSH, DRO

OSH: Who specifically from Tribe? To what degree might an individual have a say in who from the tribe is involved or does it default to a specific tribal member position? Analogous to how county personnel may be involved in non-tribal adult cases?

DRO: If agreed to or requested by the individual.

Abstain (0)

(OHA skipped): adults have different level of decision making and autonomy than a youth does and the state should not further restrict them

XXX. Equity

79. Require the state to address inequities resulting from variations in first responder responses by establishing standards and training for law enforcement and other first responders on where to take a person who is experiencing a mental health crisis

Recommendations Idea #: 108

Recommend this idea as currently drafted (2):
MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OHA, CCO

Would recommend this idea with specific changes to its wording (specify) (2):
ODHS, DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (1):
NAMI

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
OSSA

Abstain (0)

Consensus Survey Comments
NAMI: A more specific approach may be to partner with the CIT Center of Excellence at DPSST before prescribing a whole new set of requirements. This likely can be accomplished by enhancing something the state already does.

ODHS: Recommendations include several comments that training is already available as alternative trainings that can do this

DRO: Also by specifying that a mental health response should be the primary (and first) option for first responders - NOT law enforcement.

OSSA: I really don't know what this means. I also don't think a standard training could be achieved because every community has different resources available to address mental health crisis. As is, we are already being trained in CIT and TIC.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, DRO, MOMI, OAHHS, OCDLA, ODHS, OHA, OJD, OSH, Tribes

DRO: Also by specifying that a mental health response should be the primary (and first) option for first responders - NOT law enforcement.

No (1):
OSSA

OSSA: The need for clarification on this issue is not unique to law enforcement and first responders. The entire system is a challenge right now, please don't single out Law Enforcement. Once clearly established paths are developed, and resources are uniformly available in all communities, this training would make sense.

It Depends (4):
LOC, ODAA, CCO, NAMI

LOC: Local authorities and police departments are already bearing the brunt of the response to the mental health crisis without the funding. Standards designed to improve the treatment available to the patient are obviously helpful, but must not shift the burden to the very agencies we want to have less contact with the mentally ill.

ODAA: Best practices are great and law enforcement partners will do their best, but mandating standards that work in Multnomah County will not go far in Harney and will expose LEO to liability in this and other areas.

CCO: CIT Training already exists. If this is something additional or something that will mandate that every community and every LE agency participate in CIT then yes.

NAMI: This may be addressed through CIT, which many departments offer across Oregon. A better approach may be to partner with the CIT Center of Excellence at DPSST before prescribing requirements. Law enforcement and other first responders are a fickle bunch. Our experience is it's better to partner than to mandate.

Abstain (0)

80. Provide education and training to behavioral health providers about issues that may contribute to racial and ethnic disparities among individuals who are civilly committed (e.g., risk of dangerousness assessments)

Recommendations Idea #: 109

Recommend this idea as currently drafted (5):
ODHS, MOMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OSH: would collaborate closely with impacted institutions/professional organizations to not duplicate training requirements/efforts already in place nor simply create excessive time burdens but instead aim to efficiently help improve training quality/outcomes/use of best practices.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSSA, Tribes

No (1):
OHA

OHA: this can be included in certification/license processes

It Depends (1):
OSH

OSH: Can we identify how this training would be designed and implemented in a manner to be more effective than trainings already being provided in training programs in order to yield greater understanding/practice and reduce disparity risks?

Abstain (2):
LOC, NAMI

81. Require state to address geographical inequities in the civil commitment system by providing more funding and training to rural areas that lack the staffing and resources necessary for inpatient-level of care

Recommendations Idea #: 110

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OAHHS, DRO, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
NAMI

Consensus Survey Comments
OSH: recommend modifying to read "...to address inequities (e.g. based on geographic and demographic needs assessment data)..."

DRO: Distribution should be equitable and based on actual data, rather than simply providing funding and training without some clue about the actual needs of each area.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODHS, OJD, OSH, OSSA, Tribes

No (0)

It Depends (3):
DRO, OHA, ODAA

DRO: Distribution should be equitable and based on actual data, rather than simply providing funding and training without some clue about the actual needs of each area.

OHA: Communities should have a say in this. Perhaps they'd appreciate AOT over more hospitals.

ODAA: Funding should be proportionate to need. An empty facility in rural Oregon isn't helpful to those turned away from urban counties. If there is transport to unused locations, then it should be statewide and can be utilized by anyone once local need is met.

Abstain (1):
NAMI

82. Amend statute to require OHA and OJD to track demographic data of individuals in the civil commitment system to assess disparities by race, ethnicity, sexual orientation, gender identity, or cultural characteristics

Recommendations Idea #: 111

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, NAMI, OHA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

(ODHS skipped)

Consensus Survey Comments
ODHS: what is intent and purpose with data collection?

DRO: We are in favor of aggregate (anonymized) data that is subsequently made available to the public.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, OJD, OSH, OSSA

DRO: We are in favor of gathering aggregate (anonymized) data and subsequently making it available to the public.

No (0)

It Depends (3):
OHA, ODHS, NAMI

OHA: Already done. But this would also need to include CMHPs and providers.

ODHS: for people on Medicaid, this data should be available already. Tracking and assessing are two different efforts. do we know what is available already for people on Medicaid?

NAMI: Again, the how is just as important as the idea. Such requirements usually trickle down to the CMHP and provider level. So while OHA and OJD may be "required," the people and entities that are burdened aren't OHA and OJD. Such data would be great to have, but it if only adds yet another burden to entities already drowning under similar requirements, it won't be a helpful requirement.

Abstain (1):
Tribes

83. Amend statute to require bias and implicit bias training for all professionals working with the civil commitment population

Recommendations Idea #: 112

Recommend this idea as currently drafted (3):
ODHS, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OAHHS, DRO, OHA

Would recommend this idea with specific changes to its wording (specify) (3):
OCDLA, OSH, NAMI

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
MOMI

Abstain (1):
OSSA

Consensus Survey Comments
OCDLA: It's not clear what the training is meant to address.

OSH: critical to ensure outcomes-focused, evidence-based approaches to this type of training.

NAMI: This should be required in rule vs. statute. Legislation could direct OHA to draft such a rule.

MOMI: There is not enough evidence that these types of training work. I'd rather see funding committed to solid and more CIT training and how to establish co-responder programs.

OJD: but this should be in rule not statute

DRO: Who is doing the training and what is the curriculum? Has evidence-based research on the effectiveness of implicit bias training been adequately explored? Will training be ongoing? Is training tailored to Oregon and mental health and addressing those particular historical inequities?

Recommendations Survey Results

Yes (9):
AOC, AOCMHP, CCO, MOMI, OAHHS, ODAA, ODHS, OSSA, Tribes

No (1):
OHA

OHA: This can be addressed in contracts or in certification processes.

It Depends (4):
DRO, OCDLA, OJD, NAMI

DRO: Who is doing the training and what is the curriculum? Has evidence-based research on the effectiveness vs. harm of implicit bias training been adequately explored? Will training be ongoing? Is the training tailored to Oregon and mental health and addressing those particular historical inequities?

OCDLA: It depends on what the training is meant to address.

OJD: This is a good idea to have training on bias but sure this is a statutory change

NAMI: Likely better in rule than in statute.

Abstain (1):
LOC

(OSH skipped): Incredibly important factor but also an extremely challenging issue to address and effectively impact. If time, energy, and funding is dedicated to pursuing this, extra careful attention to use of evidence-based approach will be imperative. Statute vs OAR?

XXXI. Psychiatric Advance Directives

84. Require OHA to promote the use of psychiatric advance directives to avoid the need for civil commitment when an individual experiences a mental health crisis (TOP 5 IDEAS OF DRO)

Recommendations Idea #: 115

Recommend this idea as currently drafted (4):
NAMI, OJD, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, MOMI, OHA

Would recommend this idea with specific changes to its wording (specify) (0)
OSH,

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)
AOC,

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

(ODHS skipped)

Consensus Survey Comments
OSH: concept deserves exploration/consideration but needs to include explicit discussion/clarity around what the expected benefits are and the likely legal and clinical limitations are with advance directives when patients revoke it while in the midst of acute symptoms that may or may not be impacting their decisions in a rational manner

ODHS: need to identify rules around revoking the psychiatric advance directives

MOMI: Agree that PADs can be utilized effectively. Disagree that a PAD avoids the need for involuntary care.

DRO: Assuming it could and would actually be used to avoid the need for civil commitment, then this would be a great way for an individual's own voice to guide their care.

Recommendations Survey Results

Yes (10):
AOC, CCO, DRO, LOC, MOMI, NAMI, OCDLA, ODHS, OJD, OSSA

NAMI: Definitely a requirement that needs fiscal support.

No (1):
OHA

OHA: OAR 309-033-0220(3) already requires this of CMHPs, who are the ones working directly with people (as compared to OHA)

It Depends (4):
OSH, OAHHS, AOCMHP, ODAA

OSH: Debate over the legal durability of the directive in context of severe mental illness.

OAHHS: We would like more information. For example, what effect would this have on individuals who would be best served at the Oregon State Hospital?

AOCMHP: These documents don't seem to carry a lot of weight for admitting hospitals, etc and don't seem to take the place of involuntary care as the level of care indicated in the psychiatric advance directive may not meet the current need for safety of self and others. Also, what is the legal process should the person have a psychiatric advance directive, are subsequently unable to make their own decisions (also, who decides they aren't able to make their own decisions?) and then verbalize that they do not want to follow the advance directive?

ODAA: These ADs are easily revoked by the individual. Until that is resolved, they are of limited utility. We'd welcome a discussion on modification of these directives to be of more utility, at which time they would probably help.

Abstain (1):
Tribes

XXXII. Guardianships

85. Increase state funding for public guardian services for people who need long-term support options due to a behavioral health condition (TOP 5 IDEAS OF AOC, OSH)

Recommendations Idea #: 116

Recommend this idea as currently drafted (6):
OCDLA, OSH, NAMI, ODHS, MOMI, OJD

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OAHHS, OHA, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
DRO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
CCO

Consensus Survey Comments
ODHS: there are times when a person may be civilly commited as a way for the state to enforce decisions and choices to help keep the person safe. For many, guardianship may be the answer as opposed to a civil comitment

DRO: There may be a need for more funds for a competent public guardian for indigent respondents, but there are many reasons for a guardianship and behavior/mental health should not be it's own category. This seems like an attempt to work around the current civil commitment system. Perhaps the funding stream for the public guardian would best be tackled by another group looking at the guardianship statutes.

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA

No (1):
DRO

DRO: Why are we only talking about increasing funds for a public guardian for people with behavioral health needs? This seems like an attempt to get around commitment. While there may be a greater need for a competent, public guardian for indigent people, there are many reasons for a guardianship and behavior/mental health shouldn't be its own separate category.

It Depends (0)

Abstain (1):
Tribes

XXXIII. Commitment of Individuals with Intellectual Disability

86. Require state to develop or provide access to specialized treatment programs for individuals committed for intellectual disabilities (TOP 5 IDEAS OF ODHS)

Recommendations Idea #: 118

Recommend this idea as currently drafted (3):
MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, DRO, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
ODHS

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OHA

Consensus Survey Comments
ODHS: services are available to support people based on their intellectual or developmental disability. Creating specialized treatment programs may be beneficial but they are needed for people with dementia and TBI as well. Any cognitive impairment

DRO: NOT institutional. But otherwise we are in favor of specialized programs that don't separate individuals from their communities and support systems.

Recommendations Survey Results

Yes (11):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (4):
DRO, OHA, ODAA, ODHS

DRO: NOT institutional. But otherwise, we are in favor of specialized programs that don't separate individuals from their communities and support systems.

OHA: Isn't this covered with SACU?

ODAA: This is a very small population but one that needs specialized services. The current system provides specialized stand alone services for those with IDD who are in need of CC so I'm not sure what you're recommending. The services provides under a 427 commitment are different from a 426 commitment and the differences between mental illness and IDD are one of the reasons we have two separate types of commitment.

ODHS: there are specialized programs for people with IDD. Referencing 'specialized treatment programs' is not clear as IDD is not something that is 'treated'. Thus ODDS has programs for people with IDD but they should not be treatment programs.

Abstain (1):
NAMI

NAMI: This idea is not consistent with current legislative proposals to end commitment for this population.

87. Require state to provide statewide training for behavioral health treatment providers on working with civilly committed individuals with intellectual disabilities

Recommendations Idea #: 119

Recommend this idea as currently drafted (3):
MOMI, DRO, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OAHHS, ODHS, DRO, OSSA

Would recommend this idea with specific changes to its wording (specify) (1):
OSH

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (2):
NAMI, OHA

Consensus Survey Comments
OSH: not necessarily to add to statute, but recommend identifying specific target outcomes/improvements and collaborating with training programs so that training efforts are not simply duplicated.

ODHS: this is needed regardless of civil commitment

DRO: Who is doing the training? What is the curriculum? What are the goals of training?

OHA: ODHS should oversee these

Recommendations Survey Results

Yes (8):
AOC, AOCMHP, CCO, MOMI, OCDLA, ODAA, OJD, OSSA

No (1):
OHA

OHA: These commitments should be happening in ODDS. If it were to be required though, it should say ODDS needs to provide training and education.

It Depends (4):
OSH, OAHHS, DRO, ODHS

OSH: Will be important to not replicate what is already taught in formal training programs but carefully identify what educational intervention will achieve the additional outcome desired.

OAHHS: We would like more information. The state should consider developing a crisis response system for individuals with intellectual disabilities.

DRO: Who is doing the training? What is the curriculum?

ODHS: There needs to be statewide training for behavioral health treatment providers regardless of a person being civilly commited.

Abstain (3):
LOC, Tribes, NAMI

XXXIV. Co-Occurring Mental Illness and Substance Use Disorder

88. Explore different treatment models for civilly committed individuals with co-occurring mental illness and substance use disorder

Recommendations Idea #: 122

Recommend this idea as currently drafted (6):
OSH, NAMI, ODHS, MOMI, OJD, OSSA

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (3):
OAHHS, DRO, OHA

Would recommend this idea with specific changes to its wording (specify) (2):
OCDLA, CCO

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (0)
O

Consensus Survey Comments
OCDLA: I would support a bill to study this concept. It's not clear what else this is suggesting.

DRO: What does it mean to "explore"?

CCO: Unsure WHO would be exploring the treatment modalities...providers should be the ones speaking to treatment and OHA should be the authority on recommendations of evidence based treatments that exist.

Recommendations Survey Results

Yes (12):
AOC, AOCMHP, DRO, MOMI, NAMI, OAHHS, ODAA, ODHS, OHA, OJD, OSH, OSSA

NAMI: A study bill might be helpful with this idea.

No (0)

It Depends (2):
LOC, OCDLA

LOC: This is such a powerfully vague suggestion that selecting yes would be meaningless.

Abstain (2):
Tribes, CCO

XXXV. Education about Civil Commitment

89. Expand training to behavioral health providers, county behavioral health entities, judges, district attorneys, and public defenders on the purpose, legal requirements, and processes of civil commitment to include the perspectives of both the justice system and behavioral health system

Recommendations Idea #: 125

Recommend this idea as currently drafted (5):
NAMI, ODHS, MOMI, OJD, CCO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, DRO, OHA

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (0)

Abstain (1):
OSSA

Consensus Survey Comments
DRO: Agree with many of the "it depends" comments: in reality, judges hear from the people affected by civil commitment every day (both through the PAMIs themselves and collateral fact witnesses like families). It seems a bit redundant. What goals are specifically being achieved?

Recommendations Survey Results

Yes (14):
AOC, AOCMHP, CCO, DRO, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSH, OSSA, Tribes

No (0)

It Depends (1):
OHA

OHA: If OJD provides staff to do this

Abstain (1):
LOC

XXXVI. Structural System Changes

90. Amend statute to require OHA to provide a broader scope of treatment and services to civilly committed individuals that support social determinants of health (e.g., safe housing, recovery-oriented mental health services for health and well-being) (TOP 5 IDEAS OF OAHHS)

Recommendations Idea #: 127

Recommend this idea as currently drafted (4):
ODHS, MOMI, OJD, DRO

Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process (5):
OCDLA, OSH, OAHHS, OSSA, CCO

Would recommend this idea with specific changes to its wording (specify) (0)

Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify) (0)

Cannot recommend this idea, even with specific wording changes or combined with other ideas (1):
NAMI

Abstain (1):
OHA

Consensus Survey Comments
OHA: Already required to do so in CFAA

Recommendations Survey Results

Yes (13):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OJD, OSSA, Tribes

OAHHS: Would OHA provide these services or fund these services? Appropriate funding is critical.

OJD: yes with the caveat that this will require significant funding

No (1):
NAMI

NAMI: Beyond facility-based care, ACT, etc., what more should OHA do? Once someone discharges from commitment, they aren't OHA's responsibility. They are and should be the responsibility of their CCO or other payer. For those circumstances where someone is without coverage or Medicare, any requirement of OHA will trickle down to CMHPs in the CFAAs and be yet another unfunded mandate. Better to work within the structures and payers we have to improve care coordination and discharge planning so a commitment doesn't end abruptly or with a discharge to a halfway house or shelter.

It Depends (2):
OSH, OHA

OHA: Funding, FTE allocation internally and to CMHPs, more leveraging of matching dollars and other resources, etc.

Abstain (0)