Recommendations Survey Results with Comments

I. Community-Based Behavioral Health Services

1. Require the state to ensure access to community-based behavioral health treatment by individuals before they need civil commitment by requiring every region to have an adequate network of community-based resources (12/2/2/0)

Idea #: 2

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

---

No (2):
NAMI, OHA

NAMI: The state already has a role to ensure network adequacy through its regulatory powers via OHA and DCBS for Medicaid and commercial insurance that the state can regulate, respectively. The state cannot guarantee services for ERISA plans and Medicare nor can it regulate ERISA plans or Medicare. In other words, laws are already in place to grant the state the powers it needs. The challenge is the regulatory agencies using those powers. Oregon's parity law is already among the strongest in the country, and the law addresses commercial plans and Medicaid to have adequate networks and to cover treatment services commensurate to need for the duration necessary to ameliorate the underlying cause driving crises. The challenge becomes one of budget (Medicaid) and resistance (commercial plans not paying for EASA, for example). NAMI's hope is that as annual reporting required under the parity law, it becomes abundantly clear where disparities exist, guiding where investments need to be made and where stronger regulation needs to occur.

OHA: Civil commitment looks different in various parts of the state. And the CCOs do network adequacy, which would meet this need.

It Depends (2):
CCO, OSH

CCO: In rural and frontier counties, this is very difficult. If the state provides the funding and the infrastructure to recruit the employees needed to staff these treatment facilities then it would be more possible but placing the burden on the CCO or the community to build, fund and staff these facilities in rural and frontier regions is not realistic.

OSH: Ensuring access to community based/less restrictive care is an appropriate goal broadly in terms of approach to mental healthcare and more specifically for potential to reduce the number of people who end up ultimately needing civil commitment (i.e., because they received earlier, community-based intervention) and for as reassurance that when civil commitment is implemented, it has not been done prematurely or unnecessarily). However, achieving such a robust community resource system is complex and fraught with challenges, with potential to fall short at times for a variety of reasons. If this requirement for access was established in statute or OAR and the system failed to provide the access described for an individual, this should not be cited as a justification for dismissal of a civil commitment petition since lack of access to earlier intervention does not in any manner neutralize or reduce the individual's risks of morbidity or mortality for the condition that has developed.

Abstain (0)

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 (10/0/5/1)

Idea #: 3

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

No (0)

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

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 (13/1/1/1)

Idea #: 4

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

1. 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 (14/1/1/0)

Idea #: 5

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)

2. Create a state funding mechanism to reimburse community case managers for outreach efforts to individuals in need of behavioral health care (13/0/3/0)

Idea #: 6

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)

3. Establish a fee schedule/funding code for billing Medicaid for behavioral health preventative care, such as 23-hour crisis and respite (12/0/3/1)

Idea #: 7

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

---

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.

4. Require state to build and fund more mental health crisis centers so emergency rooms are not the only option (13/1/2/0)

Idea #: 8

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 Psychiatric 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 stabilized.

Abstain (0)

5. Require first responder training on use of mental health crisis centers as an alternative to emergency rooms (12/0/3/1)

Idea #: 9

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

6. Educate providers on when an individual may be released from a psychiatric hold following submission of an NMI to the court (13/1/1/1)

Idea #: 10

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

1. 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 (10/1/4/1)

Idea #: 11

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

1. Amend statute to expand criteria a judge MAY consider when determining whether to issue a warrant of detention (e.g., inability to meet basic needs) (10/2/4/0)

Idea #: 12

Yes (10):
AOC, CCO, LOC, MOMI, NAMI, OCDLA, ODAA, OSH, OSSA, Tribes

No (2):
OAHHS, DRO

OAHHS: We have too many questions at this point.

DRO: This would violate due process protections in place for PAMIs. Why need to specify in the statute if this is optional? That is exactly what caselaw is for.

It Depends (4):
AOCHMP, OHA, OJD, ODHS

AOCMHP: The statement if very broad - depends on the revised language in the statute. What criteria would be utilized to determine if the answer to this should be yes? We do not want holds that are nonsensical.

OHA: This would require funds for staffing to be able to shelter and treat individuals being held. On face value, it is not sufficient to implement without overwhelming the system.

OJD: The criteria for issuing a warrant of detention must be consistent with the criteria for commitment, so it depends on whether there are changes to the criteria for commitment.

ODHS: pushing towards 'yes' but there needs to be a safe place to keep the person on the warrant of detention.

Abstain (0)

2. Require Oregon Judicial Department to collect data on the factual findings in which judges issue warrants of detention (7/0/7/2)

Idea #: 13

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

1. 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 (13/0/1/2)

Idea #: 14

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

2. 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 (10/0/4/1)

Idea #: 15

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)

3. Require civil commitment investigators to participate in continuing education following initial certification that includes updates on relevant legal and clinical information (14/0/2/0)

Idea #: 16

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.

Abstain (0)

VI. 14-Day Voluntary Diversion

1. Amend statute to increase the maximum period of voluntary diversion from 14 days to a longer duration (workgroup to recommend the specific duration allowable) (9/1/6/0)

Idea #: 17

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

1. Amend statute to require state or local behavioral health care systems to follow up periodically with individuals following a 14-day diversion from commitment (frequency and duration to be determined) (5/3/8/0)

Idea #: 18

Yes (5):
MOMI, OAHHS, OCDLA, ODAA, Tribes

ODAA: This will be difficult to follow up if the person can't be located. We want to be sure not to be punitive to the agency if they put in best efforts for follow up but are unable to do so.

No (3):
AOC, DRO, OHA

AOC: Requires a lot of extra resources for oversight that might not be available. May not be best place to allocate.

DRO: This violates the 14th Amendment due process clause. Entirely separate from referring the individual to voluntary services or connecting them with wraparound services, which we would be in favor of.

OHA: Discharge from hospitals and ERs are already guided by statue. This would be better addressed in CMHP CFAAs or CMHP OARs.

It Depends (8):
OSH, LOC, AOCMHP, OJD, CCO, ODHS, NAMI, OSSA

OSH: Would this be for the purpose of ongoing clinical support? Or to reassess clinical status to determine 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 available? 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.

LOC: If diversion was appropriate then a care provider of some sort is already involved. The follow up treatment should orbit the mental health provider, not the state

investigator. While the standards are mismatched the central position that treatment is what is needed remains of paramount importance.

AOCMHP: When someone is no longer on a 14 day diversion, there is no legal obligation for them to be following through with mental health services. There is therefore no role for a commitment investigator to follow up with them. This could be intrusive and could also be redundant as the hospital that does the discharge planning should be following up.

OJD: This depends on whether funding is provided for the check-ins.

CCO: If the 14 day diversion is complete, then there is no current way to require the individual to engage with the behavioral health care system so if the amendment to this statute would also require the individual to engage with the provider then I would support it. But if it is just requiring the provider to try to engage that I would not support it, as community providers already do that now following a 14 day diversion.

ODHS: depends on if this is a voluntary involvement or required involvement. Required will likely not produce intended benefit.

NAMI: This largely should be the role of a payer when applicable. Once a 14-day diversion concludes, the transition from the hospital should include in-depth discharge planning that involves the CMHP. However, for those covered by CCOs, by virtue of their acuity, people are largely eligible for Intensive Care Coordination. Unless there's a gap in coverage of some kind where a payer doesn't exist, this either already is a responsibility (CCO) or should be a responsibility (commercial). For those without coverage or with Medicare coverage, this would be appropriate.

OSSA: "Follow up" is too vague. My hope would be individuals would stay engaged in treatment after the diversion. Follow up falls short of the need.

Abstain (0)

2. Amend statute to require that peer support services are provided to an individual upon completion of diversion treatment (3/1/12/0)

Idea #: 19

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)

3. Require OHA to compare civil commitment diversion programs among Oregon counties and identify best practices, including accountability mechanisms for community treatment providers (10/0/4/1)

Idea #: 20

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

1. Amend statute to require that citations include information about eligibility for 14-day intensive treatment option (diversion) (11/1/2/2)

Idea #: 21

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

1. Amend statute to clarify when in the civil commitment process the court must appoint legal counsel to financially eligible individuals (13/0/2/1)

Idea #: 22

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

2. Amend statute to require continuity of appointed legal counsel throughout process when feasible (12/1/2/1)

Idea #: 23

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

3. 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 (9/1/4/1)

Idea #: 24

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

1. Amend statute to require OHA to provide relevant medical records requested by defense attorneys in a civil commitment case at least 24 hours before the hearing (8/3/4/1)

Idea #: 25

Yes (8):
AOC, CCO, DRO, LOC, MOMI, ODAA, OSH, OSSA

LOC: Attorneys need more than 24 hours.

No (3):
OAHHS, Tribes, OHA

OAHHS: Medical records are provided by providers. OHA does not provide medical records. Requiring OHA to provide relevant medical records will not improve the timeliness of a defense attorney receiving medical records.

Tribes: This will be difficult to sort through "relevant medical records" will leave too much room for interpretation.

OHA: OHA is not the owner of the medical records, the provider who documented the note would have ready access to the records. It is already in statute that investigators have access to records. Could be more of a training piece.

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

AOCMHP: This is already the process. Whenever statutes say “OHA” they actually mean “CMHP” and the verbiage confuses courts and hospitals.

OCDLA: It should be more than 24 hours, but definitely an agency other than the hospitals should be the responsible parties for providing the information.

OJD: "Relevant" should be defined and funding provided to OHA so that a 24 turnaround timeline can be met.

ODHS: relevant will need to be defined. This is also something the person must be informed about.

Abstain (1):
NAMI

2. Amend statute to require hospitals to share pertinent documentation from electronic health record with defense attorneys for civil commitment hearings (10/1/4/1)

Idea #: 26

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

1. 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)) (12/1/2/1)

Idea #: 27

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

2. Require state to create a centralized database of mental health examiners that is available to courts and CMHPs (14/1/1/0)

Idea #: 28

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)

3. Amend statute to expand training requirements for mental health examiners in civil commitment cases (12/1/2/1)

Idea #: 29

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

4. 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 (12/0/2/2)

Idea #: 30

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

5. Amend statute to clarify that only one examination report is required per examiner. (Statute currently refers to examination reports in the plural.) (12/1/1/2)

Idea #: 31

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. Criteria for Civil Commitment

1. Amend statute to lower the legal threshold for civil commitment (5/4/7/0)

Idea #: 32

Yes (5):
CCO, LOC, MOMI, ODAA, OSSA

No (4):
AOC, DRO, OCDLA, ODHS

DRO: We believe that the current threshold is the lowest possible threshold that satisfies the 14th Amendment.

OCDLA: Lowering the threshold for commitment will possibly increase the number of people being referred for commitment, but there has been no data presented to suggest that would improve overall outcomes for patients or the community. Further, "lowering the threshold" is extremely vague and doesn't do anything to further clarify the population intended to be reached. I appreciate that we have all discussed the many people falling through the cracks with the current statute, but I have no confidence that merely "lowering the standard" will reach more people we intend to. As previously discussed at length in the meetings, increasing the number of commitment referrals to a system that is already over capacity and unable to support the people in it would only continue to strain resources and reduce the quality of care for everyone in it. It's easy to blame the statute for systemic problems with poverty and healthcare, but changing the statute won't solve those underlying problems.

ODHS: there is not compelling evidence presented during the workgroups that would support a lower legal threshold will solve any problem.

It Depends (7):
OSH, OAHHS, AOCMHP, Tribes, OHA, OJD, NAMI

OSH: There is ample support in pursuing this but also a question of whether the threshold needs "lowering" vs whether it simply needs to be further defined in statute so that it is less vulnerable to the unpredictable interpretations and outcomes of appellate decisions.

OAHHS: What would the threshold be? What is the state's plan for providing access to care for the additional individuals who would be civilly committed? The current civil commitment process is not working well. We are concerned that many individuals who are civilly committed cannot access care at the Oregon State Hospital. In addition, Oregon does not have the continuum of care needed to serve our community members who are civilly committed.

AOCMHP: It depends on the new criteria and what it would consider.

Tribes: needs more discussion; what would the threshold be lowered too?

OHA: Lowering the threshold without additional funds for capacity would be problematic. In the end, the goal is not to civilly commit people. A tiered approach would be favored.

OJD: The legal standard of clear and convincing should continue. We do think that the criteria for civil commitment should be more clearly defined in statute.

NAMI: The actual specifics of how to amend the statute are important to NAMI Oregon. Generally speaking, NAMI Oregon favors altering statute so that it's clear what the criteria are, leaving less open to interpretation by the Court of Appeals.

Abstain (0)

XIII. Court Determination of Mental Illness

1. Amend statute to add a definition of “mental disorder” for purposes of determining whether an individual is a "person with mental illness" (10/0/6/0)

Idea #: 33

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)

XIV. Court Options Following Determination of Mental Illness

1. Amend statute to create a tiered system of civil commitment with different criteria for each tier, which would authorize courts to order community-based outpatient commitment, community-based inpatient commitment, or commitment at the Oregon State Hospital (8/3/5/0)

Idea #: 34

Yes (8):
AOC, CCO, LOC, MOMI, ODAA, ODHS, OSSA, Tribes

No (3):
DRO, ODAA, NAMI

DRO: Involuntary commitment should be limited to the statutory definition and not extended to include less acute situations where people will be stuck in involuntary outpatient commitment. Fix the system you have before complicating it substantially. We need to be funding our current statutory system and courts need to be utilizing the system already in place for outpatient commitment which has been looked over due to lack of resources. We would be in favor of exploring statutory amendments that bring civil commitment placement more structure and oversight. See Aid & Assist statute: findings on the record as to appropriate level of care for each individual (separate from availability of service.)

ODAA: Initially, this seems like a good idea, but when discussing the practical nature of it, it turns into a logistical nightmare and will grossly overcomplicate the system.

NAMI: Oregon's history with civil commitment is rife with abuse, neglect, and violating individuals' civil rights. The state should act incrementally and demonstrate it can actually do right by patients who are civilly committed before being granted wide powers to force people into care.

It Depends (5):
OSH, OAHHS, AOCMHP, OCDLA, OJD

OSH: Flexibility in level of care increases our potential to better tailor treatment to the individual and to achieve least restrictive option. However, what specifically would be the source and nature of criteria used by the judge to determine this (e.g., whether inpatient care should take place at community inpatient setting vs Oregon State Hospital, etc)? Furthermore, are these separate site designations (ie, levels of care) associated each with a specific duration of commitment? Or is duration determined separately from site…based on what criteria?) Seems most appropriate for level of care

determinations to come from clinicians while level of coercion be determined by the judge.

OAHHS: A tiered system of civil commitment may be an idea to explore. What does community-based inpatient commitment mean? It is important to ensure that licensed independent practitioners may appropriately exercise their professional judgment and apply their clinical expertise.

AOCMHP: We only bring hearings forward for people who require inpatient psychiatric hospitalization, so this is not applicable. Currently there is no infrastructure for an outpatient commitment, including what happens if a person refuses to participate in outpatient commitment or what the roles of the CMHPs, Courts and other entities are. No system set to determine how to monitor outpatient commitments. Would this have implications for other criteria like extended criteria? Are all tiers of commitment considered the same degree of seriousness?

OCDLA: It depends entirely on what the criteria would be for each tier. I do not support a system where a person who does not meet commitment criteria would be able to be shuffled into a "community based" commitment under a lower standard.

OJD: The court would need information not currently provided as to the suitability and availability of community-based treatment resources.

Abstain (0)

XV. Assisted Outpatient Treatment

1. Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT) (12/2/2/0)

Idea #: 35

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

ODAA: But not at the expense of existing programs.

OJD: If the statute is changed to give authority to judges to take action if the person is not participating in treatment and if the counties cannot decline participation due to lack of resources.

No (2):
DRO, NAMI

DRO: Funding would be better spent on voluntary outpatient and wraparound services.

NAMI: The question invariably arises -- how to allocate scarce resources? If this is funded, that means other needed behavioral health services and supports either won't be funded or that they won't receive adequate funding. The question also arises that if this is the priority for funding, the only way someone can access services is to be court involved. For this concept to work, it must be priced and implemented with the rest of the system in mind.

It Depends (2):
AOCMHP, OCDLA

AOCMHP: If someone is not able to survive safely in the community without treatment, this recommendation does not appear to make sense or provide safety for the individual or the community. It is not clear how a court would enforce it. Would providers be required to accept patients on AOT? What would the safety net be for if the person is not engaging in AOT?

OCDLA: The funding shouldn't be tied to AOT specifically. Expanded community resources should be available to everyone, whether they are court involved or not.

Abstain (0)

2. Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment and services (9/3/3/1)

Idea #: 36

Yes (9):
AOC, CCO, LOC, MOMI, OAHHS, ODAA, OJD, OSH, OSSA

OJD: see above comments

No (3):
DRO, ODHS, NAMI

DRO: See above on the nature of involuntary treatment... we should be expanding voluntary services to stave off extreme decompensation.

ODHS: This should not be a judge providing the oversight. This should be a CMHP or other community resource permitted to oversee the AOT and report to the court if there are violations.

NAMI: Oregon should treat carefully. It's history is abysmal in how it treated patients under civil commitment. The state should act incrementally until it can demonstrate that it can be trusted with broader powers.

It Depends (3):
AOCMHP, Tribes, OCDLA

AOCMHP: Need clear answers on how a court would enforce participation in appropriate community based treatment.

Tribes: I need more information, how is it helpful to have court order/ court oversight, may just lead to continued overflow in jails and lack of treatment in mental health disorders.

OCDLA: I do not support risk of incarceration or contempt for failing to abide by court orders related to mental illness. I would also not support any effort to expand AOT until sufficient resources were in place to render it a useful clinical treatment service rather than a criminal justice initiative.

Abstain (1):
OHA

OHA: A provision in the statute allows a judge to appoint guardian ad litem to the case if needed. This is a more restrictive intervention that actually doesn't automatically mean expensive hospital admit. It could be a lower level, but more restrictive setting that would not please the participant enough so they start to adhere. The courts would need funds to stand up guardian ad litem programs for civil commitment and AOT, rather.

3. Provide dedicated funding to CMHPs to support 14-day intensive treatment (diversion from civil commitment) (11/0/3/2)

Idea #: 37

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.

4. 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 (14/0/2/0)

Idea #: 38

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)

XVI. Conditional Release

1. Amend statute to clarify the kinds of support that OHA must provide to persons ordered to conditional release (11/0/4/1)

Idea #: 39

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

XVII. Inpatient Commitment

1. Establish criteria in statute or rule to determine when the Oregon State Hospital must admit civilly committed individuals (11/2/2/0)

Idea #: 40

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

No (2)
DRO, ODAA

DRO: This should be a decision made by the treatment professionals. Oregon citizen money would be far better spent by requiring community partners to accept care for individuals and limit ability to turn away patients.

ODAA: The Mosman order and consequences for A&A mean that ODAA cannot support modification to entrance criteria at OSH for CC individuals if it would have an impact on the A&A population or GEI population. We must prioritize treatment for individuals involved in criminal justice.

It Depends (2)
OSH, NAMI

OSH: Will this define criteria based solely on consideration of the civil commitment patient or will this include mechanisms for determining prioritization when competing statutes or rules result in highly predictable direct conflict with one another? (eg, civilly committed patient requires admission, patient under ORS 161.370 requires immediate admission, only 1 bed available, etc.)

NAMI: Given the Mossman order, this is impractical. Rather than require OSH to admit, the obligation should be on OHA to make available a treatment facility that is commensurate with a person's needs as identified by some objective measures, such as the LOCUS.

Abstain (0)

(OHA skipped)

2. 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 (11/1/3/1)

Idea #: 41

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

---

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

3. Require treatment facilities, acute hospitals, and OSH use evidence-based and best practices related to physical space utilization to improve the therapeutic potential of civil commitments (9/2/4/1)

Idea #: 42

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

No (2):
OHA, OJD

OHA: Best practices may not always be evidence-based yet and the "and" is compounding.

OJD: I think it is appropriate to provide best practice info to facilities but if this implicated private facilities to change their facilities we would have concerns.

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

OSH: Please provide further explanation of what is meant by "physical space utilization."

OAHHS: This may make sense for Oregon State Hospital. Acute Hospitals are not intended to provide long term care. Who would pay for or fund these new requirements?

NAMI: To our knowledge, this isn't a major problem. The problem is we have too few care environments and lack a diversity of care environments that can meet the particular needs of patients. As it pertains to inpatient hospitalization, there are factors outside of their control, such as Joint Commission and CMS requirements. Granted, inpatient hospitalization is no picnic under the best of circumstances.

OSSA: Not enough space as is, reducing resources to meet best practices will put us further behind. This is a good goal in building new resources.

Abstain (1):
LOC

XVIII. Outpatient Commitment

1. Amend statutes to establish criteria for OHA or CMHP placement of civilly committed individuals, including individual's diagnostic needs, probability to succeed in that placement, and least restrictive environment possible (6/4/5/1)

Idea #: 43

Yes (6):
AOC, AOCMHP, OCDLA, OJD, OSSA, Tribes

No (4):
LOC, OHA, ODAA, ODHS

LOC: This should be left to the medical community. The treatment team can already do this.

OHA: Probability to success in the placement is too much of a hypothesis game and could be full of bias.

ODAA: Putting in a probability of success metric into statute is a bad idea when noone can agree what success is or means.

ODHS: The removal of choice is strong here. if a person is in outpatient commitment, the facility/person who is responsible needs to have flexibility to make a determination on treatment needs. ORS shouldn't dictate this eligibility criteria.

It Depends (5):
OSH, OAHHS, DRO, NAMI, MOMI

OSH: There appears to be confusion around how to interpret this idea, including controversy re: exactly how this would fit into the process, what explicit added benefit it provides, and even if it might create unnecessary constraints that limit ability to individualize treatment.

OAHHS: Would this proposal help individuals obtain access to care in an appropriate facility? A robust continuum of care outside of hospitals needs to be created.

DRO: Doesn't this happen anyway? If not, why is it not already being done? What would this add to the statute as far as requirements (i.e. seems to already be required)?

NAMI: Based on current commitment criteria, it's hard to fathom a circumstance where someone should be under outpatient care given the high acuity required to meet criteria.

MOMI: Least restrictive environment has been used as an excuse to ignore the rest of the parameters. Recommend change in wording to say least restrictive environment most evidence-based to serve the individual's needs.

Abstain (1):
CCO

2. Amend statute to require peer support and wrap-around services for individuals on outpatient commitment (9/1/6/0)

Idea #: 44

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 services.

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)

3. Require OHA to seek Medicaid waiver that authorizes use of Medicaid dollars to build public housing or otherwise provide housing assistance to individuals under court orders to participate in community-based behavioral health treatment (9/2/2/3)

Idea #: 45

Yes (9):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, ODHS, OHA, OJD

No (2):
DRO, OSSA

DRO: We should be accessing 1915(k) dollars for voluntary long-term services and supports. Utilizing Medicaid waivers for individuals under court supervision violates the "Settings Rule."

OSSA: I don't feel Medicaid is the right pot of money to build housing.

It Depends (2):
OSH, NAMI

OSH: What happens to housing assistance once individual is no longer required to participate in treatment?

NAMI: Is the presumption that someone is homeless and needs placement? If so, why wouldn't existing housing be utilized? The state is making significant investments in many types of housing. The challenge is that we can build only so much capacity at a time. If it's a reimbursement issue for services, and such services aren't reimbursed given the court's involvement, then that's a different issue. As long as services are clinically necessary, court involvement should not preclude reimbursement. If a waiver is necessary to achieve this end, then Oregon would benefit from pursuing a waiver.

Abstain (3):
Tribes, OCDLA, ODAA

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

ODAA: ODAA is probably a yes on this, but we don't know enough about how medicaid money works to give an educated response.

4. Require OHA to amend its County Financial Assistance Agreements to require and fund CMHP outreach services for civilly committed individuals placed in outpatient treatment (10/0/3/3)

Idea #: 46

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.

5. Establish mechanisms to certify, monitor, and measure the performance of facilities where civilly committed individuals are placed to provide trauma-informed care (10/1/4/1)

Idea #: 47

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 require 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

XIX. Changes in Placement

1. Amend statutes or rules to establish mechanisms to transfer individuals between support levels (see Washington's new AOT legislation) (9/2/4/1)

Idea #: 48

Yes (9):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OJD, OSH, OSSA

No (2):
ODHS, NAMI

ODHS: unless civilly committed, there needs to remain a level of choice and individual rights for a person.

NAMI: Again, Oregon's history is extremely poor when it comes to civil commitment. Before granting the state cart blanche, any change should be relatively incremental when it comes to compulsory care. A better solution here could be revising "trial visits" and ensuring that providers aren't cherry picking patients, which is still too common. Placement decisions also should be based on some objective measures, such as the LOCUS. If someone no longer needs facility-based care, there is a legitimate question about who should carry the financial risk and the responsibility to maintain engagement with someone.

It Depends (4):
DRO, OHA, OCDLA, ODAA

DRO: If this means clarifying who is transporting the individual and there is oversight, then we are in favor.

OHA: Regular check-ins with the judge on commitments over 30 days would need to be in place, and a tiered system would help people navigate through the system based on acuity (and need for treatment) rather than dangerousness primarily.

OCDLA: I could support this if the statute included due process protections and an opportunity for the AMIP to protest the change.

ODAA: Like the tiered approach, this has the potential to be a chaotic and difficult to administer process.

Abstain (1):
Tribes

2. 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) (13/1/2/0)

Idea #: 49

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)

XX. Trial Visits

1. Revise statutes and rules to change the term “trial visits” to something that more clearly describes its function (e.g., less restrictive placement) (12/1/2/1)

Idea #: 50

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

2. Amend statute to clarify the entity responsible for a civilly committed individual during a trial visit (14/0/2/0)

Idea #: 51

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)

3. Amend statute to require civilly committed individuals on a trial visit to engage in AOT by requiring regular check-ins with the judge, AOT case manager, AOT monitor, and treatment team to promote recovery and client engagement and help individuals feel heard and seen during the trial visit period (8/3/5/0)

Idea #: 52

Yes (8):
AOC, CCO, LOC, MOMI, OAHHS, OSH, OSSA, Tribes

No (3):
DRO, OHA, NAMI

DRO: (1) Someone's housing and placement cannot be contingent on voluntary recommitment which is what currently occurs with frequency. (2) This sounds incredibly burdensome to the individual and the judicial system. (3) Extending the reach of attorney representation would be a better approach than expanding overt judicial oversight. (4) AOT is generally violative of due process and has repeatedly found to be ineffective.

OHA: That would all still be just a trial visit or a new name. AOT is not a civil commitment in Oregon.

NAMI: If someone is still under commitment and is living outside of a residential facility, these services should be expected and provided. If someone stops participating or deteriorates, there should be a clear expectation that the person will be admitted to a higher level of placement.

It Depends (5):
AOCMHP, OCDLA, ODAA, OJD, ODHS

AOCMHP: Not necessary - only need to bring them to court when motivational interviewing isn't working and there's a workforce availability issue.

OCDLA: I don't think the courts necessarily need to be this involved. 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 should be used for changes in levels of care or as a last resort if there are issues with compliance and revocation is possible.

ODAA: Again, this suggestion works a lot of detail that is best left to OAR into the statutory suggestion. We do not support a statutory mandate that a person feel seen or heard. However, we do support regular check ins with a judge, a case manager, etc. An individual on a trial visit doesn't necessarily have to be on AOT, especially since AOT does not include medication mandates while a trial visit includes that as a portion of the agreement.

OJD: This will require more judicial time/funding and will require a mechanism for the court to get the necessary information.

ODHS: should still be person centered. If there can be ORS amendments to include the above check in options and then the appropriate persons/entity is selected on a case by case basis that would be preferred

---

Abstain (0)

4. Amend statute to require courts to hold status hearings for individuals on trial visits (7/3/4/2)

Idea #: 53

Yes (7):
AOC, CCO, DRO, MOMI, ODAA, OHA, OSSA

No (3):
AOCMHP, OCDLA, ODHS

AOCMHP: We have a document that informs the court of violations with explanations of what our intervention is to give that individual an opportunity to re-engage. Only want to take to court when seeking a revocation. We provide regular updates to the court and the client already.

OCDLA: Regular check ins with a judge increase stigma associated with mental illness as patients generally understand the courts to be associated with punitive criminal justice measures rather than healthcare, especially if these hearings are taking place at the courthouse. Adding an additional burden to get to court on top of other treatment requirements is unnecessarily burdensome, absent some clear evidence of a

therapeutic benefit (which I have not seen presented in this group.) The court system should be available to assist or to hear a patient if there is a challenge to a level of care change or other problem associated with the actual commitment, but we should not be creating essentially a mental health court for people who have committed no crime. Finally, regular check ins will create a workload burden on the courts and attorneys that is not balanced by a clear benefit to the patient or the purpose of the commitment.

ODHS: again should be person centered. Some people will need this and some won't.

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

OSH: Assuming this may be a logistical challenge/considerable increase in resource demand for the court systems and personnel involved. Some concern around ensuring the tone/intent of the hearing is of offering support to the patient vs adding an additional stressor during a vulnerable period of transition - ie, fears around pressures of needing to "prove" rehospitalization not needed. However, if this were to be pursued, this might be the time at which a court could determine whether there is any need for the AOT-focused Trial Visit services referenced in recommendation #51 above.

OJD: see comments above

NAMI: What benefit does this add? Is the problem being solved that we have individuals on trial visits who get lost in the system? If so, shouldn't the system be held accountable? Is a court the best entity to hold them accountable, or are we added court oversight because of the legal system's frustration with the health care system?

Abstain (2):
LOC, Tribes

XXI. Medication

1. Require OHA to train providers of civilly committed individuals on the potentially traumatic effects of involuntary medication and how giving individuals more choice may improve treatment outcomes (7/4/2/3)

Idea #: 54

Yes (7):
AOC, AOCMHP, DRO, NAMI, OAHHS, OCDLA, OSSA

No (4):
LOC, OHA, ODAA, MOMI

LOC: Medical school already does this. This suggestion is a reaction to a system of care and medical education that hasn't existed for over 50 years.

OHA: This could be in certification processes and required there.

ODAA: We want providers to have clear guidelines to follow when utilizing involuntary medications and not muddy the waters.

MOMI: This suggested "training rule" is a thinly veiled attempt to make providers more afraid to medicate against objection. One of our family constituents is dead because a doctor was ALREADY afraid to use his authority to medicate against objection. Doctors need more training about the NEED to medicate against objection when someone in their care is obviously experiencing brain damage from untreated psychosis. A person in psychosis is an unreliable reporter about their experience and has already lost capacity for choice because of the nature and severity of their brain-based disease.

It Depends (2):
OSH, ODHS

OSH: This is typically a standard yet major component of psychiatric training. If this is not being effectively incorporated into actual practice, how might OHA approach such training differently (compared to formal clinician training programs) that can have greater potential to increase effectiveness trauma informed approach?

ODHS: If a person is required by courts to take medications, the training needs to be focused on compassion, conversation, options within limits to help a person consent to the medications.

Abstain (3):
Tribes, OJD, CCO

OJD: We did not feel we had enough expertise to answer.

2. Require providers to include the individual under civil commitment as much as possible in developing treatment plans, including medication options (11/0/3/2)

Idea #: 55

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.

3. Require providers, when possible, to consider alternative treatment options when a committed individual has valid reasons not to want an ordered medication (8/1/5/2)

Idea #: 56

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.

XXII. Recertification for Continued Commitment

1. Require OJD to collect data on individuals who are recertified more than once to identify that population's unique needs (14/0/1/1)

Idea #: 57

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

2. Amend statute or rule to require OHA to notify individuals facing recertification about the availability of patient rights organizations, such as the OHA Office of Recovery and Resilience (Washington State has a similar Office of Behavioral Health Advocacy) (14/0/0/2)

Idea #: 58

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

DRO: There should be automatic attorney appointment. Additionally, notify individual about Disability Rights Oregon (P&A) and ombudsman.

No (0)

It Depends (0)

Abstain (2)
LOC, Tribes

3. Amend statute to require court to appoint defense counsel as soon as possible in the recertification process (13/0/2/1)

Idea #: 59

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

4. Amend statute or rule to require that OHA notifies defense counsel and an ombudsperson when recertification is pursued (11/1/3/1)

Idea #: 60

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

5. Require OHA to collect data on how individuals facing recertification navigate the civil commitment system (10/2/1/3)

Idea #: 61

Yes (10):
AOC, CCO, DRO, MOMI, OAHHS, OCDLA, ODAA, OSH, OSSA, Tribes

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

No (2):
OHA, ODHS

OHA: This is too vague.

ODHS: It's not clear that this data will be reliable as it's a system collecting data that presumes understanding of behavior but without understanding the person's various variables in their lives. Also could presume the client is being truthful if asked about reasons for behavior.

It Depends (1):
OJD

OJD: Not sure how navigation is being defined.

Abstain (3):
LOC, AOCMHP, NAMI

NAMI: This is too vague.

6. Require OJD to collect data on the total number of recommitments, number of contested recommitments, reasons for contesting, and how long people remain in the civil commitment system (15/0/0/1)

Idea #: 62

Yes (15):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA

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

No (0)

It Depends (0)

Abstain (1):
Tribes

XXIII. Discharge and Dismissal

1. Require providers or treatment facility to include and involve individuals under civil commitment in discharge planning (11/1/3/1)

Idea #: 63

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

2. 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 (14/1/0/1)

Idea #: 64

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

3. 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 (11/1/4/0)

Idea #: 65

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)

4. 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 (14/1/1/0)

Idea #: 66

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.

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)

5. Require state to fund support for non-Medicaid covered outreach services to individuals after dismissal of civil commitment case (12/0/2/2)

Idea #: 67

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.

6. Require OSH to notify the local CMHP when discharging an individual from civil commitment (12/0/4/0)

Idea #: 68

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)

7. Require OHA or CMHPs to track and report community-based supports provided to individuals following discharge and dismissal of commitment cases (10/1/4/1)

Idea #: 69

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

8. Require OHA or CMHP to provide notice of discharge from commitment to the individual's legal counsel (10/0/5/1)

Idea #: 70

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

9. Establish a system to improve communication between jails and the state hospital for justice-involved individuals who are discharged to custody after civil commitment (15/0/0/1)

Idea #: 71

Yes (15):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA

No (0)

It Depends (0)

Abstain (1):
Tribes

10. 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 (9/1/3/3)

Idea #: 72

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

11. Require OHA to collaborate with tribes before discharging a tribal member from commitment with adequate time to plan for care coordination (13/0/2/1)

Idea #: 73

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

12. Require OHA or CMHP to provide all notices of discharge from commitment with enough time to coordinate care (8/1/7/0)

Idea #: 74

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)

13. Amend OHA contracts to specify who should be notified and when they should be notified of an individual’s discharge from civil commitment (11/0/4/1)

Idea #: 75

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

XXIV. Data Sharing and Confidentiality (Case Management)

1. Establish procedures to encourage investigators and treatment teams to seek a release of information that enables them to continue communication with the individual's family members or natural supports throughout the commitment process (9/2/5/0)

Idea #: 76

Yes (9):
AOC, CCO, LOC, MOMI, NAMI, ODAA, ODHS, OJD, OSSA

NAMI: This should mirror expectations in place under HB 2023 from the 2015 Legislature.

No (2):
Tribes, OHA

Tribes: investigators don't need this to do their investigation, this makes implies that they shouldn't get the information if they don't have an ROI and they should have access to make their determinations. This adds another layer of administrative burden.

OHA: Out of scope for investigators.

It Depends (5):
OSH, OAHHS, AOCMHP, DRO, OCDLA

OSH: This is considered best practice within treatment settings already. Ideally should be considered one component of a more comprehensive, consistently taught curriculum re: civil commitment in Oregon for investigators.

OAHHS: How would this proposal change current law?

AOCMHP: The role of the investigator is to determine probable cause. Other contracted providers would engage in discharge planning with the hospital.

DRO: Individuals retain the autonomy to grant and withhold consent to discuss personal health information. "Encourage" to seek ROI is vague... does it involve putting pressure on the PAMI to sign ROI, or just putting pressure on CMHP to attempt to utilize ROI if agreed to. It would be unacceptable to pressure the PAMI to sign an ROI.

OCDLA: I'm not sure if this is what's meant by "ROI" but the AMIP should have the ability to decide who gets that information.

Abstain (0)

2. 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 (14/0/2/0)

Idea #: 77

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)

3. Establish a centralized state repository for NMIs than can be accessed by investigators, providers, and courts (11/2/3/0)

Idea #: 78

Yes (11):
AOC, AOCMHP, CCO, LOC, MOMI, ODAA, ODHS, OHA, OSH, OSSA, Tribes

OSH: Having historical data available is an important tool when considering 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, given the potential for bias based on historical data when that data may not always be relevant to current circumstances is certainly a risk. Clear and specific guidance should be formally developed and provided to investigators (or others) as to how to most appropriately make use of such data, if it is

available, and how to mitigate risk of implicit bias. (This is a situation where there exists a trade-off -- risks with a repository and risks without one).

AOCMHP: Who is responsible for maintaining the database?

No (2):
OAHHS, DRO

OAHHS: How would this work? What would the costs be? (we expect it would be expensive) How would patient confidentiality be protected?

DRO: This is overly prejudicial (see answer 11) and unfairly impacts marginalized communities who have historically had higher rates of involvement with law enforcement. NMI is very early in the process when not enough is known about the individual's mental health to see if anything needs to happen. If accessed by "courts" does that include criminal cases, family law cases, evictions, etc.? However, if this is incorporated, need to include DRO (P&A) and defense access.

It Depends (3):
OCDLA, OJD, NAMI

OCDLA: There would need to be clear restrictions on who could access the information and how it could be used. I would also want the NMIs to expire from the database after a certain period of time.

OJD: We have concerns about privacy, retention, security and who is maintaining this.

NAMI: This one is a tough one. Investigators should know about previous NMIs to evaluate whether they are pertinent. But an NMI alone isn't necessarily telling. So what value would it add for a provider, who should be evaluating a person on current circumstances and historical information provided by people who have witnessed the behavior in the past? And why should the court access it? If past NMIs aren't pertinent and don't show up in the investigator's report, why should the court have access? It may be best to limit this to investigators.

Abstain (0)

4. Establish a statewide system for tracking civil commitment to improve data sharing and standardization of care across counties (15/1/0/0)

Idea #: 79

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)

5. Explore use of psychiatric advance directives to facilitate needed information exchange and storage (12/0/3/1)

Idea #: 80

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

XV. Data Collection, Analysis, and Reporting (Policy)

1. Establish a civil commitment monitoring system (e.g., a robust and funded program that follows people through the entire civil commitment system for improved care coordination, treatment outcomes, and compliance) (10/4/2/0)

Idea #: 81

Yes (10):
AOC, AOCMHP, MOMI, OAHHS, OCDLA, ODAA, OHA, OSH, OSSA, Tribes

---

No (4):
LOC, DRO, ODHS, NAMI

LOC: This is what the ombudsman and counsel are for.

DRO: Aren't people being followed? How are people not being followed during their commitment? What information is needed that is not already being used?

ODHS: the benefit of this is not clear.

NAMI: We are already supposed to have this system, or something akin to it. Creating something new to layer on top of structures we have isn't efficient. Changes to the existing structure should be considered, instead.

It Depends (2):
OJD, CCO

OJD: Who is going to do this and who has access to the information

CCO: It is unclear as to who would be monitoring this system

Abstain (0)

2. Collect data and report how placement of individuals under civil commitment differs in different communities (11/2/3/0)

Idea #: 82

Yes (11):
AOC, AOCMHP, DRO, LOC, MOMI, OCDLA, ODAA, ODHS, OJD, OSH, 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 will collect and what will the data be used for.

No (2):
OAHHS, CCO

It Depends (3):
OHA, NAMI, OSSA

OHA: Who is to collect and analyze it?

NAMI: Where this resides -- who's responsibility this is -- is just as important as the idea, if not more important. We are awash in requirements for data collection. Yet, we seem to always declare we lack data. Clearly there's a disconnect. Layering on one more requirement, which will trickle down to the provider level, isn't prudent.

OSSA: I support if the goal of this is to identify what works and doesn't harm the reputation of small, rural communities with almost no resources.

Abstain (0)

3. Collect and analyze socioeconomic data about individuals in the civil commitment process (13/0/0/3)

Idea #: 83

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)

4. 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 (13/0/3/0)

Idea #: 84

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)

5. Improve data collection efforts by to match court records involving the same individual across cases and case types (12/2/0/2)

Idea #: 85

Yes (12):
AOC, AOCMHP, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA

No (2):
DRO, CCO

DRO: Impinges on individual due process rights - unduly prejudicial because it would be used as evidence of the predictability of future behavior.

It Depends (0)

Abstain (2):
Tribes, NAMI

6. 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 (11/0/5/0)

Idea #: 86

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: ORS 427 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)

7. Collect data to compare and report the types, quantity, and outcomes of treatment and services provided by counties to civilly committed individuals (12/1/2/1)

Idea #: 87

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

8. Research civil commitment systems in other states and other parts of the world (10/0/4/2)

Idea #: 88

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

9. 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 (11/1/2/2)

Idea #: 89

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 information 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.

Abstain (2):
OSH, Tribes

XVI. Rights of Individuals in Civil Commitment System

1. Require Oregon Public Defense Services to educate defense lawyers on effective representative of person with mental illness who do not want to be committed (13/1/2/0)

Idea #: 90

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)

2. Require OHA to identify individuals in civil commitment cases who may require specialized legal advocacy (e.g., people with intellectual and developmental disabilities) (8/3/5/0)

Idea #: 91

Yes (8):
AOC, CCO, DRO, MOMI, NAMI, OAHHS, OSH, OSSA, Tribes

No (3):
LOC, OHA, OJD

LOC: They are already getting appointed counsel. They are best situated to determine if a different expert is needed.

OHA: This would be with OJD as they notify and assign public defense.

OJD: This does not seem manageable at the time of appointment, but we believe lawyers need education on representation intellectual and developmental disabilities.

It Depends (5):
AOCMHP, OCDLA, ODAA, ODHS, NAMI

AOCMHP: This is very broad and does not seem feasible as there are thousands of people who are investigated on NMIs every year and this would require an enormous resource.

OCDLA: All people on commitments require specialized advocacy. The training requirements from OPDS should cover other sub-populations (ASD, IDD, etc) under the commitment umbrella.

ODAA: It would be nice but may also be very difficult to pull this off with current timelines.

ODHS: While it would be great to have legal advocates specific for people with co-occurring disorders, it would be better to have an expectation that each person with IDD has an advocate assigned rather than identifying those who could benefit from it.

NAMI: This is not feasible at the OHA level. This should be at the investigative level. If there is a requirement, it should be directing OHA to put this in rule.

Abstain (0)

3. Amend statute or rule to appoint the same defense counsel to represent and individual throughout the civil commitment process when possible (10/3/3/0)

Idea #: 92

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

No (3):
DRO, OJD, ODHS

DRO: Logistically seems very difficult and likely not practicable. However, presumably most counties (or all counties) do not have more than one main OPDC civil commitment

defense contract provider anyway, so it would go to the same contract holder as a matter of course.

OJD: No practical in many communities.

ODHS: the coordination and potential delays this could cause a client aren't outweighing the benefit to me.

It Depends (3):
OSH, AOCMHP, OCDLA

OSH: Under what circumstances will the patient's preference for a different attorney override this requirement for consistency?

AOCMHP: May delay the process unnecessarily.

OCDLA: I'm not sure if this is referencing AOT, or through appellate procedure, or something else. Lawyers from the same firm can communicate information with each other and would not necessarily get in the way of continuity of care.

Abstain (0)

4. Amend rules to establish a process that supports individuals and families to access advocates, including patient advocacy organizations, legal advocates, and peers (13/0/3/0)

Idea #: 93

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)

XVII. Funding System

1. Amend statute to require state agencies and counties to track and report the use and outcomes of designated behavioral health funding (13/0/1/2)

Idea #: 94

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

2. 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 (10/1/3/2)

Idea #: 95

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

3. Research creative ways that other states have used Medicaid for housing and other needs of civilly committed individuals (12/1/1/2)

Idea #: 96

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

XVIII. Transportation

1. 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 (15/0/1/0)

Idea #: 97

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)

XVIX. Liability

1. Assess the types and level of concern about different areas of liability in the civil commitment system (11/1/2/1)

Idea #: 98

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.

2. 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 (11/1/3/1)

Idea #: 99

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

XXX. Provider Safety

1. Provide training and education on vicarious trauma to staff of residential treatment facilities, acute hospitals, and OSH (11/1/2/2)

Idea #: 100

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

2. Require residential treatment facilities, acute hospitals, and OSH to provide situational training for staff to recognize when a situation is becoming unsafe (14/0/1/1)

Idea #: 101

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

XXXI. Collaboration with Oregon Tribes

1. Evaluate how tribal communities and tribal courts interact with the medical and legal systems in civil commitment processes (16/0/0/0)

Idea #: 102

Yes (16):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (0)

Abstain (0)

2. Require the state to seek input from tribal governments and treatment providers on the civil commitment system, including AOT (14/0/1/1)

Idea #: 103

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

3. 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 (11/1/3/1)

Idea #: 104

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

4. Evaluate how cooperative agreements between Oregon and each of the Oregon Tribes may be used to improve the civil commitment process for tribal members (16/0/0/0)

Idea #: 105

Yes (16):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, NAMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

OSH: FYI: recommend looking at Alaska programs for diversion and civil commitment stakeholder coordination.

No (0)

It Depends (0)

Abstain (0)

5. 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 (10/1/4/1)

Idea #: 106

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

6. Amend rules to allow tribes to participate in civil commitment proceedings involving tribal members, similar to a child welfare case (12/1/2/0)

Idea #: 107

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 shouldn't 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.

XXXII. Equity

1. 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 (11/1/4/0)

Idea #: 108

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)

2. 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) (12/1/1/2)

Idea #: 109

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

3. 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 (12/0/3/1)

Idea #: 110

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

4. 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 (12/0/3/1)

Idea #: 111

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

5. Amend statute to require bias and implicit bias training for all professionals working with the civil commitment population (9/1/4/1)

Idea #: 112

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?

6. Amend statute to require OHA to increase the number of secure residential treatment facilities throughout the state to ensure that individuals under civil commitment can be placed in their own community (12/2/2/0)

Idea #: 113

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

NAMI: This is inappropriate for statute. The Public Consulting Group analysis should help determine overall need, and the report looks at needs by region, which will be more helpful than a law.

No (2):
OHA, CCO

OHA: More emphasis needs to be placed on AFH, RTH, RTF. Civil commitment does not require SRTF level of care. We want folks to integrate into community, which means no locks.

It Depends (2):
DRO, ODAA

DRO: Instead of randomly increasing beds, need to study and do a needs-based assessment. Involuntary SRTF is not hospital-level of care, and is not Medicaid-funded.

ODAA: This cannot be at the expense of siting for A&A/GEI individuals and SRTFs that meet those needs.

Abstain (0)

XXXIII. Transition between Aid & Assist and Civil Commitment

1. Amend statute to address time limits and other procedural requirements when initiating a civil commitment proceeding for an individual who is a defendant in a criminal case and has been found unfit to proceed (9/2/4/0)

Idea #: 114

Yes (9):
AOC, AOCMHP, LOC, MOMI, OAHHS, ODHS, OHA, OJD, OSSA

No (2):
DRO, CCO

DRO: There are already time limits - no different for clients whether or not they are involved in the criminal justice system as well. See Jackson v. Indiana; and Mink. Is this a way to work around statute of limitations issues?

It Depends (4):
OSH, OCDLA, ODAA, NAMI

OSH: Is this referring to standard civil commitment or to ORS 426.701 civil commitment? Both? Are there significant differences in time limits/procedural requirements if initiated in the community vs if initiated for an OSH inpatient whose ORS 161.370 commitment is ending?

OCDLA: I would need to see what was suggested. Generally I support making it easier to take people out of the .370 system when they should be in the civil commitment system, but I would want it to be clear it's meant to be a transfer, not a way to keep someone charged with a crime (especially a low level crime like trespass or disorderly conduct) that comes from their mental illness and they should be in the hospital.

ODAA: This would need to be a very technical discussion.

NAMI: Our understanding is that someone in jail wouldn't qualify for civil commitment because they are no longer in imminent danger of harming themselves or harming others and their basic personal needs are presumedly being met. Rather than addressing time limits and procedural requirements, Oregon should look at how to alter criteria for commitment so that it folds in the aid and assist population.

Abstain (0)

(Tribes skipped)

XXXIV. Psychiatric Advance Directives

1. 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 (10/1/4/1)

Idea #: 115

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

XV. Guardianships

1. Increase state funding for public guardian services for people who need long-term support options due to a behavioral health condition (14/1/0/1)

Idea #: 116

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

XVI. Commitment of Individuals with Intellectual Disability

1. Require Oregon Developmental Disabilities Program to establish acute support options for people with intellectual disabilities with a co-occurring mental illness (12/2/2/0)

Idea #: 117

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

ODAA: Is this the right entity to develop acute care facilities?

No (2):
DRO, ODHS

DRO: They are not responsible for getting people psychiatric care... it is the job of the OHA.

ODHS: If not for an intellectual disability, people in this category would benefit from all other efforts and opportunities available to people with mental illness and co-occurring conditions. These are the opportunities that are also needed for people with ID, but it is not due to the ID that they have this need. The IDD program supports people due to the intellectual or developmental disability. OHA has supports for people related to a mental health condition. There is no alternative option through APD for people with physical impairments or TBI, there is no reason that the IDD/ODDS program should be figuring out how to support the mental health/co-occurring conditions.

It Depends (2):
OCDLA, NAMI

OCDLA: I don't know what those options would look like and I don't want to agree until I see them.

NAMI: This must encompass more than the Oregon Developmental Disabilities Program. This likely would involve multiple agencies and payers.

Abstain 0()

2. Require state to develop or provide access to specialized treatment programs for individuals committed for intellectual disabilities (11/0/4/1)

Idea #: 118

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.

3. Require state to provide statewide training for behavioral health treatment providers on working with civilly committed individuals with intellectual disabilities (8/1/4/3)

Idea #: 119

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 committed.

Abstain (3):
LOC, Tribes, NAMI

4. Amend statute to require OHA and DHS to ensure that facilities and providers are available to support people with co-occurring mental illness and intellectual disabilities (11/3/2/0)

Idea #: 120

Yes (11):
AOC, AOCMHP, CCO, LOC, MOMI, OAHHS, OCDLA, ODHS, OSH, OSSA, Tribes

No (3):
DRO, OHA, NAMI

DRO: Start by enforcing existing anti-discrimination laws (e.g. ADA).

OHA: Specialized options makes more sense.

NAMI: Laws already exist around network adequacy and having services available to address the underlying conditions causing crises for the duration necessary for recovery. The question is how to force the agencies via Medicaid to enforce such provisions, or to at least honestly price what investment it will take to build up provider networks. On the commercial side, DCBS needs to more aggressively use its regulatory powers. For uncovered, ERIS, Medicare -- there may be a role for the state. But it's hard to see how they can meet the needs entirely with state general funds.

It Depends (2):
ODAA, OJD

ODAA: It would be inefficient to require this of all facilities, but perhaps one or two per region would be appropriate and to assure placement at one of those facilities for these individuals.

OJD: Not sure if this requires a change of statute or whether it should be part of a certification process.

Abstain (0)

5. Require state to develop and implement plans to expand Oregon's access to qualified evaluators who can diagnose and assist with treatment decisions for individuals with intellectual disabilities (15/0/0/1)

Idea #: 121

Yes (15):
AOC, AOCMHP, CCO, DRO, LOC, MOMI, OAHHS, OCDLA, ODAA, ODHS, OHA, OJD, OSH, OSSA, Tribes

No (0)

It Depends (0)

Abstain (1):
NAMI

XVII. Co-Occurring Mental Illness and Substance Use Disorder

1. Explore different treatment models for civilly committed individuals with co-occurring mental illness and substance use disorder (12/0/2/2)

Idea #: 122

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

2. Amend statue and rules to require publicly-funded behavioral health treatment facilities to train providers in assessment and treatment of individuals with co-occurring mental illness and substance use disorder (12/2/1/1)

Idea #: 123

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

OJD: We are wondering whether this is better addressed as a rule/certification change than as a statutory change.

No (2):
OHA, NAMI

OHA: Rule changes, yes. Or certification/license requirements.

NAMI: There's aren't a lot of generally recognized instruments that assess someone for co-occurring disorders. Nor is the issue that providers don't recognize, assess, and diagnose co-occurring disorders. It's that without adequate reimbursement and helpful rules and contracts, providers who serve the publicly funded system cannot provide these services.

It Depends (1):
LOC

LOC: We should be hiring people already trained in this field. It is unreasonable to try and contort providers who are not previously trained and educated in this niche into this specialized provider role with a few short training sessions.

Abstain (1):
CCO

3. Amend statute to prohibit dual-diagnosis programs from excluding individuals on the basis of their mental health symptom acuity (6/2/6/2)

Idea #: 124

Yes (6):
AOC, AOCMHP, LOC, MOMI, OAHHS, ODHS

AOCMHP: Although the sentiment is appreciated, there will be different levels of dual diagnosis care, so some person's MH symptom acuity would be contraindicated for the level of treatment.

No (2):
OSH, OHA

OSH: Would be preferable to have increased availability of dual dx services of different care levels - tailor the treatment/setting to the acuity level of the patient.

OHA: Not every facility is equipped for all levels of acuity.

It Depends (6):
DRO, OCDLA, ODAA, OJD, NAMI, OSSA

DRO: Depends on the individualized treatment needs of the individual. Individuals should have the right to appropriate care, but not to "specific" care. Increase accountability for exclusion criteria.

OCDLA: I don't want to take away the ability of providers to say what they feel capable of managing. I imagine there are some instances in which a facility is saying they don't

have the ability to manage a patient at that level of acuity. The response should then be to find a placement that does have that ability rather than put someone in a setting that has already been determined not to match their level of need.

ODAA: It may be beneficial for a handful of treatment centers to focus on SUD only, to specialize, perhaps, but the vast majority should be dual diagnosis.

OJD: Programs need to be developed that will treat individuals with co-occurring disorders and high level of MH acuity but not all programs should be required to do so.

NAMI: This idea is too broad. Rather than prohibit in all circumstances, we should at this issue as a matter of network adequacy while also rooting out bad actors who exclude mental health as a matter of expediency.

OSSA: High acuity may be too disruptive in a program. Maybe once a person is stabilized they should be able to participate.

Abstain (2):
Tribes, CCO

XVIII. Education about Civil Commitment

1. 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 (14/0/1/1)

Idea #: 125

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

2. Require circuit court judges to participate in regular listening sessions with people with lived experience in the civil commitment system (including families) to hear how the system is working from their perspective (8/2/4/2)

Idea #: 126

Yes (8):
AOC, AOCMHP, CCO, MOMI, OAHHS, ODHS, OHA, Tribes

OAHHS: Yes, this is valuable. In addition, it would be valuable for the judges to hear from community providers and hospitals regarding how the system works and the limitations of the current system.

No (2):
DRO, ODAA

DRO: Not sure this would help or change the legal process. Judges hear from those people in every hearing, so they definitely are exposed to people's experiences in the system.

ODAA: ODAA is reluctant to mandate the courts do listening sessions.

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

OSH: Hearing directly from people receiving care in the system is important to broaden and deepen insight, particularly that of the more marginalized voices involved. Would recommend that listening sessions also occur with clinicians and with public safety, each group with potential for offering insights and stories to expand understanding.

OCDLA: The focus should be mostly on the person with lived experience. I can see how this could be read just to have the families' perspective, or even both the family and the person, but primarily the person with lived experience should be the focus.

OJD: This should be encouraged not necessarily required.

NAMI: "Require" may be too strong. Might be more appropriate to offer such sessions more frequently and widely.

Abstain (2):
LOC, OSSA

XVIX. Structural System Changes

1. 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) (13/1/2/0)

Idea #: 127

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)

2. Amend statute to create a process for expunging civil commitments from an individual's record (6/2/5/3)

Idea #: 128

Yes (6):
AOC, DRO, LOC, MOMI, OCDLA, OJD

MOMI: A person's commitment record should not be used against them in attempting to get work and housing. However, the record is needed if they decompensate, and a history of illness is key to getting the right level of care in this new moment. Families would prefer rules that do not allow discrimination in work and housing based on history of civil commitment--with enforcement.

No (2):
ODAA, ODHS

ODAA: ODAA does not support this.

ODHS: without exploring the unintended consequences of what this might mean, my vote is no.

It Depends (5):
OSH, OAHHS, AOCMHP, OHA, NAMI

OSH: Assuming this is referring to legal records and not to medical record. This creates a challenge around the fact that in psychiatry, past behavior is identified as the best predictor of future psychiatrically driven behaviors. Uncertainty as to whether the psychosocial benefits of expungement outweigh the risks of missing this major element of the individual's history. Warrants extensive discussion/exploration and theoretical navigation of any predictable negative consequences.

OAHHS: Would the expungement mean that providers would not have access to information on prior civil commitments?

AOCMHP: Not relevant - this is already private health information and not available to the public. Additionally, this information prohibits people from owning guns, which we would want to stay intact.

OHA: More research on consequences in Oregon is needed.

Abstain (3):
Tribes, CCO, OSSA

XXX. Comments on this Survey

AOCMHP: I responded, 'It depends', to the questions we weren't able to reach consensus on and provided additional information from those who had answered 'no' or 'it depends' to clarify why we weren't able to get to 'yes'. These questions are: 13, 14, 15, 25, 34, 35, 36, 50, 69, 74, 76, 80, 91, 92, and 128. The reasons for lack of consensus on these questions seem to relate to size of county, bandwidth, and numbers of civil commitments/NMIs.

DRO: The survey was very vague... the ideas are really only snippets of ideas that are so dependent on circumstances and context that almost any of them could change things in a negative way or in a positive way. It is very hard to weigh in when the concepts are so untethered.

ODHS: Many questions are challenging to answer without knowing if funds or resources will be available. Several questions felt loaded or dependent on other parts of the same question.

MOMI: The top priority for families is a lower threshold for civil commitment to prevent harm instead of requiring violence and tragedy. In the current system, there has to be a victim before intervention is possible. That victim is usually a member of the family. This cannot be the plan.

XXXI. Comments on Commitment to Change Workgroup

DRO: There has been too little representation in this process of people with actual lived experience (as opposed to families which is a very different perspective). The experiences and frustrations of families, while valid, do not take into account the emotions, experiences, and civil liberties of the individuals. There was some lip service to lived experience, but the reality fell very flat.

MOMI: A few members of this committee entered the work with a completely closed mind--determined to stop civil commitment from expanding and intent on making it harder to hospitalize someone "against their will." They refused to listen or see the obvious reasons for the work--that the status quo is failing to protect life and safety. They weaponized committee surveys to further their own agenda and were closed to reasonable discussions. That was disappointing.