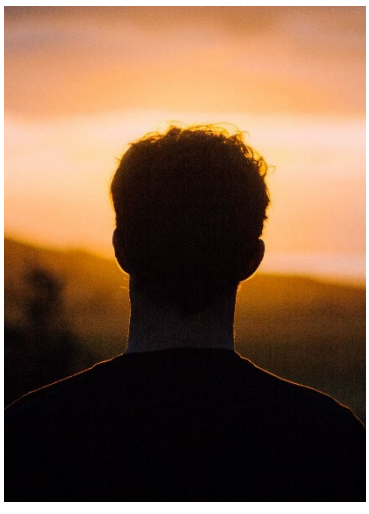
Commitment to Change Workgroup

A Review of Oregon's Civil Commitment System



Final Report to the Chief Justice

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Prepared on behalf of:

Commitment to Change Workgroup

In Memoriam

In dedication to Chris Thomas for her excellent facilitation and support to the workgroup in navigating difficult conversations with a diversity of perspectives.

Contents

Letter from the Co-Chairs, Chief Justice's Behavioral Health Advisory Committee

The **Chief Justice's Behavioral Health Advisory Committee** (BHAC) recommended the formation of the **Commitment to Change Workgroup** because Oregon's civil commitment system is failing to protect some of the state's most vulnerable residents. Our courts receive nearly 8,000 notices of mental illness in a year, each prompted by a serious concern that an individual's mental disorder is so severe that it is causing the person to be dangerous to themselves or others or making them unable to meet their basic needs. Less than 6% of those individuals reach the legal threshold for civil commitment. We are concerned about the roughly 7,500 individuals experiencing serious mental health challenges who may not receive needed services, supports, and treatment. We are concerned that many of the roughly 500 individuals who are civilly committed each year are placed in settings that are not equipped to meet their needs because more appropriate settings are not available to them. These concerns are not new, and they are not unique to judges.

The current focus on Oregon's civil commitment system is part of expanded interest in the state's behavioral health system. A day rarely passes without media coverage of the impact of unmet behavioral health needs on our communities. Individuals with behavioral health challenges who become involved in the justice system are particularly dependent on the availability of appropriate care, whether they are facing criminal charges and found unfit to stand trial, or found guilty except for insanity (GEI), or their illness is presenting such imminent risks that commitment is possible. We recognize that changes to any one part of the behavioral health system can impact other parts. Likewise, changes to one process at the intersection of behavioral health and the justice systems, such as aid and assist, GEI, civil commitment, and extremely dangerous person commitment, can impact the other processes. Therefore, changes to the civil commitment system, like changes to other processes at the intersection of the behavioral health and justice systems, should be made with awareness of their global impacts.

This report reflects hundreds of hours of thought and discussions about Oregon's civil commitment system by the individuals who make the rules, carry out the work, and experience it as an involuntary participant or advocate of participants. We are grateful to former Chief Justice Martha L. Walters and current Chief Justice Meagan A. Flynn for creating and sustaining the Commitment to Change Workgroup. We applaud the dedication, collaboration, and thoughtful contributions of workgroup members and staff.

This report presents dozens of recommendations for actions to improve the civil commitment system, but its value does not end there. Undoubtedly, more work remains, and discussions about Oregon's civil commitment system will continue. This comprehensive overview of the civil commitment system provides an ongoing resource and sets the groundwork for continuing work.

Nan Waller
Judge, Multnomah County Circuit Court

Matthew Donohue
Presiding Judge, Benton County Circuit Court

Executive Summary

Former Chief Justice L. Martha Walters formed the Commitment to Change (CTC) Workgroup in 2022. She charged it with completing a comprehensive review of Oregon's civil commitment system and developing recommendations for how to improve that system, in time for Oregon's 2025 legislative session. The workgroup engaged in facilitated meetings for two years. After a year of learning about all parts of the civil commitment system and discussing concerns, the workgroup developed and considered 244 reform ideas from workgroup members, constituent survey results, and listening sessions for people with lived experience and Oregon's Tribes.

Mental Illness and Pathways to Care

A higher percentage of Oregonians report having a mental illness than in any other state (27%), six percentage points higher than the national average.[1] Individuals experiencing a mental illness must navigate a complex system of public and private insurance coverage to receive care. Federal laws establish parity requirements between insurance coverage of physical and mental health care that apply to both public and private insurers.[2] Coordinated care organizations (CCOs) — which administer Oregon's Medicaid program, the Oregon Health Plan (OHP) — are responsible for providing behavioral health care for the roughly one-third of Oregonians currently enrolled in the OHP.[3] Some individuals experiencing severe mental illness may have a guardian appointed to direct their care, while others may be required to receive mental health care under a court order.

"Not all battles are visible and neither are the victories."
– Brittany Burgunder

Photo by Ramon Rosati

[1] Mental Health America, *The State of Mental Health in America-2023*. Accessed 23 October 2024.

[2] Centers for Medicare and Medicaid Services, The Mental Health Parity and Addiction Equity Act (MHPAEA). Accessed 31 October 2024.

[3] Oregon Health Authority, Office of Health Analytics, Oregon Health Authority Medicaid Enrollment Report, updated 1 October 2024; Oregon Health Authority, Oregon Health Plan. Accessed 23 October 2024.

About the Civil Commitment System

Civil commitment is court-ordered involuntary treatment or care for individuals whose mental illness or intellectual disability results in:

- an imminent danger of harm to self or others, or
- an inability to provide for basic personal needs that are necessary to avoid serious physical harm in the near future.

Civil commitment laws establish due process rights to protect individuals from involuntary treatment or confinement without a court order. The civil commitment system encompasses both the legal processes that precede a court order for commitment and the course of treatment that follows. This report provides a summary of the history of civil commitment nationally and in Oregon.

Steps in Oregon's Civil Commitment Process

The civil commitment process is complex. It includes many steps and requires action by multiple entities across the behavioral health and justice systems. Workgroup meetings were organized around the chronological steps of a civil commitment from the time the court receives a notice of mental illness or an emergency psychiatric hold, through the legal processes to determine if commitment is appropriate, continuing through the treatment provided to civilly committed individuals, and ending with the support to assist individuals with transition following commitment. This report provides an overview of the entire process and information about each step.

Concerns about Oregon's Civil Commitment Process

The membership of the workgroup reflected the diversity of participants in the civil commitment system. That diversity, coupled with listening sessions and constituent surveys, offered the workgroup the opportunity to develop broad awareness and deep understanding of the challenges and concerns with the civil commitment process.

Universal concerns included the lack of access to adequate mental health care before a person's mental disorder becomes severe enough to require commitment, as well as appropriate care during a commitment and continuing care after a commitment. Workgroup members also had shared concerns about the lack of clarity in current statutory criteria that courts use to evaluate dangerousness and inability to meet basic needs. Additionally, members raised concerns about whether defense counsel is appointed early enough in the commitment process to protect the person's rights, and whether the initial five-judicial-day timeline established in statute between the start of an emergency psychiatric hold and the hearing is sufficient to adequately complete all tasks required by statute. The full range of concerns expressed are outlined in bulleted lists, organized into 40 categories, spanning 19 pages of this report.

Workgroup Recommendations

The workgroup reached unanimous consensus on 51 recommendations across 26 categories. Some of the recommendations address specific steps in the civil commitment process, such as the investigation following a notice of mental illness, the appointment of counsel, and the mental health examination. Others address more global issues, such as community-based behavioral health services, data collection and analysis, and equity. In its final member survey, the workgroup considered multiple variations of each idea and noted all versions that they could support. They did not reach consensus on the same version of any idea in most cases. Therefore, the wording of recommendations in the final report reflects the core concept of the idea. The specific variations of ideas that each member would recommend are provided in the Revisions Survey results, available on the CTC Workgroup webpage of the Oregon Judicial Department website.

Other Ideas and Positions

While the workgroup's final recommendations are limited to those that received unanimous agreement, many other ideas were supported by a majority of workgroup members. Beyond the 51 recommendations, the report lists 36 ideas that were supported by all but one, nine ideas supported by all but two or three, and more than 100 additional ideas that were supported by the majority of respondents.

Looking Ahead

This report provides a rich source of information for policymakers and interested parties to better understand the civil commitment system, including an extensive list of stakeholder concerns and ideas to resolve them. The recommendations include a mix of specific, legislation-ready proposals and other concepts for further consideration. Policymakers can use this report to prioritize reforms for the 2025 legislative session and build on two years of work by nearly two dozen stakeholders committed to a better civil commitment system.

Click here to see the final recommendations.

Commitment to Change Workgroup Members

The chief justice appointed workgroup members to represent designated stakeholder interests in Oregon's civil commitment system. For some stakeholders, the individual initially appointed as a representative was replaced by another representative. The following membership list reflects the members appointed by the Chief Justice Order No. 22-019.[4]

Oregon Judicial Department Hon. Matthew Donohue Hon. Nan Waller **Oregon Health Authority** Zach Thornhill **Oregon State Hospital** Dr. Katherine Tacker **Disability Rights Oregon** Jude Kassar **Mothers of the Mentally Ill** Jerri Clark **Oregon Tribes** Angie Butler **Coordinated Care Organizations** Melissa Thompson **Oregon Association of Hospitals and Health Systems** Meghan Slotemaker **Oregon Legislature** Sen. Floyd Prozanski (D – District 4) Sen. Kim Thatcher (R – District 11) Rep. Jason Kropf (D – District 54) Rep. Christine Goodwin (R – District 12) **Governor's Office** Juliana Wallace	**Oregon Department of Human Services** Chelas Kronenberg **National Alliance for Mental Illness, Oregon Chapter** Chris Bouneff **Mental Health and Addiction Association of Oregon** Janie Gullickson **Association of Oregon Community Mental Health Providers** Cherryl Ramirez **Association of Oregon Counties** Marcus Vejar **League of Oregon Cities** Dakotah Thompson **Oregon District Attorneys Association** Channa Newell **Oregon Criminal Defense Lawyers Association** Allison Knight **Oregon Association Chiefs of Police** Chief Jim Ferraris **Oregon State Sheriffs' Association** Sheriff Matt Phillips

[4] This was the second Chief Justice Order (CJO) appointing members to the workgroup. Chief Justice Martha L. Walters issued the first CJO on Aug. 23, 2022, and a corrected version on Sept. 1, 2022. The second CJO was issued to replace the representatives of some entities, replace the organization representing families of individuals with lived experience, and add representatives of the Governor's Office, Oregon Tribes, League of Oregon Cities, and coordinated care organizations. Previous members included Judge Suzanne Chanti, William Osborne, KC Lewis, Sandy Bumpus, Scott Healy, Gina Nikkel, and Kevin Campbell. Other changes followed this CJO: Janie Gullickson resigned from the workgroup in November 2023 due to time constraints; Rep. Charlie Conrad succeeded Rep. Christine Goodwin; and Chief Ferraris retired midway through the workgroup process and was not replaced.

About the Workgroup

Purpose, Charge, and Scope

Oregon's civil commitment statutes have remained largely unchanged since 1973, despite periodic efforts to refine them. Reform has been challenging due to the complexity of the system's governance and funding structures, as well as fundamental differences in goals, objectives, and philosophies among the multiple government entities, organizations, and individuals that oversee, manage, advocate, and experience its operations.

Historically, efforts to improve Oregon's civil commitment system have focused narrowly on particular concerns and failed to reach necessary consensus for legislative success. The Oregon Judicial Department's Behavioral Health Advisory Committee (BHAC) advised former Supreme Court Chief Justice Martha L. Walters to try a different approach: a comprehensive review of the civil commitment system that gives voice to all impacted stakeholders and seeks to build consensus through inclusion, transparency, and respect for all perspectives.

Chief Justice Walters charged the CTC Workgroup to review all of Oregon's civil commitment statutes, consider both systemic and discrete changes through a wholistic lens, and develop recommendations for Oregon's 2025 legislative session. Reform goals included greater statutory clarity, improvements to civil commitment processes, better outcomes for individuals engaged in the civil commitment system, and protection of public safety.

Consistent with its charge, the workgroup defined its scope to evaluate the civil commitment system from the time a person is placed on a psychiatric hold or identified in a notice of mental illness, continuing through the stages of investigation, opportunities for diversion, psychological examinations, hearing, placements following adjudication, discharge, dismissal, and transitional supports. The workgroup also considered the underlying principles of civil commitment, current science on mental illness, legal criteria and processes for commitment, and the intersections of civil commitment with criminal justice, behavioral health, and social service systems.

A well-functioning civil commitment system depends on a well-functioning behavioral health system. However, Chief Justice Walters distinguished the CTC Workgroup charge from complementary state and local initiatives to expand and improve behavioral health care generally, and she asked the workgroup to focus on the formal processes of the civil commitment system.


Role of the Oregon Judicial Department

The civil commitment system involves multiple entities that come together through the courts. The Oregon Judicial Department (OJD) served as a convener of the CTC Workgroup by providing an expert, neutral facilitator to present information, facilitate discussion, and promote consensus-building. In addition to employing dedicated staff to develop resources, coordinate outreach, manage member and public input, and provide administrative support, OJD also participated in the workgroup as a stakeholder represented by two circuit court judges.

Workgroup Representation

Former Chief Justice Walters and current Chief Justice Flynn appointed 24 workgroup members to represent a broad range of stakeholders in the civil commitment system, including government agencies, professional and private organizations, and communities that collectively develop, manage, fund, advocate, adjudicate, monitor, and otherwise participate in the civil commitment system. Members represented courts, state agencies, legislators, local governments, Oregon Tribes, health care providers, law enforcement, public defense and prosecution, and people with lived experience.

The Chief Justices recognized the inherent challenges of creating a representative workgroup that is both inclusive of all who have an interest in the workgroup outcome and nimble enough to carry out the charge within a limited time. They also recognized that the views of individuals within a single constituency are rarely monolithic, and that the workgroup needed a way to receive the diversity of perspectives across and within each constituency.

Responding to those considerations, the workgroup established processes to inform and incorporate the voices of all Oregonians with an interest in the state's civil commitment system through balanced representation, a constituent communication plan, and constituent listening sessions.

Workgroup Representation

Behavioral Health Providers	•Cherryl Ramirez, Oregon Association of Community Mental Health Programs •Meghan Slotemaker, Oregon Association of Hospitals and Health Systems •Melissa Thompson, CCO Oregon
Law Enforcement	•Matt Phillips, Oregon State Sheriffs' Association •Jim Ferraris, Oregon Association Chiefs of Police
Legal Representation	•Allison Knight, Oregon Criminal Defense Lawyers Association •Channa Newell, Oregon District Attorneys Association
Local Governments	•Marcus Vejar, Association of Oregon Counties •Dakotah Thompson, League of Oregon Cities
Oregon Executive Branch	•Juliana Wallace, Office of Governor Tina Kotek •Zachary Thornhill, Oregon Health Authority •Dr. Katherine Tacker, Oregon State Hospital •Chelas Kronenberg, Oregon Department of Human Services
Oregon Judicial Branch	•Judge Nan Waller, Multnomah County Circuit Court •Judge Matthew Donohue, Benton County Circuit Court
Oregon Legislative Branch	•Sen. Floyd Prozanski, Oregon Senate •Sen. Kim Thatcher, Oregon Senate •Rep. Jason Kropf, Oregon House of Representatives •Rep. Christine Goodwin, Oregon House of Representatives
Oregon Tribes	•Angie Butler, Oregon Health Authority Tribal Mental Health Program and Policy Analyst
Organizations Serving People with Lived Experience	•Jude Kassar, Disability Rights Oregon •Chris Bouneff, National Alliance on Mental Illness Oregon •Jerri Clark, Mothers of the Mentally Ill •Janie Gullickson, Mental Health and Addiction Association of Oregon

Workgroup Decision-Making

Policy-driven workgroups typically seek consensus among stakeholders on how to resolve the concerns that prompted the workgroup, and the CTC Workgroup is no exception. However, the workgroup learned that the complexity of the civil commitment system and the different roles of those who work or participate in it result in strongly divergent perspectives on some issues, even within a single stakeholder group. For this reason, the Workgroup agreed that consensus should be defined narrowly as unanimous agreement among members that respond to the workgroup's final survey, and that even if the result is fewer consensus-driven recommendations, there is great value in identifying the different perspectives for policymakers to consider.

Workgroup Process

The workgroup met from October 2022 through September 2024. It was facilitated by Chris Thomas from October 2022 to June 2024, and by Debra Maryanov from June 2024 to September 2024. Staff support was provided by Candace Joyner, Laura Cohen, Debra Maryanov, Christopher Hamilton, and Brianna Navarro.

The workgroup process was designed to inform members and stakeholders, enhance meaningful collaboration, and maximize inclusion and transparency in the following ways.

Education to Level-Set Workgroup Knowledge

Workgroup members came to the table with a variety of vantage points and levels of knowledge about the civil commitment system. Over two years, the workgroup developed a broader common understanding of the system through reading assignments, review of state and national data, informational presentations, and group discussions. This educational component of the workgroup enabled members to address systems issues more effectively and consider how changes to one part of the system may impact other parts.

Professionally Facilitated Workgroup Meetings

Workgroup members actively participated in more than 60 hours of meeting time and countless additional hours to complete assigned readings, engage in constituent outreach, and complete member surveys. A professional facilitator guided the meetings, which included presentations on the civil commitment statutes, rules, and processes; relevant academic research; and input from hundreds of Oregonians who contacted workgroup staff, completed a series of surveys, or participated in listening sessions centering Oregon Tribes and people with lived experience.

Constituent Communication Plan

The workgroup was committed to maximizing opportunites for meaningful participation by individuals impacted by and interested in Oregon's civil commitment system. With transparency and inclusion as guiding principles, the workgroup implemented a Constituent Communication

Plan to enable ongoing information-sharing between workgroup members and all others interested in providing input. Each workgroup member served as a liaison between the constituents of its organization and the workgroup in the following ways:

- Members were asked to develop an email distribution group to share information with the constituents that they represented.
- Workgroup staff prepared a monthly constituent survey on the discussion topics for the upcoming workgroup meeting, with space for respondents to provide general comments on any issue related to civil commitment.
- Each workgroup member was asked to distribute the survey link and the most recent meeting minutes to their email distribution group with a request for reply in advance of the next workgroup meeting.
- Workgroup staff distributed the surveys to the workgroup's interested persons list; and
- Workgroup staff compiled survey responses and reported results during each monthly meeting to inform member discussions.

Listening Sessions

Workgroup staff facilitated six listening sessions for interested groups, including two for Oregon Tribes and four for individuals with lived experience, their families, and natural supports. The listening sessions for Tribes were held on Sept. 8, 2023, and March 15, 2024. The first listening session for people with lived experience was held on May 19, 2023, as part of *Peerpocalypse*, an annual conference hosted by the Mental Health and Addiction Association of Oregon. Two listening sessions were held for families and natural supports of people with lived experience, one on Dec. 5, 2023, and one on April 15, 2024. A fourth listening session was held on March 20, 2024, for individuals with lived experience of psychiatric holds. Feedback from each listening session was presented to the workgroup. All suggestions for system improvement offered in constituent survey comments and listening sessions were included in the comprehensive member survey of ideas for consideration as workgroup recommendations.

Inclusive Review of Ideas

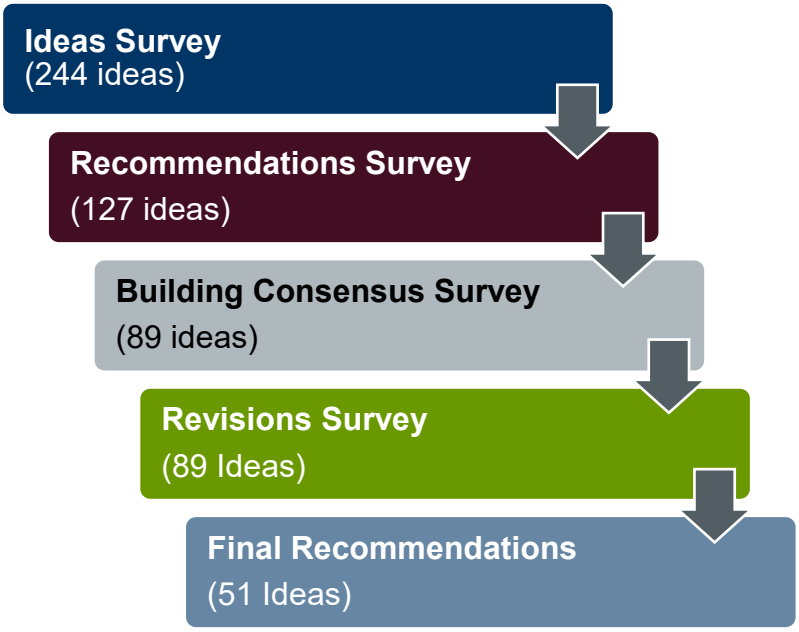
Workgroup staff compiled all concerns about the civil commitment system and ideas for improvement that were identified in workgroup meetings, constituent surveys, member surveys, listening sessions, and direct communications with workgroup staff. The workgroup discussed the concerns during meetings and evaluated the ideas in a series of member surveys.

Member Surveys

Workgroup processes generated hundreds of ideas to improve Oregon's civil commitment system. The workgroup sought consensus using a modified version of the Delphi Method[5] to consider each idea with opportunities for members to respond individually through member surveys and collectively through meeting discussions.

Workgroup members completed four surveys, referenced as the Ideas Survey, the Recommendations Survey, the Building Consensus Survey, and the Revisions Survey. For each survey, members were asked to respond to ideas from the lens of the stakeholder interest they were appointed to represent. For example, members representing a state agency or an organization responded from the lens of their agency or organization leadership. Four of the workgroup's 24 member positions were appointed to represent the range of perspectives among people with lived experience, including individuals with mental illness, families of individuals with mental illness, advocates for individuals with mental illness, and individuals who provide peer support to individuals with mental illness. To ensure meaningful representation of their workgroup constituents, each member was asked to communicate regularly with interested individuals, both to share information about workgroup discussion and to gather input for the workgroup.[6]

Path of Ideas



[5] The Delphi Method is a structured communication technique that uses a group of experts to develop a consensus on a topic through multiple rounds of questionnaires and discussions, each building on the last.

[6] See Constituent Communication Plan above.

Workgroup Report

This report provides an overview of Oregon's civil commitment system, areas of concern, all ideas presented to the workgroup, all survey results, and workgroup recommendations.

Highest Hopes and Greatest Fears

At the first meeting, members identified their highest hopes and greatest fears for the workgroup. As listed below, the workgroup's highest hopes may be summarized as new ideas, more resources, better mental health treatment, greater legal clarity, and improved collaboration. Their greatest fears may be summarized as a flawed workgroup process, inability to achieve consensus, no change resulting from the workgroup, uninformed outcomes, and making the system worse.

Table 1: Highest Hopes

New Ideas	More Resources	Better Treatment	Legal Clarity	Collaboration
Excitement this is being addressed Listen and learn **Bring more options to table and process**	**More availability of resources to prevent hospitalization; more community care access** Local resources for intellectual and developmental disability population in community **No Oregon State Hospital backups and more local options**	**Prevent people from having to be committed** Build a system to get people what they need without traumatizing them **Provide humane and timely services, bring concepts, and areas together** Improve experience for people who need hospital care and for families and community **Meet need of those with behavioral health issues in the community, more doors**	**Add definitions to statutes while resources are built out** Go back to 1973 and look at it then and reconsider definition standards	**Make sure people get what they need and balance with ensuring public safety** Correct the disconnection of justice including criminal justice populations **Break through silo and look at holistically and stop flow to the Oregon State Hospital**

Table 2: Worst Fears

Flawed Process	No Consensus	No Change	Uninformed	Make Worse
We will get bogged down and lose momentum I don't want to waste my time here – make these discussions productive **Fear the learning curve will limit potential outcomes** Top-down perspectives taking priority	**That the workgroup will not get to consensus and we will not be able to make changes to better meet the needs of individuals with mental illness** That we don't have all the representation needed to make the conversation truly meaningful **Tunnel vision that doesn't recognize how civil commitment issues impact WHOLE system** I fear that we will not come to a consensus and ultimately pass meaningful legislation **We don't be able to find balance between voluntary and involuntary treatment**	**We won't accomplish anything after so much time spent in this workgroup** There will be no actionable items that truly impact improvements in mental health care delivery of services **That progress will be slow; lots of meeting time with no accountability to achieve results** Fear recommendations of this workgroup will not be implemented **Nothing will change** Improvements are not made/no action **That people with intellectual and developmental disabilities will not have increased access to community services** That there will be no change **All of our great intentions and solutions will result in a report that goes nowhere**	**This is a topic area I don't have a lot of knowledge about** Not being truly trauma-informed	**That people with intellectual and developmental disabilities will not have increased access to community services** That there will be no change **All of our great intentions and solutions will result in a report that goes nowhere** That we do not approach this radically. Our defunding and infrastructure apathy have led to a status quo that criminalizes mental illness in the name of personal liberty that is ultimately lost when we force those suffering from mental illness into the criminal system

Mental Illness and Pathways to Care

Mental illness touches every segment of our society, regardless of race, ethnicity, religion, or economic status.

According to a nationwide survey completed in 2023 by the nonprofit Mental Health America, nearly 21% of adults in the U.S. are experiencing a mental illness, with 5.4% of the population experiencing a severe mental illness.[7] The same study found that 27% of Oregonians reported having a mental illness, 6% higher than the U.S. average, giving Oregon the highest prevalence of mental illness of any state.

Mental Illness in Prison

79% of adults in custody in Oregon are reported to have some level of mental health needs while in custody.

Oregon Department of Corrections, Adults in Custody Population Profile for 10/01/2024

According to the Oregon Department of Corrections Adult in Custody Population Profile, 20% (2,447 individuals) of Oregon adults in custody have severe mental health needs, 10.6% (1,281 individuals) are identified as having high treatment needs, and 15.7% (1,887) are identified with moderate treatment needs.[8] Another 19% (2,277) were identified as benefiting from treatment, and 13% (1,544) as having a mental health condition but no treatment needed. Only 21% (2,577) of adults in custody in Oregon reported no mental health needs.

Access to Care

Individuals experiencing a mental illness must navigate a complex system of insurance and government-sponsored coverage to receive care and may need to pay out of pocket for some expenses or treatments. For individuals seeking care on a voluntary basis, they must find a provider that can diagnosis their illness, develop a treatment plan that might include prescribed medication, and find long-term providers for their needs.

Care for mental illness can be provided by a range of professionals in a variety of settings.[9] A primary care physician or nurse practitioner may be a person's entry point for receiving mental health care. These professionals can diagnose mental illnesses and prescribe and monitor medications. Psychiatrists and mental health nurse practitioners are specially trained mental health providers. Therapists, counselors, and clinical social workers are health care professionals who can evaluate a person's mental health needs and provide therapies.

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[7] Mental Health America, The State of Mental Health in America 2023. Accessed 23 October 2024.

[8] Oregon Department of Corrections Adult in Custody Population Profile for 10/01/2024. Accessed 16 October 2024.

[9] National Alliance on Mental Illness website, "Types of Mental Health Professionals." Accessed 17 October 2024.

Psychologists also can evaluate and diagnose a person's mental illness and provide therapies. Pharmacists can dispense medication and advise on issues around those medications.

Mental Health America reports mental health workforce shortages across the country. Nationally, there are 350 individuals for every one mental health provider. Oregon is fortunate to have more mental health providers per person than most of the nation, ranking third among the 50 states with a ratio of 170 individuals for every one mental health provider.[10]

Most individuals cannot access mental health care without some form of insurance coverage, either private or public. Nationally, 10.8% of adults with a mental illness are uninsured, with a low of 4.1% in Rhode Island to a high of 24.7% in Wyoming. Oregon ranks 26th among states on the rate of adults with mental illness who are uninsured (10.2%).[11]

Oregon Mental Health Rankings

Adults With Mental Illness

- National: 21%
- Oregon: 27% (Rank: 50th)

Mental Health Workforce

- National: 350 to 1
- Oregon: 170 to 1 (Rank: 3rd)

Adults Without Health Insurance

- National: 10.2%
- Oregon: 10.8% (Rank: 26th)

Access to Mental Health Care

- Oregon ranks 30th

Ranking access to mental health care generally, Mental Health America reported that 55% of adults with a mental illness nationally received no mental health treatment (54% of adults in Oregon). Among those who did seek treatment, 28% reported that they faced barriers to receiving necessary care (33% of adults in Oregon). Oregon ranked 30th among the 50 states in access to care.[12]

Private Insurance

The federal Mental Health Parity and Addictions Equity Act (MHPAEA), enacted in 2008, requires health insurers to offer mental health and substance use disorder benefits at the same level of benefit as other medical procedures, such as receiving care for a chronic illness or surgery for a broken limb, if the insurer offers mental health and substance use disorder benefits.[13] In 2010, the federal Affordable Care Act (ACA) included mental health and

[10] Mental Health America, The State of Mental Health in America 2023. Accessed 23 October 2024.

[11] Id.

[12] Mental Health America measured access to care based on access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability.

[13] U.S. Department of Health and Human Services, Mental Health and Substance Use Insurance Help. Content updated 1 December 2021. Accessed 17 October 2024.

substance use disorder benefits as an Essential Health Benefit (EHB) for small group and individual plans. In 2013, after the rules around the MHPAEA were finalized, most insurers provided mental health and substance use disorder treatments.

Public Coverage

Within the public sector, Medicaid provides funding to states for offering health care coverage. Oregon's Medicaid program is called the Oregon Health Plan (OHP). Eligibility criteria for the OHP are complex, but generally, a person must be within a certain percentage of the federal poverty level and be an Oregon resident to qualify for the OHP.[14] Individuals also may qualify if they are a certain age or are experiencing a disability. More than 1.4 million people currently are enrolled in the OHP.[15]

Oregon law requires most people to be enrolled in a "coordinated care organization" for health care covered by OHP.[16] Others are enrolled in "open card," which provides fee-for-service coverage.[17] According to the Oregon Health Authority, "[a] coordinated care organization is a network of all types of health care providers (physical health care, addictions and mental health care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions, like diabetes."[18] Oregon has 16 CCOs operating in communities statewide.

If a person is eligible for Medicaid benefits and is receiving emergency psychiatric in-patient services, the hospital can be paid for the care with Medicaid dollars, even if the person is not yet actively enrolled in a Medicaid plan, such as the OHP.[19]

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[14] Oregon Administrative Rule 410-200-0315.

[15] Oregon Health Authority, Office of Health Analytics, Oregon Health Authority Medicaid Enrollment Report, updated 1 October 2024.

[16] Oregon Health Authority, Oregon Health Plan – Who Covers Your Care?. Accessed 23 October 2024.

[17] Reasons an OHP-eligible individual may not be enrolled in a CCO for health care include:

- They have major medical insurance as their primary health insurance.
- They are American Indian or Alaska Native and choose not to enroll in a CCO for their care.
- They are in their last three months of pregnancy and want to stay with their current birth care provider until the baby is born.
- OHP approved them for temporary fee-for-service coverage for other serious health reasons.

Oregon Health Authority, Oregon Health Plan – Who Covers Your Care?. Accessed 23 October 2024.

[18] Oregon Health Authority, Health Policy and Analytics, Coordinated Care: the Oregon Difference. Accessed 17 October 2024.

[19] Oregon Administrative Rule 309-015-0060.

Involuntary Mental Health Care

In some instances, a person experiencing a mental illness may be required to receive mental health care. If a person is placed on a "psychiatric hold", the person is likely in a hospital or care facility or will be transported to one. During that time, the facility may utilize psychiatric emergency services, such as triage and assessment, observation, crisis stabilization, intervention, and safety planning. Seclusion and restraint can be utilized on an emergency basis and subject to restrictions.[20] Significant procedures, such as administration of psychotropic medications,[21] usually require the informed consent of the person but can proceed without informed consent if obtaining informed consent is impractical and immediate action is required to preserve the life or physical health of the person or the behavior of the person creates a substantial likelihood of immediate physical harm to the person.

If an individual is civilly committed through a court process, an approved hospital or facility may administer significant treatment, such as psychotropic medication, under a good-cause standard.[22] The treating entity must be able to show that the person is unable to comprehend and weigh the risks and benefits of the proposed procedure and that the significant procedure will likely restore or prevent deterioration of the person's mental or physical health, alleviate extreme suffering, or save or extend the person's life. The treating physician also must have made a conscientious effort to obtain informed consent from the person, and the procedure must be the most appropriate and least intrusive treatment. An individual may not be deemed unable to consent to a significant procedure based solely on the person's status as committed and disagreement with the diagnosis and treatment recommendations.[23]

Individuals who are involved in the criminal justice system and who are unable to exercise their constitutional right to aid and assist in their own defense may be sent to the Oregon State Hospital (OSH) to receive restoration services. While at OSH, an individual may not be medicated involuntarily without court approval. The court considers whether involuntary medication is permissible under the criteria established by federal law in *Sell v. United* States, 539 U.S. 166 (2003), and codified in Oregon law at ORS 161.372. If the state makes sufficient required showings, a court may issue a "*Sell* order" that a person receive medication over their objections.

[20] Oregon Administrative Rule 309-033-0730.

[21] Oregon Administrative Rules 309-033-0610(18) and 309-033-0625.

[22] Oregon Administrative Rule 309-033-640.

[23] Oregon Administrative Rule 309-033-0620.

Guardianships

The court may appoint a guardian as a fiduciary to promote and protect the well-being of an adult who is determined to be a protected person due to incapacitation (ORS 125.005 (2); 125.300 (1)(a)). “Incapacitation” is defined as having a condition in which a person’s ability to receive and evaluate information effectively or to communicate decisions is impaired to such an extent that the person presently lacks the capacity to meet the essential requirements for the person’s physical health or safety (ORS 125.005 (5)). “Meeting the essential requirements for physical health and safety” means those actions necessary to provide the health care, food, shelter, clothing, personal hygiene, and other care without which serious physical injury or illness is likely to occur (ORS 125.005(5)).

Before appointing a guardian, the court must determine on clear and convincing evidence that the person is incapacitated, that the appointment is necessary to provide continued care and supervision of that person, and that the proposed guardian is qualified, suitable, and willing to serve (ORS 125.305). The court may appoint a temporary guardian, limited to 30 days, based on clear and convincing evidence that the proposed protected person is incapacitated, that there is an immediate and serious danger to the person’s life or health, and that the person’s welfare requires immediate action (ORS 125.600).

The guardianship cannot restrict the person’s liberty any more than is reasonably necessary to protect the person (ORS 125.305 (2)). A guardian’s powers include the power to determine a protected person’s place of abode and to consent or refuse to consent to medical care (ORS 125.315). In a petition for appointment as a guardian, the proposed guardian must tell the court if they intend to place the proposed protected person in a mental health facility (ORS 125.055 (2)(j)). After appointment, if a guardian wishes to place a person in a mental health facility, the guardian must file a statement with the court declaring that intent at least 15 days before changing the placement, and notice must be given to several persons, including the protected person, any interested party requesting notice, or any attorney who does or has represented the protected person in protective proceedings (ORS 125.320 (3)). There is an opportunity to object and be heard before the change occurs. However, a guardian may change a place of abode or placement in less than 15 days if necessary to protect the immediate health, welfare, or safety of the protected person or others and the notice must reflect the necessity and immediacy of the change in placement (ORS 125.320 (3)(b)). Guardianship is exclusively within the jurisdiction of the probate courts and probate commissioners and operates outside of civil commitment (ORS 125.015 (1)).

About the Civil Commitment System

Over the first year of meetings, the workgroup invested time in level-setting member knowledge about the civil commitment system, including an overview of the history of civil commitment in the U.S. and in Oregon, and the laws and processes that move an individual through Oregon's civil commitment system presently. This section of the report offers a summary of that substantive overview to provide context for the workgroup's recommendations and a continuing resource for policymakers, stakeholders, and other interested persons.

What is Civil Commitment?

"Civil commitment proceedings, governed by ORS 426.005 to ORS 426.415, are designed to provide care for mentally ill persons as well as to provide for the safety of the community. OAR 309-033-0220." *State v. T.L.B.*, 335 Or App 225 (2024)

Civil commitment is court-ordered involuntary treatment and care. When the court orders a person to be civilly committed, a local community mental health program determines the placement, including how restrictive of an environment is necessary to ensure that the person participates in the treatment. Placement may be secure or non-secure inpatient care or outpatient care. The civilly committed person may request a hearing to challenge a placement they believe is more restrictive than necessary.

Civil commitment is used as a safety net for individuals who, because of a mental disorder or an intellectual disability, are in imminent danger of harm to self or others or unable to provide for basic personal needs without involuntary care. Civil commitment laws establish substantive and procedural due process rights to protect individuals from involuntary treatment or confinement without a court order. The civil commitment system encompasses both the legal processes that precede a court order for commitment and the course of treatment that follows.

The system is complex, not only because it encompasses many steps and responsible entities, but also because it requires cross-system coordination by entities within the behavioral health and justice systems, which are governed by different authorities with

> For some, "perceptual distortions caused by disorders of mood, thought, and cognition can interfere with a person's functioning to such a severe degree that treatment is critical to the safety of the affected individual and others." However, "the same disorders that impair a person's mood, thoughts, and functioning also impair his or her insight and judgment, making refusal of care common in psychiatry," and some individuals lose their usual capacity for making decisions in their own best interest.
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> Megan Testa, M.D., and Sara G. West, M.D., "Civil Commitment in the United States," Psychiatry, October 2010: 7(10): 30-40.

distinct goals and duties. While law enforcement focuses on the safety of persons and the community, advocates for individuals with mental illness may prioritize personal autonomy and self-determination. Courts must balance their duties to intervene on behalf of individuals who cannot act in their own best interest and to preserve the rights of individuals. Mental health care providers may grapple with balancing interests in individual and community well-being, as well practical issues that impact their duties to provide treatment and services for individuals who are civilly committed, such as the availability of necessary facilities, workforce, and funding.

In sum, stakeholders have different vantage points that inform their views on the best design and operation of the civil commitment system. Policymakers have the difficult job to choose among competing priorities and ensure that the hydraulics of the system function effectively from beginning to end.

Other Court Processes that Address Mental Illness and Capacity

Civil commitment is one statutory process in the justice system in which a person experiencing a mental illness may intersect with the courts. However, depending on the circumstances, an individual experiencing mental illness may intersect with the courts through a different process.

As described above, the court may appoint a guardian to protect and care for the health and well-being of an incapacitated person.

If an individual is charged with a crime, the court may be asked to consider different aspects of the person's mental illness at various points in a criminal case. For instance, the court may consider whether the individual has the mental fitness to proceed in the case **("aid and assist" proceeding)**, whether the individual lacks criminal responsibility due to a mental illness **("guilty except for insanity" proceeding)**, or whether the individual has engaged in extremely dangerous behaviors because of a qualifying mental disorder **("extremely dangerous person" proceeding)**. The presence of a criminal case, including one involving aid and assist or guilty except for insanity proceedings, has no bearing on or connection to the civil commitment process.

Mental illness is not the only underlying condition that may be a basis for civil commitment. Oregon law also provides for civil commitment when a court determines that an **individual with an intellectual disability** is either a danger to self or others or is unable to provide for their personal needs and is not receiving care as necessary for their health, safety, or habilitation.

Table 3: Court Processes that Address Mental Illness and Capacity

Court Proceeding	Case Type	Details
Guardianship	Probate	The court must determine based on clear and convincing evidence that the person is incapacitated, that the appointment is necessary to provide continued care and supervision of that person, and that the proposed guardian is qualified, suitable, and willing to serve. ORS 125.305.
Civil Commitment (Mental Illness) ORS 426.005 – 426.395	Civil	Civil commitments are initiated under ORS Chapter 426 to determine whether a person's mental health disorder makes them a danger to self or others or unable to meet their basic needs. The risk posed by the person's conduct must be acute and serious in order to meet the standards for a civil commitment. This commitment is up to 180 days. The person is placed under the jurisdiction of the Oregon Health Authority.
Civil Commitment (Intellectual Disability) ORS 427.215 – 427.306	Civil	In these cases, the state must show, by clear and convincing evidence, that the person has an intellectual disability, and the person is either a danger to self or others or is unable to provide for the personal needs of the person and is not receiving care as necessary for the health, safety, or habilitation of the person. The court must dismiss the case if the person can give informed consent and is willing and able to participate on a voluntary basis, even if the person otherwise meets criteria. The court can also order a commitment with conditional release to family, friend, or guardian. If the court determines that voluntary treatment or conditional release to family, friend, or guardian is not in the person's best interest, the court may commit the person to the Oregon Department of Human Services for up to one year for care, treatment, or training. Treatment, as defined by ORS 427.005, means "provision of specific physical, mental, social interventions and therapies that halt, control or reverse processes that cause, aggravate or complicate malfunctions or dysfunctions."
Civil Commitment (Extremely Dangerous Person Due to Qualifying Mental Disorder)	Civil	An "extremely dangerous person" commitment requires a showing that the person engaged in extreme conduct (caused the death of another person, caused serious physical injury by

Court Proceeding	Case Type	Details
ORS 426.701 – 426.702		means of a dangerous weapon, caused physical injury by means of a firearm, engaged in specific sex crimes, or engaged in or attempted specific arson crimes). The state also must prove that the person is exhibiting substantially similar behaviors as before the extreme conduct and the person, because of a qualifying mental disorder, presents a serious danger to the safety of others and unless committed, will continue to be an extreme safety risk to others in the foreseeable future. Individuals committed under ORS 426.701 are under the jurisdiction of the Psychiatric Security Review Board (PSRB) and the commitment lasts for 24 months. Administrative rules provide that individuals experiencing intellectual disabilities are not eligible for commitment under 426.701, as intellectual disability is not a qualifying mental disorder.
Aid and Assist (Fitness to Stand Trial) ORS 161.355 – 161.375	Criminal	If the court determines that an individual charged with a crime is unable to aid and assist in their own defense due to a qualifying mental health diagnosis, the court may order the defendant to receive treatment and services to restore them to competency. Those services are provided in the community or at OSH. If the court determines that a defendant is substantially unlikely to gain or regain fitness to proceed in the foreseeable future, the case must be dismissed. If the crime is of a serious nature (murder, forcible compulsion rape, assault causing serious physical injury), the state may be able to pursue a commitment under 427.701.

Court Proceeding	Case Type	Details
Guilty Except for Insanity (GEI) (Criminal Responsibility) ORS 161.295 – 161.351	Criminal	A GEI is a defense to a criminal charge. A defendant must be able to aid and assist in their own defense in order to move forward with a case, including pursuing a GEI defense. If a person is unable to aid and assist, they cannot pursue GEI until restored to competency. In order to be found GEI, the evidence must show that as a result of a qualifying mental disorder *at the time of engaging in the criminal conduct*, the person lacks substantial capacity to either appreciate the criminality of the conduct or to conform the conduct to the requirements of the law. A defendant who is GEI is placed under the jurisdiction of the Psychiatric Security Review Board and placement is fact dependent.

History of Civil Commitment in the United States

The authority for civil commitment rests on two major legal principles: *parens patriae* and police power. The principle of *parens patriae* ("parent of the country") is an English common law doctrine that requires the government to intervene on behalf of individuals who cannot act in their own best interest. The principle of police power requires the government to protect the interests of all who live within its boundaries.[24] These principles help provide context for a statutory framework that considers whether individuals are a danger to themselves or others or unable to provide for their basic physical needs.

Mental Asylums and Institutions of the Past

Before the 1960s, decisions to require involuntary treatment were left largely to the medical community without legal standards or court involvement. In the early history of the U.S., individuals with mental illness often were placed in prisons or shelters without treatment.[25] The 19th century gave rise to publicly and privately funded asylums, and later to state-run mental institutions.[26] Admission typically followed a request from a family member, followed by certification by a physician for an indefinite period.[27] In the absence of effective treatment options, these institutions became long-term placements with little-to-no protection for the civil rights of their residents.[28]

Photo courtesy of Oregon State Library

Early Procedural Reforms for Involuntary Treatment

In the 20th century, states began to establish legal standards for involuntary treatment, such as the right to a trial with attorney representation before commitment, stricter standards to

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[24] Testa, Megan and Sara G. West. "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10, 2010, pp. 30-40.

[25] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Civil Commitment and the Mental Health Care Continuum: Historical Trend and Principles for Law and Practice, 2019.

[26] Testa, Megan and Sara G. West. "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10, 2010, pp. 30-40.

[27] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019.

[28] Testa, Megan and Sara G. West. "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10, 2010, pp. 30-40.

demonstrate a need for treatment, and shifting the final decision-making power from medical professionals to judges. This expansion of legal rights offered important safeguards for the constitutional due process rights of individuals subject to civil commitment. However, the practice of institutionalizing people with mental illness remained under scrutiny, and new legal processes created other problems, such as lengthy holds in jail for individuals waiting for the appointment of counsel and precommitment trials.[29]

Movement for Deinstitutionalization

As noted above, until the 1960s, nearly all mental health care was provided in an institutionalized setting and was intended to be long-term care. Various reports noted that the state hospitals housed not only those with mental illnesses, but also the elderly experiencing Alzheimer's or dementia, and individuals unable to care for themselves because of debilitating injuries or health conditions.[30] A movement to shift the treatment of individuals with mental illness from institutions to the community ("deinstitutionalization") grew. The movement was energized by the emergence of antipsychotic drug treatments in the 1950s as a promising treatment for mental illness, the potential for community-based outpatient treatment with the creation of Medicare and Medicaid in 1960, and the rise of the civil rights movement, prompting criticism of state hospitals as outdated, ineffective, and inhumane institutions. Many of the state hospitals shut down after President John F. Kennedy signed the Community Mental Health Centers Act in 1963 and Congress established an exclusion on the use of federal funds for hospitalization in state hospitals in 1965.[31]

Supreme Court Rulings

In 1975, the U.S. Supreme Court set boundaries on civil commitment, opining that "[a] finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement," and holding that an individual with mental illness must either present a known risk of harm to self or others, be "hopeless to avoid the hazards of freedom," or in need of psychiatric treatment.[32] In 1978, the Supreme Court established the evidentiary standard of proof for civil commitment, holding that the clear-and-convincing evidence standard "strikes a fair balance between the rights of the individual and

[29] Id.

[30] Unger, Karen. History of Mental Health Services in Oregon, 1945-1999. Mental Health and Developmental Disabilities Division, 1999.

[31] Id.

[32] *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

the legitimate concerns of the state."[33] In 1999, the Supreme Court declared that unnecessary segregation of individuals with disabilities in institutions is a form of discrimination.[34]

Lack of Community-Based Care

Changes in federal law and policy, coupled with the movement for deinstitutionalization, substantially reduced the number of individuals committed to state hospitals. At the same time, they created new gaps in care for individuals with mental illness. The promised community-based treatment system that would minimize the need for commitment by preventing escalation of mental illness and allow for outpatient commitment never developed.[35] The new medications failed to achieve anticipated levels of effectiveness.[36] A growing shortage of psychiatric hospital beds and mental health funding exacerbated unmet behavioral health care needs.[37]

Photo by Camilo Jimenez on Unsplash

Individuals experiencing mental health crises are frequently brought to hospital emergency rooms, where they may remain longer than any other type of patients and have worse outcomes.[38] Law enforcement officers trying to avoid those outcomes sometimes opt instead to arrest the individual or take no action at all.[39] State hospital beds previously occupied by civilly committed individuals are now filled with individuals in the criminal justice system found not guilty by reason of insanity and incompetent to stand trial.[40]

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[33] *Addington v Texas*, 441 U.S. 418 (1978).

[34] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[35] Testa, Megan and Sara G. West. "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10, 2010, pp. 30-40.

[36] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019.

[37] Testa, Megan and Sara G. West. "Civil Commitment in the United States," *Psychiatry*, vol. 7, no. 10, 2010, pp. 30-40.

[38] Conference of State Court Administrators, *2016-2017 Policy Paper, Decriminalization of Mental Illness: Fixing a Broken System*, 2016.

[39] Id.

[40] Id.

Evolving Standards of Commitment

Since the 1970s, many states have modified statutory requirements to establish dangerousness in a civil commitment proceeding.[41] For example, some states no longer require the risks presented to be imminent or immediate, involve a risk of violent behavior, or show a recent overt act.[42] Most states do not require a showing of active dangerousness as the sole commitment criterion, also considering alternative grounds such as "grave disability" (inability to provide for basic personal needs for food, clothing, or shelter) or "serious deterioration" (not currently dangerous but experiencing serious mental or physical deterioration such that, without treatment, the individual predictably would become dangerous).[43]

Oregon's Civil Commitment History

Mirroring national trends, and reflecting changes in societal attitudes towards mental health and the rights of individuals, civil commitment in Oregon has evolved significantly over the years.

1861-1961: Building State Hospitals

The roots of civil commitment in Oregon can be traced to early statehood. In 1861, Dr. James Hawthorne and Dr. A.M. Loryea opened the "Oregon Hospital for the Insane" in Portland to provide care for "indigent insane and idiotic persons" that were ordered by a court to receive treatment.[44] Nineteen years later, in 1880, the Oregon legislature dedicated funds to building the Oregon State Insane Asylum in Salem, later renamed the Oregon State Hospital (OSH). The doors to the hospital opened in 1883. In 1913, a second state hospital was opened in

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[41] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019.

[42] Statutes defined "dangerous to self or other" on the following six different dimensions:

- Evidenced by past behavior
  - Nature: Type of past behavior considered
  - Temporality: When harm occurred in the past
  - Magnitude: The severity of past harm
- Expected future behavior
  - Magnitude: The severity of future harm
  - Probability: How likely harm will occur in the future
  - Imminence: When behavior is predicted to occur

[43] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 2019. Gravely disabled definitions in civil commitment statutes exist in nine states (Alaska, California, Colorado, Connecticut, Idaho, Indiana, Louisiana, South Carolina, and Washington).

[44] Oregon State Hospital Museum of Mental Health, Oregon Hospital for the Insane, Portland 1861-1883, citing Larsell, Olaf, "The Doctor in Oregon"1947. Accessed 23 October 2024.

Pendleton. A third hospital, Dammasch Hospital, was opened in Wilsonville in 1961. A report in 1961 by the Oregon Mental Health Division found that nearly 20% of patients at OSH stayed longer than 25 years.[45]

Oregon State Hospital, circa 1930
(Photo courtesy of Oregon State Library)

While the institutions provided a secure care setting for individuals, the conditions and practices at the facilities brought different risks to the patients. Mass overcrowding led to tuberculosis outbreaks. In 1942, a mix-up in the kitchen at OSH poisoned hundreds and killed 47 people.[46] Major forms of therapy, such as shock therapy, hydrotherapy, and lobotomies, are now considered ineffective or inhumane. During this period, and into the 1980s, the Board of Eugenics made reproductive and marriage decisions for individuals with a mental illness. With the advent of antipsychotics, tranquilizers, and antidepressants in the mid-1950s, a major treatment shift occurred in hospital settings and Oregon saw an increase in the rate of individuals being returned to the community for treatment.[47]

Emergence of Community-Based Mental Health Care

With the national reforms underway through the Community Mental Health Act of 1963, Oregon faced a decision point on whether to apply for federal funds or strike a different path for providing community-based treatment. The Community Mental Health Act required states to match a portion of the grant funds for the community centers and decreased funds over an eight-year period. Because of the limited nature of the funds, Governor Tom McCall initially refused to accept the federal money. As a result, only a few locations in Oregon made use of the federal funds for community mental health centers and instead, state and county programs were developed to meet the needs of individuals. In 1981, President Reagan ended the eight-year grant program. In most of the Oregon locations, the federal dollars were ended before they were received.[48]

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[45] Unger, Karen. History of Mental Health Services in Oregon, 1945-1999. Mental Health and Developmental Disabilities Division, 1999.

[46] Cutler, David, et al. *From Asylum to Community: Mental Health Care in Oregon from the 1950s to 2000*, Oregon Historical Society Quarterly, vol. 123, no. 3, 2022.

[47] Unger, Karen. History of Mental Health Services in Oregon, 1945-1999. Mental Health and Developmental Disabilities Division, 1999.

[48] Cutler, David, et al. *From Asylum to Community: Mental Health Care in Oregon from the 1950s to 2000*, Oregon Historical Society Quarterly, vol. 123, no. 3, 2022.

As treatment in the community became an option for more individuals, the state hospitals began discharging patients to the community. But treatment in the community often did not include assistance with housing or other basic needs. Community mental health programs had long waitlists to see providers and individuals had limited access to medication and therapy.

Reducing the Use of Civil Commitment

While legislative efforts to increase treatment in the community and deinstitutionalize treatment of mental illness were developing, a growing advocacy movement called for reform in the treatment of patients receiving mental health services. Individuals and organizations began advocating for greater control over an individual's mental health treatment and recognition of an individual's rights. Legislatures around the country began codifying statutory changes that restricted the use of civil commitments. In Oregon, the landmark Oregon Mental Health Law of 1973 clarified criteria for civil commitment, emphasizing the need for proper legal processes and protections for individuals facing involuntary treatment. In 1974, Oregon statutory changes limited commitments to six months. As the new legal standards took effect, Oregon saw a decrease in the number of commitments. In 1972, there were 53 civil commitments per 100,000 people in Oregon and by 2020, there were nine per 100,000.[49]

Closing State Hospitals

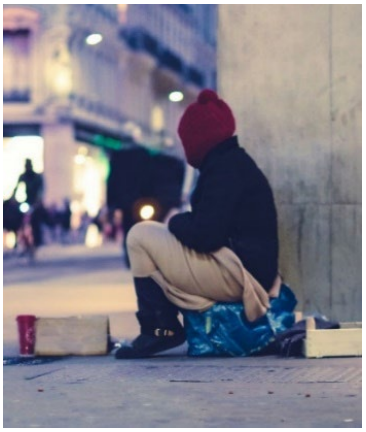


Photo by Ev on Unsplash

The nationwide trend toward deinstitutionalization gained momentum during the 1980s and 1990s, aligning with a national movement to reduce reliance on large mental hospitals. The federal Civil Rights of Institutionalized Persons Act (CRIPA) was used in Oregon to reduce institutional populations. The Americans with Disabilities Act (ADA) became law in 1990, requiring services be provided in less restrictive environments. The shift from institutionalized care to community care posed new challenges, as many individuals who had previously received institutional care found themselves without adequate support in the community. The *Willamette Week* recently republished a 1981 article that reported on the lack of housing, resources, or community support available to individuals released from institutions, noting, "Returning to the community has meant little more than a succession of single-room occupancy hotels and dreary boarding and flop houses, punctuated by periodic returns to the hospital. In some respects, today's is a crueler fate: Hospitals at least provide heat, meals, and the company of others rather than the prospect of starving or freezing to death in one of the nation's

[49] Hansen, Thomas, et al. The Dramatic Decline of Civil Commitment in Oregon, 1972 to 2020. Journal of the American Academy of Psychiatry and the Law Online, vol. 50, issue 4, figure 1, 2022.

burgeoning "mental health ghettoes.""[50] Oregon closed Dammasch Hospital in 1995 and the Eastern Oregon State Hospital in 2014. As of October 28, 2024, only 23 patients were at OSH for civil commitment under ORS 426.130, with another 34 patients at OSH under Oregon's extremely dangerous commitment statutes.[51]

Recent Reform Efforts

Oregon has continued to evaluate its civil commitment laws. In coordination with the Senate Judiciary Committee, Judge Pat Wolke formed the Workgroup to Decriminalize Mental Illness in 2017. The workgroup met regularly and attempted to provide statutory guidance on what certain terms used in the civil commitment statutes mean. The workgroup proposed legislation in 2019, and while not enacted, various permutations of that work have appeared in front of the legislature every session since. Additionally, in the last 10 years, a variety of bills addressing civil commitment and protocols have been introduced. A non-exhaustive list of bills that received hearings or were enacted are outlined below.

- Senate Bill 1522A (2024). Would have repealed statutes authorizing involuntary commitment of an individual based on an intellectual disability. Not enacted.
- House Bill 4074 (2024). Would have defined "dangerous to self or others" for purpose of taking a person with mental illness into custody. Not enacted.
- House Bill 3234 (2023). Prohibited commitment of children with intellectual disabilities without consent of parent or legal guardian. Enacted, Ch. 339 (2023 Laws).
- Senate Bill 187 (2021). Would have defined "dangerous to self or others." Not enacted.
- Senate Bill 297 (2019). Modified provisions for emergency commitment of individuals in Indian country. Enacted, Ch. 247 (2019 Laws).
- Senate Bill 762 (2019). Would have extended date by which commitment hearing must be held. Not enacted.
- Senate Bill 763 (2019). Would have defined "dangerous to self or others." Not enacted.
- Senate Bill 465 (2015). Specified duties and liabilities of Community Mental Health Programs (CMHPs) with respect to commitment proceedings. Enacted, Ch. 785 (2015 Laws).
- Senate Bill 840 (2015). Authorized and defined licensed independent practitioner as relates to civil commitment proceedings. Enacted, Ch. 461 (2015 Laws).
- House Bill 3249 (2015). Would have authorized a court to initiate civil commitment proceedings if a person is unable or refuses to comply with order of assisted outpatient treatment. Not enacted.

[50] Willamette Week, 1981: Dammasch Is Being Emptied and Portland Can't Handle All the Homeless, Jobless and Hopeless Mentally Ill, 12 March 2023.

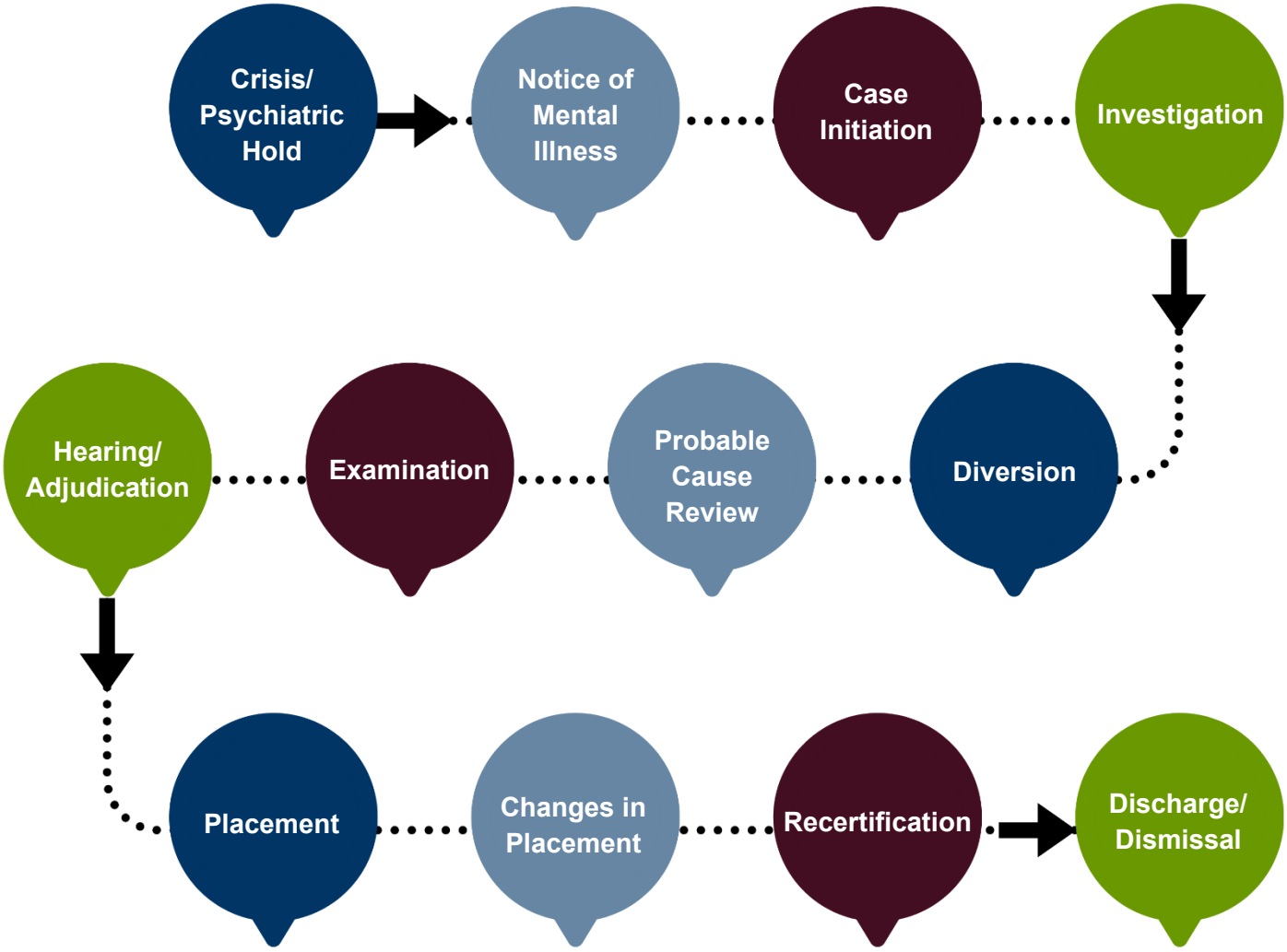
[51] OSH Current Census by County, 28 October 2024.

- House Bill 3347 (2015). Modified definition of “person with a mental illness” as used in civil commitment statutes. Enacted, Ch 433 (2015 Laws).

Oregon recognizes a need to balance a duty to protect vulnerable individuals, public safety, and individual rights. Mental health advocacy groups continue to play a crucial role in shaping policies that prioritize humane treatment and access to care. The Oregon legislature and justice system continue to look at ways to stabilize funding and to ensure that individuals receive needed mental health care.

Oregon's Civil Commitment Process

Overview of Oregon's Civil Commitment Process



Workgroup meetings were organized around the chronological steps of civil commitments for the treatment of mental illness,[52] from the time the court receives a notice of mental illness or an emergency psychiatric hold, through the legal processes to determine if commitment is appropriate, continuing through the treatment provided to civilly committed individuals, and ending with the support to assist individuals with transition following commitment.

[52] The processes for civil commitment of extremely dangerous individuals and individuals with an intellectual disability follow similar but distinct paths.

These civil commitments may be initiated in one of two ways: by a notice of mental illness or notice of an emergency psychiatric hold. When the circuit court receives either of those notices, a civil commitment case opens and an investigation begins.

Based on the information in the investigation report, the court determines whether there is probable cause to believe the individual is a person with mental illness. If not, the case will be dismissed. If probable cause exists, the court may adopt a recommendation by the CMHP and licensed independent practitioner for the individual to participate voluntarily in a 14-day period of intensive treatment in lieu of commitment (frequently referred to as diversion). Otherwise, the court issues a citation for the person to appear at a hearing to determine if the person is in fact a person with mental illness. The court appoints defense counsel for the individual and an examiner to aid the court in the hearing.

If the court finds probable cause to believe that failure to take the person into custody pending the hearing would pose serious harm or danger to self or others, the court may issue a warrant of detention for the person to remain in detention until the hearing.

Unless a statutory exception applies, the hearing must take place within five judicial days of the date the court issues the citation or the date the individual was taken into custody, whichever is sooner. The court may grant an extension of an additional five judicial days at the request of the person or their defense counsel.

At the hearing, the state presents evidence, including witness testimony subject to cross examination, to show that the person meets the statutory criteria for commitment. The examiner has an opportunity to present a report to the court of their observations and conclusions. At the end of the presentation of evidence and examiner's report, the court must decide whether the state has satisfied its burden and whether the individual is to be committed.

After the hearing, if the court determines the person has a mental illness and needs treatment, the court may release the person to participate in treatment on a voluntary basis, order conditional release, or order commitment of the person to the Oregon Health Authority (OHA) for treatment for a period up to 180 days. During the period of commitment, an individual may receive inpatient or outpatient treatment, and may be transferred between levels of care.

At the end of the 180-day period of commitment, unless OHA certifies to the court that the person is still a person with mental illness and needs further treatment, the commitment ends. The commitment may end in less than 180 days if the director of the facility or the licensed independent practitioner treating the person reports to the court that the person is no longer a person with mental illness.

If OHA certifies that the person is still a person with mental illness and needs further treatment, and the individual does not protest within 14 days of service of the certification, the court will order the commitment for an additional indefinite period of time up to 180 days. If the individual protests, the court will hold a hearing with similar processes as in the initial commitment.

Steps in Oregon's Civil Commitment Process

This section provides more information about each step in the civil commitment process, including data from OJD on how many cases go through each part of the process.

Please note that, while the processes described are specific to mental-illness commitments under ORS 426.130, the statistics also include extremely dangerous person commitment cases filed under ORS 426.701 and intellectual disability commitment cases filed under ORS Chapter 427.

1. Initiation of Civil Commitment Case

Civil commitment cases can be initiated following a psychiatric emergency hold (ORS 426.232) or by a notice of mental illness submitted by two persons; the local health officer; or any magistrate or judge of a court of a federally recognized Indian Tribe located in this state (ORS 426.070). Circuit court judges may initiate the civil commitment process with what is known as a "magistrate hold."

Oregon typically has between 7,000 and 8,000 civil commitment cases filed each year, most of which are mental illness commitment cases, but some are petitions for commitment under Oregon's intellectual disability or extremely dangerous commitment statutes.

A. Case Initiation Following an Emergency Psychiatric Hold

If an individual is placed on an emergency psychiatric hold, a Licensed Independent Practitioner (LIP) must immediately notify the appropriate court in writing. An LIP may be a physician, a licensed nurse practitioner, or a licensed naturopathic physician (ORS 426.005 (1)(d)). A variety of pathways can result in the placement of an emergency psychiatric hold. Outlined below are the types of holds and requirements for those holds used throughout Oregon, whether by law enforcement, medical personnel, or community mental health providers.

Peace Officer Custody: A peace officer may take a person into custody if the officer has probable cause to believe the person is dangerous to self or others and needs immediate care,

Variations in Practice

Notices of Case Initiation: CMHPs typically use the same form to notify the court when it receives notice of an NMI or an emergency hold. OHA is rarely notified at the time that CMHPs receive an NMI or notice of emergency hold.

Sources of Case Initiation: Civil commitment cases are often initiated by an LIP in an emergency room. Two party petitions are rare. "Magistrate holds" are more common, typically for an individual in custody who is transported to a hospital by a sheriff for an evaluation.

custody, or treatment for mental illness. The officer must take the person to the nearest OHA-approved hospital or non-hospital facility. ORS 426.228 (1).

LIP Hold for Transport: An LIP may hold a person in a health care facility for transportation to a treatment facility for up to 12 hours if the LIP believes the person is dangerous to self or others and needs emergency care or treatment for mental illness. ORS 426.231.

CMHP-Authorized Emergency Hold: The Community Mental Health Program (CMHP) director or designee may authorize involuntary admission or retention of an admitted person in a non-hospital facility or direct an authorized person to transport the person in custody to a hospital if the CMHP director believes the person is dangerous to self or others and needs immediate care, custody, or treatment for mental illness. ORS 426.233.

LIP-Authorized Emergency Hold: If an LIP believes a person who has been brought to a hospital or non-hospital facility by a peace officer or CMHP, or who is at a hospital or non-hospital facility, is dangerous to self or others and needs emergency care or treatment for mental illness, the LIP may detain the person and cause the person to be admitted or retained in the hospital or may approve the person for emergency care or treatment at an OHA-approved non-hospital facility. When approving a person for emergency care or treatment at a non-hospital facility, the LIP must immediately notify the CMHP in the county where the person was taken into custody. ORS 426.232.

Variations in Practice: Emergency Holds

The following individuals may initiate the steps that could result in an emergency hold of an individual experiencing a mental health crisis:

- Peace officer
- LIP in a health care facility
- CMHP director designee
- Emergency room LIP

LIP Duties During Emergency Hold: At the time a person alleged to have a mental illness is admitted or retained in a hospital or non-hospital facility, an LIP, nurse, or QMHP at the facility must inform the person of their right to representation by or appointment of counsel, give the person the warning under ORS 426.123 (examination information may be used in a court proceeding), immediately examine the person, and set forth in writing the person's condition and need for emergency care or treatment. The LIP must contact the appropriate CMHP and notify the appropriate circuit court in writing of the hold. The appropriate CMHP and appropriate circuit court depends on the circumstances outlined in ORS 426.234.

Five-Day Limit: A person cannot be held in involuntary detention for more than five judicial days without a hearing (ORS 426.234 (4)). In the absence of a warrant of detention, an LIP (or a CMHP after consultation with an LIP) may release the person from detention on the determination that the person is not dangerous to self or others and does not need immediate care, custody, or treatment for mental illness. ORS 426.234 (2, 3).

Emergency Holds in other States

In other states, the period in which an individual may be held in custody on an "emergency hold" before an evaluation occurs ranges from 23 hours (North Dakota) to 60 days (New York). The most common period of time is 72 hours.

Substance Abuse and Mental Health Services Administration, Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice, 2019

B. Case Initiation Following Notice of Mental Illness

A notice of mental illness (NMI) may be filed with the CMHP by two persons; a local health officer; or a magistrate or judge of a court of a federally recognized Indian Tribe located in this state. The notice must state that a person within the county is a person with mental illness and needs treatment, care, or custody.

Upon receipt of an NMI, the CMHP must immediately notify OHA and the judge of the court with jurisdiction. Upon receipt of the NMI, OHA may verify whether the person meets the criteria for commitment, if known, and inform the CMHP. ORS 426.070.

A magistrate's hold follows this process, combining a few steps. In addition to providing an NMI to the CMHP, the court issues a citation to the person with an alleged mental illness that notifies the person about the hearing and their legal rights, and a warrant of detention that requires the person to remain in the hospital pending the investigation or hearing. Magistrate holds are used most frequently when an individual in jail is experiencing an acute mental health crisis and needs treatment in a hospital setting. The notice to the CMHP triggers its duty to investigate and the rest of the commitment process.

2. Warrant of Detention

If the court finds probable cause to believe that failure to take the person into custody pending the investigation or hearing would pose serious harm or danger to the person or others, the court may issue a warrant of detention to the CMHP or sheriff of the county to take the person into custody and produce the person at the time and place stated in the warrant. ORS 426.070 (5)(b)(A).

If the court issues a warrant of detention, the person shall be informed by the CMHP or sheriff at the time the person is taken into custody of the person's rights regarding representation by or appointment of counsel. ORS 426.070 (5)(b)(B).

If a person is taken into custody by order of a warrant of detention, the person may be released only by the court. OAR 309-033-0250(6).

3. Investigation

Upon notice of an emergency psychiatric hold or receipt of a NMI, the CMHP initiates an investigation to gather information to determine whether there is probable cause to believe that the person is in fact a person with mental illness. ORS 426.070(3); 426.074; 426.200. A recommendation based upon the investigation report must be promptly submitted to the court. ORS 426.070 (3, 4).

Investigations of a person in custody must begin as soon as reasonably possible and no later than one judicial day after the initiation of the detention and 24 hours prior to the hearing. Investigations of a person who is not in custody must begin within three judicial days after the CMHP receives the NMI and must be submitted to the court within 15 days after the CMHP receives the NMI. Extensions are possible upon court approval in certain circumstances. ORS 426.074; OAR 309-033-0930.

The investigator must solicit information about the person from the person's parents and relatives, whenever feasible. When a person is identified as an enrolled member of a federally recognized Tribe in Oregon, the investigator must solicit information from that Tribe, whenever feasible. OAR 309-033-0930 (2)(b, c). Regardless of whether the person consents, the investigation should include interviews with any individuals that the investigator has probable cause to believe have pertinent information regarding the investigation. ORS 426.074 (2)(b).

CMHPs must maintain a clinical record for every person investigated that includes a copy of the NMI and a copy of the investigation report submitted to the court, among other information. OAR 309-033-0930 (2)(f).

The investigation report must include the evidence and documentation specified in OHA Behavioral Health Services rules. OAR 309-033-0940.

Variations in Practice: Investigation

Frequently, courts receive only a short form from the CMHP, rather than an investigation report, when the CMHP is recommending a no probable cause finding.

The CMHP must file the investigation report with the circuit court no later than 24 hours before the hearing and appear at the civil commitment hearing. ORS 426.074; OAR 309-022-0940 (7). ORS 426.074 (1). Copies of the investigation report also must be provided as soon as possible, but in no event later than 24 hours prior to the hearing, to the person, the person's counsel, counsel assisting the

court, the examiners, and the court for use in questioning witnesses. ORS 426.074 (3); ORS 426.075 (2).

4. 14-Day Intensive Treatment (voluntary diversion)

Within three judicial days after initiation of a prehearing period of detention, the CMHP may certify the person for a 14-day period of intensive treatment as a diversion from civil commitment if:

1. CMHP and LIP have probable cause to believe the individual is a person with mental illness;
2. CMHP in the county where the person resides approves the payment arrangement for the services; and
3. CMHP locates a suitable care facility that is approved by OHA and the CMHP in the county where the person resides.
   ORS 426.237 (1)(b).

The CMHP delivers the certificate of treatment immediately to the court of jurisdiction and notifies the person both orally and in writing. ORS 426.327 (3)(a).

Upon receipt of the certificate, the court notifies or appoints an attorney for the person, who must review the certificate with the person within 24 hours of the time it was delivered to the court. The certificate includes a treatment plan for the 14-day period of intensive treatment. If the person and the person's attorney consent to the certification within one day of its delivery to the court, the court postpones the civil commitment hearing for 14 days. ORS 426.237 (3)(b, c).

If the person is being treated in a hospital, the LIP treating the person may discharge the person at any time during the 14-day period. If the person is being treated in a non-hospital, the CMHP may discharge the person at any time during the 14-day period. If the person consents, the LIP or CMHP must confer with the person's next of kin before discharge. In all cases, the LIP or CMHP must notify the court in which the certificate was filed initially when the individual is discharged. ORS 426.237 (2, 3).

CMHP Actions in Civil Commitment Cases

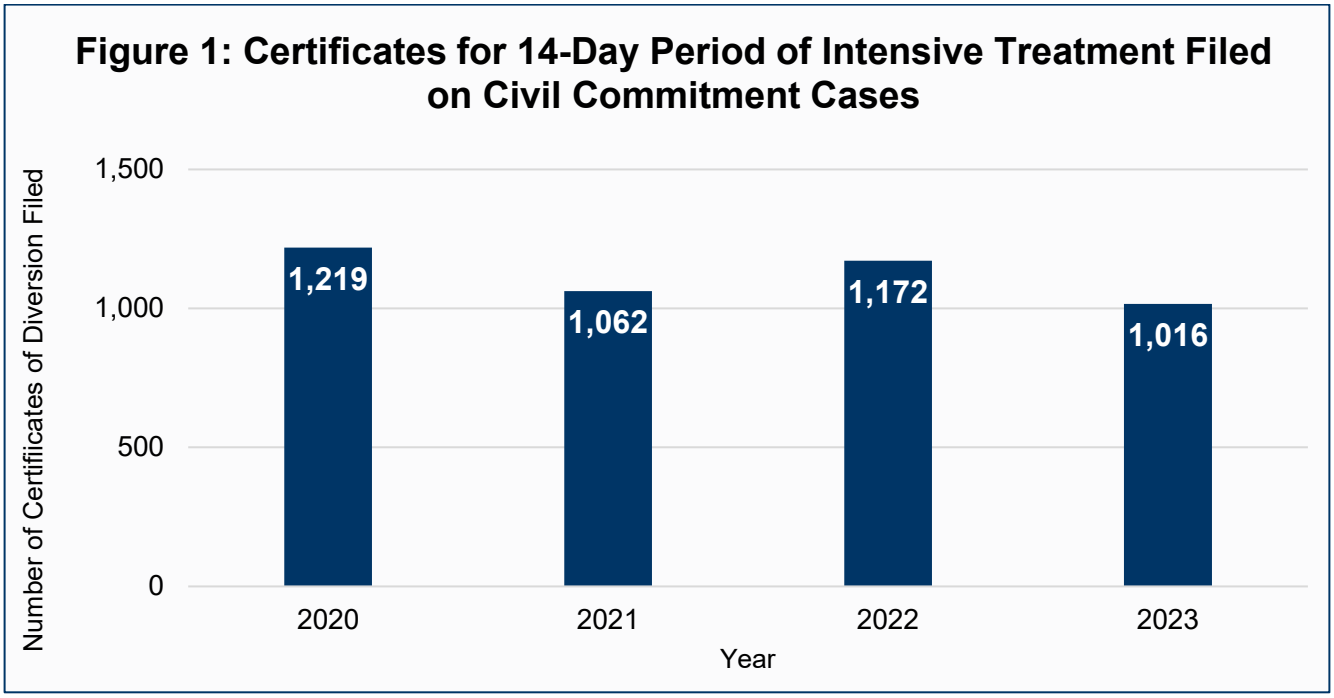
The CMHP must take one of the following actions in every civil commitment case:

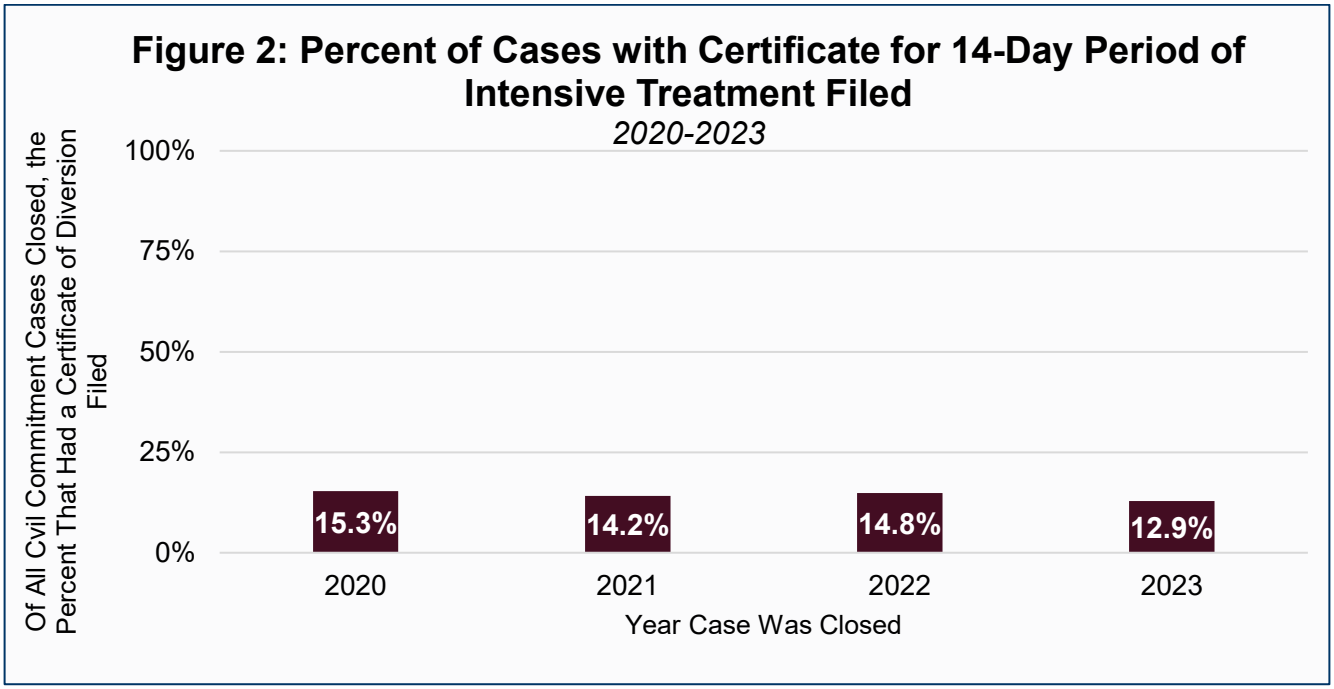
1. Certify the person for a 14-day intensive treatment period (no later than the third judicial day after initiation of a prehearing period of detention);
2. Recommend that the court find there is not probable cause to proceed with the commitment hearing because the CMHP does not believe the person is a person with a mental illness or in need of assisted outpatient treatment; or
3. Recommend that the court find there is probable cause to hold a commitment hearing because the CMHP believes the individual is a person with a mental illness or in need of assisted outpatient treatment.

If the court receives notification that the person has entered voluntary treatment or that the person has been discharged, the court is required to dismiss the case. ORS 426.237 (3)(i).

The person participating in the 14-day intensive treatment diversion may request a commitment hearing at any time during that period. The CMHP may request to proceed to hearing at any point during the 14-day diversion if the person refuses to comply with treatment. A person may not be held more than five days after the person requests a hearing. ORS 426.237 (4).

In 2023, 1,016 certificates for treatment were filed with the court (Figure 1). Out of all the civil commitment cases closed in 2023 — including both cases that resulted in dismissal and cases resulting in commitment or conditional release — 13% entered the 14-day intensive treatment process, slightly less than in prior years (see Figure 2).





Of the cases that were closed after a certificate of treatment diversion in 2023, 88% were dismissed without a hearing, indicating that the diversion was successful in preventing the need for commitment. However, 7% of cases in which the certificate for treatment was filed ultimately resulted in commitment.

5. Probable Cause Determination

Upon completion of the investigation report, the CMHP must promptly submit a recommendation to the court on whether the evidence supports a finding of probable cause that the person is a person with mental illness. ORS 426.070 (3)(c), (4). The court reviews the investigation report, considers the CMHP recommendation, and determines whether probable cause exists to hold a hearing. ORS 426.070(5). As noted above, the CMHP must file the investigation report with the court no later than 24 hours before the hearing.

Variations in Practice: Probable Cause

Counties vary in their practices for submitting the investigation report and making a recommendation on probable cause. For example, in Multnomah County, the CMHP files the report in E-Court, and copies go to the district attorney and defense counsel. In Washington County, county counsel reviews for probable cause and directs the investigator whether to file. Other counties have different processes.

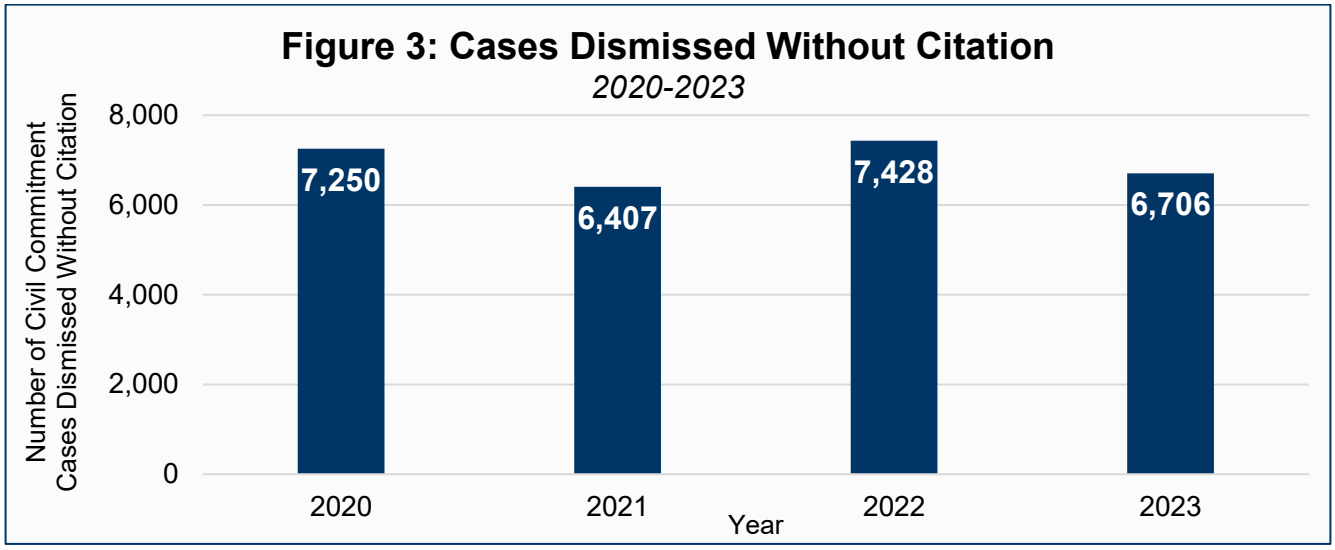
6. Citation and Service

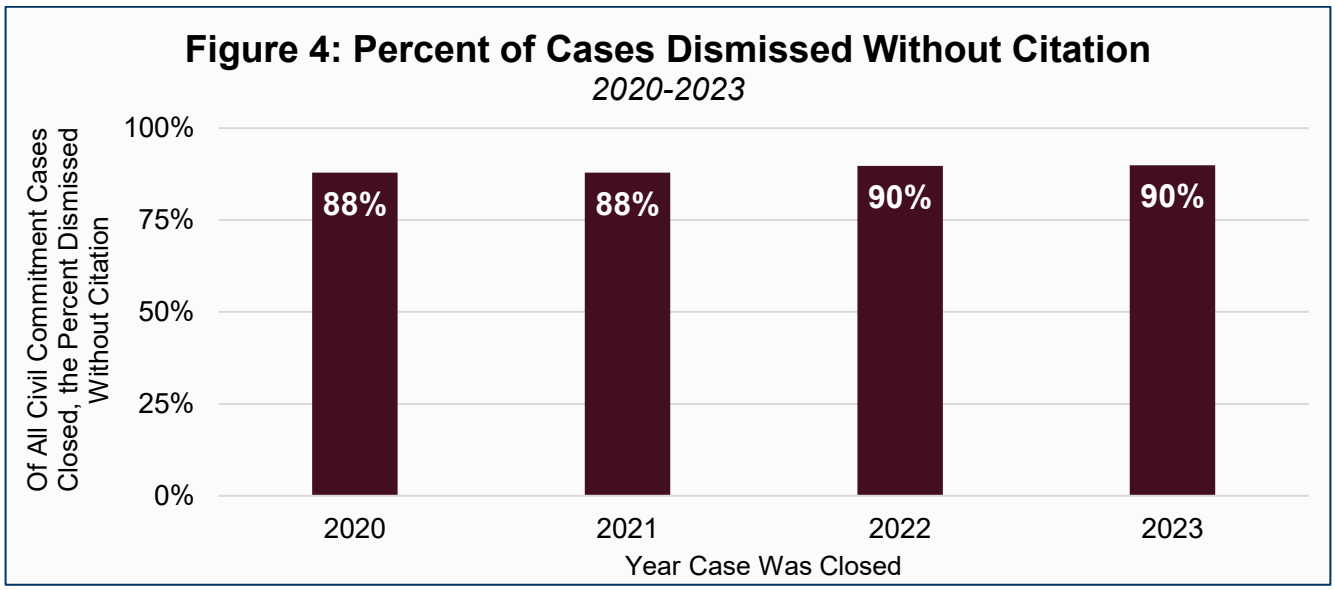
If the court concludes that there is probable cause to believe that the person investigated is a person with mental illness, the court issues a citation to the person to appear at a civil commitment hearing. The citation must state the nature of the information filed concerning the person and the specific reasons the person is believed to meet civil commitment criteria. The citation also must notify the person of the time and place of the hearing and of the person's rights to counsel and to subpoena witnesses. The server of the citation is required to provide proof of service to the court. ORS 426.090. The statute is silent regarding who is required to serve the citation, and practices vary by county.

Variations in Practice: Service of Citation

Depending on the county, citations may be served by the sheriff, hospital, investigator, CMHP, or combination of the above. Many courts do not receive a return of service before holding the hearing.

In most cases, the court does not find probable cause and dismisses the case without issuing a citation. While the number of cases dismissed without a citation fluctuates from year to year (Figure 3) the percent of cases dismissed without a citation has increased slightly over the past four years, from 88% in 2020 to 90% in 2023 (Figure 4).





7. Appointment of Counsel

The person has a right to obtain suitable legal counsel. If the person is determined to be financially eligible, the court will appoint legal counsel to represent the person at the state's expense. If the person does not request legal counsel, the legal guardian, relative or friend may request assistance of counsel on behalf of the person. If no request for legal counsel is made, the court must appoint suitable legal counsel unless counsel is expressly, knowingly, and intelligently refused by the person. If the person is involuntarily detained before the commitment hearing, the person has a right to contact an attorney or have an attorney appointed as soon as reasonably possible. In all cases, suitable legal counsel must be present at the hearing and may be present at examination and may examine all witnesses offering testimony, and otherwise represent the person. ORS 426.100(3).

8. Examination

Variations in Practice: Examination

In some counties, mental health examiners cross-examine the witnesses during the hearing.

The judge appoints a certified mental health examiner (or two upon written request of the person or person's lawyer) to examine the person's mental condition and report to the court. ORS 426.110. The examiner must be given access to LIPs, nurses, or social workers, to medical records compiled during the involuntary prehearing period of detention, and to the investigation report. The examiner initiates the examination process prior to the hearing and files a report with the court after the hearing. The report includes the examiner's opinion on whether the person is a person with mental illness, the type of treatment facility best calculated to help the person recover from mental illness, and whether the person would cooperate with and benefit from a program of voluntary treatment. ORS 426.120. The court reviews the findings of the examiners to aid in its determination of whether the person has a mental illness and needs treatment. ORS 426.130.

9. Hearing

Unless the court grants an exception for good cause, a hearing must be held within five judicial days after the court issues a citation for the hearing, or within five judicial days of the commencement of detention under a warrant of detention, whichever is sooner. ORS 426.095 (2). The hearing may be held in a hospital, the person's home or in some other place convenient to the court and the person alleged to have a mental illness. ORS 426.095 (1).

After hearing all the evidence and reviewing the findings of the examiners, the court determines whether the person meets the statutory definition of a person with a mental illness.

If the court determines that the person is a person with mental illness, it considers three possible orders:

- order the release of person and dismiss the case;
- order conditional release; or
- order commitment to the OHA for treatment.

The court must order the release of the person and dismiss the case if the court finds that the person with a mental illness is willing and able to participate in treatment on a voluntary basis and will probably do so. ORS 125.130 (1)(a)(A).

The court may order conditional release only if certain criteria are satisfied, as described below in the section on Alternatives to Commitment.

If the court finds that neither dismissal of the case nor conditional release is in the person's best interests, the court may order commitment of the person to OHA for treatment. ORS 426.130 (1)(a)(C).

If the court determines the person is NOT a person with mental illness, it may dismiss the case or order the person to participate in assisted outpatient treatment. ORS 426.130 (1)(b).

ORS 426.005 (1)(f) defines "person with a mental illness" as a person who, because of a mental disorder, is one or more of the following:

(A) Dangerous to self or others;
(B) Unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving the care necessary to avoid the harm;

(C) A person:

i. With a chronic mental illness, as defined in ORS 426.495;

ii. Who, within the previous three years, has twice been placed in a hospital or approved inpatient facility by the authority or the Oregon Department of Human Services (ODHS) under ORS 426.060;

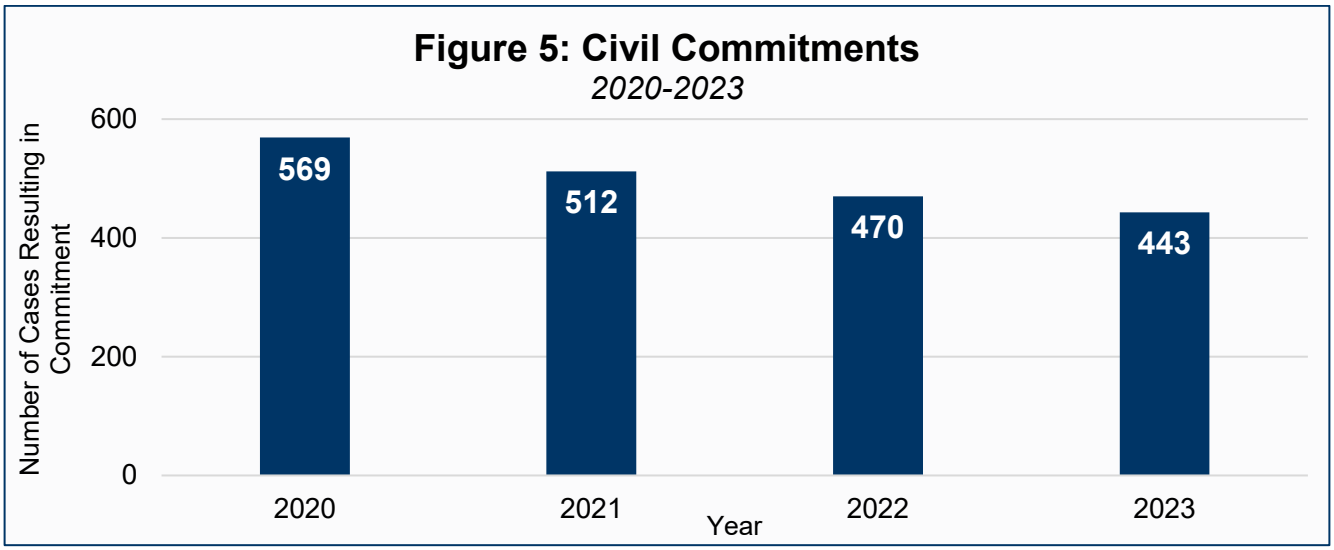
iii. Who is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in sub-subparagraph (ii) of this subparagraph; and

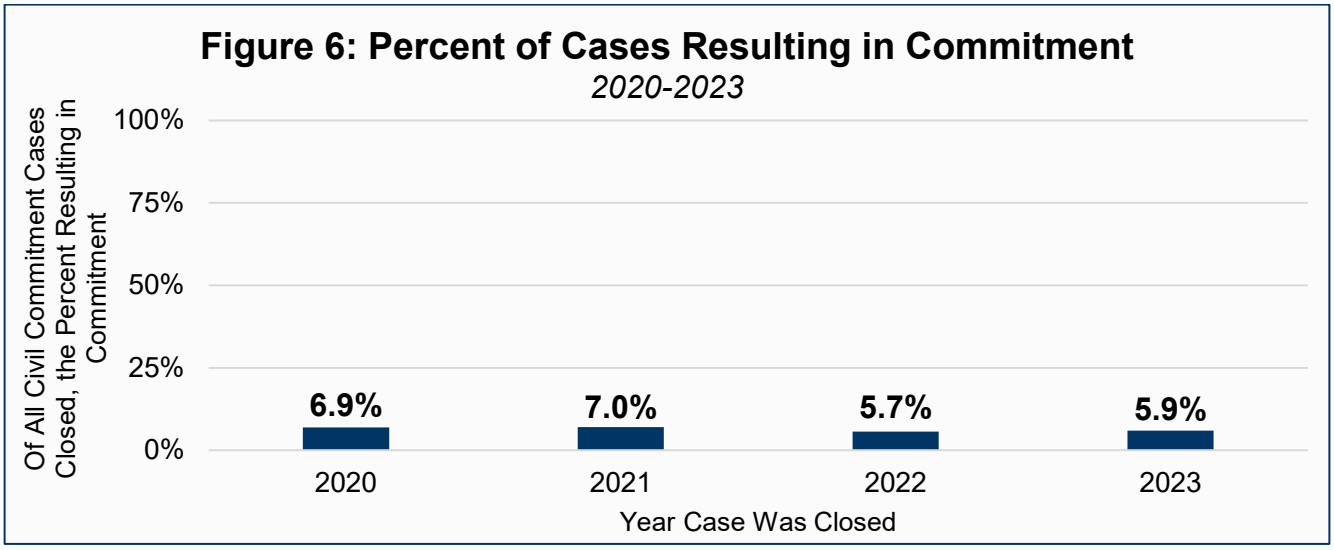
iv. Who, unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either subparagraph (A) or (B) of this paragraph or both.

In 2023, courts issued commitment judgments in 443 cases (5.9% of the civil commitment cases that were closed). Courts ordered assisted outpatient treatment in five cases and ordered conditional release in one case.

Between 2020 and 2023, the number of commitment judgments decreased from 569 to 443 (see Figure 5), and the percent of cases resulting in commitment fell from 6.9% to 5.9% (see Figure 6).

Figure 5: Civil Commitments
2020-2023





10. Alternatives to Commitment

If the court determines the person is a person with mental illness, the court may order conditional release instead of commitment. If the court determines that the person is not a person with mental illness, the court cannot order commitment or conditional release, but the court may order the person to participate in assisted outpatient treatment.

Conditional Release

If the court determines the person has a mental illness and needs treatment, ORS 426.125 provides that the court may order conditional release only if:

- The conditional release is requested by the legal guardian, relative, or friend of the person with mental illness; and
- The legal guardian, relative, or friend requesting the conditional release requests to be allowed to care for the person during the period of commitment in a place satisfactory to the judge; and
- The legal guardian, relative, or friend requesting the release establishes to the satisfaction of the court their ability to care for the person and that there are adequate financial resources available for the person's care.

Conditional release is rare in Oregon. Between 2020 and 2023, Oregon circuit courts issued seven conditional release judgments, an average of less than two per year (see Figure 7).

Assisted Outpatient Treatment

Assisted outpatient treatment (AOT) is court-supervised treatment in the community.[53] However, beyond that core concept, Oregon defines AOT differently than most states. Other states consider AOT to be a form of civil commitment and use the terms AOT and outpatient commitment interchangeably.[54] Under AOT in other states, courts approve an individualized treatment plan that typically includes case management, personal therapy, medication, and other services designed to promote recovery, and non-compliance can result in immediate hospitalization.[55]

As described above, Oregon uses the term "outpatient commitment" to refer to a placement decision by the OHA after the court orders the person to be civilly committed. Oregon law expressly provides that "[AOT] may not be construed to be a commitment under ORS 426.130 and does not include taking a person into custody or the forced medication of a person." ORS 426.133.

In Oregon, courts may order a person to participate in AOT following a civil commitment hearing in which the court determines the person **is not** a person with mental illness if it finds that the person:

- has a mental disorder; and
- will not obtain community-based treatment voluntarily; and
- is unable to make an informed decision to seek or comply with voluntary treatment; and also
- consequently, is incapable of surviving safely in the community without treatment and requires treatment to prevent a deterioration in condition that will predictably result in becoming a person with mental illness.

ORS 426.130 (1)(b)(B); ORS 426.133.

The court may order the person to participate in AOT for a period up to 12 months. ORS 426.130(2). If the court orders AOT, the CMHP may recommend a treatment plan, and the

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[53] Several studies of New York's AOT program found that it had positive effects related to medication adherence, reducing hospital readmission, promoting recovery, and reducing homelessness, psychiatric hospitalization, violent behavior, arrest, and incarceration (Conference of the State Court Administrators, 2016-2017 Policy Paper, Decriminalization of Mental Illness: Fixing a Broken System). Studies of AOT programs in California, Florida, and Ohio also found positive effects. Id.

Note: Those states define AOT differently than Oregon. The workgroup was divided on using AOT in Oregon, and some members voiced concerns. See member comments in Recommendations Survey Results, Section XV, on the CTC Workgroup website.

[54] Doris A. Fuller and Debra A. Pinals, Assisted Outpatient Treatment Community-Based Civil Commitment, January 2020. Accessed 26 October 2024.

[55] Conference of the State Court Administrators, *2016-2017 Policy Paper, Decriminalization of Mental Illness: Fixing a Broken System*.

court may adopt the plan as recommended or with modifications. ORS 426.133(4). The court retains jurisdiction over the person until the end of the period of AOT or until the court finds that the person no longer meets the criteria for AOT. ORS 426.133(6).

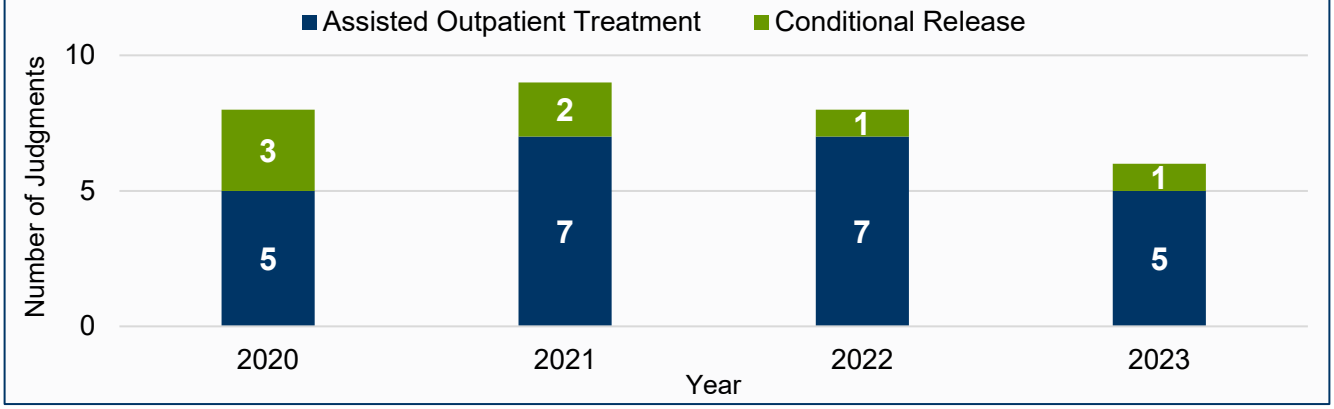
While other states have established that the consequence of non-compliance with a court order to participate in AOT is immediate hospitalization, Oregon statute is silent on the consequences of non-compliance.

Also, although the court has authority to order a person to participate in AOT, the court cannot require a CMHP to provide treatment, services, or supervision of the person if the county lacks sufficient funds for such purposes. ORS 426.133 (7)(b).

AOT is rarely used in Oregon. Between 2020 and 2023 (see Figure 7), it was ordered in an average of six cases per year.

Figure 7: Conditional Release and Asssisted Outpatient Treatment Judgments

2020-2023



11. Commitment

If the court orders commitment, the person is placed under the jurisdiction of OHA to provide treatment and care. OHA has discretion to direct the person to the facility best able to treat the person, either in an inpatient or outpatient setting, as described below. ORS 426.060 (2)(b).

OHA delegates its responsibilities for assignment of placements and transfers of civilly committed individuals to the CMHP in the county of commitment and has established rules governing placements and transfers. ORS 426.060 (2)(d); OAR 309-033-0290 (1). Under the Oregon Administrative Rules, the CMHP may place or transfer the person to any OHA-approved facility or program that the CMHP believes will appropriately meet the person's mental health needs and is consistent with applicable law. OAR 309-033-0290 (1)(a). However, the CMHP must consult with the OSH superintendent, the LIP, or the administrator of a non-hospital facility or program as described below:

- The CMHP may not place a person under civil commitment at OSH without consent of the OSH superintendent. OAR 309-033-0290 (1)(d).
- The LIP, in consultation with the CMHP, determines whether placement in a community hospital would be in the best interests of the person. OAR 309-033-0270 (3)(a).
- The administrator of a non-hospital facility or outpatient program, in consultation with the CMHP, determines whether admission to a non-hospital facility or an outpatient program are in the best interests of the person under commitment. OAR 309-033-0270 (4)(a).

Person's Rights

A person has several enumerated rights after commitment, outlined in ORS 426.385. Those include rights related to comfort and dignity, such as a right for the person to wear their own clothing, to keep personal possessions, to have access to a private storage area, and to be furnished with writing materials and stamps. Other rights are more fundamental: a right to communicate freely in person, a right to religious freedom, a right to counsel whenever the substantial rights of the person might be affected, a right to petition for a writ of habeas corpus, a right to reasonable expectation of privacy and security, a right to access fresh air and outdoors, and (unless the person has been adjudicated incompetent) the right to exercise all civil rights in the same manner and with the same effect as one not admitted to a facility. The statute also outlines the person's right to be free from unusual or hazardous treatment procedures, including convulsive therapy and psychosurgery.

Inpatient Commitment

Inpatient civil commitment refers to placements in an OHA-designated Class 1 facility, which includes OSH, certified community hospitals, and Class 1 secure residential treatment facilities. Class 1 facilities are locked to prevent a person from leaving the facility, may use seclusion and restraint, and may involuntarily administer psychiatric medication. OAR 309-033-0520; 309-033-0530.

Outpatient Commitment

Outpatient commitment refers to treatment or services provided to a person who resides in a residential behavioral health facility or their personal residence with outpatient or medication management services. OAR 309-033-0270 (4)(d). The CMHP may place a person on outpatient commitment only if an adequate treatment facility is available, and may not place a person on outpatient commitment, who at the time of initial commitment was placed in a level one facility or hospital setting. ORS 426.127 (1); OAR 309-033-0270 (4)(d).

The CMHP of the county of the court that orders the civil commitment sets the conditions for outpatient commitment and gives copies of the conditions to the following individuals and entities:

- person under commitment
- CMHP of the county where the committed person will receive treatment
- facility, service, or provider designated to provide care or treatment

- circuit court that ordered the commitment
- circuit court in the county where the person will receive treatment if different than the court that ordered the commitment.

ORS 426.127 (2), (3); 426.278.

The CMHP for the county where a person is receiving outpatient commitment may modify the conditions when a modification is in the best interest of the person. ORS 426.127(5).

If the CMHP determines that the person is failing to adhere to the terms and conditions of the placement, the CMHP must notify the court of jurisdiction and the CMHP of the county in which the person on outpatient commitment lives. ORS 426.275 (1).

The court with jurisdiction may hold a hearing to determine if the person is violating the terms and conditions of placement. Pursuant to the court's determination, a person on placement shall either continue the placement on the same or modified conditions or be returned to OHA for involuntary care and treatment on an inpatient basis. ORS 426.275 (2), (3).

If the outpatient placement is in a county other than the one of the committing court, the committing court transfers jurisdiction to the court of the county where the person is living. ORS 426.275(5).

12. Changes in Placement

At any time, for good cause and in the best interest of the committed individual, OHA may transfer a committed person from one facility to another. ORS 426. 060 (2)(b). For transfer to a facility in a less restrictive class, OHA follows the procedures for trial visits, as described below. For transfer to a facility in a more restrictive class, OHA follows the procedures under ORS 426.275 and must receive court approval.

Trial Visits

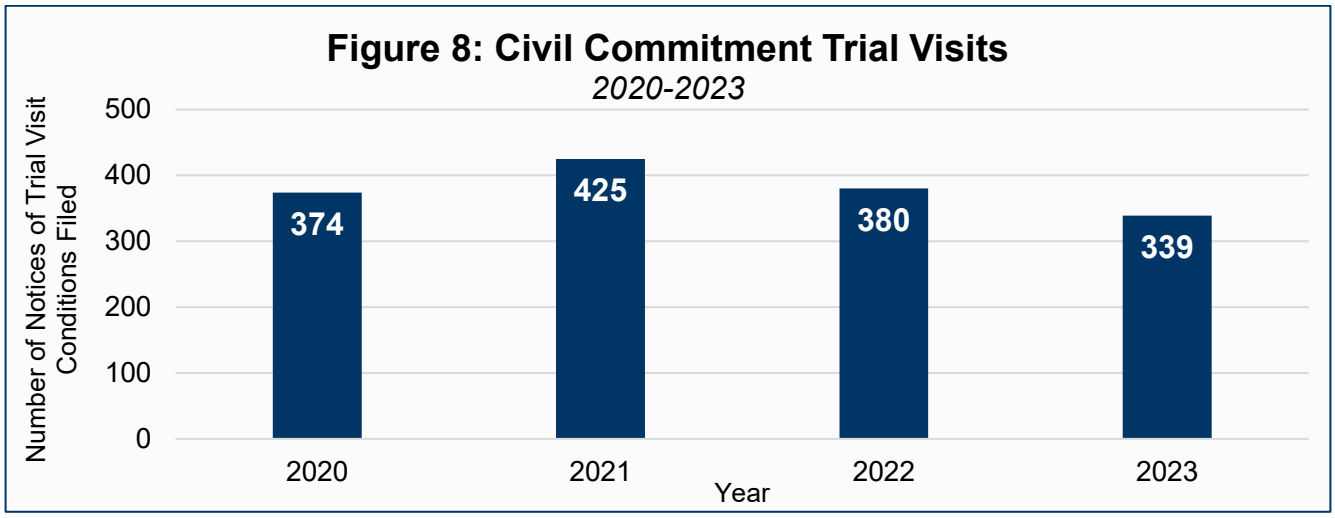
A trial visit refers to a change in placement of a civilly committed person from a higher to a lower level of care. ORS 426.060 (2)(b)(B). The trial visit may be a transfer of the committed person from the Oregon State Hospital to a community hospital, or from a level one facility (inpatient) to a lower level of care, such as treatment in another facility, outpatient care, or case management services. OAR 309-033-0270 (4)(c). OHA may require outpatient treatment as a condition for a trial visit and designate the facility, service, or other provider to provide care or treatment. ORS 426.273 (3). OHA may grant a trial visit for a period within the court-ordered length of commitment time and under any conditions OHA determines. ORS 426.273. However, OHA may not grant a trial visit without agreement by the CMHP for the county where the person would reside. ORS 426.273 (1).

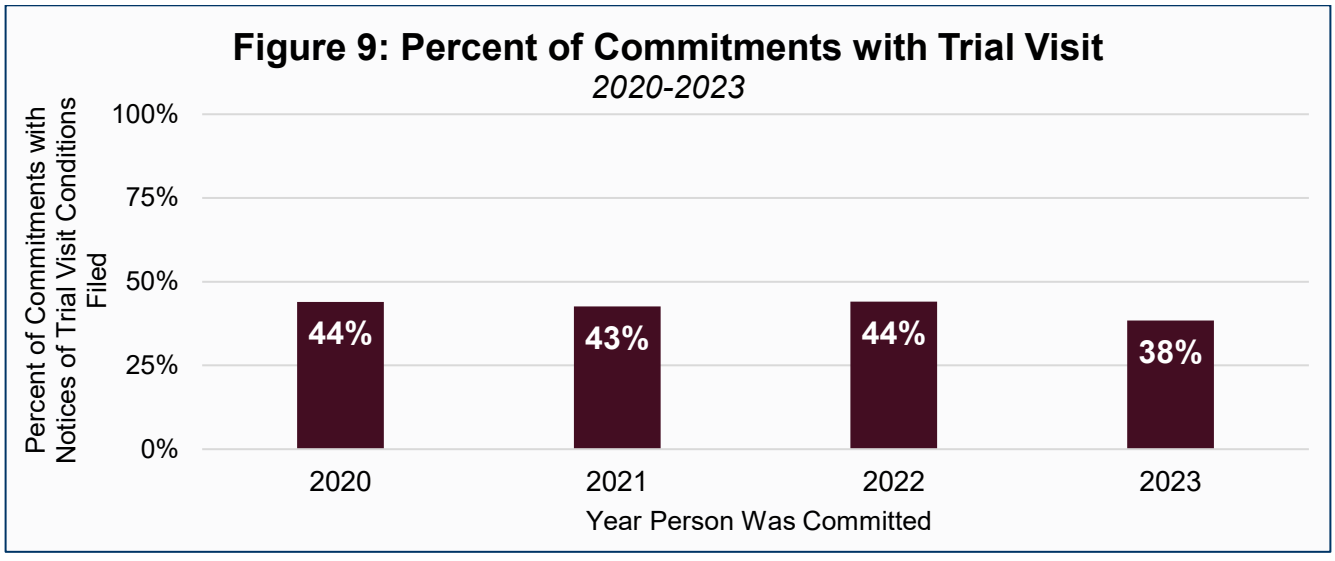
The processes for trial visits parallel those for outpatient commitment, described above. See ORS 426.275. Copies of the conditions for a trial visit go to the same individuals and entities as for an outpatient commitment. 426.278. As with outpatient commitment:

- CMHP may modify the conditions when modification is in the best interest of the person;
- CMHP responsible for the person must notify the court of jurisdiction and the CMHP of placement if the person is failing to adhere to the terms and conditions of the placement;
- Court with jurisdiction may hold a hearing to determine if the person is violating the terms and conditions;
- Court may either continue the placement on the same or modified conditions or return the individual to OHA for involuntary care and treatment on an inpatient basis;
- If the person is placed in a county other than the county where the person was committed, the court that established the period of commitment transfers jurisdiction of the case to the court where the person is living while on the placement.

ORS 426.275

Between 2020 and 2023, OJD received an average of 380 notices of trial visit conditions a year (see Figure 8), with some cases having multiple notices filed. Ultimately, notices of trial visit conditions were filed in 42% of the cases with commitment judgments issued during those four years (see Figure 9).





13. Recertification for Continued Commitment

If a person is still under commitment after 180 days, the person must be released unless the treating facility, in consultation with the CMHP of the county of residence, certifies to the court in the county where the person is being treated that the individual is still a person with mental illness and in need of further treatment. ORS 426.301 (1).

The treating facility must serve a copy of the certification on the person and inform the committing court in writing that service has been made. The certification must notify the person of their rights, including but not limited to rights to consult with an attorney, to court-appointed counsel for financially qualified individuals, and to protest the further period of commitment within 14 days. ORS 426.301 (2), (3).

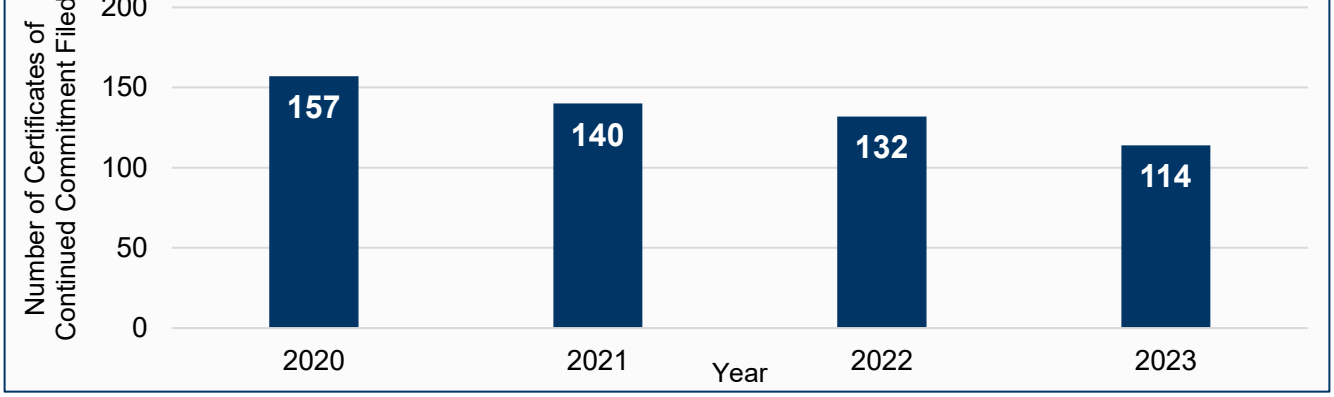
If the person does not protest the certification within 14 days, the court orders a continuation of the commitment for an indefinite period of time up to 180 days. ORS 426.301 (5).

If the person protests the certification, the treating facility immediately notifies the court, and the court holds a hearing in which the person comes before the court to hear their rights. ORS 426.303. Upon the person's request, the court holds a hearing on the continuing commitment as promptly as possible under the same processes, standards, and criteria of the initial commitment. ORS 426.307.

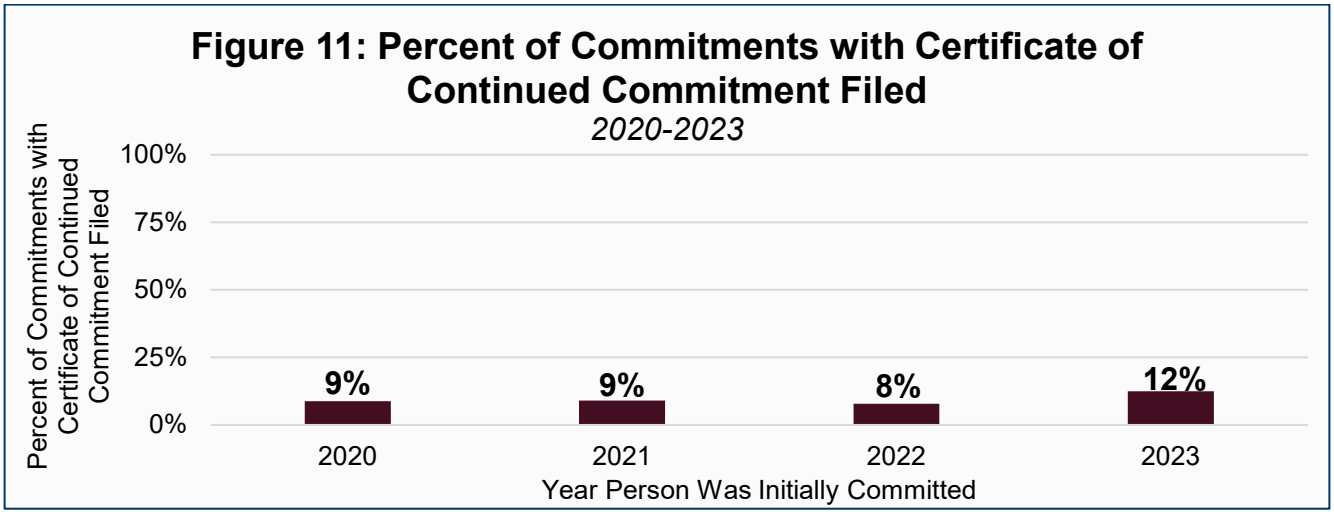
OJD received an average of 135 certificates of continued commitment a year between 2020 and 2023 (see Figure 10), with some cases having the commitment extended multiple times.

Figure 10: Certificates of Continued Commitment

2020-2023



While the number of certificates of continued commitment was lower in 2023 than in prior years, the percentage of commitments that had a certificate of continued commitment increased from 9% of commitment judgments issued in 2020 and 2021 to 12% of commitment judgments issued in 2023 (see Figure 11).



14. Discharge and Dismissal

Discharge from a care facility and dismissal of a civil commitment case are closely linked.

Before the initial commitment hearing takes place, if the circuit court receives notice from the LIP or CMHP (after consultation with the LIP) that a person has been released from an emergency psychiatric hold, and the CMHP has not recommended to the court that the person should participate in assisted outpatient treatment, then the court must dismiss the case within 14 days after the person was initially detained. ORS 426.234 (5).

If a person enters a 14-day diversion from commitment, the court must dismiss the case 14 days after certification was issued unless a hearing on commitment is requested. ORS 426.237 (3)(h), (i). If a hearing is held, and the court finds that the individual is not a person with a mental illness, the person must be discharged from the facility unless the person agrees to remain voluntarily. ORS 426.237 (4).

After a person is civilly committed, OHA may release the person from a hospital or other facility in which the person is being treated prior to the expiration of the period of commitment when, in the opinion of the facility or the LIP who is treating the person, the person is no longer a person with mental illness. ORS 426.300 (1). If the 180-day period of commitment expires without a recertification notice filed, the commitment ends, and the person must be discharged. ORS 426.301 (1).

15. Appeals

An individual subject to a court order in a civil commitment case can appeal the order in the same manner as in any other civil proceeding, and counsel may be appointed if the person is financially eligible. ORS 426.135. The statutory requirements for an appeal are in ORS Chapter 19. A notice of appeal must be filed within 30 days of the commitment order. An appeal may take several months or years before an opinion is issued. Since commitments are

no longer than 180 days in length, an appeal may not affect the length of a commitment. Of the 443 commitment judgments issued in 2023, 105 were appealed.

Statute also allows a writ of habeas corpus following a civil commitment (*e.g.*, to challenge an unwanted confinement). ORS 426.380 (1)(j).

Concerns about Oregon's Civil Commitment System

This section summarizes the concerns about Oregon's civil commitment system presented by individuals from all sources, including workgroup members, constituent surveys, listening sessions, and communications to workgroup staff. **The concerns are presented as they were offered, without verification of facts. They reflect concerns raised by individuals, not the workgroup as a whole.** Concerns are presented in the order of the chronological steps in the commitment process, followed by more general categories.

Links to Subsections

Community-Based Behavioral Health Services

- Oregon's mental health system is failing to support people across all stages of need, including prevention, intervention, treatment, and transition.
- Needed community services often do not exist or access is limited.
- Local communities are failing to provide necessary outreach to individuals with behavioral health care needs before their conditions escalate to crisis levels.
- Oregon's mental health system does not recognize how an individual's anosognosia (lack of insight) makes treatment inaccessible.
- In the many areas of Oregon with no mental health crisis center, individuals are brought to emergency departments as the only location available for services.
- People are told that they can't get care for all needed services, including physical health care, developmental services, age-related care, mental health care, and addiction services.
- Over 7,000 notices of mental illness are filed annually in Oregon, but most are dropped before a hearing, in many cases leaving individuals without a safety net or access to resources.
- Oregon lacks services and treatment options for diversion from commitment, including supportive housing and residential treatment.
- People are denied placements in housing or treatment centers because they are considered too difficult or dangerous.
- Oregon has no inpatient facilities for an individual to go voluntarily when they are experiencing a crisis and want inpatient support.
- Oregon's lack of appropriate community-based resources for step-down care from a hospital setting results in discharge plans that place individuals back into challenging situations, and progress from months of care may be lost.
- The state's practice of investing in the extreme ends of care may interfere with the legal and ethical principle to always place a person in the least restrictive level of care.
- The system lacks fluidity in its design to move individuals in one direction from a higher to a lower level of care; it is difficult to move people back and forth as needed.
- Oregon's civil commitment system heavily burdens community hospitals due to the inadequate continuum of care.

Psychiatric Emergency Holds

- Workforce shortages limit some hospitals from providing active treatment during holds.
- Individuals may refuse to engage with treatment voluntarily during a hold.
- Statutes lack needed guidance on when a commitment referral or hold is mandatory rather than discretionary (*e.g.*, when a person in clear psychiatric crisis is brought to jail, could require hospital and CMHP to evaluate for commitment rather than book them on charge).

Notice of Mental Illness (initiation of case)

- There are not enough points of referral for entry into the civil commitment system (*e.g.*, self-referral, families, district attorneys diverting people from criminal justice, a single licensed mental health worker such as a Qualified Mental Health Professional (QMHP), CMHP when a person has multiple law enforcement contacts due to mental illness).

Warrant of Detention

- Some consider the warrant of detention terminology to be offensive because it sounds like a process for a criminal proceeding.

Investigation

- Investigators may lack the qualifications to make a legal determination about probable cause.
- Educational qualifications for investigators may be too low: an individual may become a QMHP with only a bachelor's degree in nursing or occupational therapy and a license to practice in Oregon.
- Investigator training may be insufficient.
- The five-day timeline between notice of mental illness and court hearing may be inadequate for an investigator to assess how the person responds to treatment.
- Investigators may be unable to obtain information on the psychosocial history of the person under investigation.
- Investigation reports submitted to the court often lack the specific information required under OAR 309-033-0920, and investigators are not legal practitioners who can determine which information may be relevant to the court and parties.
- Statute does not require investigators to provide supporting documentation from the investigation that may be helpful to the court to make a probable cause finding.
- Statute does not require investigators to send the investigation report to the district attorney for review before submitting it to the court.
- The five-day timeline between notice of mental illness and court hearing may be insufficient for district attorney review of investigation reports before court submission.
- CMHPs have a potential conflict of interest between their role to oversee investigators and their roles to manage and pay certain costs of civilly committed individuals.
- Investigators cannot bill for their time regardless of workload or hours invested, which may lead to burnout for the investigator and funding challenges for CMHPs, underscoring the need for sustainable funding models.

14-Day Intensive Treatment

- Statute does not use the term “diversion” (uses the phrase “14 days of intensive treatment”), but that term is used in the Oregon Administrative Rules and is widely used in court proceedings and investigations.
- Statute requires appointment of a defense attorney when the court issues a citation for hearing, but appointment may not occur prior to the diversion decision.
- Statute lacks objective criteria for entry into and release from the 14-day period of intensive treatment.
- Statute provides for case dismissal when a person enters 14-day voluntary treatment, which removes the ability of the court to order AOT once the diversion ends.
- Concerns exist that individuals are limited to a certain number of diversions.

Probable Cause Determination

- Concerns exist that judges make probable cause determinations based solely on the recommendation of the investigator or do not review investigation reports individually to determine whether probable cause exists.

Citation and Service

- Statute is silent on who is required to serve the citation to the person alleged to have a mental illness, and counties vary on who serves (sheriff, hospital, investigator, CMHP, combination). Other statutes require sheriffs to serve court processes.
- Sheriffs serving the citation in uniform may cause trauma to the person with an alleged mental illness.
- There are concerns about safety risks to investigators or others who serve the citation if unaccompanied by law enforcement in certain cases. Adult protective services investigators determine whether to have law enforcement accompany them.

Appointment of Counsel

- Statute is unclear about when counsel must be appointed for civil commitment proceedings, whether it is limited to the commitment hearing or should be available at an earlier stage of the process and in the post-commitment period.
- The five-day timeline between the citation or start of detention and the hearing is insufficient for attorneys to prepare their cases.
    - The limited timeline may impact the person’s constitutional rights to due process and effective assistance of counsel.
    - Over 80% of respondents to a constituent survey question on appointment of counsel responded that 24 hours is insufficient time for a defense attorney to meet with their client and prepare an adequate defense.

    - District attorneys reported that they regularly have cases in which a hearing could have been avoided if time had been available to discuss desired outcomes and options with the person alleged to have a mental illness.
    - If the statute were to require appointment of counsel earlier in the process, it would require a lot more lawyers.
- Public defenders are often removed from a case at the time the court orders civil commitment due to staffing shortages and high caseloads, which presents a barrier to access to a legal advocate that follows the individual throughout the process.
- Individuals who reside in rural counties but are hospitalized in a different jurisdiction face challenges to maintain consistent legal representation.

Examination

- The supply of available examiners in Oregon is insufficient to meet need.
- CMHPs have a potential conflict of interest in overseeing the examiner because examiners are agents of the court who make a final recommendation to the judge.
- Examiners do not have direct access to medical records, and it may take significant time for hospitals to produce them.
- The 24 hours that examiners have to review medical records before the hearing may not allow for adequate review.
- Some examiners cross-examine witnesses during the hearing, which may be beyond the scope of their authority.
- Statute isn't clear on the number of examiners necessary for a hearing. As a result, some counties automatically appoint two examiners to every case, exacerbating the statewide problem of limited access to examiners.
- Statute is silent on whether examiners may appear at the civil commitment hearing remotely; some counties allow for remote examiners, and others do not.
- Remote examination practices raise constitutional concerns related to confrontation rights and due process.
- Concerns exist that examiners lean towards a decision in support of commitment, and that this bias may impact the due process rights of persons alleged to have a mental illness.
- Examiners may experience challenges when determining whether a developmental disability or a mental illness is driving symptoms.
- Minimum qualifications for examiners (QMHP) may be too low; however, raising qualifications may result in fewer examiners.
- Examiners may be insufficiently trained to assess the future risk of violence, whether by unstructured clinical judgment, actuarial assessment, or structured professional judgment.

Court Hearing

- The location of hearings on initial civil commitment and recertification may be traumatizing if held in a courtroom but may pose a significant burden or safety concern if held in a hospital. Remote hearings may place additional burden on hospital staff.
- Five judicial days (or 10 with good cause) may be insufficient time to complete all the tasks required before hearing (investigation; court determination of probable cause; scheduling hearing; serving citation; appointing counsel and examiner; examination; attorney preparation for hearing).
    - Respondents to a constituent survey question on whether five days is sufficient were divided, with 44% of respondents voting yes, and 56% voting no.
    - Among those who said yes, comments included that Oregon has had a five-day timeline for a long time, and it seems to be adequate, and that personal autonomy and liberty are at stake if the timeline is extended.
    - Among those who said no, comments included that a longer timeline would allow for a more thorough investigation, better information for court and parties, and potentially planning and stabilization rather than commitment, and that even the 10 days currently allowed for good cause was not enough time to build a defense especially when an expert would be helpful.
    - When asked how many days would be ideal, answers ranged from the current five days to as long as 30 days for more complicated cases, with answers of seven, 10, and 14 also suggested.
- Concerns exist that formal court processes are not trauma-informed and can trigger some individuals who are contesting commitment because they lack insight into their mental health condition.

Adjudication Standards

- Statute requires showing that a “mental disorder” is the cause of the behavior necessitating involuntary treatment but does not define “mental disorder.”
- Statute uses the phrase "person with a mental illness" as a term of art to refer to a person who, because of a mental disorder, is a danger to self, etc. If the court finds that a person’s condition does meet those criteria, the person may understand that to mean that the person does not have a mental disorder.
- The high legal threshold for civil commitment under Oregon case law interpretation results in only a small percentage of individuals who are committed following a notice of mental illness.
- The high threshold for civil commitment under Oregon case law values patient autonomy over public safety and the patient’s other important interests.
- Input from a participant at the 2023 Peerpocalypse conference: You hear a lot about advocating for people’s civil rights but no one acting on the fact that some people want it to be easier to get civilly committed.

- Families often struggle to get a loved one into voluntary treatment when the individual does not meet the bar for civil commitment.
- The high threshold for civil commitment may put persons experiencing mental health crisis but not committed at risk of criminal justice involvement.
- Concerns exist about the statutory standard for inability to meet basic needs criteria:
    - Limiting focus to inability to care for basic needs in the near future is too narrow.
    - The standard relies on prediction rather than history and behavior patterns.
    - Some say replacing the basic needs standard with a gravely disabled standard would allow focus on the whole person rather than predictions and would allow the court to determine whether oversight is necessary, while others question whether the gravely disabled standard would reach the intended population and effectively raise the threshold for civil commitment.
- Concerns about statutory standard for the dangerousness criteria:
    - Statute lacks a clear legal standard for imminent danger.
    - The lack of clear standards results in inconsistent interpretations across courts.
    - The narrow interpretation of dangerousness requires people to have caused physical harm before they can get treatment.
    - Allowing the court to consider a person's history of dangerous behavior and any threats to inflict serious physical harm is necessary to divert individuals from criminal justice involvement.
    - The standard for how long in the future to consider for risk of dangerousness should be formulated from an evidence-based risk assessment.
- Concerns from a clinical perspective:
    - The nexus between mental illness and dangerous behavior is tenuous and needs more clarity in statute.
    - Merging clinical and legal terminology in statute may lead the mental health provider to make legal determinations.
    - OAR 309-033-0920 outlines how civil commitment investigators assess danger to self or others, and self-harm is not part of the criteria.
- Concerns from a social services perspective:
    - Community mental health providers are concerned about a population that cycles in and out of the system because the individuals never quite reach the bar for commitment despite experiencing acute symptomology and not engaging in treatment, leaving people to fall through the cracks.
- Oregon is one of a minority of states that does not consider substance use disorder as a condition that would allow for civil commitment.
- Concerns also exist that the legal threshold for commitment is already too low to remove someone's rights because all civil commitment is designed to institutionalize people, and individuals should not be punished because the community failed them in providing appropriate home and community-based supports for their health needs.

- Lowering the standard for civil commitment without expanding access to appropriate levels of care available to committed individuals may not result in better outcomes.

Alternatives to Commitment (voluntary admissions, conditional release)

- Whether voluntary treatment is an option is often determined before a case reaches the courtroom, frequently by investigators.
- Counties vary on who determines whether voluntary treatment is appropriate.
- Voluntary treatment requires the judge to determine whether someone is willing, able, and probably will participate in treatment; “probably will” standard is a low bar to meet.
- Voluntary treatment is more effective when there is community support, no history of non-compliance, and an interest in engaging in community treatment options.
- Court oversight of individuals ordered to voluntary treatment may improve treatment plan adherence, but statute doesn’t allow a court to maintain oversight of individuals once they enter voluntary treatment.
- For individuals who attempt to access treatment or services in the community, but the treatment or services are unavailable, court may try to help the person get the treatment or services, but even a judge cannot create resources that do not exist.
- When providers turn away people seeking treatment, it can lead individuals to distrust the system and manage symptoms through controlled substances.
- Conditional release is like a trial visit with an assigned caregiver; the different levels of community-based involuntary treatment can cause confusion.
- Conditional release requires accessible and coordinated community services to support all parties.
- Many allegedly mentally ill persons lack the support of relatives or friends who could provide the support required for conditional release.
- When friends or family agree to be responsible for an individual on conditional release, they may be unclear on what is required or necessary for positive outcomes.
- Statute is not clear on the differences among different levels of civil commitment, and some counties misinterpret conditional release.

Assisted Outpatient Treatment

- AOT is underutilized in Oregon for individuals who are not eligible for civil commitment (courts have ordered only 13 people to AOT in last two years).
- AOT in Oregon is inconsistent with AOT nationally; unlike other states, Oregon’s AOT program is separate from its outpatient commitment program, and a person must meet the threshold for involuntary civil commitment to qualify for outpatient commitment.
- In Washington, AOT teams can transfer an individual to inpatient care if the individual is decompensating in the community.
- Counties generally do not provide AOT because they are not required do so if they do not have adequate funding for the program. Most counties do not fund AOT services.

- Private insurance would likely not cover any proposed AOT services.
- Medicaid could not fully fund AOT. Private insurance may not cover these services because of the intersection with the court system.
- If the threshold for AOT is lower than inpatient commitment, individuals would have greater incentive to participate in AOT.
- Current statutes governing AOT give the court oversight of mental health care but not enforcement powers.
- People with lived experience have varied opinions on AOT.
- Concerns exist that AOT puts the responsibility on the person to access care when a robust, rapid-access treatment system does not exist.
- AOT orders are currently for one year, while civil commitment orders have a maximum six-month term.
- Unlike the 14-day diversion program, AOT will go on a person's record.

Commitment

- Status hearings are a critical piece missing in civil commitment; they hold the individual and the system accountable for the individual's progress.

Initial Placement After Commitment

- The availability of appropriate placements for civilly committed individuals is limited, and programs can refuse to accept individuals at their discretion.
- Some individuals who need specialized placement, such as at OSH, are instead being placed in community hospitals.
- Community hospitals need more staff and resources to treat high acuity patients with behavioral health conditions.
- Community hospitals and emergency rooms lack staff and funding to treat and support long-term care for committed individuals.
- Oregon's nine federally recognized Tribes are sovereign entities with varied placement options and should be included when discussing placement options.

Outpatient Commitment

- Oregon does not provide for court-mandated outpatient treatment and leaves treatment and placement decisions to OHA.
- Residential treatment facilities assert that they require consent to administer services, which is an obstacle to placing people under involuntary treatment orders in residential treatment facilities.
- Outpatient commitments are rare because they require intensive outpatient support services.

- Oregon needs more placement options for people who meet the civil commitment threshold but do not need inpatient-level care.
- More resources are needed to improve the community support network.
- Outpatient commitment is similar to AOT but lacks court oversight and specific resources that are identified in the AOT statutes.
- Unlike structures available for civil commitment, the Psychiatric Security Review Board (PSRB) has an effective model of outpatient treatment that it uses to stabilize people in residential treatment homes that house small groups of people and are staffed around the clock.
- Oregon's outpatient commitment statute does not allow for outreach, but outreach can be done through the OHA County Financial Assistance Agreements with CMHPs.

Changes in Placement

- Oregon's event-based civil commitment criteria make transferring people to a lower level of care challenging.
- Oregon's civil commitment structure lacks fluidity and makes it difficult to move someone from a lower level of care to higher level when needed.
- Oregon needs more placement options and supported care environments for people discharged from inpatient civil commitment.
- Oregon's inpatient-based civil commitment system makes it challenging to place individuals who are non-compliant with placement conditions but do not need hospital-level care.
- Oregon's residential system requires a person to agree to placement, which may create a challenge when placing a person under civil commitment who no longer needs a hospital-level care and leads to longer acute care hospital stays.
- Requiring someone to volunteer for an involuntary placement is contradictory.
- A lack of placement options often leads to placing individuals in a different county than where they live.
- Requiring the court of commitment to transfer an individual's case to the county where the person receives services slows down the placement process.
- Counties lack a system to coordinate care for committed individuals who are transferred between counties.

Trial Visits

- OHA's current rules establish the new county of commitment as the responsible jurisdiction when transferring placement, but most site visits for people on trial visits occur virtually. As a result, transferring jurisdiction is a bureaucratic and often unnecessary step.
- At least in some counties, committed individuals may be released to the streets on a trial visit within a week of being placed in a commitment.

Recertification for Continued Commitment

- Families and loved ones need more support throughout the civil commitment process, including during recertification.
- Jurisdictions currently have varied timelines for appointing legal counsel during the recommitment process.

Discharge and Dismissal

- Concerns exist about the number of dismissals occurring before the civil commitment hearing given that each individual exhibited behavior warranting a notice of mental illness and that an order of dismissal does not support continuity of care.
- Family members express concern to judges when cases are dismissed without providing the individual with needed support and their loved ones fall through the cracks.
- Current systems are not designed to prioritize individuals for behavioral health care services following case dismissal.
- In particular, the current system does not support individuals whose commitment cases are dismissed after they were put on psychiatric hold due to drug-induced psychosis.
- Inpatient treatment programs often discharge people to the community without housing or other support.
- Programs are looking to increase treatment options, such as partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs), but this will require a cultural shift and additional support.
- Appropriate care following case dismissal requires a complex and demanding resource network.
- Access to voluntary treatment after dismissal is limited.
- Concerns exist about the lack of judicial oversight following dismissal when the person does not have a community-based safety net.
- People with lived experience note that resistance to seeking treatment occurs when clients lack choice and little individualization exists for treatment options; the lived experience community often knows what services they need.
- Cases in which acute symptomology might impair insight and prevent an individual from making informed decisions regarding medication and treatment present an ethical struggle for judges and community providers to address the misalignment between an individual's desires and what appears to be the most appropriate clinical option.
- No data is available to see what supports are provided to individuals who were the subject of a notice of mental illness but whose cases were dismissed without commitment.
- OSH does not always notify local CMHPs when it discharges an individual under civil commitment from the hospital.

- Currently, an individual's family or other natural supports cannot access the person's care plan upon discharge from commitment.
- Engagement of system providers with family or other natural supports upon discharge can be important; however, individuals who are discharged from commitment have a right to self-determination and may not want to share a discharge plan with others.
- Once the court orders civil commitment, investigators are prohibited from communicating with family members without a release of information; this sudden change in communication perpetuates problems with family engagement.
- The 48-hour notice to Tribes prior to discharge of a Tribal member is insufficient time to coordinate care coordination.

Appeals

- Concerns exist that working definitions for civil commitment are created in response to appellate court decisions that define what the statutes mean.
- Appeals often take longer to resolve than a person spends in commitment. If a person is committed for up to six months, and the appeal takes six months, then appeal may not have a practical effect on that person's commitment.

Terminology

- "Person alleged to have a mental illness (PAMI)" and "mental disorder" are stigmatizing and confusing terms.

Access to Medical Records

- Defense counsel are not receiving their clients' medical records in a timely fashion
- Some hospitals still use a paper record-keeping system, which may bar access compared to an electronic record-keeping system.
- Some hospitals are concerned that defense attorneys are not engaging soon enough.

Medication[56]

- Individuals are ordered to take medications that may fail to eradicate symptoms and have negative side effects.

[56] ORS 426.072(2)(c) authorizes a Licensed Independent Practitioner (LIP) to administer medication without obtaining prior informed consent, subject to OHA rules, to a person **alleged to have a mental illness** who has been placed in custody at a hospital or non-hospital facility. OAR 309-033-0520, the OHA rule that establishes classes of facilities that provide care, custody, or treatment to **civilly committed persons**, provides that only a Class 1 facility has express authority to involuntarily administer psychiatric medication. Class 1 facilities may include a hospital, regional acute psychiatric care facilities, and other non-hospital facility approved under OAR 309-033-0530.

- Concerns exist that there is a belief that if people just took their medications, public safety would improve.
- Providers should utilize harm reduction principles associated with treatment that offer flexibility with what treatment is, rather than just focusing on medication intervention being the only thing considered to be care.
- Access to the medication combination that works for a person can be problematic (formulary, cost, logistics).
- Historical shortcomings of the behavioral health and legal system around involuntary medication complicate discussions around this level of care.
- Civil commitment often focuses on psychotropic medication even though it is only one piece of recovery. A system of recovery should consider other avenues of safety, such as housing.
- Keeping commitment as short as possible contributes to the focus on medication-assisted treatment over non-pharmacological treatment methods.
- Individuals experience difficulties when leaving the hospital without access to medication refills.
- Too few places are available where people can go to titrate off medications safely and in a supported way.
- Concerns exist that when individuals get to the hospital, doctors give them benzos to calm them down but then discharge them to nothing and also while under the influence of the benzos, which increases risk of overdose.
- Some counties have no prescribers.

Data Sharing and Confidentiality (case management)

- State and federal laws limit the sharing of personal health information about the person alleged to have a mental illness that may be helpful for the management of a civil commitment case.
- CMHPs struggle to collect and distribute the required information within the current civil commitment investigation timeframe.
- The civil commitment system does not follow the successful model of Adult Protective Services, which uses a statewide database to track referrals, screenings, and investigations.
- Concerns exist that providers and clinicians decline to share information when needed and allowable because of their confusion about HIPAA, and that HIPAA and its restrictions are often misinterpreted, to the detriment of the person and support team.
- Current trainings are difficult to understand and do not give practical examples of when you <u>can</u> share information, so people default to saying nothing or even telling people that are not subject to HIPAA that they are violating it.

Data Collection, Analysis, and Reporting (policy)

- Cross-agency data sharing often improves analysis and leads to data-driven decision-making; however, coordination of data collection and sharing between entities is challenging, especially with legally protected information.
- Matching court records in different cases for a single individual can be challenging due to a lack of common identifiers in civil commitment and criminal cases.
- The effectiveness of civil commitments cannot be evaluated without tracking where committed individuals are placed, what treatment and services they access, and their outcomes.

Rights of Individuals in Civil Commitment System

- The civil commitment system should balance interests in personal autonomy, individual well-being, community well-being, and public safety.
- Accountability structures are needed to protect and promote the rights of individuals in the civil commitment system.
- Peers and advocates are important to protecting person-centered rights.
- Providing timely care is an important part of protecting established rights.
- Staffing shortages affect the ability of treatment organizations to provide optimal care.

Collaboration with Oregon Tribes

- Tribal courts have expressed concern about their lack of authority to civilly commit Tribal members to the Oregon Health Authority.
- Tribes need clarity on the pre-hearing process.
- Civil commitment process needs better integration with Tribal courts.
- The Confederated Tribes of Warms Springs CMHP encounters barriers when transferring a member to a hospital under the state's jurisdiction.
- Although the Confederated Tribes of Warm Springs is the only Oregon Tribe with a CMHP, other Oregon Tribes are also interested in improving implementation of the civil commitment processes and promoting access to its resources.
- Concerns exist about information-sharing gaps among OHA, CMHPs, and Oregon Tribes.

Equity

- Class-based inequities:
    - Current civil commitment processes can result in class-based inequities.
    - Low-income people are less likely to have access to behavioral health services that allow them to avoid reaching point of civil commitment or to avoid being recommitted.

    - Unhoused people are more likely to be civilly committed than those that are housed.
    - Most individuals facing civil commitment in Multnomah County are homeless or facing homelessness, and houseless individuals placed on a psychiatric hold are held longer due to the lack of outpatient resources.
- Racial, ethnic, and gender-based inequities:
    - People of color with mental health issues are more likely to end up in aid and assist system than civil commitment system.
    - Equity requires looking beyond numbers to understand instances of inequity, such as investigation reports for African American men that talk about how violent or intimidating they are compared to someone who is not an African American man, or a different perception about a man and woman who are out in public nude on a sunny day (man will get sunburned, woman will get sexually assaulted).
    - Lack of communication with Tribes leads to inequities in accessing necessary information for psychiatric holds, impacting individuals who should receive help. Tribes have unique relationships with their members and information that can aid civil commitment investigations.
- Geographical inequities:
    - Individuals living in Eastern Oregon experience geographical inequity in access to mental health services.
    - Among respondents to the constituent survey on equity issues, 79% cited geography as an area of inequity in Oregon's civil commitment system.
    - Lack of coordination among counties stemming from the county-based funding structure makes it more difficult to place individuals in appropriate settings; need better allocation of resources and more centralized sharing of resources.
    - Rural areas have limited access to psychiatric holds and face the risk of criminalization due to a lack of resources; the only reliable way into the system for highly acute individuals is through arrest, and involving law enforcement sometimes becomes necessary because of the lack of resources.
    - Resource constraints hinder adequate geographic coverage and timely responses to civil commitment cases (Marion County has one investigator, and Lane County has three, which significantly strains resources for the counties' rural areas).
- Other equity concerns:
    - There is potential inequity in how many times people go to the emergency room before an NMI is filed.
    - Concerns exist about inequities in access to treatment while civilly committed occur due to form of payment, Medicaid vs. non-Medicaid.
    - Lack of clarity in statutes can create inequities in how providers interpret and apply criteria for when to issue an NMI (nuance in standards is provided by case law).

- Some individuals placed under an NMI receive preferential treatment at local hospitals due to past interactions, which can affect objectivity.

Individuals with an Intellectual Disability

- The justice system under-identifies people with intellectual and developmental disabilities.
- Concerns exist about inconsistencies with commitment for mental illness (ORS chapter 426), such as more days between citation and hearing.
- ORS chapter 427 does not provide any guidance for conditional release of individuals committed due to an intellectual disability.
- Oregon Developmental Disabilities Services (ODDS) does not have any licensed facilities to care for civil commitments for persons with intellectual disabilities (however, as of October 2023, 10 of the 19 individuals committed under ORS Chapter 427 were living in the Stabilization and Crisis Unit (SACU), a 24-hour crisis residential program operating under the guidance of ODDS).
- Individuals committed under ORS Chapter 427 who are in community placements other than SACU lack community resources and people available to support intellectual and developmental disabilities (IDD).
- Oregon does not have hospital level of care placements available for primary intellectual disabilities diagnoses.
- Communities lack intellectual disabilities services generally.
- People who receive intellectual disabilities benefits often don't get mental health services when they need them.
- Because intellectual disabilities are typically identified as primary diagnoses, providers may struggle to determine whether developmental disabilities or a severe and persistent mental illness is causing specific symptoms. Similarly, concern exists about how examiners determine whether an intellectual disability or a mental illness is driving symptoms.
- Individuals with mental illness and co-occurring intellectual disabilities often have complex treatment needs that make it challenging to find proper placement, and community behavioral health systems face substantial barriers to serve people with co-occurring intellectual disabilities.
- Mental health providers say they do not want to accept people with intellectual disabilities diagnoses because they are not equipped to handle that population's needs.
- Specialized treatment homes are often permanent placements that do not represent a recovery model.
- Generally, hospitals and mental health providers will not hold people with intellectual disabilities who are not presenting mental health symptoms.
- OSH is currently the best placement for civilly committed individuals with co-occurring mental illness and intellectual disabilities because community-based programs lack

authority to enforce court-ordered civil commitment conditions; however, OSH has struggled to meet the needs of this population.

- Concerns exist that OSH lacks proper peer support settings and appropriate treatment options for people with intellectual and developmental disabilities.
- State hospital placements for people with intellectual disabilities present unique challenges due to the need for more specialized resources. Complex cases often result in prolonged hospitalization as providers strive to identify suitable support systems.
- Concerns exist that social services system underserve cognitive deficits related to schizophrenia (*e.g.*, someone with high acuity mental health symptoms may need help with tasks that overlap with intellectual disabilities services, but that's hard to get if you don't receive an intellectual or developmental disability diagnosis as a minor).
- Investigations for civil commitment of an individual with an intellectual disability, which includes a psychological evaluation, can take over a month before the court reviews the findings.
- The collaboration between OHA and ODHS for individuals with intellectual disabilities being considered for civil commitment can be challenging and often results in individuals being bounced between the two agencies.
- People with intellectual disabilities may face acute mental health crises that require immediate attention, but current emergency response often puts undue strain on crisis teams and local hospitals when dealing with emergencies that ODHS is not equipped to handle.
- Data from OJD and ODHS on commitments of individuals with intellectual disabilities is inconsistent.
- Oregon needs infrastructure, funding, and providers capable of addressing urgent situations involving Oregonians exhibiting unsafe behaviors regardless of their disability status, particularly in residential settings where individuals with mental health conditions and intellectual disabilities may reside.
- Guardianship does not provide a system of care for individuals with intellectual disabilities.

Co-occurring Mental Illness and Substance Use Disorder

- Oregon's civil commitment statutes are silent regarding how the court should consider substance use disorders (SUDs) in the determination of whether a person needs civil commitment; nor do they address treatment for SUDs for individuals who are civilly committed.
- Civil commitment placements do not include treatment for any co-occurring disorders; discharging an individual with a co-occurring SUD who is under inpatient civil commitment back into the community may lead to relapse.
- Oregon's civil commitment system lacks the resources to care for individuals with co-occurring SUD.

- Staffing shortages cause dual-diagnosis treatment programs to turn individuals away.
- Perceptions exist that dual-diagnosis treatment programs are selective to ensure staff feel safe and comfortable.
- CCOs can refer members to out-of-state facilities, but those facilities often do not accept people under civil commitment.
- Discharging an individual with co-occurring SUD from involuntary inpatient care to voluntary community-based care is often ineffective.
- Not all SUD treatment models are consistent with civil commitment's goals (e.g., under a harm reduction model, abstinence is not the primary goal).

Funding

- Medicaid laws restrict financial coverage for impatient services.
- Managed care limits treatment to that which is strict medical necessity.
- Oregon is in negotiations with the Centers for Medicare and Medicaid Services (CMS) on a 1115 Medicaid wavier focusing on transitional populations that would include some very temporary housing funding, but it won't come into play until maybe 2025 or 2026.
- Current funding practices do not earmark funds to establish needed behavioral health care resources for justice-involved individuals.
- Use of recently increased behavioral health funds allocated by the legislature may lack transparency and accountability for use of funds.
- Current funding structures do not support outreach efforts by local behavioral health providers because those services are not reimbursable.
- Behavioral health funding is a reactive system, in contrast to physical health funding that covers annual checkups.

Transportation

- Secure, safe, and timely transportation options for civilly committed individuals are limited.
- Inadequate transportation is a barrier for people alleged to have mental illness to meet with their counsel for the civil commitment hearing.
- Sheriffs are expected to provide transport service in rural counties that lack private transport resources, which takes up valuable time and resources for rural sheriffs' offices.
- Transportation by law enforcement may not be trauma informed.

Liability[57]

- CMHPs, community hospitals, and providers are concerned about liability for harm caused by civilly committed individuals in their care.
- Cost of liability insurance is a challenge for CMHPs that have limited funds to provide services.
- OAR 309-033-0330, which requires the county's director of placement to independently verify a person no longer meets the civil commitment threshold when placed in a community hospital or other community facility, creates tension between CMHPs, community hospitals, and local providers.
- Liability concerns may dissuade entities from reporting adverse medical events, such as a suicide that occurs within a short time following discharge from civil commitment.
- Data sharing concerns may prevent entities from sharing information about deaths in the community with previous providers.
- Fears about liability may prevent care providers from making decisions in a person's best interest.

Provider Safety

- Concerns exist that staffing shortages and inappropriate placements negatively impact staff safety in residential treatment facilities, acute hospitals, and the Oregon State Hospital.
- Exposure to vicarious trauma may contribute to staff burnout and turnover rates.

Public Safety and Well-Being

- Providers may not feel equipped to serve individuals with serious criminal offenses on their record, leaving those individuals untreated in the community.
- The failure of the criminal justice system and behavioral health system to manage individuals with behavioral health or cognitive deficits who repeatedly engage in dangerous behaviors may result in a loss of public trust in the government.
- Courts see individuals who have dozens of felony charges dismissed in multiple jurisdictions because they remain unfit to proceed in their criminal cases, who continue to engage in behavior that is challenging to public safety and public well-being, and that do not meet the legal threshold for civil commitment.

[57] ORS 426.335 provides protections from criminal or civil liability for individuals that perform responsibilities under the civil commitment statutes (including initiation, investigation, representation of the state's interest, examination, case adjudication, conditional release, inpatient commitment, outpatient commitment, and trial visits).

Transition Between Aid and Assist and Civil Commitment

- The intended outcomes of civil commitment and aid and assist services are different: the former is for acute mental health treatment; the latter is restoring competency to participate in a legal defense, not long-term stabilization or healing.
- Civil commitment timeframes may complicate the option to transfer from aid and assist; by the time an individual is assessed for a mental health disorder, the individual may no longer exhibit symptoms that are acute enough to qualify for commitment.
- The extremely dangerous person commitment statute provides a link from aid and assist to commitment; however, it is of limited use in many cases since most people do not meet the criteria.
- Concerns exist that once an individual has criminal charges, accessing treatment on the civil side might be more difficult due to stigma or other factors.

Guardianships

- Guardians of people with severe and persistent mental illness face challenges when trying to get care for the individual, such as lack of access and difficulties in physically transporting a person to treatment.
- The availability of public guardians is limited.
- Private guardians are expensive.
- Guardians do not have a mechanism to make someone go to a placement if the person refuses to go.

Other

- The behavioral health system and justice system have different interests and obligations related to involuntary treatment; courts operate in a system of mandates as a core element of achieving justice system objectives, while the behavioral health system is based on voluntary engagement.
- Current agency structures present a barrier to effective coordination among the multiple government branches and agencies that are responsible for civil commitment or other court-ordered behavioral health care.
- No state agency or commission exists that has authority to bridge individual and community needs across system silos by ensuring access to treatment and social services for people with chronic behavioral health symptoms and repeated criminal activity.
- Communication issues exist through the civil commitment process.
- Clinicians face an ethical dilemma when engaging an individual in treatment while providing legal coordination.
- Civil commitment has life-long collateral consequences, such as for obtaining employment, housing, firearms, etc., and cannot be expunged from a person’s record.

- Conduct that may have been avoided with appropriate behavioral health care can result in lifelong consequences arising from a criminal conviction.
- People in jails must have access to the level of behavioral health treatment they need so that they don't get to the point where they require civil commitment.
- The justice system lacks adequate deflection options for individuals with serious mental health issues.
- Other states are investing more money than Oregon into focusing on the needs of individuals with behavioral health issues who are identified as "frequent fliers" because they cycle through emergency rooms and jails (Oregon allocated $10 million to the Improving People's Access to Community-Based Treatment, Supports and Services (IMPACTS) program, while in other states it's over $40 million).

Workgroup Final Recommendations

The Workgroup offers 51 final recommendations. Ten of the 51 recommendations had unanimous consensus on specific wording, highlighted below in light blue (#14, 25, 26, 30, 32, 35, 40, 43, 44, and 49). For the other 41 recommendations, members agreed on the core concept but not the specific scope.[58] Refer to the Revisions Survey results, which will be available on the CTC Workgroup website, to see the variations of each idea that different members supported.

Workgroup members completed four surveys to consider ideas and move towards consensus: the **Ideas Survey**, the **Recommendations Survey**, the **Building Consensus Survey**, and the **Revisions Survey**. In parenthesis after each recommendation below is the name of the last survey where the idea appeared, along with the idea number in that survey.

- Organization or entity acronyms are spelled out in Appendix 1.
- The "Action" column lists the entities that are in the best position to make this recommendation happen. If it says "Agency," this refers to an executive branch agency to be determined.
- Notes in red at the end of some of the recommendations show which member organization or entity included this recommendation in their "Top 5" list. All the "Top 5" lists are provided in Appendix 2.

Table 4: Workgroup Final Recommendations

Category	Recommendations	Action
Community-Based Health Services	1. State should ensure that publicly-funded residential behavioral health care facilities for mental health and substance use disorders are available and accessible statewide. (Revisions, 3) (Top 5 list for AOC, OAHHS, OJD, OSSA, Tribes)	Legislature Agency
Psychiatric Emergency Holds	2. Require a state agency 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. (Revisions, 4) (Top 5 list for ODHS)	Legislature

[58] See "Other Ideas and Positions" below for additional information about the workgroup's process of designating core concepts.

Category	Recommendations	Action
	3. Clarify current funding responsibilities and establish additional mechanisms to fund community case managers that provide outreach services to individuals in need of behavioral health care. (Revisions, 5)	Legislature Counties
	4. Seek funding sources and appropriate funds for behavioral health outreach and engagement services, including through Medicaid billing and General Funds. (Revisions, 6) (Top 5 list for OHA)	Legislature Agency
	5. Develop and fund alternatives to emergency rooms and jails for individuals experiencing a behavioral health crisis, such as local crisis stabilization centers, urgent walk-in clinics, street outreach, and recovery centers. (Revisions, 7) (Top 5 list for OHA, House Republicans)	Legislature Agency Counties
	6. Educate first responders about local resources other than emergency rooms for individuals experiencing a mental health crisis. (Revisions, 8)	Agency Counties
	7. Educate providers on when an individual may not be released from an emergency psychiatric hold prior to a civil commitment hearing. (Revisions, 9)	Agency
Investigation	8. Require civil commitment investigators to participate in continuing education following initial certification that includes updates on relevant legal and clinical information. (Revisions, 14)	Legislature Agency
Probable Cause Determination	9. Amend statute and provide necessary funding to require that transitional services are offered to an individual upon completion of civil commitment diversion treatment for the purpose of ongoing clinical support. (Revisions 16)	Legislature
Citation and Service	10. Amend statute to require that information about eligibility for 14-day intensive treatment option (diversion) is provided to the person. (Revisions, 18)	Legislature
Appointment of Counsel	11. Amend statute to clarify when in the civil commitment process the court must appoint legal counsel. (Revisions, 19) (Top 5 list for DRO)	Legislature

Category	Recommendations	Action
Examination	12. Implement a statewide plan to expand the number of mental health examiners for civil commitment cases. (Revisions, 23)	Legislature Agency
	13. Create a centralized statewide database of mental health examiners who are qualified for appointment to civil commitment cases and make available to courts, CMHPs, and other specified entities. (Revisions, 24)	Legislature Agency
	14. Amend statute to clarify mental health examiners are appointed as neutral experts for the benefit of the court and are independent from counties and CMHPs. (Revisions, 26)	Legislature
Inpatient Commitment	15. Amend statute to define "mental disorder" for purposes of determining whether an individual is a "person with a mental illness." (Revisions, 28)	Legislature Agency
Court Determination of Mental Illness	16. Establish and fund statewide intensive care case management services and adequately staffed local treatment programs across the state to ensure access for all individuals following a notice of mental illness, civilly committed or not. (Revisions, 32) (Top 5 list for OAHHS, OSH)	Legislature Agency
Outpatient Commitment	17. Amend statute and provide funding to require that peer support and wrap-around services are offered and available to individuals on outpatient commitment. (Revisions, 33)	Legislature Agency
	18. Amend statute to require OHA to provide and fund outreach services for civilly committed individuals placed in outpatient treatment. (Revisions, 34)	Legislature OHA
Changes in Placement	19. Require and fund 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) during the period of commitment. (Revisions, 36) (Top 5 list for CCO, OSSA)	Legislature OHA
Trial Visits	20. Amend statute or rules to clarify the roles and responsibilities of the treatment facility, OHA, and	Legislature Agency

Category	Recommendations	Action
	CMHPs in the county of commitment, county of placement, and county of permanent residence. (Revisions, 38)	
Medication	21. Educate and consider requiring providers that treat civilly committed individuals on trial visits and outpatient commitment to include the person as much as possible in developing treatment plans, including medication options. (Revisions, 39)	Agency
	22. Educate providers that treat civilly committed individuals on evidence-based practices for whole-person care, including treatment of patients who lack insight into their conditions. (Revisions, 40)	Agency
Recertification for Continued Commitment	23. Require OJD to collect anonymized aggregate data on individuals who are certified for continuing commitment more than once. (Revisions, 41) (Top 5 list for DRO)	Legislature OJD
	24. Amend statute to require court to appoint defense counsel as soon as possible in the recertification process. (Revisions, 42) (Top 5 list for OCDLA)	Legislature OJD
	25. 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. (Recommendations, 58)	Legislature OHA
	26. 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. (Recommendations, 62)	Legislature OJD
Discharge and Dismissal	27. Designate an entity to be required to re-enroll individuals in the Oregon Health Plan for coverage that is effective upon discharge from civil commitment at OSH. (Revisions, 47)	Agency
	28. State should adequately fund outreach services not otherwise covered by public or private insurance to individuals following dismissal of a civil commitment case. (Revisions, 48)	Legislature Agency
	29. Require and adequately fund OHA to track and report aggregate (anonymized) data on	Legislature OHA

Category	Recommendations	Action
	community-based supports offered and provided to individuals following discharge and dismissal of civil commitment cases, including data from CCOs on Medicaid-covered support and from CMHPs on support not covered by Medicaid. (Revisions, 50)	
	30. Establish a system to improve communication between jails and the state hospital for justice-involved individuals who are discharged to custody after civil commitment. (Recommendations, 71)	Agency Counties
Data Sharing and Confidentiality (Case Management)	31. Establish or expand mandatory training on HIPAA to civil commitment investigators and treatment teams that is provided by legal professionals to clarify what can and cannot be shared under current law. (Revisions, 56)	Agency
	32. Explore the use of psychiatric advance directives.[59] (Revisions, 58) (Top 5 list for DRO)	Agency
Data Collection, Analysis, and Reporting (Policy)	33. Collect and analyze data on individuals who have engaged in the civil commitment process more than once, including at a minimum 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. (Revisions, 60)	Agency
	34. Research civil commitment systems in other states and other parts of the world, which may inform system improvement in Oregon. (Revisions, 63)	Agency
	35. Collect and analyze socioeconomic data about individuals in the civil commitment process. (Recommendations, 83)	Agency
Rights of Individuals in Civil	36. Provide training to defense lawyers on effective representation of individuals with mental illness who do not want to be committed (*e.g.*, training provided by the Oregon State Bar (OSB) or	OSB OPDC

[59] Psychiatric advance directive are also known as declarations for mental health treatment.

Category	Recommendations	Action
Commitment System	Oregon Public Defense Commission (OPDC)). (Revisions, 65)	
	37. Amend rules to establish a process that supports individuals to access advocates, including patient advocacy organizations, legal advocates, and peers. (Revisions, 66)	Agency
Funding System	38. Research creative ways that other states have funded housing and other needs of civilly committed individuals, including use of Medicaid. (Revisions, 69)	Agency
Provider Safety	39. Provide and consider requiring training and education on vicarious trauma for staff of residential treatment facilities, acute hospitals, and OSH. (Revisions, 73)	Agency
Collaboration with Oregon Tribes	40. Require the state to seek input from Tribal governments and treatment providers on the civil commitment system, including AOT. (Revisions, 75)	Legislature
	41. Amend statute to require OHA and OJD to consult with the mental health authority of the Tribe of a member who is subject to civil commitment proceedings, upon consent of the person if legally required, to ensure compliance with relevant laws and coordination of resources. (Revisions, 76)	Legislature
	42. Amend rules to require a designated state agency or CMHP director to consult with the mental health authority of the Tribe of a Tribal member who is subject to civil commitment proceedings, upon consent of the person if legally required, to ensure compliance with existing rules concerning collaboration and information-sharing with Tribes. (Revisions, 77)	Agency
	43. Evaluate how Tribal communities and Tribal courts interact with the medical and legal systems in civil commitment processes. (Recommendations, 102)	Agency
	44. Evaluate how cooperative agreements between Oregon and each of the Oregon Tribes may be used to improve the civil commitment process for Tribal members. (Recommendations, 105)	Agency

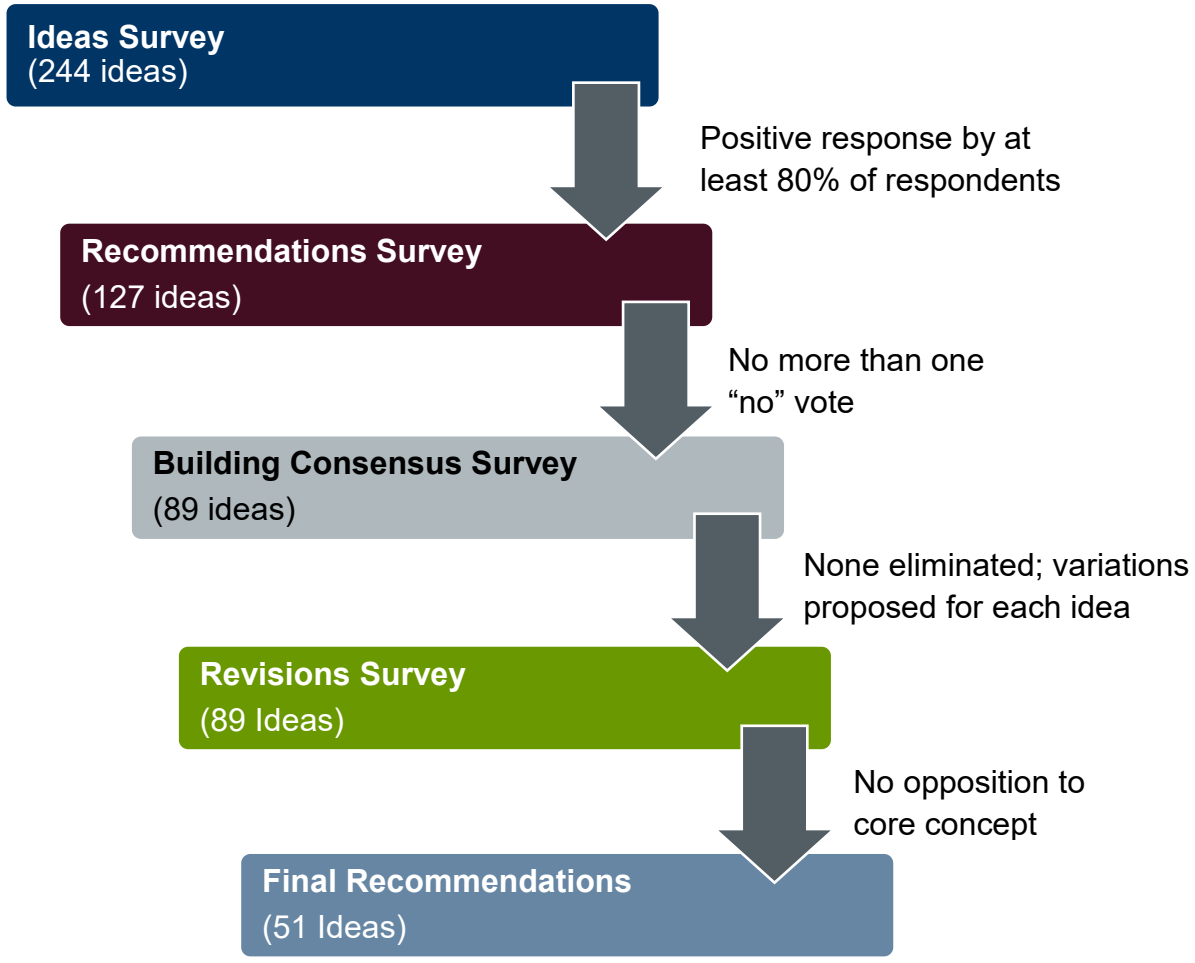
Category	Recommendations	Action
Equity	45. Provide and consider requiring education and training to behavioral health providers about issues that may contribute to racial and ethnic disparities among individuals who are civilly committed (*e.g.*, risk of dangerousness assessments). (Revisions, 80)	Agency Licensing Boards
	46. State should address geographical inequities in the civil commitment system by providing more funding and training to rural areas that lack the staffing and resources necessary to provide needed care. (Revisions, 81)	Legislature Agency
	47. Amend statute to require OHA and OJD to improve tracking of demographic data of individuals in the civil commitment system to assess disparities by race, ethnicity, sexual orientation, gender identity, or cultural characteristics. (Revisions, 82)	Legislature OHA OJD
Commitment of Individuals with Intellectual Disability	48. Require state to provide statewide training for behavioral health treatment providers on working with civilly committed individuals with intellectual disabilities. (Revisions, 87)	Agency
	49. 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. (Recommendations, 121)	Legislature Agency
Education about Civil Commitment	50. 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 that includes the perspectives of both the justice system and behavioral health system. (Revisions, 89)	OJD Agency
Structural System Changes	51. Require OHA to provide a broader scope of treatment and services to civilly committed individuals that supports social determinants of health (*e.g.*, safe housing, recovery-oriented mental health services for health and wellbeing). (Revisions, 90) (Top 5 list for OAHHS)	Legislature OHA

Other Ideas and Positions

While the workgroup's final recommendations are limited to those that received unanimous agreement, many other ideas were supported by a majority of workgroup members. Full results from each of the surveys will be available on the CTC Workgroup website.

The workgroup used surveys as a tool to narrow its focus to ideas that were likely to achieve unanimous consensus. Each new survey eliminated many ideas, including those with support of multiple entities and those among the top five ideas of some entities. This section provides more detail about the ideas that did not satisfy the workgroup's criteria to move forward towards unanimous consensus but had substantial support.

Figure 12: Workgroup Surveys and Criteria for Further Consideration



Last Stop: Ideas Survey

The first member survey (Ideas Survey, February 2024) presented all 244 ideas suggested to the workgroup by any source between October 2022 and February 2024, including ideas from workgroup members, constituent surveys, listening sessions, and communications to workgroup staff. This inclusive approach was designed to maximize public input and center the views of people with lived experience. The range of ideas presented reflected different vantage points and levels of familiarity with system operations. Some ideas were raised by multiple people, while others were raised by a single person. Some ideas were general or vague, while others were more specific.

Members were asked to evaluate each idea using a Likert scale for quantitative analysis and to offer general comments for qualitative analysis. Answer choices included:

- Great idea!
- Like with reservations (minor concerns or support only if other things happen concurrently)
- Initial reaction positive but want more information
- Neutral
- Initial reaction negative but want more information
- Strongly inclined against but open to further discussion
- Bad idea!

The results of the Ideas Survey were aggregated anonymously for member discussion.

Only those ideas receiving a “positive response” by 80% or more of respondents moved forward for additional workgroup consideration. A “positive response” was defined as any response above neutral. A “negative response” was defined as any response below neutral.

Table 8 lists the ideas that received positive responses by a majority of workgroup members but less than the 80% threshold to advance to the Recommendations Survey. Table 9 lists the ideas that received the most polarized responses, meaning that workgroup members were most evenly divided in their positions.

Last Stop: Recommendations Survey

The second survey (Recommendations Survey, May 2024) moved forward 127 ideas from the Ideas Survey. The purpose of the Recommendations Survey was to narrow the workgroup’s focus to ideas that received strong positive reactions in the Ideas Survey and to identify the positions on those ideas by each entity represented on the workgroup.

Members were asked to select one of the following choices to indicate their position on each idea and to provide narrative explanations for responses of “No” or “It Depends.”

- Yes
- No
- Abstain
- It Depends

Because the Recommendations Survey was designed to identify variations in the positions among member entities, members representing a government office, association, or organization that requires approval to speak on its behalf were asked to seek leadership approval before submitting their responses.

The workgroup discussed both the aggregate and individual member responses to the Recommendations Survey.

Seven ideas received unanimous consensus and were identified as final recommendations. Among the rest, only ideas that were not opposed by more than one respondent could move forward. Another 89 ideas satisfied that criterion, and they were called “Close to Yes” ideas. Among the ideas that did not reach the “Close to Yes” threshold, many had substantial support. Table 7 lists the 19 ideas that received a vote of “Yes” or “It Depends” by 85% or more of respondents and a “No” vote by two respondents.

Adding Variations: Building Consensus Survey

In the third survey (Building Consensus, June 2024), the workgroup reviewed the “Close to Yes” ideas more closely to identify the concerns that prompted “It Depends” responses and suggest specific wording changes and combinations of ideas that they could recommend.

For each idea, members were asked to select one of the following choices:

- Recommend this idea as currently drafted
- Recommend advancing the concept/process presented in this idea but reserve the possibility to object to the specific policy directions or unfunded mandates that may result from the open-ended process
- Would recommend this idea with specific changes to its wording (specify)
- Would recommend this idea if it were combined with other ideas in the Recommendation Survey (specify)
- Cannot recommend this idea, even with specific wording changes or combined with other ideas
- Abstain

On questions in which a member responded, “Would recommend this idea with specific changes to its wording” or “Would recommend this idea if it were combined with other ideas in the Recommendation Survey,” the member was asked to specify in the comment box the proposed wording or combination of ideas.

No ideas were eliminated from consideration after the Building Consensus Survey. At the July 2024 workgroup meeting, members discussed the aggregate responses to the Consensus Survey and started to edit ideas based on survey comments. During that review, the workgroup requested that workgroup staff prepare a fourth member survey with proposed variations on each idea for members to consider.

Last Stop: Revisions Survey

In the fourth and final survey (Revisions Survey, August 2024), the workgroup reconsidered the 89 “Close to Yes” ideas with the variations developed in the Building Consensus Survey. The Revisions Survey also provided additional information to provide context for some ideas in response to workgroup member questions and comments.

For each idea, workgroup members selected all variations of the idea that they could recommend, or they selected the box indicating that that they could not recommend any variation. The instructions for the Revisions Survey clarified that voting to recommend any version of an idea would not preclude subsequent objections to specific policy directions or unfunded mandates that may develop at a later stage in the policy process. As in the Recommendations Survey, workgroup members who represent government agencies, organizations, or other entities that require leadership approval to represent the entity were asked to acquire necessary approval for all submitted responses.

The hope was to reach 100% consensus on at least one variation of each idea. However, members were divided in which versions of the ideas they supported. They were unanimous in supporting the same variation of only three ideas. And in response to 45 ideas, at least one member indicated that they could not support any variation. Based on the survey results, the workgroup agreed that it had reached unanimous consensus on core concepts of the 42 ideas in which all respondents supported at least one version. Those ideas are included in the final recommendations, along with nine ideas that reached unanimous consensus in previous surveys.

Among the 45 ideas in the Revisions Survey that did not reach unanimous consensus, most (36) were supported by all but one respondent. The other nine ideas were opposed by two or (in one case) three respondents. Table 5 shows the responses to the 36 ideas that were supported in some version by all but one respondent, and Table 6 shows the responses for the rest. For each idea, the tables identify the entities in support and opposed and include the reasons for opposition, if provided. The Revisions Survey Results (which will be available on the CTC Workgroup website) show the idea variations that each entity supported.

Table 5: Revisions Survey Remainders Supported by All but One Respondent

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
Community-Based Health Services	1. 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. (Revisions, 2)	AOC AOCMHP CCO DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA	**OHA**
Notice of Mental Illness/ Initiation of Civil Commitment Case	2. 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. (Revisions, 10) (Top 5 list for OHA)	OHA Tribes AOC AOCMHP CCO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA	**DRO**
Investigation	3. 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. (Revisions, 13) (Top 5 list for MOMI, OSSA)	AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODHS OHA OJD OSSA OSH Tribes	**AOC***

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	4. Amend statutes or rules to require that civil commitment investigators provide all information specific in OAR 309-033-0940 or explain why missing information cannot be obtained.	CCO DRO MOMI OAHHS OCDLA ODHS OHA OJD OSH OSSA Tribes	**AOC***
14-day Voluntary Diversion	5. Amend statute to increase the maximum period of voluntary diversion from 14 days to a longer duration. (Revisions, 15) (Top 5 list for OJD, House Republicans)	AOC AOCMHP CCO DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSSA Tribes	**NAMI**
Probable Cause Determinations	6. Require OHA to compare civil commitment diversion programs among Oregon counties and identify best practices, including accountability mechanisms for community treatment providers. (Revisions, 17)	AOCMHP CCO DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA Tribes	**AOC***
Appointment of Counsel	7. Amend statute to require continuity of appointed legal counsel throughout the process when feasible. (Revisions, 20)	AOC AOCMHP CCO DRO MOMI NAMI ODHS	**ODAA***

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
		OHA OJD OSH OSSA Tribes	
	8. 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. (Revisions, 21)	AOC AOCMHP CCO DRO MOMI OCDLA ODHS OHA OJD OSH OSSA Tribes	**ODAA**
Examination	9. Amend statute to expand training requirements for mental health examiners in civil commitment cases. (Revisions, 25)	AOC AOCMHP CCO DRO MOMI ODAA ODHS OHA OJD OSH OSSA Tribes	**OCDLA****
	10. Amend statute to clarify that only one examination report is required per examiner. (Statute currently refers to examination reports in the plural.) (Revisions, 27)	AOC AOCMHP CCO DRO MOMI NAMI OAHHS ODAA ODHS OHA OJD OSSA	**OCDLA**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
		Tribes	
Court Options Following Determination of Mental Illness	11. Provide dedicated funding to CMHPs to support 14-day intensive treatment (diversion from civil commitment). (Revisions, 29) (Top 5 list for House Republicans)	AOC AOCMHP CCO DRO MOMI OAHHS ODAA ODHS OJD OSSA Tribes	**OHA**
	12. 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. (Revisions, 30)	AOC AOCMHP DRO MOMI OCDLA ODHS OJD OSH OSSA Tribes	**ODAA***
Conditional Release	13. Amend statute to clarify the kinds of support that OHA must provide to persons ordered to conditional release. (Revisions, 31)	AOC DRO MOMI OAHHS OCDLA ODHS OJD OSSA	**AOCMHP**
Outpatient Commitment	14. Establish mechanisms to certify, monitor, and measure the performance of facilities where civilly committed individuals are placed to provide trauma-informed care. (Revisions, 35)	AOC AOCMHP MOMI OAHHS ODAA ODHS OJD OSH OSSA	**OHA**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
Trial Visit	15. Revise statutes and rules to change the term “trial visits” to something that more clearly describes its function (*e.g.*, less restrictive placement) (Revisions, 37)	DRO MOMI NAMI OAHHS OCDLA ODAA OHA OJD OSH OSSA Tribes	**ODHS**
Discharge and Dismissal	16. Require providers or treatment facility to include and involve individuals under civil commitment in discharge planning. (Revisions, 44)	AOC AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODAA OJD OSH OSSA Tribes	**OHA****
	17. Require OSH to notify the local CMHP when discharging an individual from civil commitment. (Revisions, 49)	AOC AOCMHP CCO MOMI OAHHS OCDLA ODHS OJD OSH OSSA	**OHA***
	18. Require OHA or CMHP to provide	AOC AOCMHP	**OHA****

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	notice of discharge from commitment to the individual's legal counsel. (Revisions, 51)	CCO DRO MOMI NAMI OCDLA ODAA OJD OSSA	
	19. Require OHA to amend County Financial Assistance Agreements to require and fund outreach services to individuals (and their families and natural supports) who have been subject to multiple Notices of Mental Illness without a commitment. (Revisions, 52)	AOC AOCMHP CCO MOMI NAMI OAHHS ODAA ODHS OHA OJD OSH OSSA	**DRO**
	20. Require OHA to collaborate with the Tribes before discharging a Tribal member from commitment with adequate time to plan for care coordination. (Revisions, 53)	AOC AOCMHP DRO MOMI OAHHS OCDLA ODHS OJD Tribes	**OHA**
	21. Require OHA or CMHP to provide all notices of discharge from commitment with enough time to coordinate care. (Revisions, 54)	AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODHS OJD	**AOC***

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
		OSSA Tribes	
	22. Amend OHA contracts to specify who should be notified and when they should be notified of an individual's discharge from civil commitment. (Revisions, 55)	AOC AOCMHP CCO MOMI OAHHS ODHS OJD OSH OSSA Tribes	**OHA***, **
Data Sharing and Confidentiality (Case Management)	23. Establish a statewide system for tracking civil commitment to improve data sharing and standardization of care across counties. (Revisions, 57)	AOC AOCMHP CCO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA Tribes	**DRO****
Data Collection, Analysis, and Reporting (Policy)	24. Collect and analyze socioeconomic data about individuals in the civil commitment process. (Revisions, 59)	AOC AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODHS OJD OSH Tribes	**ODAA***
	25. Collect and analyze quantitative and qualitative data on individuals with	AOC AOCMHP CCO DRO	**OHA**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	traumatic brain injuries and dementia that were subject to NMIs, including the number of NMIs and number committed under ORS chapters 426 or 427. (Revisions, 61) (Top 5 list for ODHS)	MOMI OCDLA ODHS OJD OSH OSSA Tribes	
	26. Collect data to compare and report the types, quantity, and outcomes of treatment and services provided by counties to civilly committed individuals. (Revisions, 62)	AOC AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA	**OHA**
	27. 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. (Revisions, 64)	AOC AOCMHP CCO DRO MOMI ODAA ODHS OHA OJD Tribes	**OAHHS**
Funding System	28. Amend statute to require state agencies and counties to track and report the use of outcomes of designated behavioral health	AOC CCO DRO MOMI OAHHS ODAA ODHS OHA	**AOCMHP**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	funding. (Revisions, 67)	OJD OSH	
	29. 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. (Revisions, 68)	AOC AOCMHP CCO MOMI OAHHS ODAA ODHS OJD OSH OSSA	**DRO**
Transportation	30. Clarify in statute or rule who is responsible to pay for secure transport of individuals on the civil commitment process and the amount of reasonable compensation for that service. (Revisions, 70)	AOC DRO MOMI NAMI OAHHS ODAA OJD OSH OSSA Tribes	**OHA**
Liability	31. Assess the types and level of concern about different areas of liability in the civil commitment system. (Revisions, 71)	AOC AOCMHP CCO MOMI OAHHS OCDLA ODAA OHA OJD OSH OSSA	**ODHS**
	32. Require institutions caring for individuals under civil commitment to hold	AOC AOCMHP DRO MOMI	**OAHHS**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	regular morbidity conferences and encourage learning from mistakes instead of withholding information because of liability concerns. (Revisions, 72)	OCDLA ODAA ODHS OJD OSH OSSA Tribes	
Provider Safety	33. Require residential treatment facilities, acute hospitals, and OSH to provide situational training for staff to recognize when a situation is becoming unsafe. (Revisions, 74)	AOC AOCMHP CCO DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA	**OHA**
Guardianships	34. Increase state funding for public guardian services for people who need long-term support options due to a behavioral health condition (Revisions, 85) (Top 5 list for AOC, OSH)	AOC AOCMHP CCO DRO NAMI OAHHS OCDLA ODHS OJD OSSA	**DRO**
Commitment of Individuals with Intellectual Disability	35. Require state to develop or provide access to specialized treatment programs for individuals committed for intellectual disabilities. (Revisions, 86) (Top 5 list for ODHS)	AOC AOCMHP CCO DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA	**OHA**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
		Tribes	
Co-Occurring Mental Illness and Substance Use Disorder	36. Explore different treatment models for civilly committed individuals with co-occurring mental illness and substance use disorder. (Revisions, 88)	AOC AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA Tribes	**OHA**

* In the Recommendations Survey, member voted yes to this idea.

** In the Building Consensus Survey, member voted to recommend advancing the concept but reserve the possibility to object to specific policy directions or unfunded mandates that may result from the open-ended process.

Table 6: Revisions Survey Remainders Supported by All but Two or Three Respondents

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
Warrant of Detention	1. Require Oregon Judicial Department to collect data on the factual findings in which judges issue warrants of detention. (Revisions, 11)	CCO DRO MOMI OACMHP OCDLA ODHS OHA OJD OSH OSSA Tribes	**AOC*** **ODAA***
Access to Medical Records	2. Amend statute to require hospitals to share pertinent documentation from electronic health record with defense attorneys for civil commitment hearings. (Revisions, 22) (Top 5 list for OCDLA)	AOC AOCMHP DRO OCDLA ODHS OJD OSH OSSA Tribes	**ODAA*** **OAHHS**
Recertification for Continued Commitment	3. Amend statute or rule to require that OHA notifies defense counsel and an ombudsperson when recertification is pursued. (Revisions, 43) (Top 5 list for DRO, OCDLA)	AOC AOCMHP CCO DRO MOMI OCDLA ODAA ODHS OJD Tribes	**OHA** **OAHHS***
Discharge and Dismissal	4. Require state to create a funding stream to establish and maintain long-term and intensive treatment options for individuals upon	AOCMHP CCO MOMI NAMI OAHHS ODAA ODHS	**OHA** **AOC***

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	dismissal of a civil commitment case. (Revisions, 45) (Top 5 list for OAHHS)	OJD OSH OSSA Tribes	
	5. 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. (Revisions, 46)	CCO DRO MOMI NAMI OAHHS ODAA ODHS OJD OSH OSSA	**AOC*** **AOCMHP***
Collaboration with Oregon Tribes	6. Amend Rules to allow Tribes to participate in civil commitment proceedings involving Tribal members, similar to a child welfare case. (Revisions, 78)	AOC AOCMHP CCO DRO MOMI OCDLA ODHHS OJD OSSA Tribes	**OHA** **OSH****
Equity	7. Require the state to address inequities resulting from variations in first responder responses by establishing standards and training for law enforcement and other first	AOC AOCMHP CCO DRO MOMI NAMI OAHHS OCDLA ODAA ODHS	**OHA***, ** **OSSA**

Category	Close to Yes Idea as Originally Drafted (See Revisions Survey Results for specific variations supported)	Supports One or More Variations	Oppose
	responders on where to take a person who is experiencing a mental health crisis. (Revisions, 79) (Top 5 list for OCDLA)	OJD OSH	
	8. Amend statute to require bias and implicit bias training for all professionals working with the civil commitment population. (Revisions, 83)	AOC AOCMHP CCO DRO MOMI OAHHS OCDLA ODHS OJD OSH Tribes	**OHA** **ODAA***
Psychiatric Advance Directives	9. 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. (Revisions, 84) (Top 5 list for DRO)	AOC AOCMHP CCO DRO NAMI OAHHS OCDLA ODHS OJD OSSA	**OHA***, ** **ODAA**

* In the Recommendations Survey, member voted yes to this idea.

** In the Building Consensus Survey, member voted to recommend advancing the concept but reserve the possibility to object to specific policy directions or unfunded mandates that may result from the open-ended process.

Table 7: Recommendations Survey Remainders with "Yes" or "It Depends" Vote by at Least 85% of Respondents

(All idea numbers in parentheses are from the Recommendations Survey)

Category	Idea	Yes	No	Depends	% Yes or Depends
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. (2) (Top 5 list for AOC, MOMI, OJD)	12 AOC AOCMHP DRO LOC MOMI OAHHS OCDLA ODAA ODHS OJD OSSA Tribes	2 NAMI OHA	2 CCO OSH	88%
Warrant of Detention	2. 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). (12) (Top 5 list for MOMI, OSSA)	10 AOC CCO LOC MOMI NAMI OCDLA ODAA OSH OSSA Tribes	2 DRO OAHHS	4 AOCHMP ODHS OHA OJD	88%
Court Options Following Determination of Mental Illness	3. Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment. (AOT) (35) (Top 5 list for AOC, OHA, OJD, Tribes)	12 AOC CCO LOC MOMI OAHHS ODAA ODHS OHA OJD OSH OSSA Tribes	2 DRO NAMI	2 AOCMHP OCDLA	88%

Category	Idea	Yes	No	Depends	% Yes or Depends
Inpatient Commitment	4. Establish criteria in statute or rule to determine when the Oregon State Hospital must admit civilly committed individuals. (40) (Top 5 list for AOC)	11 AOC AOCMHP CCO LOC MOMI OAHHS OCDLA ODHS OJD OSSA Tribes	2 DRO ODAA	2 NAMI OSH	87%
	5. 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. (42)	9 AOC AOCMHP CCO DRO MOMI OCDLA ODAA ODHS Tribes	2 OHA OJD	4 NAMI OAHHS OSH OSSA	87%
Outpatient Commitment	6. 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. (45)	9 AOC AOCMHP CCO LOC MOMI OAHHS ODHS OHA OJD	2 DRO OSSA	2 OSH NAMI	85%
Changes in Placement	7. Amend statutes or rules to establish mechanisms to transfer individuals between support levels (see Washington's new	9 AOC AOCMHP CCO LOC MOMI	2 NAMI ODHS	4 DRO OCDLA ODAA OHA	87%

Category	Idea	Yes	No	Depends	% Yes or Depends
	AOT legislation). (48)	OAHHS OJD OSH OSSA			
Recertification for Continued Commitment	8. Require OHA to collect data on how individuals facing recertification navigate the civil commitment system. (61)	10 AOC CCO DRO MOMI OAHHS OCDLA ODAA OSH OSSA Tribes	2 ODHS OHA	1 OJD	85%
Data Sharing and Confidentiality (Case Management)	9. 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. (76)	9 AOC CCO LOC MOMI NAMI ODAA ODHS OJD OSSA	2 OHA Tribes	5 AOCMHP DRO OAHHS OCDLA OSH	88%
	10. Establish a centralized state repository for NMIs than can be accessed by investigators, providers, and courts. (78)	11 AOC AOCMHP CCO LOC MOMI ODAA ODHS OHA OSH OSSA Tribes	2 DRO OAHHS	3 NAMI OCDLA OJD	88%

Category	Idea	Yes	No	Depends	% Yes or Depends
Data Collection, Analysis, and Reporting (policy)	11. Collect data and report how placement of individuals under civil commitment differs in different communities. (82)	11 AOC AOCMHP DRO LOC MOMI OCDLA ODAA ODHS OJD OSH Tribes	2 CCO OAHHS	3 NAMI OHA OSSA	88%
	12. Improve data collection efforts to match court records involving the same individual across cases and case types. (85)	12 AOC AOCMHP LOC MOMI NAMI OAHHS OCDLA ODAA ODHS OHA OJD OSH OSSA	2 CCO DRO	0	86%
Equity	13. 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. (113) (Top 5 list for CCO, OAHHS)	12 AOC AOCMHP LOC MOMI NAMI OAHHS OCDLA ODHS OJD OSH OSSA Tribes	2 CCO OHA	2 DRO ODAA	88%

Category	Idea	Yes	No	Depends	% Yes or Depends
Transition between Aid and Assist and Civil Commitment Processes	14. 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. (114)	9 AOC AOCMHP LOC MOMI OAHHS ODHS OHA OJD OSSA	2 CCO DRO	4 NAMI OCDLA ODAA OSH	87%
Commitment of Individuals with an Intellectual Disability	15. Require Oregon Developmental Disabilities Program to establish acute support options for people with intellectual disabilities with a co-occurring mental illness. (117) (Top 5 list for ODHS)	12 AOC AOCMHP CCO LOC MOMI OAHHS ODAA OHA OJD OSH OSSA Tribes	2 DRO ODHS	2 NAMI OCDLA	88%
Co-Occurring Mental Illness and Substance Use Disorder	16. Amend statute 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. (123)	12 AOC AOCMHP DRO MOMI OAHHS OCDLA ODAA ODHS OJD OSH OSSA Tribes	2 NAMI OHA	1 LOC	87%

Category	Idea	Yes	No	Depends	% Yes or Depends
	17. Amend statute to prohibit dual-diagnosis programs from excluding individuals on the basis of their mental health symptom acuity. (124)	6 AOC AOCMHP LOC MOMI OAHHS ODHS	2 OHA OSH	6 DRO NAMI OCDLA ODAA OJD OSSA	86%
Education about Civil Commitment	18. 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. (126)	8 AOC AOCMHP CCO MOMI OAHHS ODHS OHA Tribes	2 DRO ODAA	4 NAMI OCDLA OJD OSH	86%
Structural System Changes	19. Amend statute to create a process for expunging civil commitments from an individual's record. (128) (Top 5 list for OCDLA)	6 AOC DRO LOC MOMI OCDLA OJD	2 ODAA ODHS	5 AOCMHP NAMI OAHHS OHA OSH	85%

Table 8: Ideas Survey and Recommendations Survey Remainders with Positive Response by Majority of Respondents

(Survey name and number in parentheses)

Category	Idea
Community Behavioral Health Services	1. Amend statute and rules to prohibit behavioral health providers from refusing behavioral health care to individuals who experience high acuity symptoms. (Ideas, 3)
	2. Expand telehealth and help hotlines to improve public access to mental health providers, including psychiatric prescribers. (Ideas, 5)
	3. Require COUNTIES to build, own, operate, or fund more community-based facilities designed to provide shorter-term inpatient behavioral health care. (Ideas, 7)
Notice of Mental Illness/Initiation of Civil Commitment Process	4. Require OHA to provide access to historical NMIs and other investigation files for use by investigators in subsequent investigations of the same person. (Ideas, 14)
	5. Amend statute to add jail officials to the list of people who can refer someone for a civil commitment investigation. (Ideas, 16)
Investigation	6. Require training for investigators on writing reports in a way that people without clinical background can understand. (Ideas, 26)
14-Day Voluntary Diversion	7. Require appointment of counsel for financially eligible individuals named in a notice of mental illness BEFORE the CMHP delivers a certification of 14-day intensive services (diversion) to the court. (Ideas, 27)
	8. Require consultation of counsel with person named in a notice of mental illness BEFORE the CMHP delivers a certification of 14-day intensive services (diversion) to the court. (Ideas, 28)
	9. Amend statute to include objective criteria for whether diversion is appropriate to ensure consistent consideration of all individuals named in a notice of mental illness. (Ideas, 29)
	10. Amend statute to require that the civil commitment case remains open pending the individual's successful completion of a diversion program so that the court may consider all options that would have been available before the certification of diversion. (Ideas, 31)
	11. 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). (Ideas, 32; Recommendations, 18)
	12. Amend statute to require OHA to assign a "diversion navigator" to individuals upon certification for 14-day intensive treatment (i.e., civil commitment diversion) that will assist the individual to access continuing behavioral health treatment and services beyond the period of intensive treatment. (Ideas, 33)
Probable Cause Determination	13. Require judges to review each investigation report to make a probable cause determination. (Ideas, 38)

Category	Idea
Citation and Service	14. Require courts to provide information in the citation written in a manner that is understandable to the average person. (Ideas, 40)
	15. Amend statute to require access to all documentation submitted to the court as a basis for the civil commitment to the person named in the NMI and to provide notice of that right on the citation. (Ideas, 41)
	16. Amend statute to require that citations include more information about the civil commitment process, such as the risks and benefits of participating in the civil commitment process and the role of defense counsel. (Ideas, 43)
	17. Amend statute to establish which entity/entities are required to serve the citation for a civil commitment hearing. (Ideas, 44)
	18. Amend statute to clarify when law enforcement must or may be present for service of the citation. (Ideas, 45)
	19. Amend statute to require an entity to establish a process and educate service providers on trauma-informed ways of serving the citation. (Ideas, 46)
	20. Amend statute to require the state to collect data on how often and in what situations law enforcement is present for the service of citations. (Ideas, 47)
	21. Amend statute to require an advocate be assigned to the person named on the NMI for the duration of the civil commitment process. (Ideas, 48)
Examination	22. 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. (Ideas 52; Recommendations, 25) (Top 5 list for DRO)
	23. Establish statewide database for mental health examiners to access relevant medical records of the individual they were appointed to examine in a civil commitment case. (Ideas, 57)
	24. Amend rules to raise the minimum qualifications of mental health examiners from Qualified Mental Health Professional (QMHP) to licensed master's level clinician. (Ideas, 59)
	25. Amend statute to prohibit examiners from cross-examining witnesses in a civil commitment hearing. (Ideas, 62)
Hearing	26. Amend statute to authorize remote civil commitment hearings. (Ideas, 63)
	27. Amend statutes to extend timeframe between notice of mental illness (NMI) and hearing to allow CMHPs to collect and distribute the required information and promote informed decision-making. (Ideas, 64)
	28. Require OJD to evaluate whether current hearing practices are trauma-informed and to use findings to implement necessary changes. (Ideas, (Ideas, 67)
	29. Amend statute to require courts to provide procedural justice education to all court staff and judges to promote trauma-informed civil commitment hearings. (Ideas, 68)

Category	Idea
Criteria for Civil Commitment	30. Amend statute to lower the legal threshold for civil commitment. (Ideas 70; Recommendations, 32) (Top 5 list for CCO, House Republicans, MOMI, OJD, OSSA, Tribes)
	31. Amend criteria for civil commitment to consider substance use disorder, paired with risk of harm to self or others or inability to meet basic needs, as the basis for civil commitment. (Ideas, 71)
	32. Amend statute to expand the clinical diagnoses that qualify for civil commitment, such as mental disorder, intellectual disability, developmental disability, substance use disorder, traumatic brain injury, autism, or a combination of diagnoses (workgroup to determine which clinical diagnoses to recommend). (Ideas, 72)
	33. Amend statute to require courts to consider whether the individual attempted to seek treatment but was unable to do so due to lack of availability. (Ideas, 74)
Court Determination of Mental Illness	34. Amend and clarify statutory definitions and provide examples of events that would meet civil commitment criteria that judges can consider when making decisions. (Ideas, 80)
	35. Amend statutory definition of "person with mental illness" to consider the history of a person's mental disorder(s). (Ideas, 81)
	36. Amend statutory definition of "person with mental illness" by replacing consideration of whether the person is "unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm" with whether an individual is "gravely disabled." (Ideas, 82)
	37. Amend the statutory criteria of "danger to self or others" to consider not only past behaviors but also predicted harm. (Ideas, 83)
	38. Amend statute to clarify the scope of "basic personal needs that are necessary to avoid serious physical harm in the near future" so that it's not left to court interpretation. (Ideas, 84)
Court Options Following Determination of Mental Illness	39. Amend statute to authorize court to order persons with mental illness in need of treatment directly to outpatient treatment with court oversight (rather than an OHA placement determination that follows commitment). **Note: This recommendation differs from AOT in that AOT does not require a finding that the individual is a person with mental illness, and participation in treatment services for individuals ordered to AOT is voluntary. (Ideas, 87)
	40. 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 (Ideas 88; Recommendations, 34) (Top 5 list for CCO, House Republicans, MOMI, OHA, OSH, OSSA, Tribes)
	41. Amend statute to identify criteria that courts must consider when determining the maximum commitment period for a particular case,

Category	Idea
	so that courts order shorter maximum commitment periods when appropriate, such as 30, 60, 90 days. (Ideas, 89)
	42. Amend statute to require the court to consider an evidence-based risk assessment score when determining the length of commitment for "dangerous to self or others." (Ideas, 90)
Assisted Outpatient Treatment	43. Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment and services (Ideas 93; Recommendations, 36) (Top 5 list for CCO, MOMI, OSH, Tribes)
	44. Create a state funding mechanism for AOT that is like the one available to the Psychiatric Security Review Board (PSRB) for individuals under its jurisdiction who receive community-based treatment and care. (Ideas, 94)
	45. Amend statute to clarify that CMHPs are responsible for coordinating treatment and services for AOT. (Ideas, 96)
	46. Amend statute to allow courts to order an assessment of a person in AOT to determine if a higher level of intervention is needed (e.g., short-term stabilization). (Ideas, 97)
	47. Amend statute to establish criteria in which courts may order short-term stabilization for a person in AOT that requires a higher level of intervention without restarting the civil commitment process. (Ideas, 98)
	48. Amend statutes to require establishment of an "AOT monitor," a designated liaison between the court and treatment team to hold the system accountable for ensuring individuals receive needed care, provide outreach, and bolster participant engagement. (Ideas, 99)
	49. Amend statute to require CMHP to provide a discharge plan for AOT participants that includes continuing person-centered care coordination and substance use treatment as needed. (Ideas, 100)
Inpatient Commitment	50. Amend statute to require OHA to ensure access to community-based hospital and OSH beds for all civilly committed individuals who need inpatient level of care. (Ideas, 104)
Outpatient Commitment	51. 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. (Ideas 107; Recommendations, 43)
	52. Require STATE to extend the availability of resources that are appropriate and accessible to civilly committed individuals in outpatient placements. (Ideas, 109)
	53. Require COUNTIES to extend the availability of resources that are appropriate and accessible to civilly committed individuals in outpatient placements. (Ideas, 110)
	54. Revise rules on outpatient civil commitment to align with the Psychiatric Security Review Board (PSRB) model for placement of

Category	Idea
	individuals under its jurisdiction that are placed on conditional release. (Ideas, 112)
	55. Require state to establish necessary community-based structures and sustainable funding for resources before adopting legislation to expand outpatient commitment. (Ideas, 113)
	56. Amend statutes to combine outpatient commitment and AOT (this is the Treatment Advocacy Model for AOT). (Ideas, 114)
Changes in Placement	57. Amend statute to require regular court status hearings for civilly committed individuals to hold the system accountable for an individual's progress and promote need-based transfers of care. (Ideas, 118)
	58. Amend statute to allow care team to transition committed individuals between levels of civil commitment. (Ideas, 119)
	59. Require OHA to collaborate with acute care hospitals and emergency rooms to move individuals in the civil commitment system to a safer and more therapeutic placement within a pre-determined timeline. (Ideas, 120)
	60. Amend statutes and rules to clarify conduct and responsibility for transfers of committed individual between counties. (Ideas, 121)
Trial Visit	61. 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. (Ideas 125; Recommendations, 52)
	62. Amend statute to require courts to hold status hearings for individuals on trial visits. (Ideas, 126; Recommendations, 53)
Medication	63. 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. (Ideas, 127; Recommendations, 54)
	64. Amend rules to designate a trauma-informed method for administering involuntary medication that considers an individual's opposition to taking it. (Ideas, 130)
	65. Require state or counties to establish a hotline to improve rapid access to medication management. (Ideas, 131)
Recertification for Continued Civil Commitment	66. Require courts to consider alternative options to civil commitment for people who been recertified for commitment multiple times. (Ideas, 134)
	67. Amend statute or rule to create new alternative support and care options for civilly committed individuals at risk of multiple recertifications for commitment. (Ideas, 135)
Discharge and Dismissal	68. Amend statute to ensure that courts have oversight on dismissals that occur before the hearing to ensure continuity of care is available. (Ideas, 141)
	69. Require treatment team to find housing for individuals before discharge from inpatient civil commitment. (Ideas, 145)

Category	Idea
	70. Require treatment facility to assign support to individuals when they are discharged from civil commitment. (Ideas, 151)
	71. Require OHA to amend County Financial Assistance Agreements to require CMHPs to notify and engage with families/natural supports when a person is discharged from civil commitment when appropriate. (Ideas, 153)
Data Collection, Analysis, and Reporting (policy)	72. 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). (Ideas, 163; Recommendations, 81)
	73. Require OHA and OJD to collect and evaluate data on civil commitment outcomes before making legislative recommendations for reform. (Ideas, 165)
Rights of Individuals in the Civil Commitment System	74. Require OHA to identify individuals in civil commitment cases who may require specialized legal advocacy (e.g., people with intellectual and developmental disabilities). (Ideas, 174; Recommendations, 91) (Top 5 list for ODHS)
	75. Amend statute or rule to appoint the same defense counsel to represent an individual throughout the civil commitment process when possible. (Ideas 175; Recommendations, 92)
	76. Amend statute to establish a right of individuals receiving mental health services to be present during treatment decisions regardless of their ability to participate in those discussions. (Ideas, 177)
Funding System	77. Create a separate stream of funding for behavioral health care of people in court-mandated processes. (Ideas, 178)
	78. Restructure the state's behavioral health funding system to allocate funds based on actual treatment and services provided to individuals rather than formula-based allocations to counties. (Ideas, 179)
Transportation System	79. Establish a state-funded statewide transport system between the Oregon State Hospital and counties that provides transportation for court-ordered individuals for admission, discharge, trial visits, and community-based placements. (Ideas, 183)
	80. Amend statute or rule to establish requirements for transportation of individuals to and from psychiatric holds or the Oregon State Hospital that prohibits the use of law enforcement unless necessary to mitigate a dangerous situation, and when transportation by law enforcement is necessary requires OHA or CMHP to provide adequate notice to sheriffs' office to provide transport by a plainclothes officer with an unmarked vehicle. (Ideas, 184)
Provider Safety	81. Ensure that community hospitals have adequate staffing and specialized units to ensure staff safety. (Ideas, 190)
Public Safety and Well-Being	82. Require state and local governments to develop public safety plans that manage individuals with behavioral health or cognitive deficits who engage in dangerous behaviors that cannot be addressed by Oregon's criminal justice or civil commitment systems. (Ideas,192)

Category	Idea
	83. Develop proposals to address potential harm to public well-being that result from encountering people with acute mental health symptoms living on the street without options. (Ideas, 193)
Collaboration with Oregon Tribes	84. Amend statute to authorize Tribal courts to civilly commit Tribal members to the jurisdiction of the Oregon Health Authority. (Ideas, 197)
Equity	85. Require the state to address geographic inequities in the civil commitment system by directly funding residential treatment facilities for placement of individuals in the civil commitment system, rather than allocating funds to CMHPs for payment management. (Ideas, (204)
	86. Require the state to address inequities in the initiation of civil commitment proceedings by clarifying in statute and Notice of Mental Illness (NMI) forms the criteria for civil commitment that have developed in case law. (Ideas, 206)
	87. Require the state to address potential socioeconomic disparities in the use of civil commitment by considering social determinants of health as part of health equity in behavioral health. (Ideas, 207)
Transition between Aid and Assist and Civil Commitment Processes	88. Amend statute to require jails to provide a mental health assessment by a qualified clinician of inmates who appear to need mental health care, and to transfer inmates who meet clinical criteria to a hospital. (Ideas, 213)
	89. Amend statute to expand eligibility criteria for commitment of individuals determined to be an “extremely dangerous person.” (Ideas, 214)
Guardianships	90. Amend statute to authorize guardianships for individuals with mental illness before they reach the crisis point to support them in receiving and engaging in needed services. (Ideas, 217)
	91. Establish emergency guardianship service for individuals who do not meet civil commitment criteria and would be unlikely to engage in voluntary treatment. (Ideas, 218)
	92. Amend statute to expand authority of guardians to ensure that individuals under their care receive needed treatment and services (e.g., authorize guardians to place individual in a residential treatment facility over the individual’s objection). (Ideas, 219)
Terminology	93. Revise statutes to avoid stigmatizing individuals with mental illness by clarifying that ORS 426.130 provides the circumstances in which a person with a mental disorder can be committed (i.e., current terminology appears to focus on the person’s diagnosis and not the behaviors that are associated with person’s diagnosis, which are the focus of the proceeding). (Ideas, 221)
Appeals	94. Create a rapid appeal process for civil commitment cases. (Ideas, 222)
Commitment of Individuals with	95. Amend statute to require OHA and DHS to ensure that facilities and providers are available to support people with co-occurring mental

Category	Idea
an Intellectual Disability	illness and intellectual disabilities. (Ideas, 226; Recommendations, 120) (Top 5 list for OSH)
Education about Civil Commitment	96. Create a mechanism for people to submit questions, feedback, opinions, and experiences about the civil commitment system and get answers (e.g., a website with a moderated chat). (Ideas, 233)
Structural System Changes	97. Require OHA to establish the role and provide an advocate for individuals that is present throughout the civil commitment process. (Ideas, 234)
	98. Amend statute to require counties to have a civil commitment coordinator that would be responsible for providing coordination between providers and the legal system through the civil commitment process from notice of mental illness (NMI) to discharge. (Ideas, 235)
	99. Amend rules to establish clear expectations for a CMHP-led civil commitment monitoring program. (Ideas, 236)
	100. Amend statute to require the state to ensure access to court-ordered behavioral health care treatment and service options at every level of the care continuum. (Ideas, 238)
	101. Establish a new state agency or independent commission that regulates and/or oversees all court-ordered behavioral health services and serves a liaison between state and local government entities at the intersection of the behavioral health and justice systems (e.g., aid and assist, civil commitment, GEI, psychiatric evaluations and examinations). (Ideas, 241)

Table 9: Most Polarized Ideas

(Closest Split between Positive and Negative Responses by Two or Fewer Responses)

Category	Idea	Positive Response	Negative Response
Probable Cause Determination	1. Require CMHP to provide a behavioral health liaison to the local district attorney's office as a clinical consultant for review of investigation reports. (Ideas, 39)	7	5
Investigation	2. Remove CMHP oversight of civil commitment investigators to avoid conflicts of interest. (Ideas, 20)	5	7
Warrant of Detention	3. Amend statute to add limiting criteria that a judge MUST consider before ordering a warrant of detention. (Ideas, 18)	6	4
Criteria for Civil Commitment	4. Amend statute to consider a substance use disorder a criterion for inability to meet basic needs. (Ideas, 73)	7	7
	5. Amend statute to lower legal threshold for commitment of "extremely dangerous person with qualifying mental disorder." (Ideas, 77)	7	8
	6. Amend statute to expand the clinical diagnoses that qualify for civil commitment, such as mental disorder, intellectual disability, developmental disability, substance use disorder, traumatic brain injury, autism, or a combination of diagnoses (workgroup to determine which clinical diagnoses to recommend). (Ideas, 72)	8	7
	7. Amend statute to require courts to consider whether the individual attempted to seek treatment but was unable to do so because community providers refused to treat them. (Ideas, 74)	7	6
	8. Amend statute to include as a criterion for civil commitment whether a reasonable person would accept the treatment being offered. (Ideas, 73)	6	5
Examination	9. Amend statute to expressly authorize remote mental health examinations for civil commitment cases. (Ideas, 56)	8	7
Hearing	10. Create regional mediation programs as an optional service for person named in NMI and defense counsel. (Ideas, 69)	5	5

Category	Idea	Positive Response	Negative Response
	11. Amend statute to require court to appoint a temporary guardian ad litem when necessary to protect a party's best interests in a civil commitment case. (Ideas, 66)	5	3
Assisted Outpatient Treatment	12. Amend ORS 430.630 to remove the "subject to the availability of funds" exceptions from the service requirements of community mental health programs. (Ideas, 92)	5	6
Public Safety and Well-Being	13. Require government entities to assess the potential impacts on individuals in the civil commitment system, public safety and well-being in communities, and public trust and confidence in government before making changes to the civil commitment system. (Ideas, 191)	7	6
Medication	14. Amend statutes to allow involuntary medication or court oversight of medication prior to a full civil commitment. (Ideas, 132)	5	7
Terminology	15. Amend language in statute and rules from "person with mental illness" and "mental disorder" to "person alleged to need involuntary treatment." (Ideas, 220)	6	5
Equity	16. Amend statute to require independent review of civil commitment case files by at least one person who has not seen the individual's name, demographic information, or any information that might create bias. (Ideas, 209)	6	4
Structural System Changes	17. Amend statutes to separate the legal process of civil commitment from broader healthcare mandates. (Ideas, 243)	4	5

Looking Ahead

The challenges facing Oregon's civil commitment system are not new, and the Commitment to Change (CTC) Workgroup is not the first to propose reforms. Previous efforts have been unsuccessful for a variety of reasons. One reason is the substantial financial investment necessary to meet the growing needs of Oregonians who experience serious mental illness. Perhaps an even greater barrier to reform than funding, however, has been the consistent lack of consensus among those seeking reform. Historically, Oregon policymakers have prioritized legislation with broad consensus. This report documents the complexity of Oregon's civil commitment system and the diverse range of perspectives by its many actors and participants who want change. The inertia resulting from lack of consensus around civil commitment reform is not surprising.

In addition to differences of opinion, Oregon's civil commitment system faces a structural challenge that is inherent from its juxtaposition between two systems: the behavioral health and justice systems. For individuals who experience mental illness and go through the civil commitment system, cross-system collaboration is essential to provide timely health care, personal and community supports, and legal protections. However, the path may feel uncoordinated and disjointed when gaps in needed services or barriers to accessing them cause a person to fall through the cracks. The behavioral health and justice systems have notable differences in their legal duties, professional obligations, and policy priorities. No single body oversees and manages the civil commitment process from beginning to end to ensure a seamless experience and effective outcome for the people whose lives may depend on it.

The CTC Workgroup was formed with an awareness of these barriers to reform. What sets this workgroup apart is not the consensus recommendations that it offers, although achieving consensus on so many ideas is notable, but rather its comprehensive evaluation of the civil commitment system to lay a foundation for effective reform. The workgroup identified concerns about each step in the civil commitment process and talked about global concerns such as data, equity, and funding. The workgroup developed an inclusive framework to invite public input and incorporated that input regularly into meeting discussions. The workgroup considered hundreds of ideas and declared the positions of the entities they represent on each one as a step towards building consensus or understanding different perspectives.

Policy leaders have more work to do, whether more efforts to reach consensus on the bigger and more polarized ideas or decisions to adopt policies that have broad support but are unlikely to ever reach consensus. Consider the following suggestions for how to use this report to support that work.

1. Educate participants of future workgroups, committees, and task forces to understand the complexities of the civil commitment system before considering reforms.

2. Review the extensive list of focused and global concerns as a foundation to start the next discussion with solutions rather than spending time restating the problems.
3. Revisit the hundreds of reforms proposed in greater depth and with fresh perspectives.
4. Consider the positions of nearly two dozen different stakeholder groups presented in the report, survey results, and workgroup minutes as a starting place to set priorities and move promising ideas forward.

Appendices

Appendix 1: Frequently Used Acronyms

Members of Workgroup with Organizational Acronyms

AOCMHP	Association of Oregon Community Mental Health Providers
AOC	Association of Oregon Counties
CCO	CCO (Coordinated Care Organizations) Oregon
DRO	Disability Rights Oregon
LOC	League of Oregon Cities
MOMI	Mothers of the Mentally Ill
NAMI	National Alliance on Mental Illness Oregon
OAHHS	Oregon Association of Hospitals and Health Systems
OCDLA	Oregon Criminal Defense Lawyers Association
ODHS	Oregon Department of Human Services
ODAA	Oregon District Attorneys Association
OHA	Oregon Health Authority
OJD	Oregon Judicial Department
OSH	Oregon State Hospital
OSSA	Oregon State Sheriffs' Association

Acronyms Used Frequently in Report

AOT	Assisted Outpatient Treatment
CCO	Coordinated Care Organization
CFAA	County Financial Assistance Agreement
CMHP	Community Mental Health Program
CTC	Commitment to Change
GEI	Guilty Except for Insanity
HIPAA	Health Insurance Portability and Accountability Act
LIP	Licensed Independent Practitioner
NMI	Notice of Mental Illness
OAR	Oregon Administrative Rule
OHP	Oregon Health Plan
ORS	Oregon Revised Statutes
QMHP	Qualified Mental Health Professional

Appendix 2: Workgroup Member Top-Five Ideas Lists

Workgroup members were asked to identify the top five ideas that they would recommend from the ideas in the Recommendations Survey. Thirteen workgroup members submitted a list, as provided below. All idea numbers refer to the Recommendations Survey.

Ideas on the Most Top 5 Lists

1. **Idea 34 (7 lists):** 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. (CCO, House Republicans, MOMI, OHA, OSH, OSSA, Tribes)
2. **Idea 32 (6 lists):** Amend statute to lower the legal threshold for civil commitment. (CCO, House Republicans, MOMI, OJD, OSSA, Tribes)
3. **Idea 4 (5 lists):** Require the state to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care. (AOC, OAHHS, OJD, OSSA, Tribes)
4. **Idea 35 (4 lists):** Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT). (AOC, OHA, OJD, Tribes)
5. **Idea 36 (4 lists):** Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment. (CCO, MOMI, OSH, Tribes)

Association of Oregon Counties

- **Idea 2:** 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.
- **Idea 4:** Require STATE to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care.
- **Idea 35:** Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT).
- **Idea 40:** Establish criteria in statute or rule to determine when the Oregon State Hospital must admit civilly committed individuals.
- **Idea 116:** Increase state funding for public guardian services for people who need long-term support options due to a behavioral health condition.

Coordinated Care Organizations

- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 34:** 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.
- **Idea 36:** Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment and services.
- **Idea 49:** 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).
- **Idea 113:** 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.

Disability Rights Oregon

- **Idea 22:** Amend statute to clarify when in the civil commitment process the court must appoint legal counsel to financially eligible individuals.
- **Idea 25:** 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.
- **Idea 60:** Amend statute or rule to require that OHA notifies defense counsel and an ombudsperson when recertification is pursued.
- **Idea 62:** 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.
- **Idea 115:** 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.

Mothers of the Mentally Ill

- **Idea 2:** 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.
- **Idea 12:** 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).
- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 34:** 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.
- **Idea 36:** Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment.

Oregon Association of Hospitals and Health Systems

- **Idea 4:** Require STATE to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care.
- **Idea 41:** 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.
- **Idea 64:** 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.
- **Idea 113:** 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.
- **Idea 127:** 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).

Oregon Criminal Defense Lawyers Association

- **Idea 26:** Amend statute to require hospitals to share pertinent documentation from electronic health record with defense attorneys for civil commitment hearings.
- **Idea 59:** Amend statute to require court to appoint defense counsel as soon as possible in the recertification process.
- **Idea 60:** Amend statute or rule to require that OHA notifies defense counsel and an ombudsperson when recertification is pursued.
- **Idea 108:** 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.
- **Idea 128:** Amend statute to create a process for expunging civil commitments from an individual’s record.

Oregon Department of Human Services

- **Idea 5:** 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.

- **Idea 86:** 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.
- **Idea 91:** Require OHA to identify individuals in civil commitment cases who may require specialized legal advocacy (e.g., people with intellectual and developmental disabilities).
- **Idea 117:** Require Oregon Developmental Disabilities Program to establish acute support options for people with intellectual disabilities with a co-occurring mental illness.
- **Idea 118:** Require state to develop or provide access to specialized treatment programs for individuals committed for intellectual disabilities.

Oregon Health Authority

- **Idea 7:** Establish a fee schedule/funding code for billing Medicaid for behavioral health preventative care, such as 23-hour crisis and respite.
- **Idea 8:** Require state to build and fund more mental health crisis centers so emergency rooms are not the only option.
- **Idea 11:** 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.
- **Idea 34:** 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.
- **Idea 35:** Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT).

Oregon Judicial Department

- **Idea 2:** 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.
- **Idea 4:** Require STATE to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care.
- **Idea 17:** Amend statute to increase the maximum period of voluntary diversion from 14 days to a longer duration (workgroup to recommend the specific duration allowable).
- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 35:** Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT).

Oregon Legislature House Republicans

- **Idea 8:** Require state to build and fund more mental health crisis centers so emergency rooms are not the only option.
- **Idea 17:** Amend statute to increase the maximum period of voluntary diversion from 14 days to a longer duration (workgroup to recommend the specific duration allowable).
- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 34:** 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.
- **Idea 37:** Provide dedicated funding to CMHPs to support 14-day intensive treatment (diversion from civil commitment).

Oregon State Hospital

- **Idea 34:** 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.
- **Idea 36:** Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment and services.
- **Idea 41:** 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.
- **Idea 116:** Increase state funding for public guardian services for people who need long-term support options due to a behavioral health condition.
- **Idea 120:** 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.

Oregon State Sheriffs' Association

- **Idea 4:** Require STATE to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care.
- **Idea 12:** 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).
- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 34:** 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.

- **Idea 49:** 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).

Oregon Tribes (Response provided by the Confederated Tribes of the Umatilla Indian Reservation)

- **Idea 4:** Require the state to build, own, operate, or fund more community-based facilities designed to provide shorter-term behavioral health inpatient care.
- **Idea 35:** Allocate sufficient legislative funding for needed community-based mental health resources to ensure capacity for assisted outpatient treatment (AOT).
- **Idea 32:** Amend statute to lower the legal threshold for civil commitment.
- **Idea 34:** Amend statute to create a tiered system of civil commitment with different criteria for each tier, authorizing courts to order community-based outpatient commitment, community-based inpatient commitment, or commitment at the Oregon State Hospital.
- **Idea 36:** Amend AOT statutes to authorize courts to oversee and enforce court-ordered participation in appropriate community-based treatment and services.

Appendix 3: Documents Available on the Commitment to Change Workgroup Website

The following documents will be available on the CTC Workgroup website.

Chief Justice Orders to Establish the CTC Workgroup

Workgroup Member Survey Results

- Revisions Survey Results[60]
- Building Consensus Survey Results
- Recommendation Survey Results
- Ideas Survey Results

Meeting Briefs
November 2022 – August 2023

Meeting PowerPoint Presentations
October 2022 – September 2024

Meeting Minutes
October 2022 – September 2024

Listening Sessions Summaries

- Listening Sessions with People with Lived Experience
    - Peerpocalypse: May 19, 2023
    - Families and natural supports of people with lived experience: Dec. 5, 2023
    - Individuals with lived experience of psychiatric holds: March 20, 2024
    - Families and natural supports of people with lived experience: April 15, 2024
- Listening Sessions with Oregon Tribes
    - Sept. 8, 2023
    - March 15, 2024

[60] The Revisions Survey Results show which variations of the ideas presented in the workgroup's final recommendations as core concepts that members indicated they could support.