Crisis & Commitment: Oregon Behavioral Health Update 2016

Presented by Hon Pat Wolke, Josephine County Circuit Court &
Eric J. Neiman, Lewis Brisbois
October 7, 2016

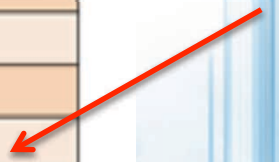
Mental Health America (2016)

Overall Ranking

Rank	State
1	Minnesota
2	Massachusetts
3	Connecticut
4	Vermont
5	South Dakota
6	New Jersey
7	North Dakota
8	Iowa
9	Alaska
10	New York
11	New Hampshire
12	Illinois
13	Maryland
14	Pennsylvania
15	Kansas
16	Delaware
17	Maine

Rank	State
18	Georgia
19	Colorado
20	Nebraska
21	Kentucky
22	Hawaii
23	California
24	Ohio
25	Florida
26	Oklahoma
27	North Carolina
28	DC
29	Wyoming
30	Missouri
31	Alabama
32	Michigan
33	Texas
34	Montana

Rank	State
35	Mississippi
36	New Mexico
37	Wisconsin
38	South Carolina
39	West Virginia
40	Tennessee
41	Arkansas
42	Virginia
43	Louisiana
44	Indiana
45	Idaho
46	Utah
47	Washington
48	Rhode Island
49	Nevada
50	Arizona
51	Oregon



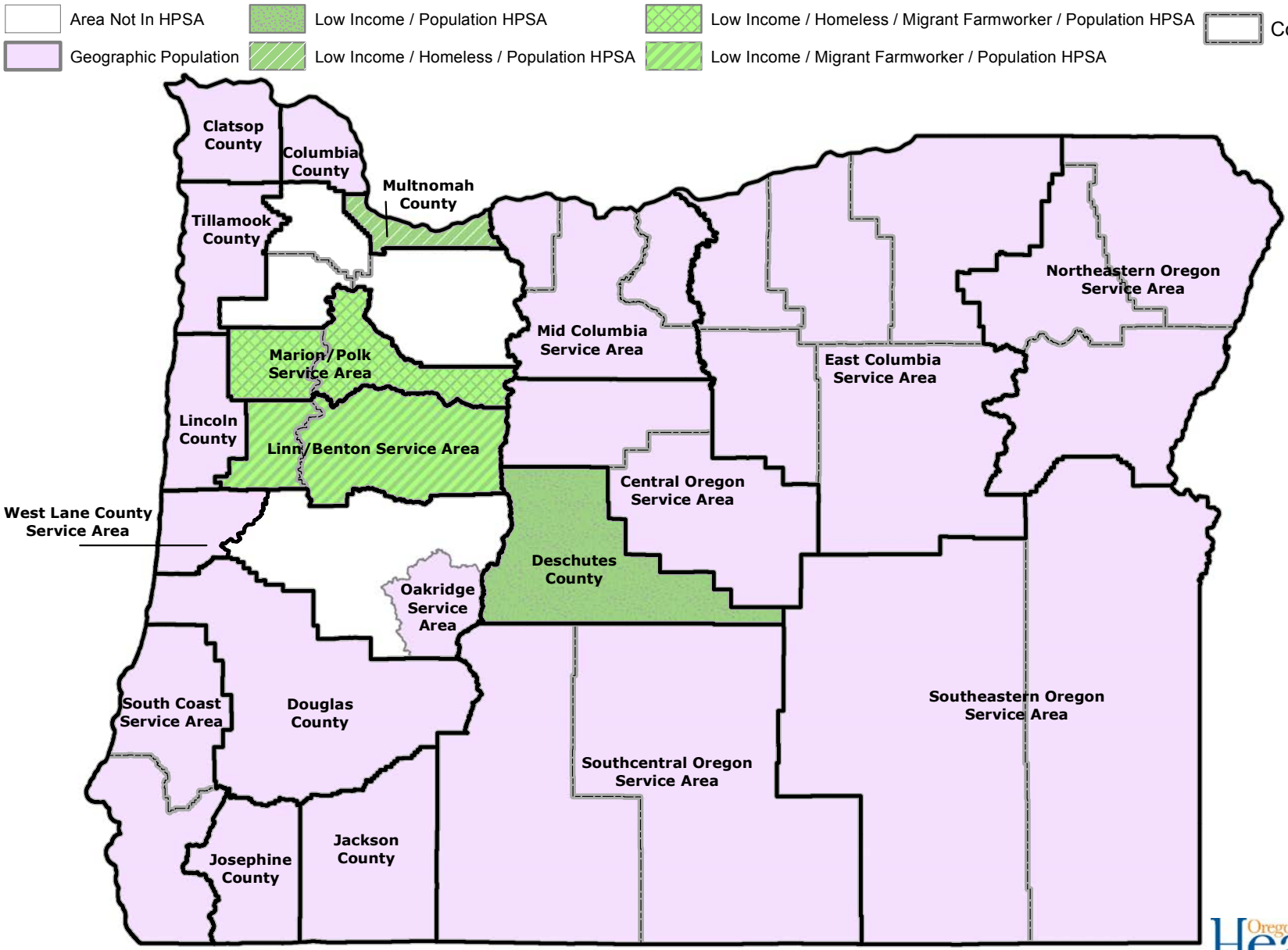
Supply of psychiatrists shrinks

Lack of doctors creates access problem in U.S., Oregon

By Markian Hawryluk / The Bulletin
Published Aug 11, 2016 at 12:07AM

Mental health parity laws passed in 2008 require insurance companies to treat mental illness the same way they treat medical conditions. But a dwindling supply of psychiatrists — both nationwide and in Oregon — is leaving many patients with complex mental health issues without timely access to psychiatric care.

Mental Health Care Health Professional Shortage Area (HPSA) Designations by Type, As of 01/01/16



Created by Office of Forecasting, Research & Analysis, Department of Human Services, 2/10/2016

Oregon Health Authority

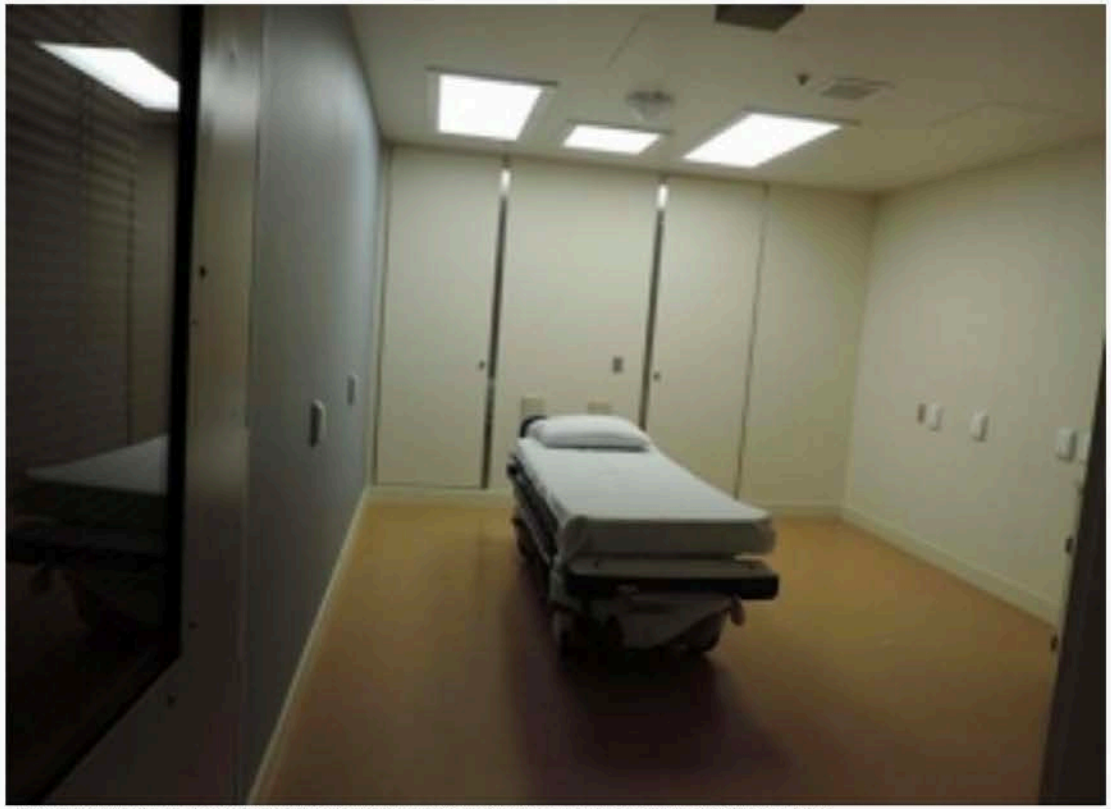
Oregon & DOJ Agreement

- November 9, 2012 voluntary agreement
- January 2, 2014 USDOJ Interim Report to the State of Oregon:

"*Despite the stated commitment to transform to a community-based system, the data provided demonstrates that there has not been an increase in the provision of community mental health services*."

All Stacked Up And No Place To Go

Psychiatric patients are being warehoused in Portland's emergency rooms in growing numbers.



PATIENT WAREHOUSE: Legacy Emanuel Medical Center in Northwest Portland boards psychiatric patients in this room.

By NIGEL JAQUISS
Updated July 15, 2014
Published July 15, 2014

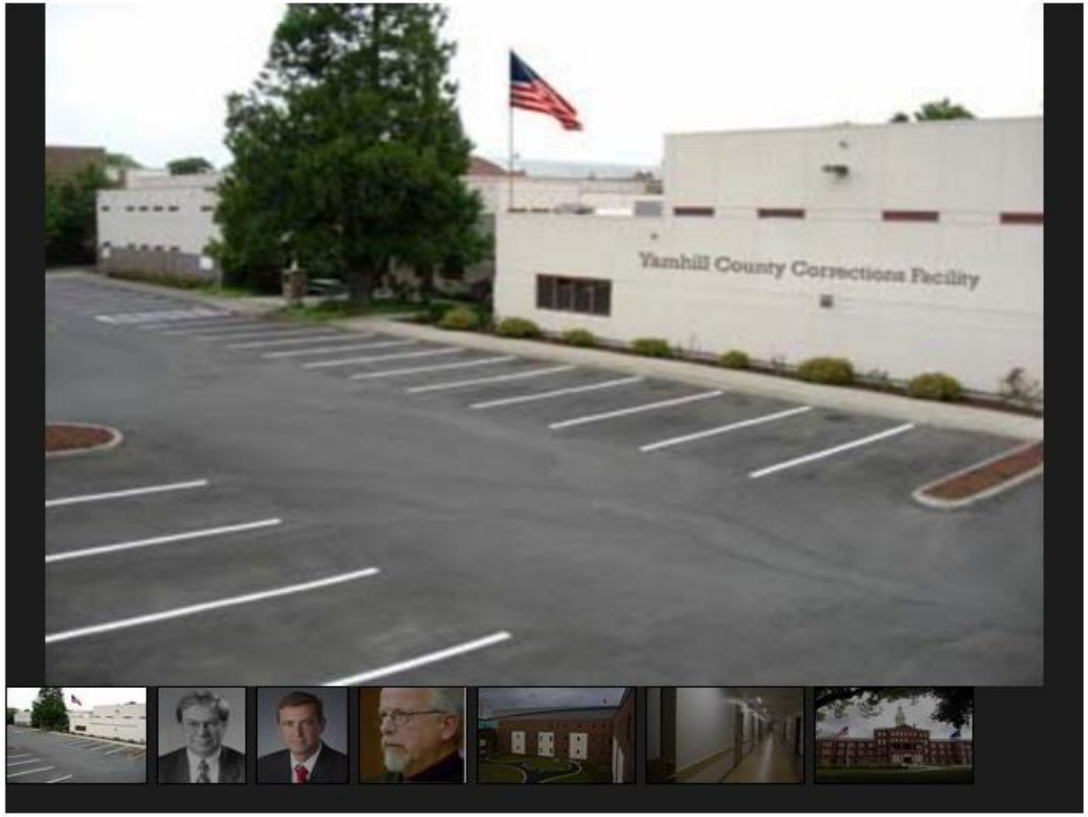
Jennifer Ann has found herself in Portland emergency rooms more than two dozen times in the past 20 years—almost always for the same reason.

"Usually I go," she says, "because I feel I'm going to kill myself."

On good days, Jennifer Ann, 56, is a high-functioning mother of four. She's a lifelong Portlander with bobbed hair and a self-deprecating wit. She's held administrative positions in the wood products industry, and now works as a mental health advocate. On bad days, Jennifer Ann (who asked that WW not use her full name) is helpless as schizoaffective disorder—a combination of bipolar disorder and schizophrenia—takes over. Last September, she went to the ER at Providence Portland Hospital at Northeast 47th Avenue and Glisan Street during a crisis. Hospital staff loaded her onto a gurney and lodged her in a stark room for 44 hours without therapeutic services.

32 comments

Woman with mental illness stashed in jail: 'Cruel' ordeal never should have happened



After a Yamhill County judge ordered a woman to be civilly committed because of her mental illness, the woman sat in jail for 10 days, awaiting an appropriate psychiatric bed in the state. Judges, her lawyer and mental health advocates stepped in to try to find a solution.

1 / 7 | Fullscreen | Share | Caption

By Maxine Bernstein | The Oregonian/OregonLive
Email the author | Follow on Twitter
on February 20, 2015 at 6:03 PM, updated February 22, 2015 at 12:59 PM

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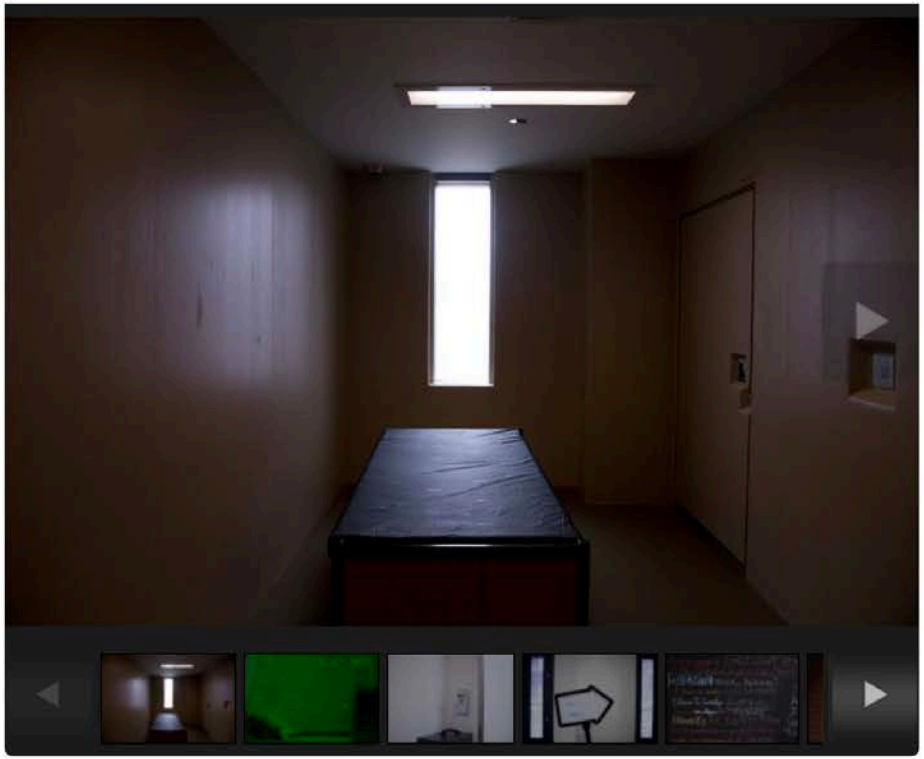
Two West Linn High students killed in Gorge highway crash

195

Threatening family or naked in the cold: Would that get you committed in Oregon?



The seclusion room at Oregon State Hospital in Salem. Patients can be held there for up to four hours, said Greg Roberts, superintendent of the state mental hospital. A tour of Oregon State Hospital, November, 2015 Beth Nakamura/Staff

1 / 48 Fullscreen Share Caption Buy

By Aimee Green | The Oregonian/OregonLive
Email the author | Follow on Twitter
on May 28, 2016 at 7:01 AM, updated May 28, 2016 at 12:23 PM

On a quiet spring night in 2013, Thomas James Jr. lobbed three flaming bottles full of fuel at a Northeast Portland house. An 18-month-old girl slept soundly inside.

Fire raced up the siding as the toddler's parents tried to put it out. That's when James held a lighter to a fourth bottle and hurled it at the two, coating them with gas. They escaped deeply shaken, but unhurt.

They were astonished to see who was responsible: James was their next-door neighbor.

The couple didn't know that James suffered delusions, had cut off his electricity and put a mattress over his window. They didn't know that police had come to the house less than 24 hours earlier to check on James, but left when he assured them he didn't pose an immediate danger to himself or others.

Now police finally had an unambiguous reason to intervene.

The story of Thomas James Jr. highlights shortcomings in Oregon civil commitment law and the limited recourse it gives police and other front-line workers to force help on people with serious mental illness.

Civil Cases Filed by Year

2012	9,459
2013	9,582
2014	8,619
2015	8,512

Per Oregon Judicial Department, 5/21/16

Changes in Oregon

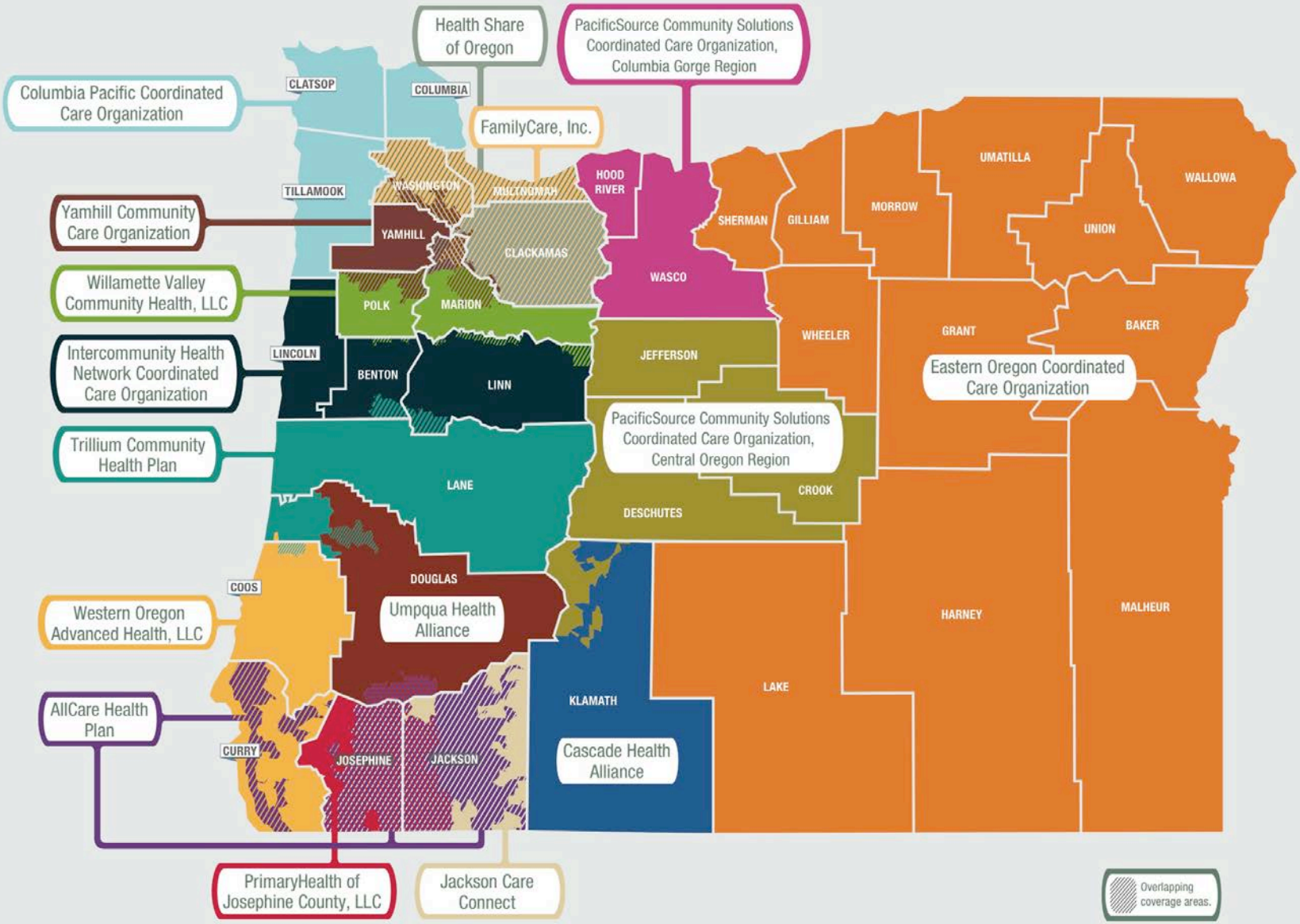
- Unity Center for Behavioral Health
- Providence Willamette Falls Child Adolescent Psychiatric Unit
- Providence Milwaukie Geropsych Unit
- Washington County Mental Health Urgent Care
- Increase in beds at Oregon State Hospital

“A New Day in Oregon”

- January 2014 Medicaid expansion
- Number of adults receiving treatment for mental illness increased 60%

- *Atlanta Journal of Commerce, 9/2015*

Coordinated Care Organization Service Areas



Oregon Health Authority

U.S. Department of Justice

U.S. Department of Justice
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Ellen F. Rosenblum
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July 25, 2016

Ellen F. Rosenblum
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Salem, OR 97301-4096

Re: Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness

...ealth Services for Adults with Serious and

...partment of Justice and the State of Oregon ...olve the United States' investigation of the ...te of Title II of the ADA and *Olmstead v. L.C.*, 527 U.S. 581 (1999), as they apply to adults with serious and persistent mental illness. During that time, Oregon has been engaged in transforming its health care system – a transformation that has included the integration of the systems delivering physical and mental health care, the expansion of coverage under Oregon's Medicaid program (the Oregon Health Plan), and the development of improved quality of services through an

integrated setting appropriate to their needs and achieve positive outcomes."

Since November 2012, the State and the United States have had extensive discussions about steps the State has undertaken or will undertake to develop or expand services that will help individuals with serious and persistent mental illness live

successfully in community settings, including steps to divert such individuals away from unnecessary contact with law enforcement and to effective community services. The State has memorialized the steps it will take in the attached Oregon's Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness.

In light or the State's representations that it will implement the Plan and the State's commitment to provide quarterly data to the United States regarding the Plan's implementation and to meet annually with the United States and the Independent Consultant to discuss the State's progress in implementing the Plan, the United States is suspending its investigation into Oregon's community mental health system for a period of three years from the date of this letter, consistent with the time frame for Oregon to implement the Plan. If however, the State stops its efforts to comply with the Plan or is in a sustained period of noncompliance with the Plan, the United States may then proceed with its investigation. Further, at the end of that three-year period, the United States' investigation will terminate, as will the parties' November 2012 agreement. In light or the State's commitment to provide data to the United States regarding the Plan's implementation, the State is no longer required to provide the United States the data set forth in the matrix attached to the November 2012 Agreement.

cc: John Dunbar, Special Assistant Attorney General

Executive summary

The Oregon Health Authority, in partnership with State Senator Sara Gelser, heard from approximately 550 consumers and family members over the course of seven Town Hall meetings across the state. Systemic challenges and holistic supports are

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In short, we heard there are not enough services and supports to meet the needs of Oregonians. There is a provider shortage resulting in long wait times to see a prescriber. There are not enough specialty services for children. Emergency department (ED) experiences are often unpleasant. Service integration is insufficient

In short, we heard there are not enough services and supports to meet the needs of Oregonians. There is a provider shortage resulting in long wait times to see a prescriber. There are not enough specialty services for children. Emergency department (ED) experiences are often unpleasant. Service integration is insufficient to ensure that cross-agency and inter-agency communication happens. Housing, employment, and transportation are in short supply. We heard stories from family members who care deeply about their loved ones and struggle tirelessly every day to get the help their loved ones need. Consumers do not receive the quality, coordinated care and support they deserve.

input provided by 550 consumers and family members will help chart the strategy behind these system investments.

Behavioral Health Collaborative Small Group Discussions
August 25, 2016

Does the problem statement adequately and succinctly address what we, as a collaborative, are working to address?

- The term "human services" is lacking because much of what we need to coordinate doesn't fit under health systems. All that DHS is not captured in the problem statement when we don't call out human services.
  Could add to state – "health and human services"
  - Child Welfare is limiting of all social and human services
- Grammar issue in "lack of access do not meet the needs"
- Do not mention "prevention" and "upstream"
  - Difference between "continuum of care" and branches and departments. If we say continuum of care this would be inclusive of "prevention". Insert as #2 so it proceeds integration
- Lack of access is important but what about quality and effectiveness/outcomes
  - This might be caught in "do not meet the needs of Oregonians", so maybe addressing the grammar issues will address this.
  - Consider adding coordination to integration… this are different things and need both
- Prevention is missing from the statement, health behaviors
- Lack of coordination among service providers: Primary care
- Workforce- Under paid, overworked, under educated, over burdened
- Fluency to figure out what the problem is and the willingness to participate when identified
- Cultural Lens needed to view the whole community, all populations.
- It doesn't adequately address **Tribal issues (need to be named specifically)**
- Multiple issues in silos (DD, APD, Child Welfare, Behavioral Heath) and funding streams.
- Need an investment in prevention (root causes) rather than after the fact treatment
  - Invest in fighting poverty, abuse/neglect, trauma
- There's a fragmentation of the system AND payment
- Family causes much of the injury yet they're excluded from the solution/treatment. Despite the injury this is who they want to be with and who they come back to, which is why they need to be a part of the treatment/solution. Prevention at this level? Emphasis needs to be on family healing not stigmatization of the negative behaviors that got them there in the first place. Problem = we treat/measure deficit.
- Second point should include communication
- Need to consider development disabilities (seniors + people with disabilities). Missing justice involved youth (criminal AND juvenile).
- Problem is upstream but spending is downstream (ex: OSH gets a lot of funds but serves fewer patients than other sources) – need to identify source and distribution of funds and those served (need incentive based programs to use local resources first including systems around reimbursement). USDOJ focuses on OSH.
- Credentialing difference between insurance types (private vs. public) is not addressed
- What about broadly defining groups involved (CCOs, state agencies, community behavioral health providers, etc.) as "agencies that touch people"?
- **First** seems clear enough
- **Second** seems child focused but could be generalized to adults too
  - Better use our system strategically so that we are all using our resources at the right time
  - Any individual within a family system leads to others, whether services starts with children or adults
  - Individual / customer needs a voice no matter how large the system (ie CCO, agencies) to assure we are actually addressing their needs and not just delivering what we are designed to deliver
- **Third** lists some supports but could be other areas that are in short supply such as housing, employment and transportation
  - Framework seems to be based on medical disease instead of wellness, although this third statement comes closer than the first two
  - Peers need to be added to the **third** statement as well as natural supports
- How to help clients transition when treatment is complete and have natural supports continue with the individual from the beginning, from a friend to peer supports, formally organized or self-selected from past experience
  - The goal is to have individuals independent from the public system, not just well enough to leave a particular level of care and yet still not be a part of the community
  - Services need to be closely linked instead of disjointed, in a manner that a person entering the system would easily navigate the process to meet their needs in a seamless manner
  - A continuous provider relationship is critical
- The whole statement should be stated positively if we are wanting a vision statement
- Metrics need to be meaningful
  - More than just admissions data (for example) but outcomes oriented
- Not measuring just programs but individual outcomes, measuring the human level of success
- Not using evidence-based practices across the board; add "quality"
- "Unevenness" of services (depending on geography, other factors)
- Better call-out of "upstream" concept
- Specific inclusion of DD and APD (Cherryl)
- What does "fragmented" mean? Does it include payment models (e.g. Medicare, commercial, etc.)? (Cherryl)
- Better transparency about what public $ provide (Bob)

What are the pieces missing from the conceptual framework that are necessary to accomplish our goal?

- Accountable Health Communities- Multi-agency community meetings, I.e. linkage with schools if we want to affect prevention
- Actual Metrics
- Linking framework to the specific problem statement
- No ACES/ Trauma in the framework
- Understanding the right questions to get to root of the issue, right solutions applied to the issues.
- Are the right providers in the room when problem solving
- Cycle of poverty, lack of resources, unemployment
- Person and Family trapped vs. helpfully surrounded by policy, systems, and translators
- Not Ideal, something more dynamic (org chart- people we serve on top, staff and management foundational support)
- All systems working together in the same direction
- Tribes
- Culturally specific practices (policy)
- FQHCs, rural health clinics
- Private providers/funders/commercial insurance
- Peer delivered service/Traditional Health workers – group is unsure where this would be reflected in the frame work… (System? Person & Family?) Family navigators in the early childhood system
- Add caregiving (elderly, disabled, child care) Unpaid family care giving
- Should OHA be on the framework? This was simply posed as a possibility. OHA manages the FFS Medicaid program and public health
  - May be included in administrative, legal regulatory, financing
  - Does seem to be reflected
- We are all translating the framework differently
- Is it appropriate to have children and adults depicted on the same framework when addressing those needs and our adult/children's systems are so different
- "Family of Choice"
- Right framework and right idea – connection of family, policy, system (including institutional care like OSH and jails for under state in systems)
- General areas missing
  - Person centered vs population based statement
    - we have problems on both fronts, individual issues make up the population challenges and not addressed merely through a public health (mass) perspective
  - Fragmentation goes from the individual through to policy and effects the individual when trying to unify services
    - funding continues fragmentation down to the individual services
  - Even Policy is an expression of community / society
  - Technology and it's use in the community
    - How it influences support services
- Edits to each section
  - Policy
    - Cross system development that includes housing resources embedded within provider services
  - System
    - No discussion of the private sector (commercial insurance) verses public sector
      - CCOs much more involved in the system of services than private insurance which creates a gap that is difficult to cross
    - Public safety is a concern because the system is still only designed to meet only specific needs of the population
    - How do we keep healthcare specialties and yet recognize specialized services and seamlessly incorporate the service array into an individual's services?
    - Law enforcement perspective and involvement
      - the public's connection with dispatch the services are very narrow
        - Dispatch only sends police and fire but not behavioral health
        - Medical transportation from dispatch does not have access to the entire array of transportation, only ambulance
        - Same for jail services which has a narrow array of services
    - Some of our informal supports are becoming formalized
      - Community networks can end up formalized into the system and losing its community identity and become incorporated into the service system of care
  - Translators
    - Continuity of care that is seamless, fluid with all the partners involved
    - Need to embed employment to increase independence and empowerment
    - PSS pay is much less than QMHPs and yet those are much lower than Occupational Therapy
      - At the same time, even our service workforce who qualifies for private insurance through the agency can also end up qualify for public assistance and OHP
    - We have multiple systems of care instead of one System of Care
      - We have behavioral healthcare and physical healthcare, instead of just Healthcare

[illegible] here is more community networking

Behavioral Health Collaborative Small Group Discussions
August 25, 2016

- Jumps immediately from indivi
  of communities, such as faith, recovery groups (non-professional)
- Education which is formal but also informal
- Better term definition (Bob) (e.g. those having to do with economic class)
- Does not call out equity!?!?
- What is the question? **Is this is an accurate conceptual statement?**
- What do the %s mean (esp. in terms of ability to have influence over changing/improving)?
- !!!Does the conceptual statement appropriately address things that are controllable by state/local government!!!????
- **PRETTY SUCKY!!!!** (Caroline)
- Primary care medical home inclusion
- System does not include health care (includes CCO/insurer); missing commercial, FQHC, SBHC
- *Make sure bands are accurate*
- ***Missing - "culture" - communication, community*** (Ajit)
- Conflation of person and family (Bob)

Imagine we have solved this problem, what have you done (what's your role) to help with this change?

- Looked at the criminal justice system to divert people out of jail who are in need of mental health care (Marion County). (funding, county FTE to go into jails to do MH assessments, coordination between criminal and MH systems, work force development, team based care, mobile crisis, public safety coordinating council with police)
- As commissioner coordinate the CCO community advisory… Oregon has a system that is outcome based with a global budget but we are required to use encountering which is "widget" focused. Marion County working on case rate system to develop payment methods to move toward outcome based care.
- Advocate for consumers/individuals. Life longer healthier lives
- Consumers can go through which ever door they are most comfortable with. Consumer chosen access. Choice.
- Insurance blind supports and services to meet the needs.
- All of Oregon's older adults have access to the behavioral health services to meet their needs because their needs aren't reduced as they age.
  - Would have a stage in which to talk to all system and legislators and tribes to discuss the good work being done but to correct and address further need.
- Integration of the private health insurance sector into the public sector. Have conversations with provider groups, stakeholders, make connections and bring private insurance into the main stream

across health plans private or public and across all commercial plans. Comparable benefits across systems.

- Seamless transition from OHP to private health plans and vice versa (Medicare as well).
- Contracts for CCOs will have accountability
- Reduction of duplicative services based on silos
- Commercial health plans will cover national models that Medicaid is covering (Wraparound, EASA)
- Common pool of services and support blind to payers. This also sustains providers and makes them financially viable
- Integration of all services, role clarification so that everyone that walks in has trust of the system and knows that integrated health providers will keep them safe, provide for them and give them the skills to monitor their own health. Tribes do this for their people and ensure everything is paid for in order to meet the needs of tribal members. Tribes cover financial burden of deductibles or premiums
- Removal of financial barriers
- Standardized benefit packages
- Community Norming (MH first aid for example) – everyone using the same language to build allies and reduce stigma
- Change in provider culture created with economic leverage. It's no longer an insurance coverage issues, move toward meaningful individual engagement and looking inward to address how to truly engage consumers.
- Services and supports will be of high quality, outcomes based, payer blind.
- Least Restrictive Care
- Case management/ navigators at front end to help people get what they need affect the most people at the beginning of episode of care
- People are well with a healthy dose of prevention, it hasn't cost a lot of money.
- Coordinating with the other social services to affect change
- CCOs get better at risk stratification and spending in creative ways, incentivize
- Less crisis events, more wrap around supports, front end services
- Not criminalized, Not stigmatized,
- Get Ahead of the issues
- Looking at both the up and downstream issues
- Speak a common language, mobilize communities, targeted investments, incentivized policy outcomes, integrated services, and realigned payment system
- Embraced alternative services (computers & tele-health)
- Invested in root causes/prevention and aligned the budget along the social determinant percentages outlined in the conceptual framework
- Supported the individuals who support the social determinants
- Low cost/high scale (upstream/preventative) approach
- Private commercial payer would pay for wraparound services
  - No difference between the public and private sectors of insurance and what services are covered

service codes

- Serve clients so that the system is not siloed into different segments (DD, MH, etc.), which gets segmented through
  - Funding or payment
  - Licensing or regulation
  - Eligibility criteria
  - Specialties within healthcare
    - Generalists throughout healthcare system need to seamlessly interact with specialties throughout all of healthcare (physical, behavioral)
- Parity of wages between behavioral health and physical health
- Community-based resources to address all needs within the community that is connected with the healthcare system but keeps its independence from that professional system
- An example of an outcome: "Recovery is having a place to live, three meals and a date on Saturday night"
- Help to drive outcomes
- Continue to focus on quality
- True MH parity (not dependent on payer); including provider expectations (Cherryl)
- Set standards and promote advancements (legislative; funding; policy; etc.)
- Build trust among the players (Bob)
- Allow for continued questioning of current system/structure with opportunity to adapt/evolve
- Greater level of accountability/appropriation of accountability (e.g. OHA has CMS accountability but does not make transparent where this accountability sits at the local level)
- Integrating MH to make it a "normal" part of medical care (all levels - ED, primary care, etc.)
- **Fund innovation!!!** - "checkerboard" analogy (current funding structure allocates $ to defined "squares"; does not allow for creative approaches with flexibility on ROI)

Where does what you have done to solve the problem fit into the conceptual framework?

- Coordinated Care noted in the framework
- Policy- prevention, agency coordination,
- System intervention at the personal and population levels.
- No wrong door to start services and get what is needed
- Mental health embedded in primary care
- We have created change in all parts of the conceptual framework in the list above

What is one next step (actionable) you can do to help now?

- Change the payment infrastructure
- Create a multi-tiered system of providing support (a collaborative effort between health care and education)
- Keeping the community buoyant and work toward prevention
- Bring back tangible recommendations/identification of problems

The Register-Guard

STATE GOVERNMENT

Oregon faces $1.2 billion hole in its healthcare budget, initial funding request shows

By Saul Hubbard
The Register-Guard
SEPT. 7, 2016

- To remove certain “low-priority” medical services from Oregon Health Plan coverage, including treatment of collapsed lungs, hearing loss, neonatal eye infections, gall bladder cancer, and a significant portion of mental health and dental coverage. While those changes would save between $45 million and $112 million, Oregon would need federal approval to reduce its coverage in any area. And the changes “would make it very difficult for physical, dental and mental health providers to deliver high quality, comprehensive care,” officials wrote in their proposal.
- To reduce funding for community-based mental health care by 20 percent, saving $39 million.
- To delay expanding capacity at the Junction City psychiatric hospital and/or close an existing ward at the facility, saving up to $35 million.
- To delay building of three transitional cottages at the Junction City hospital for people who are ready to move out of secure treatment at the site, saving up to $12 million.
- To require that mental health providers stick to a preferred drug list for Oregon Health Plan patients, saving $8 million.
- To eliminate Medicaid payments to teaching hospitals to offset costs of taking on doctors-in-training, saving $22 million.

Originally published October 5, 2013 at 7:04 PM | Page modified October 8, 2013 at 4:24 PM

First of two parts

‘Boarding’ mentally ill becoming epidemic in state

TIMES WATCHDOG: Far more involuntarily detained patients are stuck in chaotic hospital ERs and ill-equipped medical rooms. They wait days, even months, for treatment. The practice traumatizes thousands of mentally ill residents, wreaks havoc on hospitals, and wastes millions of taxpayer dollars.

By Brian M. Rosenthal
Seattle Times staff reporter

Matthew Jones stripped off his clothes, kicked over a trash can and ran into Kirkland’s Juanita Beach Park. He wanted to swim across Lake

◄ PREV 1 of 5 NEXT ►

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

CASSIE CORDELL TRUEBLOOD, et al.,

Plaintiffs,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES, et al.,

Defendants.

JUDGMENT IN A CIVIL CASE

CASE NUMBER: C14-1178 MJP

THE COURT HAS ORDERED THAT

Defendants are ordered to cease violating the constitutional rights of Plaintiffs and class members by providing timely competency evaluation and restoration services, and a permanent injunction is entered by the Court.

injunction is entered by the Court.

Dated April 2, 2015.

William M. McCool
Clerk of Court

s/Mary Duett
Deputy Clerk

In the Matter of the Detention of DW

- "We affirm the trial judge's ruling that the ITA does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities."

- "Patients may not be warehoused without treatment because of lack of funds."

In the Matter of the Detention of D.W., 181 Wn.2d 201, 332 P.3d 423 (2014)

Piazza v. Kellim (2016)

- Underage nightclub
- Shooting outside
- Shooter had been diagnosed with schizophrenia
- Exchange student killed
- Lawsuit against Zone and Rotary
- Cite: *Piazza v. Kellim*, 360 Or 58 (2016).

Piazza v. Kellim (2016)

- Trial court dismissed
- Court of Appeals reversed
- Oregon Supreme Court affirmed Court of Appeals
- Case remanded for trial

“Our preference for giving voice to the community's judgment through a jury determination prevails..."

“Psychiatric Boarding”

“…what's happening in California ERs is a public health crisis, and it's happening now.”

Chris Van Gorder, president and CEO, Scripps Health, January 11, 2016.

“We have replaced the hospital bed with the jail cell, the homeless shelter and the coffin. How is that compassionate?”

Tim Murphy-R- PA

Part I

The Problem with Oregon's Existing Civil Commitment Law

The Problem with the Existing Law

"Right now, people cannot be committed for psychiatric treatment in Oregon unless they are imminently dangerous to themselves, or they are gravely disabled (about to die). We have this rule despite the fact that the best experts are poor predictors of dangerousness. It's like trying to time exactly when to slam on the brakes of a bus speeding toward a brick wall, so it just touches the wall without causing damage or injury."

Dr. Christopher J. Lockey M.D. President of the Oregon Psychiatric Association. Board Certified Forensic Psychiatric Physician at the Oregon State Hospital. OregonLive.com February 9, 2013

Existing Legal Criteria for Civil Commitment

- ORS 426.005 (1)(e):
- "Mentally ill person" – means 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 and is not receiving such care as is necessary for health or safety.

Pre 2015 Law Change

  - (b) Unable to provide for basic personal needs <u>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</u>.

2015 Law Change

(This does not include the definition of a chronically mentally ill person)

Actual Criteria for Civil Commitment in Oregon

- Statute + Case Law
- ORS 426.005(1)(e):
- "Mentally ill person" – means a person who, because of a mental disorder, is one or more of the following:

(a) Dangerous to self or others. Likely to occur in the near future based on the A.M.I.P.'s condition at the time of the hearing. The record must show a foundation for "predicting future violent behavior." (Google – Predicting Future Dangerousness)

(b) Unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety. The state must show, by clear and convincing evidence, that the A.M.I.P. probably would not survive in the near future, because he or she is unable to provide for basic personal needs. *State vs. Bunting*, 112 Or App 143 (1992).

Part II

3 Case Studies

Case Study # 1 - Facts

- 40 Year old woman, living on her own, with schizophrenia.
- Does not believe that she is mentally ill, has quit taking her medication.
- She fought with staff at the hospital.
- Asked the staff to kill her, said she doesn't want to go on living.
- Subject to delusions and voices which tell her to do certain things, which she obeys. (Computer in her head which tells her how to run her life and is trying to kill her)

HOLDING – REVERSED

State vs. NAP, 216 Or App 432 (2007)

Case Study # 1 – Holding Reversed

1. Evidence must show *current* dangerousness.
2. Evidence must show that AMIP is a danger to herself or others in the *near* future.
3. Facts not extraordinarily persuasive.

State vs. NAP, 216 Or App 432 (2007)

Case Study # 2 – Facts

- 49 Year old woman, with schizoaffective disorder, paranoid, delusional, voices tell her to act out sexually. Charged with public indecency and sexual assault of her puppy.
- No mental health medication for the past 2 years.
- Suffers from diabetes, and refuses medication.
- Evicted from her apartment.

HOLDING – REVERSED
State vs. Bunting

State vs. TLH, 202 Or App 63 (2006)

Case Study # 3 - Facts

- 45 Year old Woman with bipolar disorder.
- Recently found wandering the road after dark, partially unclothed.
- One week prior, involved in a serious traffic accident that she cannot remember.
- Entered into a stranger's house after dark.
- Destroyed her own property.
- Evicted from her home, living in her car.
- No Family willing to help, and no plan for food/shelter.

HOLDING – REVERSED
State vs. Bunting

State vs. BC, 235 Or App 412 (2010)

Case Study # 3 – Holding – Civil Commitment Reversed

State vs. Bunting, short term lack of housing, food, etc. does not mean that she would not survive in the near future.

State vs. BC, 235 Or App 412 (2010)

Year	Civil Commitment	Oregon Population	Civil Commitments Per 100,000
1990	1244	2,842,321	**44.6**
1991	1087	2,927,800	**38.0**
1992	996	2,990,610	**33.9**
1993	942	3,059,110	**31.3**
1994	925	3,119,940	**30.4**
1995	896	3,182,690	**28.5**
1996	829	3,245,100	**26.0**
1997	842	3,302,140	**25.8**
1998	864	3,350,080	**26.1**
1999	915	3,393,410	**27.4**
2000	937	3,431,085	**28.0**
2001	983	3,470,385	**28.9**

Source: Oregon Health Authority

Year	Civil Commitment	Oregon Population	Civil Commitments Per 100,000
2002	589	3,502,588	**24.8**
2003	759	3,538,591	**22.4**
2004	719	3,578,895	**20.9**
2005	766	3,626,938	**21.5**
2006	770	3,685,206	**21.7**
2007	676	3,739,359	**18.3**
2008	602	3,784,182	**16.1**
2009	550	3,815,775	**14.5**
2010	593	3,837,300	**15.5**
2011	557	3,857,625	**14.5**
2012	468	3,883,735	**12.2**

Source: Oregon Health Authority

Corresponding Decrease in Inpatient Beds for the Mentally Ill

In 1955 there were 558,992 inpatient beds for the mentally ill. Today, there are approximately 35,000 nationwide.

As of July 13, 2007, there were approx. 1,032 psychiatric beds in the state of Oregon. Of which the vast majority were utilized by "forensic" patients (i.e. those defendants found guilty but insane; and/or those in the state hospital for restoration of competency). Source: Joseph E. Bloom MD, et al. "The Majority of Inpatient Psychiatric Beds Should not be Appropriated by the Forensic System."

Hope for the Future?

3 New Initiatives

Assisted Outpatient Treatment

- ORS 426.133
- Effective 1/1/14
- Used once

Comparison of Statutory Criteria

CIVIL COMMITMENT
ORS 426.005(1)(E)

- Prediction of future dangerousness.
- Unable to survive in the near future.

TREATMENT ORS 426.133

- Will not voluntarily seek treatment.
- Unable to make an informed decision to seek or comply with voluntary treatment.
- Incapable of surviving safely.
- On a downward trajectory.

ASSISTED OUTPATIENT

Assisted Out-patient Treatment in Oregon

- Can last for up to one year – Civil commitment is for a period of 180 days
- Does not allow for forced medication
- Requires a treatment plan and subsequent appearances before a judge
- Subsequent appearances would be similar to a participant in mental health court – Progress tracked and assessed

Case Study #3 – “BC”

HOLDING – Commitment Reversed

Prior to A.O.T. : BC is Released

- Consequences of inaction:
  - ”BC”:Death/Serious Injury/deterioration in mental & physical health
  - Public: Involved in a car accident w/ “BC”
    Involved in confrontation w/ ”BC”
  - Financial: ↑ Police contacts, ↑ costs for her care, hospitalization & treatment

Could "BC" Meet the Criteria for AOT?

1. 18 years old? – YES
2. Willing to participate in voluntary treatment? – NO
3. Able to make an informed decision? – NO
4. And as a result:
   a. Incapable of surviving safely in the community without treatment; and
   b. If left untreated, will predictably deteriorate so that she would become legally committable.

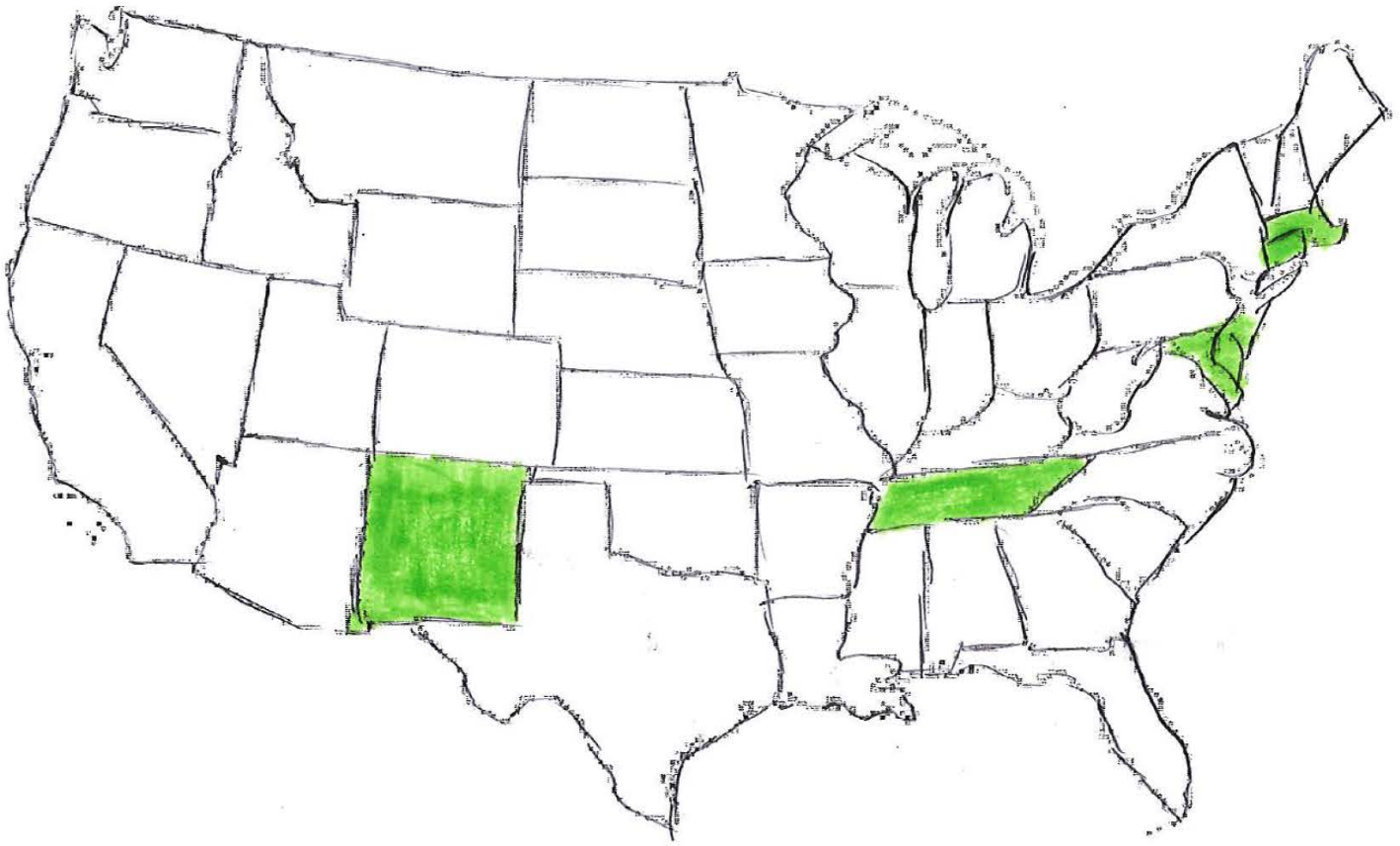
Procedure for A.O.T.

- Judge could decide that BC, although not legally committable, meets statutory criteria for AOT.
- Judge would direct BC and a representative of the mental health department to return to court within 7 days with a proposed treatment plan.
- Proposed treatment plan could include, among other things, engagement with services, including counseling and housing, eligibility for benefits; and medication.

Procedure for A.O.T.

- BC & the representative of the mental health department would be rescheduled to appear in court periodically, to assess her progress.
- At any time, prior to the one year period of assisted out-patient treatment, judge could dismiss the case, provided that BC was participating satisfactorily in treatment, and would continue her treatment on a voluntary basis.

States WITHOUT A.O.T



Helping Families in Mental Health Crisis Act – Passed the House of Representatives 422-2 On 7/6/16

	Old	New
Agency:	SAMHSA "Substance Abuse & Mental Health Services Administration	Assistant Secretary of Mental Health and Substance Abuse Disorders

	Old	New
Focus:	“Easy” Mental Illnesses SAMSHA has defined bad grades, bad marriages, bullying and unemployment as “mental illnesses”	“Serious” Mental Illnesses Resulting in: Incarceration, homelessness, violence, co-occurring disorders, suicide and hospitalization

	Old	New
$500 Million in Block Grants	Low level mental illnesses	Serious mental illnesses
Assisted Outpatient Treatment	$0	$20,000,000 per year
HIPAA	Medical Providers cannot give information & claim they cannot receive information.	Medical providers <u>can</u>: 1. <u>Receive</u> info from loved ones about the patient. 2. <u>Give</u> limited info to loved ones re: diagnosis, tx plan, rx, next appt.

	Old	New
Money Limitations	A. IMD Exclusion "Institutions for Mental Disease"	A. Greater coverage for inpatient stays
	B. 190 day lifetime cap on inpatient stays	B. Eliminated
	C. Cannot see medical and mental health provider on same day	C. Eliminated
	D. Expensive medications vs. inexpensive medications	D. Disallowed

Misc…

1. Disability rights organizations:

   Cannot lobby against civil commitment and/or A.O.T.

   Cannot counsel mentally ill to disregard advice of caregivers
2. Hospitals to prepare discharge plans
3. Money to study violent acts by mentally ill
4. Establishes interagency serious mental illness coordinating agency
5. Support funding for peer specialists

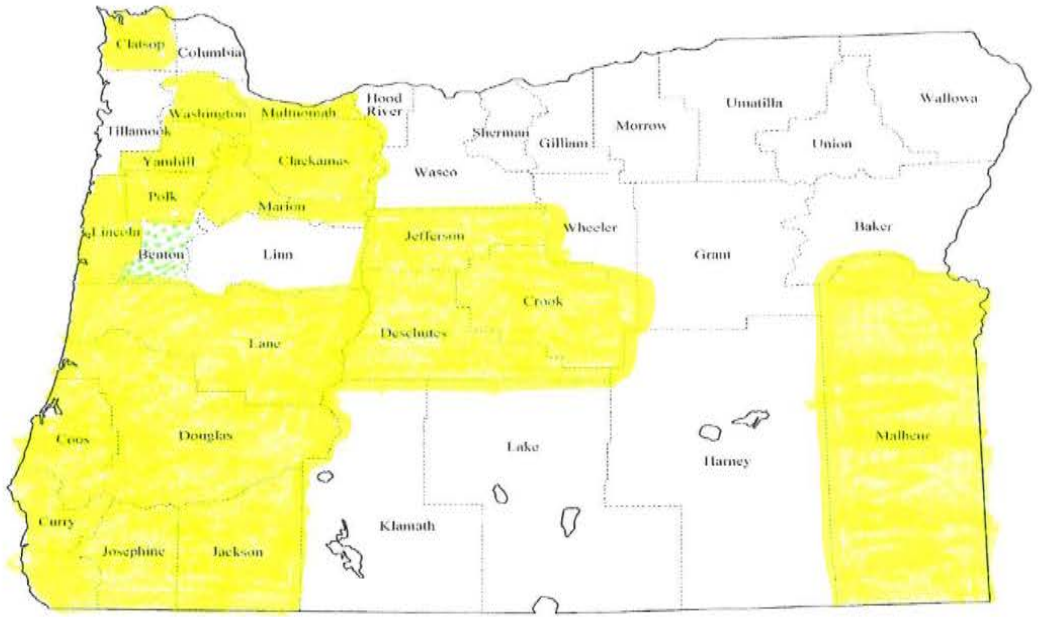
For More Information

Mental illness policy.org

Treatment Advocacy Center

Rep. Tim Murphy

Mental Health Courts in Oregon



(4) Oregon Mental Health Judges Association

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