Compiled by the

Legislative Policy and Research Office

Psychiatric Security Review Board Work Group Report

December 2021

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EXECUTIVE SUMMARY

The Psychiatric Security Review Board (PSRB) work group was convened by Senator Floyd Prozanski, chair of the Senate Judiciary Committee, at the request of the PSRB, at the conclusion of the 2019 legislative session. [2] The goal of the work group was to address concerns about the PSRB process.[3] The work group included persons from the legislature, state agencies, advocacy organizations, the criminal defense and prosecution bars, the judicial branch, law enforcement, the mental and behavioral health systems, affected persons, and representatives of the PSRB.

The work group set a scope, identified issues, and held more than a dozen monthly meetings during 2020. The recommendations in this report go beyond legislative recommendations. The work group attempted to reach consensus wherever possible, and areas of disagreement are noted in the report.[4]

This report includes background on the PSRB, as well as the work group processes. It offers an in-depth discussion and recommendations on a variety of issues that the PSRB, related state systems, and affected individuals have identified as key to the PSRB's continued ability to fulfill its mission, which is:

> "to protect the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest, and person-centered care."[5]

It is the work group's goal that the recommendations include legislative changes, administrative rule changes, court processes suggestions, interdisciplinary training, and best practices, and will be reviewed by the appropriate individuals and entities and implemented in timely and thoughtful ways. The work group further wishes to acknowledge how important it is for stakeholders to continue to improve their communication, as it is only through concerted multidisciplinary efforts that the Oregon PSRB system can continue to work toward better outcomes for individuals and public safety.

As a result of the work group's efforts, two bills were passed in the 2021 session. Senate Bill 205 and Senate Bill 206 were passed by both chambers and signed by the Governor on July 14, 2021. Senate Bill 205 allows the court to order an individual to be committed to Oregon State Hospital (OSH) or other secure mental health facility while a petition is pending. Senate Bill 206 modifies the court-conditional release process by

[2] See PSRB letter to Senator Floyd Prozanski, Appendix A.
[3] Staffing for the work group was provided by PSRB and the Legislative Policy and Research Office.
[4] This report was written by PSRB and the Legislative Policy and Research office, with opportunities for the work group to review. The recommendations do not necessarily reflect consensus. The Legislative Policy and Research Office has no position on the policy concepts offered herein.
[5] See PSRB Handbook, Appendix B. Also see ORS 161.336(1)(a) (2019), ORS 161.351 (2019), ORS 419C.532 (2019), which provide that the board shall have as its primary concern the protection of society.

increasing required communication between parties, agencies, and organizations involved in the process. It modifies requirements for the court in determining whether a person should be conditionally released, specifies when mental health consults and mental health evaluations must be ordered by the court, and directs the PSRB to establish, by rule, standards for mental health consultations and evaluations.

The work group's recommendations are grouped into six categories: Legislative, Administrative, Practice, Policy, Training, or Budget. A brief summary of recommendations considered by the work group is included below. Not all ideas are presented as part of this executive summary; only a subset are highlighted. For a detailed discussion and complete list of recommendations and information about whether consensus was reached on an issue, please refer to the complete report.

Legislative recommendations

- Expand the committing court's requirement to engage in at least a consultation for all non-Measure 11 felonies to determine if court conditional release is an option (pg. 40);
- Require the committing court to order a community evaluation when the consultation provides information that a court conditional release can be achieved. Full evaluations for Class C felonies would still be required regardless of the consultation (pg. 40);
- Require that the consultation and/or community evaluation be conducted prior to the court entering a final disposition. Require the final disposition and placement decision be made at the same hearing. Require that a finding for a Guilty Except for Insanity (GEI) cannot be made until these evaluations have been completed (pg. 40);
- Devise a funding mechanism to cover the cost of court-ordered Community Mental Health Programs (CMHP) community evaluations (pg. 41);
- Replace the word "controlled" with a term that is more person-centered and respectful to those under the PSRB (pg. 41);
- Use a different term for "Qualified Mental Disorder" in the Fitness to Proceed/Aid and Assist statutes to avoid confusion, provide legislative authority for differing definitions, and offer clarity to evaluators and decision-makers (pg.15);
- Clarify and codify the case law regarding exclusion of substance abuse disorders and sexual misconduct disorders from the definition of Qualified Mental Disorder (pg.15);
- Require regular reporting to the legislature on the location, actual cost, and availability of services as well as their use (e.g., private, GEI, Aid and Assist, Civil Commitment) and the primary barriers to additional services in any given area (pg. 49);
- Allow remote appearance and testimony for parties and witnesses unless an objection is filed by any party or the court or there are other technical issues (pg. 53);
- Ensure there is parity among those adjudicated Responsible Except for Insanity (REI) to expungement laws (pg. 57); and
- Clarify peace officer authority by integrating the language of ORS 161.336 (2019)

into ORS 133.310 (2019) (Authority of peace officer to arrest without warrant) or other statute that law enforcement more regularly uses that establishes their authority to take a person into custody (e.g., ORS 426.228 (2019) authority of peace officers). Or specifically establish an "authority of peace officers" section under ORS 161.336 (2019) (pg. 60).

Administrative recommendations

- Increase the administrative requirements for certification of forensic evaluators with the goal of ensuring evaluators have a specialty in forensic evaluation (pg.12);
- Create an advisory committee to expand administrative rules to include minimum content for examinations and reports related to ongoing jurisdiction or discharge from the PSRB (pg. 30);
- Add clarity to the definition of "substantial danger" to assist the Board, evaluators, those serving clients under the Board, and clients themselves on what that means (pg. 35); and
- Draft administrative rules to create a standardized CMHP court-ordered conditional release consultation and reimbursement process through the Oregon Health Authority (OHA) (pg. 41).

Practice changes

- Create evaluation best practices and training to better account for substance-induced qualifying mental disorders (e.g., waiting periods or re-evaluation after a certain period of time to assess symptomatology after an individual has achieved sobriety) (pg. 15);
- Ensure that drug screenings are administered following an arrest and ensure that the selected panel of substances tested is comprehensive (pg.15);
- Provide training and encourage District Attorneys (DAs) to review their policies related to adjudicating GEI cases. DAs should consider devising strategies to detect red flags related to malingering and substance use (pg. 21);
- Collect data on the percentage of defendants sentenced to less than the maximum statutory sentence. Gather data on the legal community's awareness of the discretion (pg. 23);
- OSH and community treatment providers examine policies and practices related to Mental Health Declarations and encourage early development and ongoing modification throughout PSRB commitment. Include the declaration in End of Jurisdiction packets to ensure prospective treatment providers are aware the individual has one (pg. 33);
- The Oregon Health Authority (OHA) and PSRB should engage with neighboring counties mental health providers to foster a process of resource mapping and collaborative conversations aimed at promoting resource sharing and other creative solutions to the rural service gaps in Oregon (pg. 49);
- Consider a preference for Board members with lived experience rather than making it a statutory requirement (pg. 55);
- Outreach with OHA regarding secure transport options. Develop local protocols to address transportation issues (pg.60); and

- Develop evaluation standards for examiners conducting the assessment of an extremely dangerous person with mental illness (pg.53).

BACKGROUND

The Psychiatric Security Review Board

The Psychiatric Security Review Board (PSRB) was originally created in 1977 by the Oregon Legislative Assembly based on a recommendation from the Governor's Task Force on Corrections. The legislature recognized that individuals who commit crimes due to a mental illness have different rehabilitative needs than convicted defendants. In 2007, the Legislative Assembly expanded the PSRB and its responsibilities to supervise those youth who have been found responsible except for insanity (REI). In 2013, the Legislative Assembly created a new type of civil commitment and appointed the PSRB to supervise those individuals found to be extremely dangerous persons with mental illness. Over the past 40 years, the PSRB's legislative responsibilities have expanded to five program areas: Guilty Except for Insanity; Responsible Except for Insanity; Firearm Restoration Program; Sex Offender Reclassification and Relief Program; and PSRB Civil Commitment.

Guilty Except for Insanity (GEI). On January 1, 1978, the PSRB assumed jurisdiction over all persons now known as "Guilty Except for Insanity" (GEI)[6] who pose a substantial danger to others.[7] GEI is the affirmative defense used by defendants in *criminal* cases to argue they should not be held criminally responsible for their actions because of the qualifying mental disorder experienced at the time of the criminal act, which caused them to lack the substantial capacity either to appreciate the criminality of their conduct or to conform their conduct to the requirements of law.[8] Individuals who successfully assert this defense are diverted from the criminal justice system (i.e., Department of Corrections, Department of Community Justice, etc.) and into the mental health system, where they can receive the commensurate treatment, monitoring, and supervision necessary to prevent recidivism and protect the public. A person must be able to aid and assist in his or her own defense in order to assert the GEI defense.

Responsible Except for Insanity (REI). In 2007, the Oregon Legislative Assembly expanded the Board's membership and its responsibilities to include a juvenile panel to oversee youth who were found responsible except for insanity (REI) of a crime, the juvenile equivalent of GEI.[9]

Firearm Restoration Program. In 2009, the Oregon Legislative Assembly enacted House Bill 2853, assigning the PSRB the authority to establish and oversee Oregon's firearm restoration program. The program provides a path by which a person whose

[6] Christopher J. Lockey and Joseph D. Bloom, *The Evolution of the American Law Test for Insanity in Oregon: Focus on Diagnosis*, 35(3) AAPL Online (September 2007) (325-329) (a history of Guilty Except for Insanity in Oregon and the evolution of the Insanity defense in Oregon).
[7] Since 2011, GEI misdemeanors are placed under the Oregon Health Authority's jurisdiction (HB 3100 (2011)).
[8] ORS 161.295 (2019); ORS 161.305 (2019)
[9] SB 328 (2007); *see also*, Stewart Newman, Mary Claire Buckley, Senia Pickering Newman, and Joseph D. Bloom, *Oregon's Juvenile Psychiatric Security Review Board*, 35(2) AAPL Online (June 2007)(247-252).

firearm rights were revoked due to a mental health determination can have those rights restored.[10]

Sex Offender Reclassification and Relief Program. In 2013, the Legislative Assembly again expanded the PSRB's jurisdiction, giving it authority to establish a sex offender reclassification and relief program. The program, which launched January 1, 2019, offers persons who successfully asserted the guilty except for insanity defense, who were also required to register as a sex offender, relief from registration requirements or reclassification of their risk designation.[11]

PSRB Civil Commitment. In 2013, the Oregon Legislative Assembly also expanded PSRB's jurisdiction over a specified population of civilly committed persons who are found by an Oregon court to be an "extremely dangerous person with mental illness."[12] This adjudication places the person under the PSRB's jurisdiction for a period of 24 months, with the possibility of a recommitment if the individual continues to meet statutory criteria at the end of their initial commitment. Distinct from the GEI defense, the State may file a petition to initiate the commitment of an alleged extremely dangerous person with mental illness regardless of whether the person is competent to stand trial in their criminal case, assuming the criteria for filing the petition exists. The commitment is a civil proceeding that is separate from any pending criminal prosecution.[13] Similar to the GEI program, persons under PSRB jurisdiction receive the necessary commensurate treatment, monitoring, and supervision to prevent recidivism and protect the public.

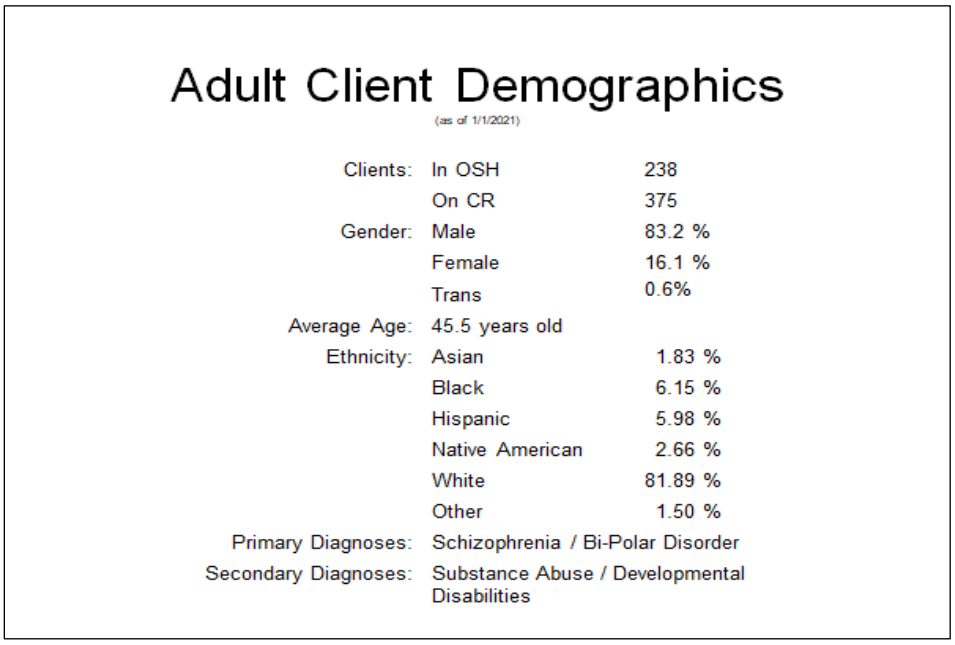
Additional information about the PSRB's history, current processes, and resources can be found at www.oregon.gov/PRB/Pages/Index.aspx. The Board's 2019-2024 Strategic Plan can be found in Appendix C.

Data

As of January 1, 2021, there were 620 GEI adults, 21 civilly committed adults, and seven juveniles under the PSRB's jurisdiction. Below are some key demographics and data regarding those individuals and their supervision under the PSRB.

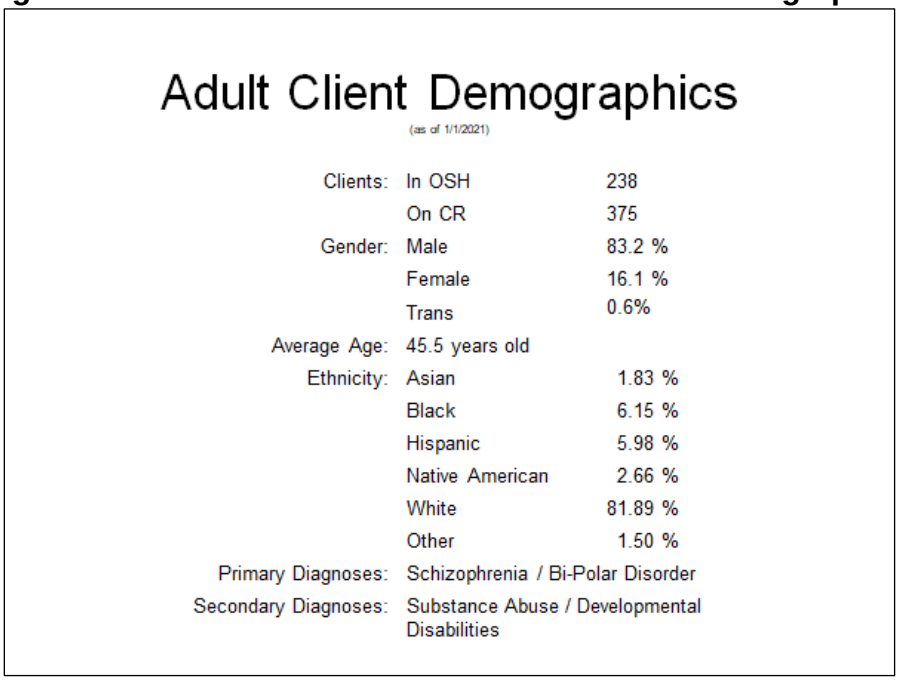
[10] HB 2853 (2009); *see also*, Julie Britton and Joseph D. Bloom, *Oregon's Gun Relief Program for Adjudicated Mentally Ill Persons: The Psychiatric Security Review Board*, 33(2-3) Behav. Sci. Law, (February 2015)(323-333).
[11] HB 2549 (2013).
[12] SB 421 (2013); ORS 426.701 (2019).
[13] ORS 426.701 (2019) provides the statutory criteria necessary for this commitment type.

Figure 1. Adult PSRB GEI Client Demographics



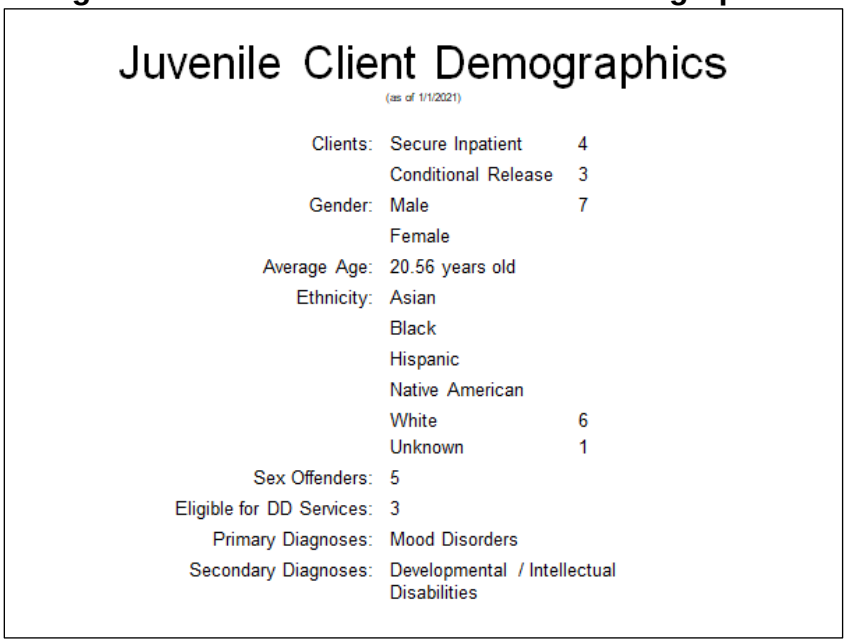
Source: PSRB

Figure 2. Adult PSRB Civil Commitment Client Demographics



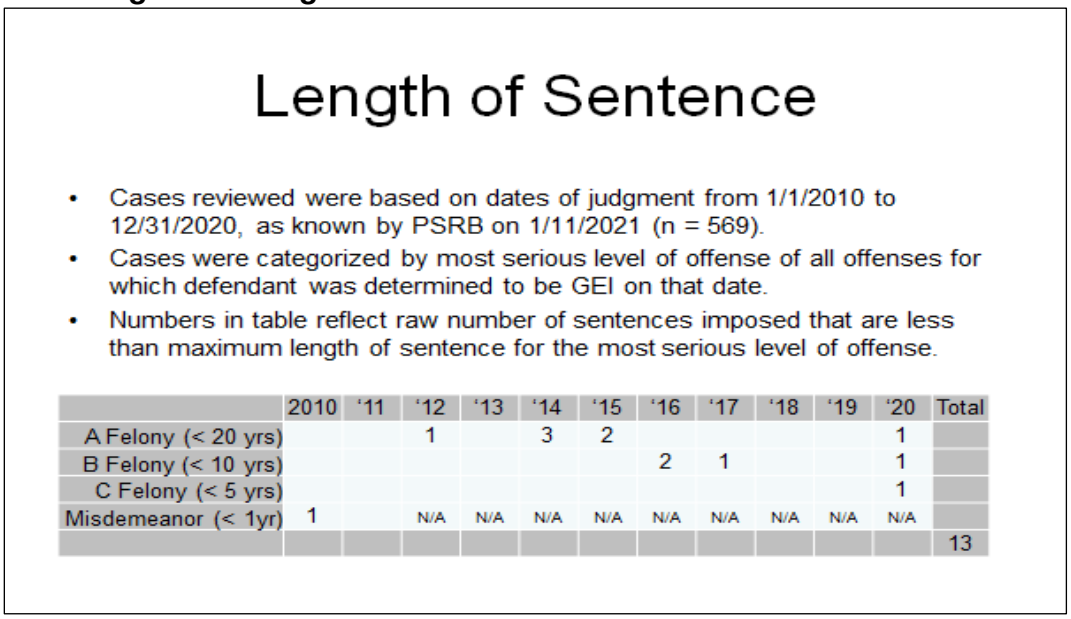
Source: PSRB

Figure 3. Juvenile PSRB REI Client Demographics



Source: PSRB

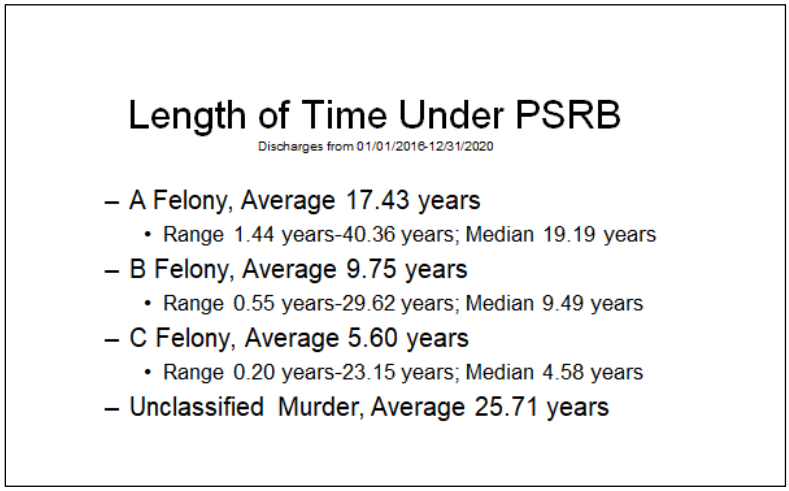
Figure 4. Length of Sentence for Adult PSRB GEI Clients



	2010	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	Total
A Felony (< 20 yrs)			1		3	2					1	
B Felony (< 10 yrs)							2	1			1	
C Felony (< 5 yrs)											1	
Misdemeanor (< 1yr)	1		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
												13

Source: PSRB

Figure 5. Length of Time Served for Adult GEI Clients



Source: PSRB

Housing. In 2019, 36 percent of the individuals under PSRB jurisdiction were receiving treatment at the Oregon State Hospital and 64 percent were on some form of conditional release. Specifically:[14]

- 205 individuals (36 percent) were in the Oregon State Hospital;
- 69 individuals (12 percent) were in secured residential treatment facilities;
- 138 individuals (24 percent) were in residential treatment facilities;
- 17 individuals (3 percent) were in adult foster homes;
- 40 individuals (7 percent) were in semi-independent supported housing;
- 17 individuals (3 percent) were living independently with intensive case management;
- 77 individuals (13 percent) were living independently with case management; and
- 9 individuals (2 percent) were in Department of Corrections custody.

Revocation. In 2020, approximately 0.63 percent of individuals on conditional release were "revoked" or placed back in the state hospital by the PSRB after determining they could no longer be safely maintained in the community.

Recidivism. From 2011-2018, the cumulative annual recidivism rate for PSRB supervisees on conditional release was 0.87 percent. Comparatively, the recidivism rate for individuals on parole and probation is 18 percent and 14 percent, respectively.

From 2011-2018, 984 PSRB supervisees were conditionally released and living in communities in Oregon. In that time, 35 PSRB supervisees committed a felony or misdemeanor while under supervision and were subsequently convicted of that crime.

[14] See Appendix D PSRB Agency Snapshot (2020).

The Work Group

Work Group Processes. The work group, coordinated by the Executive Director of the PSRB and Legislative Policy and Research Office (LPRO) Counsel to the Senate Judiciary Committee, met monthly from 2019-2021, with a four-month hiatus due to COVID-19 restrictions. During the initial meetings, the work group focused on organization. The work group determined its membership, drafted a scope of work, and identified the specific relevant issues it would analyze to offer recommended changes. It then drafted a workplan that divided the issues across eight meetings and set the discussion agendas.[15]

Prior to each meeting, facilitators reached out to expert work group members to gather and distribute relevant background information in the form of statutes, administrative rules, law review articles, research articles, or presentations to work group members for their review prior to the meeting. Meetings began with identified experts presenting on the background of an issue, identifying areas for needed change, and fielding any technical questions from the group. Work group members then participated in facilitated discussions of the issue and possible solutions. At the next meeting the work group engaged in preliminary brainstorming. After initial review of each issue, the work group collected information and possible recommendations for review. The group then began to develop specific legislative, administrative, training, and best practice solutions to be presented in this report.

In September 2020, the work group determined that subcommittees would be necessary to provide a deeper examination of some of the issues and recommendations, particularly those that would result in the development of legislative proposals. A summary of subcommittee work was provided to the larger work group meetings. Subcommittees of the work group included:

- Law Enforcement;
- PSRB Civil Commitment;
- Juvenile Psychiatric Security Review Board (JPSRB);
- Early Discharge; and
- Court Conditional Release.

In October 2020, the work group identified two areas to focus on for the 2021 legislative session: Court Conditional Release and PSRB Civil Commitment. Legislative concepts 1647 and 1642 were drafted and the work group concluded with discussions focused on improving the drafted language and achieving consensus with respect to these concepts. Senate Bill 205 (LC 1647) and Senate Bill 206 (LC 1642) were passed by both chambers and then signed by the Governor on July 14, 2021.

[15] *See* Appendix E for a copy of the Interim PSRB work group workplan.

Scope.[16] When an individual is found to be guilty except for insanity (GEI), the criminal court must enter an order either committing that individual to the care of the state hospital or, if the court finds that the person can be adequately controlled with supervision and treatment and that necessary supervision and treatment are available, placing the person on conditional release. When a person is placed on conditional release, the PSRB assumes jurisdiction and supervision of the individual.

The State has a mental health system specifically designed for these populations and the PSRB has jurisdictional and supervisory authority.

The Psychiatric Security Review Board's Statutory Functions are to:

- accept jurisdiction over GEI, REI, and civilly committed clients who are extremely dangerous persons with mental illness;
- protect the public and balance the public's concern for safety with the rights of the client;
- conduct hearings, make findings, and issue orders;
- monitor the progress of each client under its jurisdiction, including those clients committed to the state hospital;
- place a client on conditional release and revoke conditional release if the client violates the terms of that release; and
- maintain a current history on all clients.

The PSRB carries out its functions by conducting hearings and monitoring clients. "In determining whether a person should be committed to a state hospital or secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society." ORS 161.351(3) (2019).

The PSRB impacts multiple disciplines across Oregon's criminal justice and mental health systems in a variety of ways. Stakeholders across these systems have raised the following concerns as within the scope of the work group:

- which individuals come under the jurisdiction of the PSRB;
- how individuals are conditionally released by the court;
- how individuals are discharged from PSRB jurisdiction;
- quality, quantity, and funding of community-based resources available to individuals under the jurisdiction of the PSRB;
- quality, quantity, and funding of community-based resources available to individuals whose PSRB jurisdiction lapses;
- PSRB's ability to track outcomes for individuals who have been discharged; and
- composition and organization of the PSRB.

[16] Adopted by the work group on 10/25/2019

Issues Identified. Below are the discrete issues the work group identified as within its scope, necessary, and appropriate for its consideration.

Court-Ordered Conditional Release
- Process
- Resources
- Evaluations

Pre-Jurisdiction ("Front Door")
- Definition of Qualifying Mental Disorder
- Evaluations
  - Training and Qualifications of Evaluators
  - Certification
  - Quality Assurance
  - Evaluator Material Access
- Number of Evaluations Necessary for GEI Finding
- Stipulations to GEI
- Malingering and/or Fraudulent GEI Pleas

Data Collection
- Standardized Definitions
- Predictive Analytics
- Specific Data Collection and Analysis Capacity:
  - PSRB Demographic Reporting
  - Recidivism
  - Services (quality and quantity and mapping)

Law Enforcement Coordination
- Role During Revocations
- Resources
- Extradition Protocol

Board Composition/Oversight
- Expansion of Board
- Ombudsman/Advisory Council

Resources
- Create a Robust Continuum of Community Mental Health Care Services
  - Funding
- Specific Service Gaps:
  - Housing
  - Transportation
  - Peer Support Work
- Board Oversight/Ombudsman

Post-Jurisdiction ("Back Door")
- Length of Jurisdiction
- Early Discharge
  - Requirements
  - Authority
  - Considerations When Directly Following Hospitalization
- Discharge Evaluations/Discharge Plans
- Law Enforcement Notification

Juvenile PSRB
- Placement Resources
- Underutilization

Consumer Voice
- Person-Centered Language
- Consumer Representation

PSRB Civil Commitments
- Process for Initiation and Hearings
- Evaluations
- Safety and Ability to Hold Persons While Hearings Are Pending
- Continuation of Commitment
- Discharge
- Examiner Training

CERTIFIED FORENSIC EVALUATOR STANDARDS, TRAINING, AND AVAILABILITY

To assert the insanity defense, a defendant must file with the court a report of a psychiatric or psychological evaluation, conducted by a certified evaluator. This section discusses issues related to a court's finding that an individual meets the criteria to assert the insanity defense, and therefore, is appropriate for the jurisdiction and supervision of the PSRB. Much of this discussion by the work group focused on the examination and evaluation component of this process.

These reports play a vital role in the evidence a court or jury uses to accept or reject a GEI defense. Reports that do not adequately address the statutory criteria for the GEI defense or do not address the evaluation components laid out by administrative rule have the potential to cause a decision by a judge or jury that results in an inappropriate GEI adjudication. If a person is inappropriately placed under PSRB jurisdiction, the PSRB is required to discharge that person at a subsequent hearing, even if they are very dangerous, due to a lack of jurisdiction. When that happens, the discharged individual may be released back into the community with no safety provisions in place. In that instance, the criminal case cannot be re-initiated by the State due to Constitutional protections against double jeopardy. Therefore, the PSRB is invested in strengthening the training and review standards associated with certified forensic evaluators.

The work group identified concerns with the inter-rater reliability and quality assurance of evaluations, training challenges, feedback for certified evaluators, funding concerns, and an overall shortfall in the number of high-quality evaluators.

Background[17]

House Bill 3100 (2011), codified at ORS 161.309 (2019), requires any defendant who plans to assert the insanity defense to file with the court an evaluation performed by a certified forensic evaluator. In that same bill, the legislature gave OHA the responsibility to create a formal certification program for psychiatrists and psychologists providing GEI evaluations "to ensure that forensic evaluations meet consistent quality standards and are conducted by qualified and trained evaluators."[18] OHA must certify qualified applicants, provide training, and maintain a statewide list of certified evaluators.

Issue 1: Inconsistency of evaluations both in quality and content. Participants discussed whether the established certification training is succeeding at effectively training future evaluators. Work group participants generally agreed that the initial and recertification curricula covered the necessary topics outlined in OHA rules. The content of the training required includes but is not limited to legal foundations relevant to GEI, report writing, ethics, risk assessment, and expert testimony preparation.[19] During the work group, participants who were also faculty for the certification training shared improvements planned for future training (e.g., expanding the length of the training and adding components based on newly passed legislation).

While the curriculum itself meets the content outlined in the rules, one area of ongoing concern pertained to those professionals who participate in the training, but who have no other background experience in the field of forensic evaluation either through their graduate program or other work experience. For reference, the minimum requirements for an applicant to become a certified forensic evaluator include:

[17] See Appendix G for relevant materials considered by the work group.
[18] OAR 309-090-0000
[19] OAR 309-090-0040

- have a current Oregon license to practice;
- complete an application including a $250 nonrefundable application fee;
- attend the statewide Oregon Certified Forensic Evaluator Training (OCFET); and
- submit three redacted forensic evaluations for panel review.[20]

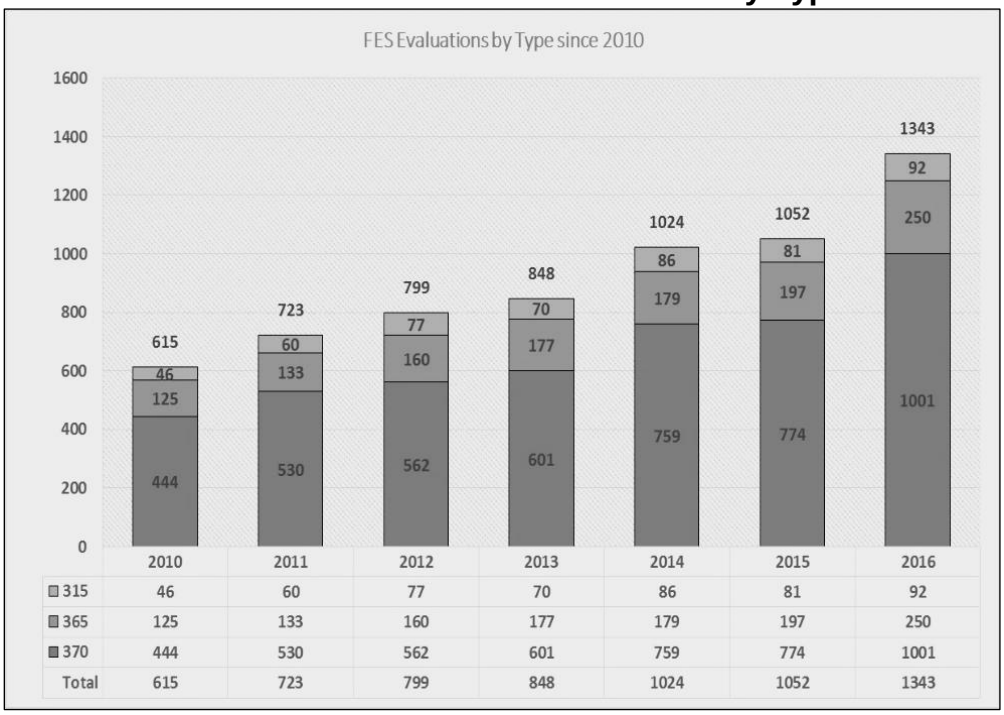
Participants who are also training faculty explained that the relatively brief training program (three days) could not reasonably provide the requisite education and experience necessary to competently conduct a criminal responsibility evaluation. Related to this concern was the reported challenge in teaching evaluators how to effectively develop and communicate a "nexus statement," which is a section of a criminal responsibility evaluation that explains the connections/relationship between the qualifying mental disorder and the criminal act. This section was identified as one of the most important and most difficult sections for evaluators to articulate in a criminal responsibility evaluation. Shared preliminary research showed that, even with training, the nexus section of a report does not tend to improve, except for those who do a poor job to begin with. Anecdotally, participants expressed concern in the wide variability in this section of the evaluation. This concern was compounded by the subjective perspective of several participants that the overwhelming majority of GEI cases are stipulated, rarely lending themselves to the direct and cross-examination of the person who authored the criminal responsibility evaluation. Concern was also expressed about the wide variability in training and experience attorneys have with reading and interpreting these types of evaluations. Overall, this discussion left a desire for additional administrative or legislative requirements to possibly increase the minimum qualifications and continued education units to become a certified forensic evaluator or maintain the certification.

Issue 2: Hiatus of the Forensic Evaluator Review Panel. In addition to training requirements, OHA rules established a Forensic Evaluation Review Panel Process.[21] Participants in the work group concurred on the important role this panel plays in quality assurance, establishing a complaint process, providing feedback to evaluators, and crafting and overseeing remediation plans when necessary. [22] Participants in the work group shared concern that the panel has not ever been fully operational, and more recently, has not existed in any form. In 2018, OHA reassigned the oversight and management of the panel to the Oregon State Hospital's Legal Affairs Department. Legal Affairs, who was represented in the work group, provided an overview of the history of the panel, the challenges of launching and sustaining the panel (e.g., recruitment and funding), and their plan for future directions. It was also announced that Legal Affairs was initiating a separate work group to examine the Oregon Administrative Rules and issues such as whether the panel could be restored and whether the goals associated with the panel could be achieved.

[20] OAR 309-009-0010. There are some differences for certification for juvenile evaluations, including an additional day of training and a juvenile specialization.
[21] OAR 309-090-0035
[22] OAR 309-090-0055 to 0065

Issue 3: Minimum number of criminal responsibility evaluations required for a GEI finding; Forensic Evaluator "shortages;" and evaluation "back-up" both at the state hospital and in private evaluations. Another concern identified by the work group pertained to the shortage of evaluators, particularly considering research that evidenced forensic evaluations were on the rise. Although data on statewide private evaluations is not available, data from the Oregon State Hospital Forensic Evaluation Service offers a snapshot showing a significant increase in the number of evaluations conducted in recent years:

Table 1. Forensic Certified Evaluations by Type [23]



	2010	2011	2012	2013	2014	2015	2016
315	46	60	77	70	86	81	92
365	125	133	160	177	179	197	250
370	444	530	562	601	759	774	1001
Total	615	723	799	848	1024	1052	1343

Source: Oregon State Hospital
Data: OSH Forensic Evaluation Service

While evaluator shortages and funding issues are relevant to Oregon's entire forensic mental health system, this report limits this discussion to their impact on PSRB. For example, while all examiners are ethically bound to be objective in their approach to evaluations, some variability does exist between examiners, and some examiners have developed a reputation for being defense- or prosecution-friendly. This provoked a question about whether courts should require more than one criminal responsibility evaluation. This was further debated in light of the current practice that allows defense attorneys to keep the results of a criminal responsibility evaluation confidential if the results do not support their legal arguments. The work group also discussed whether there was utility in the courts hiring evaluators, which is the practice in some states.

[23] Data provided by the Oregon State Hospital Forensic Evaluation Service. Note: 315 evaluations are GEI evaluations whereas 365/370 represent aid and assist evaluations.

The work group was provided a survey of state statutes and practices.[24] All states, including Oregon, allow for the defendant and the prosecution to seek independent evaluations in contested cases. No state *requires* two evaluations for a court to find an individual GEI. Some states designate an individual or state entity who must perform the evaluation for the state, while other states rely on a panel of independent evaluators.

This discussion segued back to whether there are enough evaluators available to require more than one criminal responsibility evaluation. While there is a lengthy list of certified forensic evaluators in Oregon, participants thought it could be more helpful to know which professionals on that list were regularly conducting criminal responsibility evaluations. There was a sense that the number of available evaluators who were competent in conducting criminal responsibility evaluations in the private sector was relatively low compared to the list of all individuals who hold a certification.

The work group also broached the topic of funding available to evaluators. Currently, criminal responsibility evaluations are paid for by the Office of Public Defense Services if the defendant is an indigent client.[25] Participants familiar with evaluator reimbursement rates shared that Oregon's reimbursement rate for forensic evaluators is low, which further interferes with recruiting quality evaluators for this type of work. The state also has the right to obtain its own evaluation of a defendant, and these are typically provided by the Oregon State Hospital (OSH).[26] Evaluators at OSH were concerned with their ability to keep up with the growing number of evaluations, from both a fiscal and a workload perspective.

Recommendations

- **Legislative Change:** None.
- **Administrative Change:** Increase the administrative requirements for certification with the goal of ensuring evaluators who have a specialty in forensic evaluation.
- **Administrative Change:** Increase standards for evaluations and the authority of the review panel.
- **Administrative Change:** Increase standards of evaluation review in GEI cases that are stipulated.
- **Budget Change:** Increase the funding for forensic evaluations so that the Office of Public Defense Services can better reimburse private evaluators for their services.
- **Budget Change:** Provide position authority for additional evaluators for the Forensic Evaluations Service Division.
- **Practice Change:[27]** Create a Multi-system work group on Forensic Evaluations.

[24] The PSRB executive director was privy to this survey of Forensic Directors via relevant listserv and can provide a copy upon request.
[25] ORS 161.309 (2019).
[26] ORS 161.315 (2019).
[27] See Appendix H for a background paper on the pros/cons of court-appointed evaluators.

Forensic Evaluations are used for all forms of Civil Commitment, the Aid and Assist Process, GEI/REI Determinations, and to support PSRB decision-making. The concerns around GEI/PSRB evaluations cut across these topical areas and the need for evaluations in any of these topical areas affects overall access to forensic evaluators. The PSRB work group suggests that a larger systemwide conversation about Forensic Evaluations be convened to develop systemwide standards and solutions but where appropriate account for specific considerations of each topical area, while avoiding a patchwork of standards and solutions with which Forensic Evaluators must comply.

DEFINING AND EVALUATING A QUALIFYING MENTAL DISORDER

To assert the GEI defense, individuals must demonstrate, through the examination of a certified forensic evaluator, that they suffered from a qualifying mental disorder (QMD) at the time the offense took place. Thereafter, the PSRB maintains jurisdiction when the State demonstrates (through evidence presented at a contested hearing) that the person continues to suffer from a QMD or, when the burden of proof is on the individual, the individual fails to demonstrate they no longer suffer from a QMD.

"Qualifying mental disorder" is not a clinical or psychological term. It is the legal term used to determine whether the insanity defense is appropriate and whether PSRB jurisdiction should be maintained. Because it is a legal term and because the statute does not define what it includes (only what it does not include), the term has been interpreted by the courts, but questions remain regarding whether certain disorders constitute QMDs, resulting in litigation and confusion among practitioners in some cases.

This section explores the challenges related to the definition and evaluation of a QMD and how those challenges impact the PSRB's decision-making and the forensic system as a whole. In general, if substantial evidence does not support that an individual suffers from a QMD, the PSRB must discharge the individual. In the best cases, the absence of a QMD can be extremely positive and signify that a person has recovered from the condition that rendered them dangerous. However, in the worst-case scenarios, the PSRB must discharge the individual from its jurisdiction, even if the evidence also demonstrates that the individual is still considered to be a substantial danger to others. At the point of discharge, the individual is free of all monitoring, supervision, and treatment.

Background[28]

ORS 161.295 (2019) states, in relevant part:

> (1) A person is guilty except for insanity if, as a result of a qualifying mental disorder at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

[28] See Appendix I for relevant materials considered by the work group.

(2) As used in chapter 743, Oregon Laws 1971, the term "qualifying mental disorder" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor does the term include any abnormality constituting solely a personality disorder.

ORS 161.295 (2019) originally used the term "mental disease or defect." It was changed to qualifying mental disorder in 2017.[29] Notably, as originally enacted, ORS 161.295 (2019) did not omit personality disorders from the definition of what is now called a Qualifying Mental Disorder. Legislation enacted in 1983 made that change.[30]

Qualifying mental disorder is further defined by the PSRB at OAR 859-010-005:

(11) "Qualifying Mental Disorder" (formerly "Mental disease or defect") means:
(a) a developmental or intellectual disability, traumatic brain injury, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM 5) of the American Psychiatric Association; or
(b) any diagnosis of a psychiatric condition which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of an individual's functioning and is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) of the American Psychiatric Association.
(c) "Qualifying Mental Disorder," described in subsections (a) and (b), excluding those conditions described in subsection (d) includes:
(A) A disorder in a state of remission which could with reasonable medical probability occasionally become active; or
(B) A disorder that could become active as a result of a non-qualifying mental disorder.

The term qualifying mental health disorder is also used in the statutes related to aid and assist, ORS 161.365-370 (2019), but the relevant aid and assist rule, OAR 309-090-0005(25), defines it differently.

***Issue: Qualifying mental disorder is ill-defined in the statutes*.** In preparation for discussing this issue, the work group received Robert Kincherff's 2010 publication, "Proposition: A Personality Disorder May Nullify Responsibility for a Criminal Act."[31] The crux of this discussion centered on whether additional language should be added to the definition of qualifying mental disorder to clarify what diagnoses should be included, whether the statute should expand to particular conditions, and whether the statute should further limit other types of conditions.

[29] 2017 c.634 sect. 3.
[30] 1983 c.800 sect. 1
[31] This discussion was fostered by a review of Kinscherff, R., A Personality Disorder May Nullify Responsibility for a Criminal Act, *Journal of Law Medicine and Ethics*, 745-59 (Winter 2010).

Participants discussed the extent to which the definition, in its current form, may be over-inclusive, inadvertently including individuals who are unlikely to benefit from the comprehensive monitoring, supervision, and treatment resources available to those under PSRB jurisdiction, such as those who are not diagnosed with a severe and persistent mental health condition. On the other hand, the work group discussed how the definition, in its current form, may be under-inclusive, excluding individuals with severe forms of treatable conditions who would benefit from these resources.

Kincherff's article proposed a different conceptualization of defining conditions that should be permitted to nullify or reduce criminal responsibility. He took the position that personality disorders reflect "long-standing, maladaptive patterns of experience and conduct that compromises the functioning of a person across time, relationships, and environments," and his paper took the position that the diagnosis of personality disorder should not, in itself, preclude an insanity defense.

Notably, this was a topic that engendered a variety of opinions, particularly between legal and clinical professionals, but also among clinical professionals. Ultimately, there was a lack of consensus on what changes could be made, but a discussion summary is provided for future work about whether the definition of qualifying mental disorder should:

- codify the Administrative Rule definition as it applies to GEI;
- be expanded to include personality disorders proven to respond to treatment (e.g., Borderline Personality Disorder) based on the history that personality disorders were excluded from the definition of qualified mental health disorder in 1983 because of their unresponsiveness to treatment[32];
- be limited to disorders that are classified under the rubric of "severe and persistent";
- specifically exclude diagnoses that are "unspecified";
- appropriately account for the complexity and interplay of comorbid conditions, such as substance use disorders; personality disorders; and other health conditions; and/or
- be the same for the aid and assist statutes and the GEI statutes.

Additionally, the work group discussed whether eligibility for PSRB jurisdiction should:

- be based on severity of symptomology and behaviors as opposed to specific diagnoses[33]; and/or
- remain as is, given the extensive case law and the multiple areas of law that could be impacted with any change.

Recommendations

- **Legislative Change:** Use a different term for Qualified Mental Disorder in the Fitness to Proceed/Aid and Assist statutes to avoid confusion, provide legislative authority for differing definitions, and offer clarity to evaluators and decision-

[32] Ibid.
[33] *Id.*

makers. The work group did not achieve consensus to pursue this change during the 2021 session.

- **Legislative Change:** Clarify and codify the case law regarding exclusion of substance abuse disorders and sexual misconduct disorders from the definition of Qualified Mental Disorder. The work group did not achieve consensus on this. The work group noted that a change would, at minimum, require extensive legal research that is beyond the workload capacity of the work group.
- **Practice Change:** Create evaluation best practices and training to better account for substance-induced qualifying mental disorders (e.g., waiting periods or re-evaluation after a certain period of time to assess symptomatology after an individual has achieved sobriety).
- **Practice Change:** Ensure that drug screenings are administered following an arrest and ensure that the selected panel of substances tested is comprehensive.
- **Area for Further Discussion:** Convene a small work group to explore the research on criminal culpability and the severity of symptomatology versus specific mental health diagnosis. The group would be charged with drafting a proposal that operationalizes a GEI and PSRB statutory scheme based on severity of symptomatology as opposed to specific diagnosis. Any changes would need to consider the increased census and fiscal impact on OSH and PSRB.

EFFECTIVELY RULING OUT A NON-QUALIFYING MENTAL DISORDER

The previous section examined the challenges associated with defining and assessing for a qualifying mental disorder. This section focuses on the challenges of effectively ruling out non-qualifying mental conditions for the purposes of asserting the insanity defense and the implications of ineffectively ruling out these conditions.

Background

Ongoing PSRB jurisdiction is proper when a preponderance of the evidence supports that a person has a *current* qualifying mental disorder that, when active, renders a person a substantial danger to others. In the absence of a qualifying mental disorder, or in the absence of evidence that connects the qualifying mental disorder to a person's danger, the PSRB is required to discharge a person, even if the evidence demonstrates that the person is a substantial danger to others.

ORS 161.295 (2019) states, in relevant part,

> As used in chapter 743, Oregon Laws 1971, the term "qualifying mental disorder" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct, nor does the term include any abnormality constituting solely a personality disorder.

A non-qualifying mental disorder is further defined by the PSRB rule OAR 859-010-005 as follows:

(d) “Non-Qualifying Mental Disorder” is defined as a mental disorder in which the condition is:
(A) A diagnosis solely constituting the ingestion of substances (e.g., chemicals or alcohol), including but not limited to alcohol-induced psychosis;
(B) An abnormality manifested solely by repeated criminal or otherwise antisocial conduct; or
(C) An abnormality constituting a personality disorder.

Over the years, a series of cases have interpreted the language of ORS 161.295 (2019) and corresponding OARs to exclude substance dependency,[34] alcohol dependence,[35] sexual misconduct disorder,[36] a combination of qualifying mental disorder and voluntary intoxication from the definition of a qualifying mental disorder,[37] and transitory, substance induced psychosis.[38]

OAR 309-090-0025 provides guidance for the content of written evaluations assessing criminal responsibility, the evaluation required for any judge to consider a defendant’s use of the insanity defense. Two non-qualifying conditions that evaluators are required to address in these evaluations are malingering and substance abuse.

House Bill 3100 (2011) was passed, in part, to improve and standardize forensic evaluations. OAR 309-090-0060 states “a consideration of malingering must be present in every evaluation,” including criminal responsibility and fitness to proceed evaluations. However, in the aftermath of the PSRB’s discharge of Anthony Montwheeler, increased scrutiny was placed on the PSRB and Oregon’s forensic system regarding the implications of discharging a person who testified during his PSRB hearing that he malingered during the trial to escape the consequences of prison.

Issue 1: Effective Rule Out of a Substance Use Disorder and Malingering. The work group engaged in robust discussions regarding the implications of substance use disorders and malingering on the Board’s decision-making. The two non-qualifying conditions most challenging to rule out are substance use disorders and malingering. Following a GEI adjudication, these two non-qualifying conditions are later argued as the basis for contesting the PSRB’s jurisdiction, regardless of whether the person continues to be a substantial danger to others. In the absence of an otherwise qualifying mental disorder, these circumstances have the potential to result in a jurisdictional discharge from the PSRB, even if the evidence also demonstrates that the individual is still considered to be a substantial danger to others. At the point of discharge, the individual is free of all monitoring, supervision, and treatment.

If the court of original jurisdiction believed that a defendant was malingering or that the primary driver of the instant offense was substance abuse, the defendant would likely not be successful at asserting the insanity defense. However, the work group identified

[34] *Tharp v. PSRB*, 338 Or. 413, 110 P. 3d 103 (2005).
[35] *Ashcroft v. PSRB*, 111 P. 3d 1117, 338 Or. 448 (2005).
[36] *Beiswenger v. PSRB*, 192 Or App 38, 84 P. 3D 180 (2004).
[37] *State v. Peverieri*, 84 P. 3d 1125, 192 Or. App. 229 (2004).
[38] *State v. Folks*, 290 Or App 94 (2018).

a variety of factors that complicate the decision-making at the front door of the PSRB. The role of certified forensic evaluators was fundamental to discussing these issues, as their initial formulation of a diagnosis and their opinion of whether one qualifies for the insanity defense lays a foundation not only for the court's decision, but for subsequent clinical opinions and decisions made by the PSRB.

- Evaluators are not able to definitively opine on the legal standard of whether a QMD or other condition better accounts for the cause of the instant offense, noting the complication of this analysis for even the most skilled evaluator.
- Evaluators may lack access to or not know about information relevant to their evaluation of criminal responsibility (e.g., records of past providers, assessments, legal history, results of urine drug screens).
- Evaluators have difficulty ascertaining whether a person is exaggerating because the tools of diagnosis are based on self-report and the reported symptoms are not necessarily observable. Defendants who are motivated can learn which symptoms to endorse. Having collateral documentation is key to successfully untangling whether a person is malingering symptoms.
- Where there is more than one evaluator, they can have access to the same records but draw different conclusions as to whether the defendant meets the criteria for using the insanity defense.
- There is an absence of a 1:1 ratio between a qualifying mental disorder or non-qualifying condition and an explanation of the underlying offense behavior. Ruling out these conditions can be extremely complicated, even for the most skilled evaluator.
- There can be poor quality evaluation.
- Sometimes evidence is overlooked that is included in the criminal responsibility evaluation, which is more likely in a stipulated facts trial.
- The evaluator may bring to light that it is possible that the qualifying mental disorder could be substance induced, but the defendant is still found GEI.

In the worst-case scenarios, individuals who were successful at asserting the insanity defense may later claim they intentionally exaggerated their symptoms, a condition known as malingering. Dr. Michelle Guyton, Ph.D., ABPP presented the concept of malingering to the work group.[39] The definition of malingering used was "the deliberate fabrication/exaggeration of symptoms to fulfill an external goal," and there was an emphasis that this fabrication was intentional, gross, and directed toward something tangible.[40] Dr. Guyton presented data on the prevalence of malingering in forensic evaluations:

- Eight percent of criminal defendants in 314 fitness to proceed (FTP) or guilty except insanity (GEI) evaluations in Michigan Center for Forensic Psychiatry were identified by clinicians as malingering (Cornell & Hawk, 1989)[41].

[39] See Appendix J.
[40] Steve Rubenzer, The Case for Assessing for Negative response Bias, Not Malingering, 20 J. Forensic Psychol. Res. & Prac. 323 (2020)
[41] Dewey G. Cornell and Gary L. Hawk, *Clinical Presentation of Malingerers Diagnosed by Experienced Forensic Psychologists*, 13 Law & Hum. Behav. (375) (1989). (how malingerers differ from psychotics in the criminal justice system).

- 29 percent of 154 defendants referred for forensic evaluation in federal penitentiary were identified as malingering using the SIRS (Boccaccini et al., 2006).
- 21 percent of FTP assessments, using Structured Interview of Reported Symptoms (SIRS), were identified as malingering (Vitacco et al., 2007).
- 17 percent of incompetent to stand trial (IST) admissions at Napa SH were possibly malingering; 94 percent of these confirmed using more extensive, multiple measures (McDermott et al. (2017).

As previously mentioned, the overarching concern for the PSRB is that it is required to discharge individuals when the evidence demonstrates they do not have a qualifying mental disorder. However, the PSRB tends to be highly deferential to the underlying evidence and decisions that placed an individual under its jurisdiction. Thus, notwithstanding evidence at the trial level that appeared to be overlooked or minimized, the PSRB's decision to discharge a client on the basis of malingering or substance use takes time. The work group discussed the impact these individuals have on the system during this period:

- This population has a reduced likelihood of benefiting from the types of treatment services developed to support the PSRB population.
- Because of their level of dangerousness, this population is often placed at a higher level of care than is *medically necessary* due to their levels of dangerousness or risk of substance use relapse.
- This population tends to be disruptive in the treatment setting and can either negatively influence or otherwise exploit more vulnerable clients.
- Dual jurisdiction issues exist. A subset of individuals has been prosecuted and adjudicated GEI for one crime and guilty for another crime, and in some cases both crimes occurred during the same period of time. A dual jurisdiction seems to provide assurances that if the qualifying mental disorder remits and the PSRB grants a discharge, a DOC sentence remains. The impact of a dual jurisdiction is that once a person can be conditionally released, conditional release can only be made to the Department of Corrections. This disincentivizes mental health treatment and recovery. In addition, individuals who might otherwise be safely managed in the community unnecessarily use resources and beds at the OSH.

The work group examined this issue to determine whether an additional remedy could be developed and implemented. The three legislative ideas presented included:

Malingering statute: Malingering language was presented by dissemination of the case, *U.S. v Greer*.[42] In Greer, the Court held:

1. The sentencing guidelines providing for a two-level increase in offense level if a defendant willfully obstructs or attempts to obstruct the administration of justice during investigation, prosecution, or sentencing may be applied to a defendant who feigns incompetence in an effort to delay or avoid trial and punishment.

[42] *U.S. v Greer*, 158 F.3d 228 5th Cir. 1998.

2. Obstruction of justice enhancement may be applied to a defendant even with a history of psychological problems and diagnosed personality disorders who feigns mental illness to delay or avoid trial and punishment.
3. The district court did not clearly err in enhancing the defendant's sentence for obstruction of justice based on the finding that the defendant willfully feigned mental illness in a conscious and deliberate effort to obstruct justice and delay proceedings. (An analysis of the case is provided in a publication by Knoll & Resnick (1998)).[43]

***Fraudulent Plea*:** Someone pleads GEI and subsequently (within a particular timeframe or by some standard that is created) is discharged due to fraudulent plea, then referred back to the DA for retrial.

Provisional or Deferred GEI adjudication: Where the issue of malingering or a question of substance abuse is raised in a criminal responsibility evaluation (or some other standard that is created), parties enter into a provisional or deferred GEI. During a prescribed period of time, the person is transitioned to PSRB jurisdiction. If within that time period, there is evidence to support a finding that the symptoms associated with the instant offense are more likely attributed to a substance use disorder or there is evidence to support a finding of malingering, then an alternative judgment takes effect. If not, the person remains under PSRB jurisdiction.

The overarching consensus from participants was that a statutory change is worthy of consideration, particularly when in those cases where the qualifying mental disorder is unclear from the outset and where substance use or malingering are raised in the initial evaluation process. At the same time, most members of the work group agreed that additional time and careful consideration would be necessary to move forward with any concept for the 2021 legislative session. It was asserted that a new statute of this magnitude would require a lengthy period of examination and resources.

A summary of this discussion is as follows:

- Some members were unclear on the data demonstrating that this was an ongoing problem that was not already addressed by the passing and implementation of House Bill 3100 (2011), and thought forensic evaluations have much improved since that time. The decreased number of early discharges that have been granted over the past five years supported this perspective.
- Some members expressed reticence toward making a statutory change based on a sensationalized case (i.e., Anthony Montwheeler).
- Legal experts in the group expressed grave concern about the constitutionality of re-referring resolved GEI cases back to the court for trial (double jeopardy). They were also concerned about self-incrimination, the provability of the crime of

[43] Knoll IV, J.L. and Resnick, MD, *U.S. v. Greer*: *Longer Sentences for Malingerers*. 27(4) J. Am. Acad. Psychiatry Law (1999) (621-625).

malingering, and the chilling effect that deferred judgment may have on individuals considering the assertion of the defense.

- There was agreement by all members of the work group that the law should continue to provide an opportunity for persons under the Board's supervision to pursue a jurisdictional discharge. Given the Board was designed to assist individuals with the opportunity to recover and effectively manage their mental illnesses, any new law to address malingering or substance use should be carefully crafted to not inadvertently penalize a person seeking discharge. In addition, given the wide variability of outcomes in the course of all mental health diagnoses (regardless of whether substance use is involved) and the challenges with ruling out substance use that may have occurred prior to or at the same time as the mental health symptoms, work group members would not want to automatically assume that those who recover from their underlying mental health condition actually had a substance-induced disorder. For example, a person whose qualifying mental disorder has been resolved through treatment might not pursue a jurisdictional discharge for fear that they might be accused of malingering or of using substances.
- Members agreed that the system was not designed to oversee those who malinger and those whose symptoms resolve in the absence of using substances. However, a distinction was drawn between these two clinical populations. With malingering, there is an intentionality of misleading the evaluator and the system. With substance use disorders, our clinical and scientific understanding is changing over time, specifically with regards to the role substances like methamphetamine and cannabis play in the manifestation of substance-like symptoms. In addition, there are myriad patterns of recovery responses at the point an individual is no longer accessing these substances. In the majority of cases, psychotic symptoms remit in the days to weeks following the removal of substance use without the need of medication. But in some cases, symptoms persist for months to years. There is research on this topic that would be important to review (Japan, Australia) for future discussion.
- Some members expressed concern regarding the length of time by which an adjudication could be deferred in a deferred/provisional GEI adjudication. Specifically, they were concerned that the time frame might be arbitrary because it's likely to be predicated on research based on different causal mechanisms over the course of mental illnesses across individuals.
- Malingering could be difficult to prove under a malingering statute and there might be limited resources for any district attorney to litigate its existence. The crime of malingering could be difficult to prove beyond a reasonable doubt. Further, evidence required to prove such a charge would come from, in many instances, confidential and involuntary examinations, raising concerns about due process violations and self-incrimination. To date, no such legislative concept has been introduced, nor did this work group reach consensus on the issue.
- To address concerns of hamstringing jurisdictional discharge requests or fear of the system penalizing clients members considered that not all GEI adjudications would need to be deferred. A new law might limit deferred adjudications to those cases where malingering or a possible substance-induced psychosis are offered

as possible explanations for the underlying criminal charge at the trial stage. Another perspective was concern with the over-use of a provisional or deferred GEI if developed. Given the complicated variables at play in a GEI defense and the relatively short amount of time to evaluate and process these cases, the use of a deferred or provisional GEI could become the norm.

- Another perspective was that the use of a provisional or deferred GEI could be a deterrent to treatment and recovery if the person has a looming prison sentence if perceived to not have a qualifying mental disorder. Further, if such a statute was not carefully crafted, it could inadvertently disincentivize those persons legitimately pursuing this defense due to the criminal charges that could be attached.
- A recent court of appeals case is on point, *State v. Folks,* regarding the court's position on transitory versus chronic/persistent symptoms in the absence of substance use.
- Malingering statute: Even if prosecutors determined they did not have the resources to pursue this sentence enhancement, a law on the books could disincentivize the exaggeration or feigning of mental health symptoms at the trial level. *U.S. v. Greer* affirmed a state's use of a statute enhancing the sentence of a defendant who was malingering during the trial phase.
- Another perspective offered was that the solutions to the issues of malingering and non-qualifying mental disorders is unlikely to be found in circuiting a person back to the criminal court, namely because of constitutional issues. Oregon has made the decision as a state to allow for no responsibility based on a qualified mental disorder and there will always be tension given that a person's mental state can change over time. With the decision of a GEI being determined by the prosecutors, defense counsel, and the defendants at the outset, it seems that the solution should be formulated within the PSRB system, when PSRB is presented with the person's condition at that time.
- If a provisional or deferred statute was crafted for this population, ensure there is due consideration to concerns regarding the preservation of evidence and witnesses.

Recommendations

- **Legislative:** None.
- **Other Areas of Future Discussion:** Convene a small work group leading up to the 2023 legislative session specifically on this issue to continue to explore these legislative concepts. Initiate a comparative analysis across states to examine how other states that have these statutes implement them and whether they have any data supporting the benefits of such statutes.
- **Other Areas of Future Discussion**: The use of dual jurisdiction should be examined further. The legal community should understand the implications/impact of using dual jurisdiction as a "just in case"/back-up strategy should the PSRB subsequently grant an early jurisdictional discharge for lack of a qualifying mental disorder or other basis. In effect, this is more akin to a "guilty, but mentally ill" adjudication, which is a controversial use of the insanity

defense.[44] In addition, there are ethical considerations to be examined related to Oregon State Hospital treatment providers recommending or otherwise supporting a decision to support a conditional release to a prison environment.

Issue 2: Stipulated Facts Trials. The work group broached the topic of stipulated facts trials resulting in a GEI disposition. There was an anecdotal belief that the significant majority of cases that successfully assert the insanity defense are stipulated facts trials. The work group explored potential dangers of stipulated facts trials with regard to inappropriate cases coming before the Board. Specifically, given issues raised about defining and evaluating a qualifying mental disorder and effectively ruling out non-qualifying conditions, the work group discussed that stipulated facts trials exclude the opportunity to direct or cross-examine the certified forensic evaluator who conducted the criminal responsibility evaluation. One extreme example presented was an attorney's disclosure to the PSRB that they had not reviewed the criminal responsibility evaluation at the time of the stipulated facts trial, which unequivocally opined that the person was not suitable for the defense.

Recommendations

- **Legislative Change:** None.
- **Practice Change**: Provide training and encourage District Attorneys to review their policies related to adjudicating GEI cases. DAs should consider devising strategies to detect red flags related to malingering and substance use. Determine if there are any situations by which a stipulated facts trial might not be considered. (Senate Bill 200 was passed by the Legislative Assembly during the 2021 session. It requires the district attorney in each county to develop and adopt written policies regarding guilty except for insanity (GEI) dispositions.)
- **Training**: PSRB and OHA partner to provide periodic training or other materials to assist professionals in the legal system (e.g., courts and attorneys) with knowing what to look for in a criminal responsibility evaluation.

LENGTH OF JURISDICTION CONCERNS

Background

In the context of early discharges and the average length of time an individual remains under the jurisdiction of the PSRB, the work group examined ORS 161.328(2) (2019) which provides:

> The total period of commitment under this section *may* not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.

In a previous version of this statute (ORS 161.327(8) (2019)), judicial officers were required to order a period of jurisdiction to the Board equal to the maximum sentence provided by the statute for the crime for which the person was found GEI. Senate Bill

[44] See Borum R and Fulero SM. *Empirical research on the insanity defense and attempted reforms: evidence toward informed policy*. 23 Law Hum Behav. (1999) (375–393).

420 (2011) changed the language to provide judicial officers with additional discretion, presumably to shorten the period of commitment-based presented evidence. This change was part of a larger effort to better regulate the state hospital census and ensure that those who did not need a state-hospital level-of-care were conditionally released to the community or discharged from the PSRB.

Issue: Should those found GEI be committed to periods equal to the presumptive sentence a person would have received under CJC sentencing guidelines?
Although there is no data, the work group hypothesized from anecdotes that the significant majority of GEI adjudications continue to be sentenced to the maximum sentence provided by the statute for the crime for which the person was found GEI. Based on this hypothesis, the work group discussed what factors contribute to a judicial officer not exercising this discretion, including:

- stipulated facts trials; and
- insufficient knowledge by legal professionals that this discretion exists

In light of the assumption that defendants frequently receive a commitment period equal to the maximum sentence, the work group also re-examined House Bill 2556 (2015), which went even further than Senate Bill 420 in its proposal that the maximum period of commitment or conditional release of a person found GEI of a felony be equal to the presumptive sentence the person would have received under the sentencing guidelines of the Oregon Criminal Justice Commission. This bill did not pass. Some members of the work group noted that the maximum jurisdiction remained appropriate in many cases since the PSRB has a legal obligation to discharge a client if the client no longer suffers from a qualifying mental disorder or no longer represents a substantial danger.

Recommendations

- **Legislative Change**: Determine whether the legal community would be in a better position to reduce the length of jurisdiction if there was a mechanism to reassert jurisdiction or civilly commit individuals who met a particular set of criteria. This concept was also explored as a potential solution when a person's jurisdiction expires, but data indicates the continued presence of a qualifying mental disorder and dangerousness. See "Post-Jurisdiction," Issue 3 Recommendations.
- **Practice/Policy Changes:** Collect data on the percentage of defendants sentenced to less than the maximum statutory sentence. Gather data on the legal community's awareness of the discretion.
- **Training:** PSRB and OHA continue to provide education and outreach in collaboration with Oregon Department of Justice (OJ), Oregon District Attorneys Association (ODAA), and Oregon Association of Defense Counsel (OADC).

POST-JURISDICTION

This section discusses issues related to the determination that an individual is no longer appropriate for the jurisdiction and supervision of the PSRB and should therefore be released back into the community without further monitoring or supervision.

Background

Oregon law provides two ways a person may be discharged from the Board's jurisdiction: a jurisdictional lapse or a jurisdictional discharge.

A jurisdictional lapse is the date by which an individual's PSRB jurisdiction would naturally expire. Regardless of the mental status or level of dangerousness at that time, the person is discharged from the Board's jurisdiction. The person may continue to access services voluntarily and may qualify for a civil commitment under specific circumstances.

A jurisdictional discharge occurs during a full hearing where a person establishes, or the State fails to establish, by a preponderance of the evidence, that the person continues to meet jurisdictional criteria.

At every hearing, the PSRB must determine:

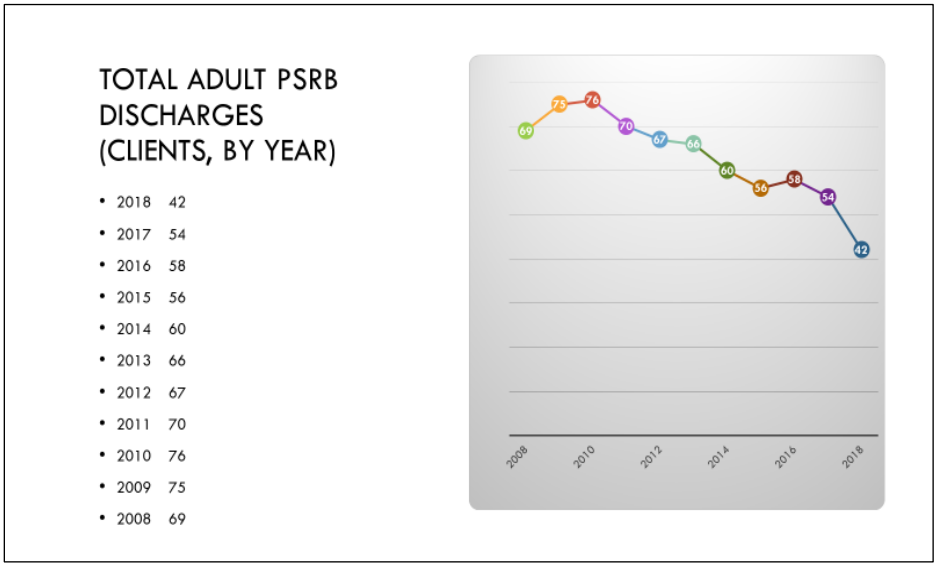
- whether the individual has a qualifying mental illness;
- whether the individual is a substantial danger to others; and
- if yes to both of the above, whether the qualifying mental illness is connected to the dangerousness.

If the answer to any of the above three criteria is "no", the PSRB must discharge the individual for lack of jurisdiction. In the best-case scenario, persons who no longer meet jurisdictional criteria have provided evidence demonstrating they either resolved or learned to effectively manage their qualifying mental disorder, so they are no longer a substantial danger to others. In the worst-case scenario, persons who no longer meet jurisdictional criteria provide substantial evidence demonstrating they no longer have a qualifying mental disorder that is connected to their danger. However, there remains data and testimony indicating that substantial dangerousness continues due to some other condition (e.g., criminality, personality disorder, sexual paraphilia). These latter cases are of concern to public safety, the implications of which include:

- no form of ongoing supervision;
- re-traumatization to victims of the instant offense;
- public perception that the person has "gotten away with the crime;"
- increased public safety risk; and
- tort liability claims against the Board or the Oregon Health Authority, or individual providers if a subsequent crime is committed.

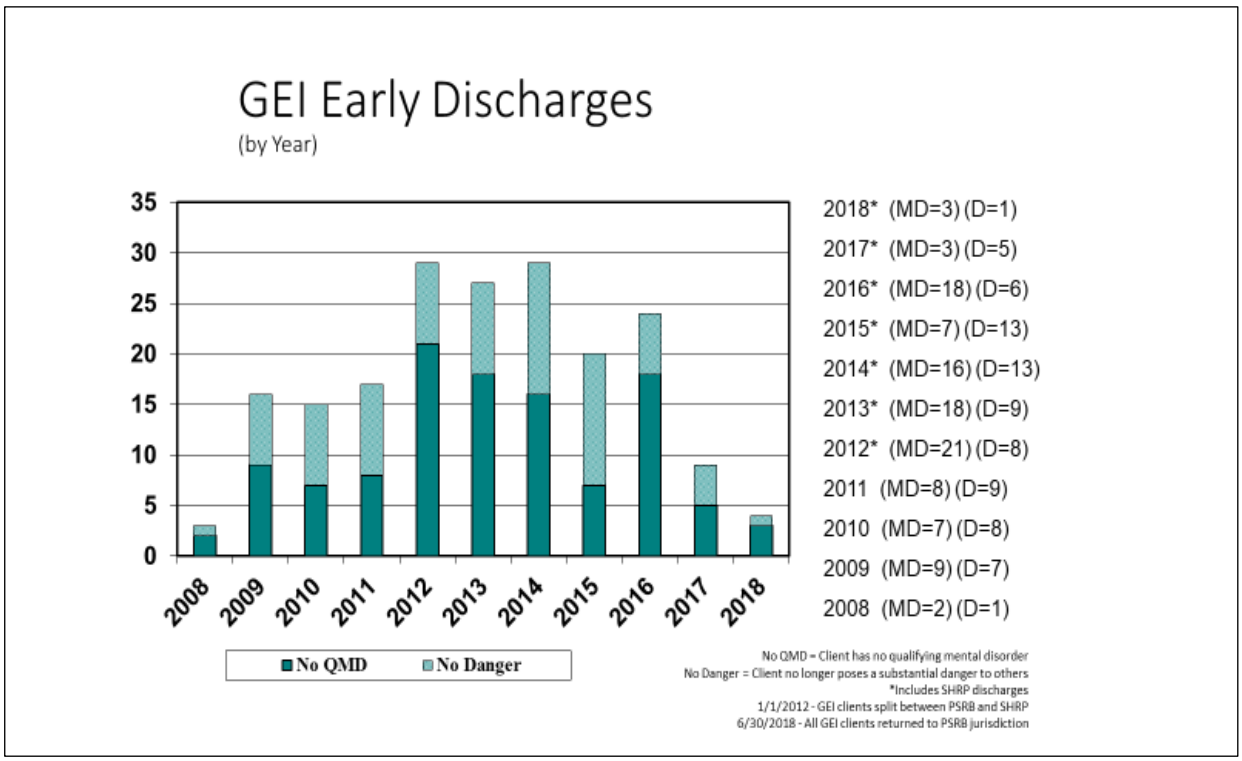
The following data from the PSRB were presented to the work group to illustrate the history of jurisdictional lapses and jurisdictional discharges over the past decade.

Figure 6. Total Adult PSRB Discharges by Year



Source: PSRB

Figure 7. GEI Early Discharges by Year



Source: PSRB

Figure 8. Adult GEI Placement at Time of Discharge

	2017									
	Hospital	SRTF	RTH	ECF	AFH	Semi	ICM	Indie	Other	
Total	6	7	16	1	2	6	1	7	3	49
	2018									
	Hospital	SRTF	RTH	ECF	AFH	Semi	ICM	Indie	Other	
Total	8	2	7	0	4	4	3	7	1	36
	2019									
	Hospital	SRTF	RTH	ECF	AFH	Semi	ICM	Indie	Other	
Total	4	4	8	0	1	1	0	5	0	23

Source: PSRB

Issue 1: Apparent inconsistencies between the discharge statutes. The work group reviewed the statutes governing discharge from the Board's jurisdiction.

Criminal Court Discharge Statutes

Discharge is governed by the following statutes in the criminal courts (i.e., at the time of a GEI adjudication)

ORS 161.327(1):	ORS 161.329:
After the defendant is found GEI, if the court finds by a preponderance of the evidence that a person found guilty except for insanity of a felony is affected by a qualifying mental disorder and ***presents a substantial danger to others***, the court shall order as follows: (a) Commitment to OSH OR (b) Conditional release	After the defendant is found GEI, the court shall order that the person be discharged from custody if: **(1)** The court finds that the person is no longer affected by a qualifying mental disorder, or, if so affected, no longer ***presents a substantial danger to others and is not in need of care, supervision or treatment; …***

The work group broached the inconsistencies between these two statutes; however, it did not have time to examine or consider legislative changes. The consensus was that the language was necessary and that a statutory clean-up would inadvertently change the meaning of the law. Regarding the language difference in ORS 161.327(1) and ORS 161.329 (Criminal Court Discharge Statutes), those need to be distinct because 161.327(1) addresses the possibility of *either* commitment (i.e., custody) to OSH *or* Conditional Release. ORS 161.329 addresses *custody* specifically, which requires an additional prong of the need of care, supervision, or treatment. ORS 161.329 could be amended to read the same as the PSRB Discharge language.

PSRB Discharge Statutes

Once a person is under the Board's jurisdiction, discharge is governed by the following statutes:

ORS 161.346 Application for Discharge or Conditional Release	ORS 161.351 Discharge by Board	ORS 161.336 Conditional Release by Agency; Termination or Modification of Conditional Release; Hearing
(1) … If the board finds that a person under the jurisdiction of the board: **(a)** Is no longer affected by a qualifying mental disorder, or, if so affected**, no longer *presents a substantial danger to others*,** the board shall order the person discharged from commitment and conditional release.	(1) Any person placed under the jurisdiction of the PSRB shall be discharged at such time as the board, upon a hearing…[when] that the person is no longer affected by a qualifying mental disorder or, if so affected, ***no longer presents a substantial danger to others that requires regular medical care, medication, supervision or treatment*.** (2) [Remission]. A person whose qualifying mental disorder may, with reasonable medical probability, occasionally become active ***and when it becomes active will render the person a danger to others*** may not be discharged.	(5)(a) Any person conditionally released under this section may apply to the board for discharge from…an order of conditional release on the ground that the person is no longer affected by a qualifying mental disorder or, if still so affected, ***no longer presents a substantial danger to others and no longer requires supervision, medication, care or treatment.***

The work group examined the impact of the inconsistencies in the PSRB discharge statutes. In addition, the work group discussed ORS 161.336(5)(a) (2019), which, strictly interpreted, prevents the Board from discharging any person who still requires medication, care or treatment. The practical effects of this interpretation were discussed, namely, that clients stop taking all of their medications to prove to the Board that they no longer have a qualifying mental disorder or they are no longer dangerous. This appears to be inconsistent with the purpose, in part, of PSRB jurisdiction: that is for individuals to learn to effectively and safely manage their mental illness. Given the significant majority of persons placed under the PSRB who suffer from chronic, severe and persistent mental illness with a lifetime course and poor prognosis without treatment, the work group discussed how the statute effectively disincentivizes individuals from continuing with their treatment.

The work group discussed the appropriate interpretation to be that discharge is appropriate when the person no longer presents a substantial danger to others or requires supervision over the medication, medical care or treatment of the condition that renders the person a substantial danger to others. Some participants supported changing all PSRB discharge statutes (ORS 161.336 (2019), ORS 161.346 (2019), and ORS 161.351 (2019)) to: "no longer presents a substantial danger to others." In effect, removing all language related to medical, medication, supervision, care, and other treatment. Concerns were raised about removing these terms and the impact of the statutory interpretation.

Recommendations

- **Legislative Change**: The work group agreed regarding the need for consistency among the three discharge criteria statutes. However, the work group disagreed on the specific language change. Some members believed that removing language related to "supervision," "medical care," "medication," or "treatment" would be appropriate. Other members believed that this language should remain, but clarified to read that the person may be discharged if the person continues to have a qualifying mental disorder and "no longer presents a substantial danger to others AND no longer requires *supervision of regular medical care, medication, or treatment*." Other members voiced concern that the above-mentioned proposals do not address a related concern that ORS 161.346 (2019); ORS 161.336 (2019); and ORS 161.351(1) (2019) do not cover the qualifier in ORS 161.351(2) (2019) regarding remission. From that perspective, consistency across the PSRB statutes could be achieved with the following language:

  > no longer presents a substantial danger to others, no longer requires *supervision of medical care, medication, or treatment [of a qualifying mental disorder]* AND does not have a qualifying mental disorder which may, with reasonable medical probability, occasionally become active *and when it becomes active will render the person a danger to others*

- **Legislative Change**: The determination of what criteria establish future substantial dangerousness, particularly when a person's mental illness is identified as being in remission, continues to require further examination. The

work group identified the inherent challenges associated with estimating the probability that an individual, whose symptoms are in remission (possibly by virtue of being under PSRB jurisdiction), might occasionally experience a return of those symptoms and may become a danger to others. Further examination of this challenge could lead to ideas for legislative, training, or other practice changes.

- **Legislative Change**: In the future, with additional examination of the legislative history and implications, consider whether changes could also be made to the criminal court statutes consistent with the discussion in this report.

***Issue 2: Lack of standardization, training, and feedback related to evaluations supporting ongoing jurisdiction or discharge from the PSRB. Lack of clarity of what evidence should be submitted when contesting jurisdiction*.** The work group considered the difference between the statutory elements qualifying a person to use the insanity defense and the statutory elements qualifying a person to remain under or be discharged from the PSRB's jurisdiction. The work group discussed that there are no administrative rules or training through the certified forensic evaluator training program to educate evaluators on the psycho-legal issues and content of reports that assess an individual's appropriateness for discharge from the Board's jurisdiction. Consequently, the evaluations received by the Board are widely variable, and while often lengthy, lack content that is necessary to the Board's decision-making. The lack of standardization, training, and feedback was also raised in the reports that accompany applications for Gun Relief, Sex Offender Reclassification or Relief, and the examinations used to recertify individuals for additional periods of commitment under ORS 426.701 (2019).

The work group also discussed whether certain standards should be met for jurisdiction to be contested at a hearing. Presently, jurisdiction must be examined and the Board must make findings of fact at every hearing. One standard discussed was whether an evaluation should be required in order for the Board to consider a jurisdictional discharge. Presently, a certified forensic examiner must conduct, and the court must consider a criminal responsibility evaluation for one to be adjudicated GEI. While there is authority for the state to request the Board order an evaluation or for the Board to order an evaluation on its own initiative, the work group identified funding as a significant factor in obtaining such evaluations. Another factor was the availability of evaluators to conduct these evaluations, particularly when an individual is on conditional release and the provider does not have the credentials to conduct them, but also at OSH where their evaluators are needed to conduct other evaluation types.

Another standard discussed was whether a person might be restricted from contesting jurisdiction while committed to the OSH. The purposes of setting this standard were discussed:

- incentivizes recovery and supports the goals of PSRB supervision;
- mitigates the risk and effects of institutionalization, particularly for those persons who avoid engagement in conditional release planning due to a goal of being discharged directly from OSH;

- provides the Board with direct evidence that with reduced monitoring, supervision and treatment, the person demonstrates the ability to safely manage their mental health condition;
- is consistent with research supporting the power of environmental and psychosocial factors, such as 24-hour, intensive, inpatient hospitalization serving as a powerful treatment whereby a person can be symptom-free and psychiatrically stable in the absence of medications; and
- prevents unplanned discharges and clients being returned to unsafe and unstable living arrangements.

The work group discussed other models of contracting evaluators. Of particular interest to the PSRB is the model used by Oregon's Board of Probation and Post-Prison Supervision (BOPPPS). Under that model, the criteria for what is required at a hearing for a dangerous offender is outlined in ORS 144.228(2)(2019). In addition, BOPPPS contracts with evaluators providing these assessments, which ensures that the evaluations are meeting the standards and including the information necessary for BOPPPS to make informed decisions. One area of feedback presented to the work group was consideration of the historical role that OHA plays in funding services related to the PSRB. The Health Systems Division (HSD) of the OHA is the point of contact for funding services that the Board orders that are not otherwise covered by Medicaid or another entity. This includes funding evaluations when a treatment team is in support of a discharge from the PSRB but does not have the expertise or the credentials to conduct this type of evaluation. Presently, HSD's sole role in this process is to fund the service. HSD does not play a role in identifying or referring providers to competent evaluators; in training evaluators to conduct these evaluations; or in reviewing the quality of these evaluations.

Recommendations

- **Legislative Changes**: None.
- **Administrative Changes**: PSRB devises an advisory committee to expand administrative rules to include minimum content for these types of reports and examinations.
- **Training**: Consider expansion of certified forensic evaluator training or initiating an addendum or stand-alone training for those evaluators who conduct these specialty assessments.
- **Other Areas of Future Discussion:** The PSRB plans to further examine and consider the BOPPPS evaluator model. This type of change would require a fiscal shift of funding. While there was no consensus regarding creating other standards for a person to request a jurisdictional discharge, there were some cautionary perspectives for future work sessions to consider:
    - Avoid inadvertently creating barriers that result in longer periods of hospitalization.
    - Avoid creating standards that are so fixed they hamstring the Board's decision-making role or do not allow for flexibility of individual differences.
    - Consider the financial impact of increased standards.

- Consider that there are standards of care in the field of forensic psychology as well as other professions, and weigh the costs and benefits of setting policies that are below those standards of care.

Issue 3: Increasing public safety post-PSRB jurisdiction. At discharge from the PSRB's jurisdiction, individuals are no longer mandated to receive monitoring, supervision, or treatment and no longer need to follow any other conditions that were deemed necessary for public safety and ordered by the PSRB. Unless the person has a guardian or meets criteria for civil commitment, all services, including services for housing, are voluntary and the criteria of accessing those services is largely non-forensic. The work group discussed the public safety concerns related to individuals who continue to have a qualifying mental disorder that would cause them to be dangerous in the future at the time of their jurisdictional lapse. The work group also discussed a handful of cases sensationalized by the media involving individuals who were previously under PSRB's jurisdiction, and then committed subsequent violent felonies post-jurisdiction. This problem was the focus of a ProPublica series, which found (after originally reporting significant errors and recalculating its data), that of the 526 people found guilty except for insanity on felony charges who were released[45] by the PSRB between 2008 and 2017, 115 were subsequently charged with felonies; 84 with misdemeanors. The report stated that according to Oregon records, 16 individuals were charged with serious crimes of violence, including murder, rape, attempted sexual abuse of a minor, kidnapping, sexual abuse, aggravated assault and attempted murder.[46] At the time of the publications, there was no mechanism in place to collect data on the recidivism of individuals post-PSRB jurisdiction similar to that of individuals who are placed on probation or Post-Prison Supervision.

The work group was presented with several indicators that might correlate with dangerousness post-PSRB discharge:

- Individuals may refuse to engage in any discharge planning or refuse services following discharge.
- Individuals may describe plans that are indicative of risk or concern to public safety (e.g., stopping medication and treatment; starting substances or pre-offense behaviors).
- Individuals may have had little to no time on conditional release during their period of jurisdiction.
- Anosognosia is a neurological symptom of psychotic and Bipolar disorders, preventing individuals from recognizing their illness and seeking treatment.[47] For some individuals, this symptom is thought to be linked to their not seeking out treatment post-PSRB jurisdiction.

[45] The article did not differentiate between those individuals who were released due to a jurisdictional lapse versus those who the PSRB granted an early jurisdictional discharge. Pro Publica, *A Sick System: Repeat Attacks After Pleading Insanity* (2019).
[46] ProPublica and the Malheur Enterprise, *Correction: Stories on Insanity Defense Included Factual Errors and Inaccurate Data* (January 18, 2019) https://www.propublica.org/article/correction-stories-on-insanity-defense-included-factual-errors-and-inaccurate-data (last visited December 20, 2021).
[47] Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness.* 66(3) Case West. Reserve Law Rev. (2016) (657-700).

- Individuals may be psychiatrically stable enough to fall short of civil commitment criteria at the time of their discharge.
- Individuals may want continued treatment, but do not meet criteria for the level of care they were in under PSRB supervision.
- Individuals are not able to access housing or lose access to housing.
- Mr. D, in a specific case, required a Secure Residential Treatment Facility (SRTF) level of care while under PSRB but met minimal criteria for ongoing residential and treatment services at discharge. He stayed connected with his PSRB peers for the years post-PSRB jurisdiction; however, COVID-19 interfered with ongoing connection with that peer group.[48]

One solution the PSRB presented to the work group was to develop a mechanism to extend PSRB's jurisdiction under specific situations where public safety may be at risk. This is in the context of data showing that 28 percent of those individuals discharged from the Board's jurisdiction over the past three years were living at the Oregon State Hospital or in a Secure Residential Treatment Home (see Figure 8).

Connecticut's statute was considered as a model. There, the court retains the ultimate legal authority over whether an acquittee remains under the jurisdiction of the Board. In essence, the Board has no control over who comes under its jurisdiction (similar to Oregon) or who leaves its jurisdiction (different in Oregon[49]). If at the end of an acquittee's commitment, the state's attorney is of the opinion that the acquittee should remain under the Board for additional supervision, then the state's attorney can request the court (not the Board) extend the commitment upon the state's demonstrating, by clear and convincing evidence, the extension is proper.

These time-limited recommitments require a recommendation from the Board and a hearing before the court. The court is free to take the Board's recommendation or rule against the Board's recommendation. The Board uses the testimony and clinical reports from the acquittee's treaters to reach a recommendation to support or deny a recommitment. The acquittee's attorney usually hires an independent evaluator (psychiatrist or psychologist), often paid for by the Public Defender's office, to testify at the court hearing. They might also testify before the Board, but more likely just at the court level, since it is the court making the final determination. In Connecticut, these reports are a matter of public record and not protected by any privacy laws.

This solution did not garner much discussion or support when initially presented to the work group. Some members of the work group cautioned looking at other states, particularly those that have smaller populations, high average lengths of stay in their hospital settings, and a small proportion of clients on conditional release. Other members believe that such a process in Oregon could promote public safety and may

[48] Alex Castle, *Pendleton Man Accused of Assaulting 16-year-old Girl,* East Oregonian (June 2, 2020). <https://www.eastoregonian.com/news/pendleton-man-accused-of-assaulting-16-year-old-girl/article_a2f51f12-a518-11ea-9888-93e0edfd0d2d.html> (last visited December 20, 2021).
[49] ORS 161.327 and *PSRB v. Pilip*, 111 Or App 649, 826 P2d 125(1992): Once jurisdiction passes to PSRB under this section, the trial court's jurisdiction terminates and it has no authority to place conditions on PSRB's supervision and release of the defendant.

be worth exploring further. However, there was consensus that any solution identified must not inadvertently create policies that unnecessarily increase inpatient state hospitalizations.

Recommendations

- **Legislative Change**: Examine and reduce the threshold criteria for a civil commitment for individuals who were previously adjudicated GEI. The GEI adjudication serves as a cautionary red flag that once these individuals reach the imminent danger threshold, the public is at risk. Caveats to legislative change might include:
    - consideration of certain crime types versus all GEI adjudications;
    - limiting or reducing the threshold depending on the number of years since discharged from the PSRB;
    - having individuals who meet these criteria placed under PSRB jurisdiction (vs. county mental health/OHA); and/or
    - legislative changes to the civil commitment threshold in Oregon are currently being examined in the Decriminalization of Mental Illness work group. Therefore, this legislative change was not examined in depth during the PSRB work group.
- **Policy or Practice Change**: OSH and community treatment providers examine policies and practices related to Mental Health Declarations and encourage early development and ongoing modification throughout PSRB commitment. Include the declaration in End of Jurisdiction packets to ensure prospective treatment providers are aware the individual has one.
- **Policy or Practice Change:** At the outset of this work group, PSRB partnered with the Criminal Justice Commission (CJC) to devise a strategy commensurate to that of the Department of Corrections to collect and report data on those who have been arrested, incarcerated, and convicted for a new felony post-PSRB jurisdiction. This data will be made available to the legislature, stakeholders, and the public for examination and further solution development if needed.
- **Other Areas for Future Discussion**: Further examine the interest, necessity, and practicalities of developing a mechanism to extend PSRB's jurisdiction in cases where public safety risk exists at the end of PSRB jurisdiction.

Issue 4: Should PSRB's authority related to early discharge be limited? This section addresses discussion points related to the Board's authority and standards of practice. The work group explored potential changes to the PSRB model with the goal of enhancing public safety.

- Should PSRB have the authority to grant early discharges from its jurisdiction? (Connecticut's model was presented as an option in the previous section.)
- Should the burden of proof at discharge be preponderance of evidence or something else, such as clear and convincing?
- Should there be a notice requirement in early discharge requests?
- Should the Board have additional time to deliberate early discharge requests?
- Should there be a mandatory end of jurisdictional hearings at some point prior to the end of jurisdiction discharge?

These topics did not garner much discussion in the work group, but the overall consensus was that the PSRB should maintain its authority to grant early discharges from its jurisdiction. Similar feedback found in other discussions was that no statutory or other change should inadvertently or unnecessarily lead to increased lengths of stay at the Oregon State Hospital.

Recommendations

- **Legislative Change**: None.
- **Practice or Policy Change**: Members of the work group were deferential to the PSRB's examination of deliberation timelines and notice requirements. The PSRB will take a look at these issues internally to discuss potential changes. Any changes to its policies or practices would be presented to stakeholders and go through other typical processes (e.g., Rules Advisory Committee) prior to adopting.
- **Other Areas for Future Discussion**: Members had little feedback on the issue of burden of proof. A comparative analysis of other states would assist with informing any recommended changes to the burden of proof standards.

Issue 5: Lack of statutory definition of substantial danger to others and "nexus."
Alison Bort, Executive Director of the PSRB, provided a presentation to the work group on the statutes and case law relevant to the challenges of defining "substantial danger."[50] A distinction was made between the legal standards required for a person to assert the insanity defense, namely a retrospective look at the behaviors at the time of the instant offense, and the legal standards required for an individual to be discharged from the Board, namely, a prediction of dangerousness in the future.

In *Drew v. PSRB*, 322 Or. 491 (1996)**,** the court explained, "Determinations of future dangerousness suffer from inherent uncertainty, because future human action is inherently uncertain." Predicting future dangerousness is also inherently complicated for experts who evaluate risk[51] and there is ample research describing the challenges of defining this term in the civil commitment field.[52]

The lack of clarity of substantial danger to others has a negative impact on the system as a whole. For example, participants discussed that it contributes to the perception of inconsistency and a lack of transparency for what clients need to do to be conditionally released from the hospital, step down in levels of care, or achieve an early discharge from Board jurisdiction. This tends to result in those under the Board's jurisdiction feeling their situation is unjust and feeling they are being kept locked up. Similarly, those providing the monitoring, supervision, and treatment of those under the Board's jurisdiction are unclear regarding what must be accomplished to support a client's conditional release, decrease in level of care, or discharge from the Board's jurisdiction.

[50] See Appendix K.
[51] Michael A. Norko and Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 Brief Treat. Crisis Interv. 73, (73) (2008).
[52] Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness.* 66(3) Case West. Reserve Law Rev. (2016) (657-700).

A closely related but separate issue to substantial danger is the concept of "nexus." The prevailing opinion is that the evidence must demonstrate a nexus or connection between a person's qualifying mental disorder and their dangerousness. The issue of nexus was first raised in the work group's discussions about Certified Forensic Evaluators and training issues. As described in that section of this report, the "nexus statement" is one of the most important sections of a criminal responsibility report and also one of the most difficult components to teach and improve with training. The work group discussed the lack of statute, rule, and case law on the term. It remains unclear how much of a nexus or connection is needed between a person's qualifying mental disorder and a person's dangerousness for the Board to maintain jurisdiction. This becomes more complicated when the qualifying mental disorder is not in its active state and the person's dangerousness is presently low. The nexus analysis is complicated when the person is also affected by a non-qualifying mental disorder.

There was a suggestion that case law on this topic could further assist in codifying clearer definitions. The group did not have sufficient time or resources to deeply dive into the case law in this area; however, cases that might be helpful for future discussions include:

- *Tharp v. PSRB*, 110 P.3d 103 (Or. 2013)
- *Rinne v. PSRB,* 443 P.3d 731 (2019)
- *Einstein v. PSRB*, 998 P.2d 654 (Or. 2000)
- *Drew v. PSRB,* 909 P.2d 1211 (Or. 1996)
- *Martin v. PSRB*, 818 P.2d 1264 (Or. 1991)

Recommendations

- **Legislative Change:** None.
- **Administrative Change:** Add clarity to the definition of "substantial danger" to assist the Board, evaluators, those serving clients under the Board's jurisdiction, and clients themselves on what that means. This would be best achieved (if at all) through administrative rule rather than statute.
- **Practice or Policy Change:** PSRB and OSH examine the standards related to a "conditional release readiness" determination to ensure there is a mutual understanding of the threshold by which a conditional release can be considered. Ensure these standards are transparent to those providing services to individuals under PSRB and to the individuals themselves. Determine which of these standards might be included in the OARs (see above recommendation).
- **Other Areas for Future Discussion**: Convene a small work group to review the Oregon Court of Appeals cases to further explore the possibility of codifying "substantial danger to others" and "nexus." Examine whether the definition of substantial danger should be defined and more clearly connected to future dangerousness.
- **Other Areas for Future Discussion:** A comparative state analysis was conducted on nine states' statutory definitions of "substantial danger." There was insufficient time to review the analysis during the work group, but it is included in Appendix L.

COURT-ORDERED CONDITIONAL RELEASE

This section discusses issues related to court-ordered conditional release. A court-ordered conditional release is a legal mechanism by which an individual who can be safely managed in the community setting can bypass the costly and lengthy treatment of a state hospital stay.[53]

Background

After a court finds an individual to be GEI, it must also determine the individual's proper placement. The court may discharge the person, commit the person to the Oregon State Hospital, which is most common, or order terms placing the person in the community on conditional release—this is referred to as "court-ordered conditional release." Regardless of whether a person is conditionally released by the originating court or the PSRB, it is required for those persons psychiatrically stable enough to live and be supervised safely in the community when those resources are available. Court-ordered conditional release is governed by ORS 161.327(1)(b)(2019):

> (1)(b):[54] If the court finds that the person can be adequately controlled with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court shall order the person conditionally released.
>
> (2) When a person is conditionally released under this section, the person is subject to those supervisory orders of the court as are in the best interests of justice, the protection of society and the welfare of the person. The court shall designate a person or state, county or local agency to supervise the person upon release, subject to those conditions as the court directs in the order for conditional release.[55] Prior to the designation, the court shall notify the person or agency to whom conditional release is contemplated and provide the person or agency an opportunity to be heard before the court.[56] After receiving an order entered under subsection (1)(b) of this section, the person or agency designated shall assume supervision of the person pursuant to the direction of the Psychiatric Security Review Board. The person or agency designated as supervisor shall be required to report in writing no less than once per month to the board concerning the supervised person's compliance with the conditions of release.
> (3) In determining whether a person should be conditionally released, the court:

[53] See Appendix M for relevant materials considered by the work group.
[54] The process for the board to place an individual on conditional release, governed by ORS 161.336 (2019).
[55] In practice, this should always be the CMHP contract with the Oregon Health Authority to provide the monitoring, treatment and supervision of persons under the jurisdiction of the PSRB.
[56] There are no timeframes associated with this statute, and CMHPs report they are often asked to complete them in unreasonable timeframes. Cf. PSRB provides evaluators 30 days to develop an evaluation and conditional release plan.

(a) May order evaluations, examinations and compliance as provided in ORS 161.336 (3) and 161.346 (2)[57];
(b) Shall order that the person be examined by a local mental health program designated by the board and a report of the examination be provided to the court if each felony for which the defendant was found guilty except for insanity is a Class C felony; and
(c) Shall have as its primary concern the protection of society.

(4) Upon placing a person on conditional release, the court shall notify the board in writing of the court's conditional release order, the supervisor appointed and all other conditions of release, and the person shall be on conditional release pending hearing before the board. Upon compliance with this section, the court's jurisdiction over the person is terminated.

When a person is placed on conditional release, the court is required to designate a person, state, county, or local agency to supervise the person upon release. Administratively speaking, the monitoring and supervision of every person under the PSRB is ultimately provided by a local county or community mental health agency contracted with the OHA. Accordingly, the court, individual, and local community benefit from the CMHP determining whether the person is appropriate for a court-ordered conditional release and whether the CMHP has the resources necessary to monitor, supervise, and treat the person in the community setting.

Table 3. Court Conditionally Released Clients as a Percentage of all New GEI Cases

Court Conditionally Released Clients as a Percentage of all New GEI Cases

	Ct CR's	Total Number of New Terms Received	Percentage
2018	5	43	12%
2017	9	54	17%
2016	14	55	25%
2015	3	39	8%
2014	6	43	14%
2013	11	39	28%
2012	10	58	17%
2011	14	63	22%
2010	9	63	14%
2009	13	82	16%
2008	9	70	13%

Source: PSRB

[57]This is permissible, but rare in Class A and B felony cases.

Issue 1: Underutilization of court-conditional releases. The average length of stay between 2016 and October 2020 for a person under the PSRB and committed is 4.1 years. The cost of a state hospitalization is approximately $1,300/day.[58]

The cumulative percentage of court conditional releases from 2012 - 2020 is 14.8 percent; 85 percent of all persons found GEI are committed to OSH.[59]

Table 4. Court Conditionally Released Clients as a Percentage of all New GEI Adjudications per Year

Year	Court Conditional Releases	Total Number of New Terms Received	Percentage
2020	9	56	16%
2019	7	56	13%
2018	5	43	12%
2017	9	54	17%
2016	14	55	25%
2015	3	39	8%
2014	6	43	14%
2013	11	39	28%
2012	10	58	17%
2011	14	63	22%
2010	9	63	14%

Source: PSRB

The statutes provide the court authority to order the community mental health agency to evaluate the defendant for a conditional release regardless of the crime type; however, if the charges are solely Class C felonies, the court must order the local community mental health agency to evaluate the defendant for possible court conditional release.[60]

[58] Gordon R. Friedman, *Oregon mental health hospital is 'world's most expensive homeless shelter,' state health director says*, Oregonian (May 1, 2019). <https://www.oregonlive.com/pacific-northwest-news/2019/05/oregon-mental-hospital-is-worlds-most-expensive-homeless-shelter-state-health-director-says.html> (last visited December 20, 2021).
[59] As of January 1, 2012, GEI misdemeanants were no longer placed under the jurisdiction of the PSRB.
[60] ORS 161.327(3)(b) (2019).

This does not mean the defendant must be placed on conditional release, just that an evaluation must be done prior to the Disposition Hearing.

The data are not clear as to the depth of which conditional release is considered by the originating court. Preliminary data have indicated that community evaluations for Class C felonies are not consistently being ordered. Less clear is whether evaluations are bypassed knowing that the necessary resources (e.g., residential treatment) are not available in the community setting.

Issue 2: Poorly coordinated court conditional release planning with and notification to the PSRB of Court-Ordered Conditional Release. There are examples where persons adjudicated GEI are court conditionally released. However, consistently, these cases are fraught with problems such as the court:

- not ordering a community evaluation prior to conditionally releasing the person;
- ordering an evaluation and giving the provider minimal time to put it together (results in a denial because insufficient time to put resources together);
- relying on information from a previous evaluation (aid and assist, criminal responsibility) or evaluator that is not contracted to provide monitoring and supervision for PSRB; or
- does not communicate to PSRB that a person has been found GEI and placed on conditional release.

There are many unintentional consequences of these practices including an over-commitment of individuals to OSH when that level of care is not necessary; clients expressing confusion about the expectations and conditions associated with their PSRB jurisdiction; and revocations because of inefficient conditional release plans. In the worst circumstances, the PSRB is unaware that a client is under their jurisdiction and that person is not receiving the requisite level of monitoring and supervision to safely live in the community, both of which compromise public safety.

The most problematic outcome of poorly coordinated court conditional releases can be gleaned from the available data, which is that an estimated 25 percent of court conditional releases fail (i.e., require an increased level of care or revocation to the Oregon State Hospital) within six months.

Table 5. Court Conditional Releases Between 2012-October 2019, n=60

Successful Results (31 or 51.66%)
21 remained in original placement (Range 92-2,596 days)
10 stepped down from original placement

Less Successful Results (29 or 48.33%)
13 stepped up (Range 28 – 735 days)
16 revoked (Range 2 – 730 days)

When Revocations Take Place

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Year 1	9	6	3	2	20 (33%)
Year 2	3	2	1	0	6
Year 3+	2			1	3

Source: PSRB

After review of the process for court-ordered conditional release, the work group discussed:

- underutilization of court-ordered conditional release;
- confusion over statutory construction and requirements;
- lack of a standardized process;
- concern that adding too many new requirements will further decrease court conditional releases;
- concern over legislating matters that can be better resolved through more outreach, training, and education;
- lack of notice to PSRB and its inability to supervise individuals under court-ordered conditional release;
- respect for and deference to the judicial decision-making at the front door balanced with what appears to be a lack of judicial knowledge and understanding about court-ordered release process;
- dangers associated with the automaticity of state hospital commitments; and
- inability of CMHPs to:
    - access all necessary information to perform evaluation;
    - access funding for and services in other counties to craft conditional release plans; and
    - access funding to perform evaluations for the purposes of court-ordered conditional release.

Recommendations

- **Legislative Change:** Expand the committing court's requirement to engage in at least a consultation for all non-Measure 11 felonies to determine if court conditional release is an option.
- **Legislative Change:** Require the committing court to order a community evaluation when the consultation provides information that a court conditional

release can be achieved. Full evaluations for Class C felonies would still be required regardless of the consultation.

- **Legislative Change**: Require that the consultation and/or community evaluation be conducted prior to the court entering a final disposition. Require the final disposition and placement decision be made at the same hearing. Require that a finding for a GEI cannot be made until these evaluations have been completed.
- **Legislative Change**: Provide the PSRB a remedy when a court enters a disposition without completing the necessary criteria for their findings (e.g., community evaluation was not conducted). For example, jurisdiction cannot transfer until the steps are completed. For example, see ORS 161.327(4) (2019)[61] for similar language. Is there a potential to expand this to when a person is not placed on conditional release?
- **Legislative Change**: Add statutory language that prevents jurisdiction from transferring to the PSRB if a criminal responsibility, consultation, or community evaluation has not been completed.
- **Legislative Change:** Devise a funding mechanism to cover the cost of court-ordered CMHP community evaluations. This would exclude funding for consultations. Funding community evaluations is likely to include a fiscal impact; however, the overarching goal is to prevent unnecessary, costly and lengthy hospitalizations, and the cost of these evaluations is anticipated to outweigh the current practice. This can be measured by an analysis of increased court community evaluations.
- **Legislative Change:** Replace the word “controlled” with a term that is more person-centered and respectful to those under the PSRB. Consistent with the discussion section of this report, the clarity of language is imperative to statutes. Any change should avoid making the statutory intent less clear.
- **Legislative Change:** Oregon State Hospital may not admit new GEIs without confirmation that a community evaluation was completed.
- **Administrative Change:** Create OARs that provide guidance related to consultations and evaluations, including the type of records that would be necessary to review to provide a recommendation. Build in timelines by which a CMHP has to comply with a court’s order for either of these documents.
- **Administrative Change:** Draft administrative rules to create a standardized CMHP court-ordered conditional release consultation and reimbursement process through OHA. Draft rules to standardize the PSRB process related to court-ordered conditional release through the PSRB.
- **Training Suggested:** The Oregon Judicial Department (OJD) in conjunction with the PSRB and Association of Oregon Community Mental Health Programs (AOCMPH) should provide courts training on current court-ordered conditional

[61] ORS 161.327(4) (2019) Upon placing a person on conditional release, the court shall notify the board in writing of the court’s conditional release order, the supervisor appointed and all other conditions of release, and the person shall be on conditional release pending hearing before the board. Upon compliance with this section, the court’s jurisdiction over the person is terminated.

release and any legislatively initiated changes. Specifically, training should include key considerations, key stakeholders, and best practices for a seamless and safe transition into court-ordered conditional release that allows for meaningful PSRB supervision.

- **Training Suggested:** OJD should post PSRB Attorney/Judge Handbook on their SharePoint site.
- **Practice Change**: OJD should provide a report to the PSRB on a regular basis to ensure the PSRB is made aware of newly adjudicated GEIs.[62]
- **Practice Change**: OJD should provide a monthly report to the PSRB to notify the Board of potential cases where a notice of intent to rely on a mental health defense is filed.[63]
- **Practice Change:** Courts should hold a meeting with all court-ordered conditional release stakeholders to set in place a local process that promotes early CMHP and PSRB engagement in court-ordered conditional release planning, strong communication, and a better understanding of the communities' capacity for court-ordered conditional release and the PSRB's ability to leverage neighboring community resources to support court-ordered conditional release.
- **Practice Change:** Develop a consultation form that provides information to the courts about whether a court conditional release evaluation should be ordered.
- **Other Changes Explored, but not Agreed on**: Many of these changes were viewed as overly burdensome for the committing court, leading to a reduction in court conditional releases. Many were contemplated as being achieved/resolved through other mechanisms, such as increased outreach, training, and education.
    - Require the moving party to notify the PSRB of a request for court-ordered conditional release.
    - Upon receipt of request for court-ordered conditional release, require the court to order a CMHP consultation and the release of relevant records to the CMHP for review.
    - Upon completion of a consultation or evaluation, require the CMHP to share the results with the PSRB and the court.
    - Require the PSRB to provide the court with a recommended conditional release plan.
    - Require the court to review the consultation from the CMHP and the recommended conditional release plan from the PSRB before ordering conditional release.
    - Require the court to send the PSRB an electronic copy of the order for conditional release within one day of the order's entry.
    - Require PSRB review hearing within 90 days of court-ordered release.

[62] This practice change was implemented in March 2020.
[63] This practice change was implemented in March 2020.

Issue 3: Lack of clarity related to whether a person who is transitioned to PSRB jurisdiction pursuant to ORS 426.701 (2019) can be court conditionally released. This issue arose during the work group discussion related to PSRB Civil Commitments pursuant to ORS 426.701 (2019), but is placed in this section of the report because of the similarities it shares with GEI court conditional releases. ORS 426.701 (2019) governs the commitment of "extremely dangerous" persons with mental illness.[64] Under this commitment type, it is clear that the PSRB has the authority to place individuals on conditional release. However, the PSRB initiated a discussion with the work group as to whether the legislature intended to grant courts authority to place individuals under this commitment on conditional release.

The PSRB shared that it has had one case to date whereby a court placed a person who was adjudicated an Extremely Dangerous Person with Mental Illness directly on conditional release. This particular case shared many of the same concerns the PSRB has with GEI court conditional releases when they are poorly coordinated. Moreover, the PSRB questioned whether there is legal authority for a court to conditionally release persons found to be extremely dangerous.

Members expressed the importance of deference to judicial decision-makers who must decide whether a person should be committed to the Oregon State Hospital or placed on conditional release. Many of the recommendations that would apply to resolve GEI court conditional releases could be applied to this population to improve the coordination and planning of these conditional release plans. Further, ORS 426.701(3)(b) (2019) provides that "the court shall further commit the person to a state hospital for custody, care and treatment *if* the court finds, by clear and convincing evidence, that the person cannot be controlled in the community with proper care, medication, supervision and treatment on conditional release" (Emphasis added). This indicates that a court may contemplate a conditional release.

Conversely, the statutes that govern the GEI population explicitly provide courts with the authority to place those defendants on conditional release whereas the statutes that govern the PSRB's civil commitment population do not. Further, ORS 426.701(6)(a) (2019) governs the PSRB's initial hearing of this population, and that statute indicates the purpose of this hearing is to "determine the placement of the person and whether the person is eligible for conditional release or early discharge." The language of this statute was used to support the position that the PSRB retains the authority to conditionally release this population. Lastly, ORS 426.701 (2019) explicitly requires a finding that the person cannot be controlled in the community.

Recommendations

- **Legislative Change:** Clarify whether ORS 426.701 (2019) provides judicial officers with the authority to court conditionally release an individual. If so, provide additional language in the statute to clarify what responsibilities the

[64] Background information related to ORS 426.701 (2019) can be found here.

committing court has to court conditionally release an individual. There was no consensus on pursuing this change.

- **Other Areas for Future Discussion:** Review the legislative history and convene a smaller work group to further examine this issue.

Issue 4: Lack of person-centered language regarding conditional release standards. This issue was presented during discussions of the Board Composition, Oversight, and the Consumer Voice. The overarching goal of those representing the consumer voice is for the forensic system to acknowledge that the laws governing those in the system adopt language that is not person-centered, notwithstanding the research that person-centered language supports recovery by shifting the focus away from the person's illness, trauma, or other condition to the person's strengths.[65] The work group was presented with the idea that using language that empowers clients towards healing and recovery contributes to public safety and reduces recidivism. In this section, the work group focused on whether the term "controlled" could be replaced using more person-centered language. The word controlled is used throughout the statutes governing conditional release:

- ORS 161.327(1)(b) (2019): If the court finds that the person can be adequately ***controlled*** with supervision and treatment if conditionally released and that necessary supervision and treatment are available, the court shall order the person conditionally released.
- ORS 161.341(2) (2019): The results of the examination shall be in writing and filed with the board, and shall include, but need not be limited to, an opinion as to the mental condition of the person, whether the person presents a substantial danger to others and whether the person could be adequately ***controlled*** with treatment as a condition of release.
- ORS 161.341(3)(c) (2019): That the person continues to be affected by a qualifying mental disorder and would continue to be a danger to others without treatment, but that the person can be adequately ***controlled*** and given proper care and treatment if placed on conditional release.
- ORS 161.346(1)(b) (2019): Is still affected by a qualifying mental disorder and is a substantial danger to others, but can be ***controlled*** adequately if conditionally released with treatment as a condition of release, the board shall order the person conditionally released as provided in ORS 161.336 (2019).
- ORS 161.346(1)(c) (2019): Has not recovered from the qualifying mental disorder, is a substantial danger to others and cannot adequately be ***controlled*** if conditionally released on supervision, the board shall order the person committed to, or retained in, a state hospital, or if the person is under 18 years of age, a secure intensive community inpatient facility, for care, custody and treatment.
- ORS 161.346(2) (2019): The report must include an opinion as to the mental condition of the person, whether the person presents a substantial danger to

[65] For example, see Kathryn Hyams, Natalie Prater, Julie Rohovit, and Piper Meyer-Kalos, *Clinical Tip: Person-Centered Language* (May 11, 2018) <9.-MNCAMH-Clinical-Tip-Person-Centered-Language-May-11-2018.pdf (umn.edu)> (last visited December 20, 2021).

others and whether the person could be adequately ***controlled*** with treatment as a condition of release.
- Relevant case law includes *Lovette v. Psychiatric Security Review Board*, 102 Or. App. 548, 795 P.2d 587 (Or. Ct. App. 1990) and *Bahrenfus v. Psychiatric Security Review Board*, 124 Or. App. 320, 862 P.2d 553 (Or. Ct. App. 1993)

There was consensus in the work group that this term could be perceived as pejorative when applied to individuals who are diagnosed with mental illness to the extent that "being controlled" does not account for the person's ability to meaningfully participate and engage in their treatment and recovery. In addition, members identified that language matters and that the current language contributes to the stereotypes and stigma that currently exist with respect to those with mental illness. Although many work group members agreed that language matters, no agreement was reached on replacement language.

The consumer perspective recommended the following change: that the person be found appropriate for conditional release if "the person can self-manage their own wellness and risk mitigation with supervision and treatment support in the community." However, many members of the group believed this change would require the person to "self-manage," and could inadvertently limit, restrict or otherwise reduce the frequency of conditional releases occurring from the Oregon State Hospital. This might be true despite there being a degree of self-management required in order for a person under the PSRB to be supported for conditional release and to make steps toward lower levels of care.

Recommendations

- **Legislative Change:** None. Any future changes to the statute should avoid changing language that would make a conditional release more difficult to achieve or otherwise inadvertently change the interpretation of the statute. The work group agreed with the overall idea of substituting "adequately controlled" with more person-centered language, but also that it must be selected with caution. Consensus was not achieved at this time. Another suggestion from a work group member was, "maintain safe behaviors towards self and others under the support of supervision and treatment."
- **Area for Future Discussion:** Continue discussions to identify appropriate, substituted language. Examine statutes related to civil clients that may use more person-centered language.

RESOURCES

This section discusses issues related to the resources available in the community for the care, treatment, and supervision of individuals placed on conditional release by order of the PSRB.

Issue 1: Continuum of care. The work group identified a lack of appropriate housing options for individuals on conditional release to be a significant factor in safely maintaining individuals in the community who were found GEI. This lack of community

placements also creates a bottleneck and contributes to the census crisis at the Oregon State Hospital.

Background

From 1978 through 2009, the Oregon system was characterized by having significantly more supervisees that were hospitalized than on conditional release.[66] That gap started to narrow from 2006 to 2009. In 2010, Oregon had more supervisees on conditional release than in the hospital.[67] Notably, in 2006, the U.S. Department of Justice, Civil Rights of Institutionalized Persons Act (CRIPA) investigation of the Oregon State Hospital raised several concerns, including whether individuals were discharged into the community in a timely manner. The subsequent agreement between the State of Oregon and the U.S. Department of Justice included improving the appropriate discharge of patients from the Oregon State Hospital, which led to a significant increase in the number of individuals under PSRB jurisdiction placed in the community on conditional release.[68]

Studies have found that conditional release is essential to promoting successful reentry and decreased recidivism. Successfully maintaining individuals on conditional release, however, "is significantly dependent on the availability of suitable community living arrangements."[69] Also important to successful conditional release and reintegration post jurisdiction is the ability of the PSRB to place individuals in communities with natural support, such as with friends and family.

Below are the standard conditional release care structures, as well as the location of conditionally released PSRB individuals.

Secure Residential Treatment Facility (SRTF)[70]

- highest level of care
- resident's exit from the facility or its grounds is restricted by approved locking devices
- staffed with 24/7 awake staff who provide some services, such as daily living skills training and clinical services are provided on-site at the residence

Residential Treatment Facility (RTF) / Residential Treatment Home (RTH)[71]

- an RTF is for six or more residents, while an RTH is for five or fewer residents
- locked or restricted exits
- staffed with 24/7 awake staff who provide some services, such as daily living skills training

[66] Bloom, J. D., and Buckley, M. C. *The Oregon psychiatric security review board: 1978-2012*. 41(3) AAPL 560 (2013) (560–567).
[67] *Id.*
[68] Bloom, J. D. *CRIPA, Olmstead, and the transformation of the Oregon psychiatric security review board*. 40(3) AAPL 383 (2012) (383-389).
[69] Novosad, D. et al, *Statewide Survey of Living Arrangements for Conditionally Released Insanity Acquittees.* 32 Behav. Sci. Law 659 (2014) (659–665) (2014).
[70] OAR 309-040-0305, 2012 et seq.
[71] OAR 309-035-0105 et seq.

- mental health services are provided by the residential provider as part of outpatient or day treatment programs perhaps on-site or at off-site local community provider

Adult Foster Home (AFH)[72]

- home licensed by the Oregon Health Authority to provide residential care to five or fewer adults
- restricted access or exits
- provides room, board, care and basic support services for adults
- provider must be awake and available to aid until 11:00 pm and must live in the residence

Semi-independent Living/Supportive Housing[73]

- homes or apartments with available support services and staff part-time at the site
- on-site staff also help coordinate community services

Independent Living with Intensive Case Management[74]

- independent living
- no restrictions on access or exits
- contact with a staff member at least twice per day; once at the home
- case management team coordinating community services

Independent Living[75]

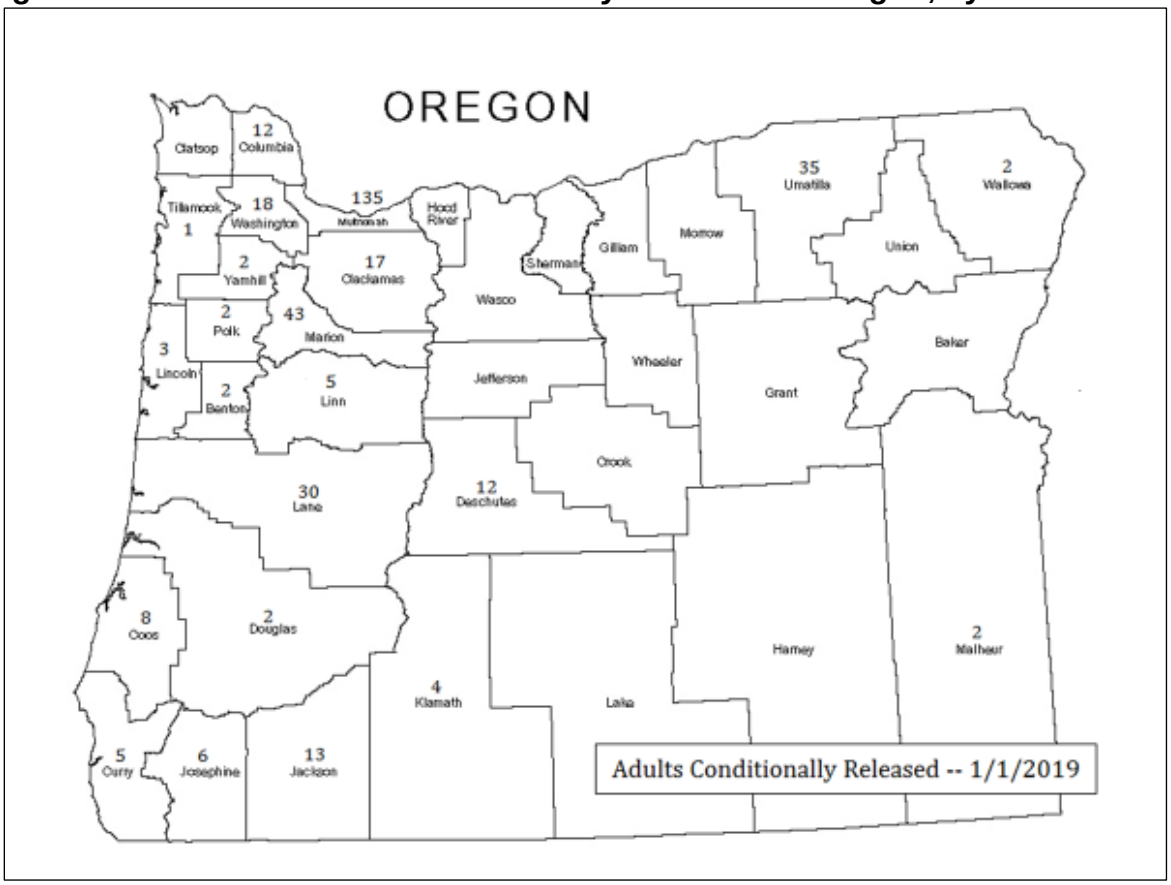
- individuals live with family, roommates or alone; no staff on-site
- frequent case manager home visits

A 2019 snapshot provides data on the level of care of persons on conditional release under PSRB jurisdiction:[76]

- 69 individuals (12%) were in secured residential treatment facilities;
- 138 individuals (24%) were in residential treatment facilities;
- 17 individuals (3%) were in adult foster homes;
- 40 individuals (7%) were in semi-independent supported housing;
- 17 individuals (3%) were living independently with intensive case management;
- 77 individuals (13%) were living independently with case management; and
- 9 individuals (2%) were in Department of Corrections custody.

[72] OAR 309-040-0305 et seq.
[73] Oregon.gov, *PSRB Agency Snapshot* (2019) <https://www.oregon.gov/prb/Documents/190026-PSRB-snapshot-draft-03.05.19.pdf> (last visited December 20, 2021).
[74] *Id.*
[75] *Id.*
[76] Oregon.gov, *PSRB Agency Snapshot* (2019) <https://www.oregon.gov/prb/Documents/190026-PSRB-snapshot-draft-03.05.19.pdf> (last visited December 20, 2021).

Figure 9. Location of Adults Conditionally Released in Oregon, by the Numbers



Source: PSRB

After review of the options available for providing housing for those on conditional release, the work group discussed the need for:

- increased SRTF beds;
- other housing and supportive housing necessary to prevent a clog from OSH and SRTFs to more independent living;
- increased crisis beds (temporary placements for clients who do not meet rigid local hospital requirements, but are living independently and experience increased symptoms and, therefore, risk of dangerousness);
- improvement in the rate of placement of individuals in SRTF/RTF/AF within their home communities;
- increased support services for independent living in rural areas;
- improved mechanisms to access secure medical transport for individuals;
- interaction between the services needed for the GEI and Aid and Assist populations; and
- growth of and increased accessibility to services that, if available, could prevent unnecessary revocations to OSH (e.g., inpatient substance use, outpatient substance use).

Issue 2: Tool for establishing service level. As required by the budget note in House Bill 5026 (2017), the Oregon Health Authority established a plan for standardization of Oregon's reimbursement rates for adult mental health residential services for those who are Medicaid eligible and those who are not Medicaid eligible[77] (Effective July 2019[78]).

These rates, embedded in OAR 410-172-0705, are built on direct care costs as well as the costs for residential services, value of hours for supervision, and engagement hours. They also include cost adjustments for capacity, geographic variation, and the Oregon minimum wage pace. Finally, the rate standardization considers the level of care provided (SRTF v RTF) and complexity of patient needs, including medical complexity and psychiatric complexity.

The Oregon Health Authority has earmarked General Funds to cover costs associated with managing persons under PSRB safely in the community that are not covered by these rates or other resources. In addition, OHA established a rubric that entitles providers to a security payment and monitoring and supervision payment for each supervised PSRB client.

The Level of Service Inventory (LSI) is the tool used to categorize which "tier" a person is assigned for the purposes of payment at the residential levels of care. This tool has been regarded by pertinent community mental health providers as under-rating service needs for persons under the jurisdiction of the PSRB as it does not sufficiently account for the level of care needs associated with a person's risk. For example, Heather Jefferis, Executive Director of the Oregon Council for Behavioral Health (OCBH) presented data based on her 40 members indicating the LSI scores of the PSRB population tend to support a Tier 2, whereas those in the general mental health residential population tend to support a Tier 3, which results in a substantially different payment.[79]

While OHA indicated that a larger pool beyond the OCBH membership resulted in different data, the data presented by OCBH are consistent with the providers who have been reaching out directly to the PSRB about this issue. This has had three changes in practice: 1) residential placements closing or threatening to close because the rates are not sufficient; 2) residential placements stating a plan to work with the aid and assist population over PSRB because this population is tiered at a higher level, and payment is higher; and 3) residential placements begin recommending lower levels of care based on financial rather than risk considerations. The first two lead to an increased census of the PSRB population at the Oregon State Hospital. The third, which was something the PSRB noted and immediately addressed and resolved with OHA when KEPRO began

[77] Legislative Fiscal Office, *Analysis Item 4: Oregon Health Authority Mental Health Residential Rates* (November 2017). <https://olis.oregonlegislature.gov/liz/2017I1/Downloads/CommitteeMeetingDocument/138658> (last visited December 20, 2021).
[78] Oregon Health Authority, *Mental Health Adult Residential Standardized Rate Implementation* (June 6, 2019) <https://www.oregon.gov/oha/HSD/OHP/Documents/MH-Residential-Webinar-060619.pdf> (last visited December 20, 2021).
[79] See Appendix N for full presentation materials.

denying authorizations to our providers, leads to increased community risk and public safety.

After reviewing the rules and policies on reimbursement, the work group discussions included:

- recent decrease in residential facilities due to:
    - new minimum wage requirements,
    - cost of operation,
    - compliance requirements, and
    - difficulty and special needs of the PSRB population;
- need to increase rate; and
- use of and access to Medicaid/Medicare funding

The work group only held one session on the topic of community resources. With the onset of COVID-19 and the planned implementation and launch of the newly identified independent and qualified agent (IQA), Comagine Health, significant change is anticipated. Therefore, the work group decided further discussions on these topics would occur naturally among stakeholders. Below are recommendations that might be considered for future discussions.

Recommendations

- **Legislative change:** Clarify that when making decisions, the PSRB is charged with placing individuals in the lowest level of care possible that ensures community safety.
- **Legislative change:** Require regular reporting to the legislature on the location, actual cost, and availability of services as well as their use (e.g., private, GEI, Aid and Assist, Civil Commitment) and the primary barriers to additional services in any given area.
- **Budgetary change:** Increase funding for community-based placements and services with a focus on rural areas. Consider a reinvestment strategy; for example, as the Oregon State Hospital GEI population decreases, ensure that those saved dollars are used for community services. Also consider a rural subsidy strategy to support the ability of local care providers to maintain operations with small numbers.
- **Administrative change:** Adopt a new tool or add a supplementary process that more effectively captures the service level needs of clients under PSRB.
- **Practice change:** The OHA and PSRB should engage with neighboring counties' mental health providers to foster a process of resource mapping and collaborative conversations aimed at promoting resource sharing and other creative solutions to the rural service gaps in Oregon.
- **Practice change:** Increase training of the IQA and providers on how to effectively capture risk in their documentation so that it can be considered in determining tier levels.
- **Other Area for Future Discussion:** The topic of secure transport was discussed during several sessions of the work group. Specifically, secure transport agencies were not readily available during times of crises when law enforcement

was not able to transport a person who had been revoked to the Oregon State Hospital.

PSRB CIVIL COMMITMENT

This section discusses issues related to the PSRB's civil commitment jurisdiction, which is governed by ORS 426.701 (2019) and 426.702 (2019). The work group discussed a variety of issues with the larger work group and also developed a subcommittee to discuss recommendations in more depth.

Background

Melissa Marerro, Deputy District Attorney in Multnomah County, provided a presentation to the work group on the history, utilization and current challenges associated with ORS 426.701 (2019) and 426.702 (2019), which govern civil commitments under the jurisdiction of the PSRB.[80] Senate Bill 421 (2013) provided an important tool for prosecutors when individuals with mental illness are "extremely dangerous," as defined by the statute, and resistant to treatment. Evidence of an individual's resistance to treatment is often based on a judicial finding that the person is unable to aid and assist in their defense in the context of a criminal case, and when there is no substantial likelihood that they will become able to aid and assist in the reasonably foreseeable future. However, resistance to treatment is more broadly defined as an impairment in the person's ability to make competent decisions and to be aware of and control extremely dangerous behavior following a period of exhaustive psychiatric treatment or refusal of such treatment.[81] With the passing of SB 421, District Attorneys may now petition the courts to civilly commit individuals who are determined to be extremely dangerous to the PSRB.

Issue 1: Statute lacks a hold provision leading to extended incarceration periods or forced community release. Under ORS 426.701 (2019), courts do not have explicit statutory authority to detain an individual who is alleged to be extremely dangerous while the civil commitment petition is pending. Petitions under ORS 426.701 (2019) are commonly filed after an individual who was charged in criminal court is determined to be unable to aid and assist, and an evaluator has opined that there is no substantial likelihood that the person will gain or regain capacity to proceed in the reasonably foreseeable future. If the court agrees with this determination, the court shall dismiss the criminal case per ORS 161.370 (2019). If the petition for commitment under ORS 426.701 (2019) has not been adjudicated by the time the court makes a final determination related to a defendant's capacity to stand trial, the person who is alleged to be an extremely dangerous person with mental illness may be released into the community with no supervision or treatment, absent some other authority to detain them. At the same time, if the aid and assist issue is not resolved until after the petition

[80] See Appendix O.

[81] ORS 426.701(c) (c) (2019) A mental disorder is "resistant to treatment" if, after receiving care from a licensed psychiatrist and exhausting all reasonable psychiatric treatment, or after refusing psychiatric treatment, the person continues to be significantly impaired in the person's ability to make competent decisions and to be aware of and control extremely dangerous behavior.

for civil commitment is resolved, the mentally ill individual very often resides in jail while the hearings are pending. Oregon jails are not equipped to handle severe cases of mental illness and a community release raises grave public safety concerns.

The work group discussed what an appropriate statutory hold provision would look like, taking into account public safety concerns, hospital census concerns, the medical and psychiatric needs of alleged extremely dangerous mentally ill persons, and due process issues related to detention and the need to ensure an adequate defense in the commitment proceedings. A subcommittee was convened from the work group and worked collaboratively to ensure that the above-mentioned considerations were appropriately addressed in any legislative solution. (SB 205 was passed by the Legislative Assembly during the 2021 session.)

Issue 2: Statutory language limits the venue where a recertified civil commitment can be filed. Pursuant to ORS 426.702 (2019), at the end of the 24-month period of commitment, the Board may certify to *the court in the county where the state hospital or state or local mental health facility providing treatment to the person is located* that the person meets criteria for another period of commitment. When a person is presented with the Board's certification, the person may protest a subsequent period of commitment. If protested, holding a hearing in the court within the jurisdiction where the person presently resides/receives treatment creates barriers. For example, the district attorney from the court of original jurisdiction is potentially required to present this case in a venue in which the district attorney may or may not be deputized, creating a myriad of challenges. In addition, that court is unlikely to have any files, records, or familiarity with the case given all matters have been adjudicated by the court of original jurisdiction or by the PSRB. Finally, victims and witnesses who may be called to testify in subsequent recommitment hearings could be required to travel to an unfamiliar jurisdiction to participate in the hearing.

Related to this issue is allowing for remote appearances. The work group discussed and agreed that it would be appropriate to allow a committed individual facing recommitment to appear remotely from their current placement, if they so desire. This would minimize disruption for the individual while preserving the right to appear in person.

Issue 3: There is no time limit by which a recommitment hearing must occur. Once the PSRB has determined that it will certify another period of commitment for an individual under ORS 426.702 (2019), it serves the circuit court with certification paperwork, who has the authority to make a final decision and issue the final order. If the person being certified protests a further period of commitment, ORS 426.702 (2019) provides the person with the right to a hearing before the court. Presently, that hearing must be held "as promptly as possible." A recent analysis (by the PSRB) of all persons under ORS 426.701 (2019) reveals that the new period of commitment is being ordered an average of 94 days past the expiration of the person's previous period of commitment. Notably, the standard deviation is +/-154 days, and the range is 50 days prior to the expiration of the period of commitment to 340 days and counting following the expiration of the period of commitment.

In terms of due process, there has not been a protested case that resulted in the circuit court granting a dismissal of the Board's certification. In other words, no person has been detained under the Board's jurisdiction while awaiting a hearing that resulted in a jurisdictional release. However, this is a possibility that the Board and other stakeholders seek to prevent from occurring. Practically speaking, the biggest problem with these delays is they have created confusion related to the Board's authority during this time. It also creates challenges with the Board's ability to hold its initial hearing pursuant to ORS 426.701 (2019) in a timely fashion.

The work group reached consensus on a legislative solution to this issue. (SB 205 was passed by the Legislative Assembly during the 2021 session.)

Issue 4: Lack of training and standards for 426.701 examinations. The work group identified a lack of training and standards on how to conduct an examination for a 426.701 evaluation resulting in a wide variability and, in some instances, poor quality examinations substantiating these commitments and recommitments.

The statute regarding these evaluations is ORS 426.701(2)(d) (2019), which refers to ORS 426.110 (2019) (Appointment of examiners). This is the same statute that governs examiners for traditional civil commitments. This statute requires the judge to appoint a *qualified* examiner. In addition, the statute added language with ORS 426.701 (2019). ORS 426.110(3) (2019) states that OHA *or the PSRB* may establish, by rule, requirements for certification as a mental health examiner for purposes of subsection (2)(b)(B), which would include the 701 involuntary commitment proceedings.

Administrative rules governing the certification of mental health examiners have not been updated following the passing of ORS 426.701 (2019). It remains that the certification requirements for a professional examining whether a person meets *traditional civil commitment* standards is the same for a professional examining whether a person meets the standards of an extremely dangerous person with mental illness. Some members of the work group noted that the psycho-legal issues involved in a 426.701 examination are fundamentally different from those of a traditional civil commitment and asserted that a proper examination of the psycho-legal criteria at issue in the former require specialty training and expertise that is not provided in the current form of the administrative rules. This perspective supports these types of examinations should be conducted by certified forensic evaluators or at a minimum, those with enhanced training. Another perspective was that the legislature labeled these as "examinations," which is legally distinct from "evaluations,"[82] and did not intend for these examinations to have the same rigorous evaluation measures that are required for criminal responsibility and competency evaluations. This perspective also voiced a concern related to the length of time and the cost of requiring these types of examinations to be conducted by a certified forensic evaluator, particularly given the other issues that were discussed relating to a lack of a hold provision.

[82] For example, ORS 161.309161.365 is an examination that is not required to be conducted by a certified forensic evaluator whereas ORS 161.309161.370 is an evaluation required to be conducted by a certified forensic evaluator.

The PSRB also shared its perspective that there has been wide variety of the types of examinations that have been received substantiating an ORS 426.701 (2019) finding. Upon admitting a new person under this commitment type, the Board has a variety of types of reports from certified forensic evaluators:

- a report that is specific to 426.701 that includes a comprehensive record review and evaluates each element of the statute to opine on whether the person meets criteria, conducted by a certified forensic evaluator;
- a report conducted by a licensed mental health investigator and cited in the order, which might include checkboxes and summary statements that the person meets criteria for the commitment; and
- a finding by the court based on a record review without any examination; in a couple of cases, the only records reviewed were OSH progress notes or in one case, a Violence Risk Assessment.

Like the GEI statutes, the Board does not have a remedy if it believes the documentation supporting the court's decision is insufficient. Moreover, when the initial examination provides little to no analysis of the elements of the statute, subsequent providers (as well as the Board) have little information about the basis for the initial commitment.

Recommendations[83]

- **Legislative Concept**: Add authority to hold an individual who is alleged to be extremely dangerous in custody at either the Oregon State Hospital or a secure mental health facility, while the commitment hearing is pending.
- **Legislative Concept**: Explain that venue is proper as follows:
    a. Initial Commitment Hearing: Either in the county in which the defendant committed the qualifying act or the county in which the defendant currently lives.
    b. Recommitment (ORS 426.702 (2019)): In the county that the Alleged Extremely Dangerous Person with Mental Illness (AEDPMI).was originally committed.
- **Legislative Concept**: Clarify that recommitment hearings under ORS 426.702 (2019) must take place as promptly as possible, but no more than a specific period of time from the date of filing a protest. (Currently, ORS 426.702 (2019) only states "as promptly as possible").
- **Legislative Concept**: Clarify that if an AEDPMI has pending criminal charges at the time the petition is filed, that the criminal case is to be dismissed following the 426.701 hearing and decision. Clarify they must do a dismissal that allows the DA's office to bring back the previous indictment.
- **Legislative Concept or Possible Rule Change**: Allow remote appearance and testimony for parties and witnesses unless an objection is filed by any party or the court or there are other technical issues.
- **Administrative and Training Change:** There was consensus that further examination and discussion is necessary to resolve the challenges presented

[83] Legislative Concept 1647 was introduced in the 2021 Legislative Session.

related to the wide variability in the examination process of this population. There was a lack of consensus that the PSRB work group was the correct place to do this. Other ideas included making this a part of the Certified Forensic Evaluator work group or to create a separate work group given the lack of consensus that only Certified Forensic Evaluators should be providing these evaluations. The work group was in agreement that additional standards and training need to be developed to guide those conducting these evaluations, ensure due process for those individuals under this commitment type, and ensure that judicial officers and the PSRB have the information necessary for decision-making.

- **Other Areas of Future Discussion**: The work group briefly addressed whether individuals under this commitment type should have heightened protection over their medical records to allow them to be more forthcoming in their treatment. Treatment progress can be stifled for those individuals who believe their treatment records could be used against them in a future criminal case. Without more protection, the impact is potentially longer, more expensive hospital stays and institutionalization. State hospitals in other jurisdictions have these protections. While there was some agreement that adding these protections has benefits, members discussed the importance of DAs having access to the records for the purposes of an individual's credibility (e.g., malingering symptoms to avoid trial or prison) or proving/disproving other elements related to using a mental illness defense in the future.

BOARD COMPOSITION, OVERSIGHT, AND CONSUMER VOICES

This section explores discussions related to clients wanting more opportunities to have their voices heard/represented while under the jurisdiction of the Board. This section also addresses concerns with statutory and other language that is not person-centered and perceived as reinforcing the stigma of not only those under the Board's jurisdiction, but of those diagnosed with mental illness.

Issue 1: Should there be consumer representation on the Board to ensure that the consumer perspective is considered in the Board's decision-making? Are there other methods to achieve this goal? The work group considered whether the Board's composition should be expanded to include a member with lived experience. The PSRB's member composition is governed by ORS 161.385 (2019), and requires the following:

- a psychiatrist experienced in the criminal justice system and not otherwise employed on a full-time basis by the Oregon Health Authority or a community mental health program;
- a licensed psychologist experienced in the criminal justice system and not otherwise employed on a full-time basis by the authority or a community mental health program;
- a member with substantial experience in the processes of parole and probation;
- a lawyer with substantial experience in criminal trial practice;
- a psychiatrist certified, or eligible to be certified, by the Oregon Medical Board in child psychiatry who is experienced in the juvenile justice system and not

employed on a full-time basis by the authority or a community mental health program;
- a licensed psychologist who is experienced in child psychology and the juvenile justice system and not employed on a full-time basis by the authority or a community mental health program;
- a member with substantial experience in the processes of juvenile parole and probation;
- a lawyer with substantial experience in juvenile law practice; and
- two members of the general public.

Expanding the PSRB to include a Board member with lived mental health experience or even a past client who has been under the jurisdiction of the PSRB was suggested. An expansion of the Board would result in requiring the PSRB to add an additional member at every hearing that it conducts in order to meet quorum. In addition, any expansion of the Board would entail increased costs to the agency and taxpayers. Work group members also discussed the historical challenges of recruiting Board members including low pay and a lengthy commitment. The work group agreed that any changes should avoid frustrating the PSRB's ability to hold timely hearings.

An alternative to expanding the Board is requiring the public member to have intentional peer support training or be someone who is a current or former person from the traditional health worker registry. While a public member *could* have peer support training, the work group addressed concerns with limiting the public member to specific individuals. One overwhelming challenge is that those with lived experience, particularly those who have lived experience within the PSRB or other aspects of Oregon's mental health system, have increased likelihood of having (positive or negative) past experiences with current PSRB clients.

Further, conflict of interest issues that might arise that would be challenging to identify. There would need to be guardrails in place to consider what bias they would bring to individual cases and how such bias could be eliminated. While it is true that all Board members could have bias with individual cases, potential conflicts are vetted through an examination of the exhibit files to determine whether a board member had previous participation in the client's treatment. Members of the work group also raised how a public member with lived experience might impact victims, whose perspective is not often represented in these types of discussions. An alternative is requiring the public member to have experience working with victims. The work group agreed that a statute requiring a Board member to have lived experience as a victim would be inappropriate.

The work group also discussed whether the legislative intent behind including a non-specific public member was that the public member was meant to be neutral. Moreover, the work group addressed whether the legislature intended for any Board member to be an advocate or a neutral, quasi-judicial decision maker. In addition, some members cautioned against excluding candidates with genuine interest but no familiarity with the mental health system who could still effectively represent the general public as a Board member. To that end, the work group recommended that further examination of the

legislative history should be considered before making any changes to the Board's composition.

Recommendations

- **Legislative Change:** No change.
- **Practice Change:** Consider a preference for Board members with lived experience rather than making it a statutory requirement.
- **Practice Change:** Provide opportunities for consumers and/or victims to present their experiences to the Board to the extent that it would not violate *ex parte* or other legal concerns.
- **Other Areas of Change**: The PSRB has integrated related initiatives and goals into their strategic plan for additional consideration.

Issue 2: Is there sufficient oversight of the PSRB? The work group had limited time to address the issue of whether the PSRB has sufficient oversight in depth. To address this issue, Alison Bort, Executive Director of the PSRB, presented a list of the current strategies the PSRB has to hold itself accountable and provide stakeholders, clients, victims, and the public opportunities to provide feedback:

- rules advisory committees
    - all Board decisions can be appealed;
- Board administrative meetings;
- Customer Service Survey—provided after every hearing and available to complete for each significant action with the PSRB (available to clients, stakeholders, victims, and public);
- grievance procedures through direct providers, counties, licensing;
- Governor's Office;
- Secretary of State Audit; and
- legislature.

While the above-mentioned strategies provide different layers of oversight over the PSRB, the PSRB acknowledges that they are not necessarily client-friendly, nor do they account for the challenges clients might have in being involved in those processes. To that end, Dr. Bort presented additional strategies developed in conjunction with Kris Anderson, Peer Coordinator for the Oregon State Hospital Advisory Council:

- Develop an FAQ/Resource Sheet for complaints
- Establish an Oversight Committee
- Establish an Alumni, Confidential Focus Groups
- Outsource Confidential Focus Groups
- Establish an Advisory Council
- Appoint an Ombudsman

In the context of OHA and OSH having established Advisory Councils, the work group explored whether there were opportunities for PSRB-related issues to be a standing

agenda item. To the extent that there was legal authority for that to occur, it was believed that such agenda items would need to focus only on patients under PSRB who are being served at OSH (i.e., not in the community). Contributing to this need is the perspective that the established Advisory Councils do not appear to have the authority to address consumer issues related to the PSRB. In the context that OHA may be examining and potentially restructuring their Advisory Councils (for reasons unrelated to this discussion), Ms. Anderson suggested that now may be a good opportunity to examine whether any council might incorporate a review of issues that (at least OSH) clients have related to the PSRB.

Another related suggestion was that the PSRB look into Oregon's Long-Term Care Ombudsman office to determine whether this type of model could achieve the above-discussed goals.

Recommendations

- **Legislative Change**: None.
- **Other Areas for Future Discussion**: Continue to examine the strategies outlined in this section to expand opportunities for consumers to have their voices heard and for the PSRB program structure and services to evolve and strengthen.

JUVENILE PSRB (JPSRB)

This area of discussion was moved to a small subcommittee of the work group comprised of experts working directly with youth and included the Oregon Youth Authority (OYA). The goal of this subcommittee was to examine the utility of the JPSRB and the cause of the small case numbers. [84]

Background

In 2007, the Board's duties expanded to include monitoring of young persons found by the courts to be Responsible Except for Insanity (REI). The court places the juvenile under the jurisdiction of the PSRB if it finds the young person has:

- a serious mental condition (defined as major depression, bipolar disorder or psychotic disorder); or
- a qualifying mental illness other than a serious mental condition and represents a substantial danger to others, requiring conditional release or commitment to a hospital or facility.

Individuals found REI are placed under the Board's jurisdiction for the maximum period to which they could have been sentenced if found guilty of the crime, or until age 25, whichever is shorter. Sentencing guidelines do not apply.

[84] See Appendix P for relevant materials considered by the work group.

In addition to expanding the Board's responsibilities, the Board also expanded its membership two-fold. All decisions related to youth found REI were scheduled before the Board's newly formed Juvenile Panel (JPSRB), which mirrored the five members of the Board's Adult Panel. The JPSRB had a maximum caseload of 21 individuals in 2012, but over the next seven years, the caseload progressively decreased. As of January 1, 2020, the JPSRB served only five individuals. Correspondingly, the number of hearings also decreased. Between 2013 and 2019, only four individuals were adjudicated REI in the state. The Juvenile Panel held eight full hearings between 2018-2019. This sharp decrease in caseload resulted in the agency including an examination of the future of the JPSRB in this work group.

Issue: Underutilization of the REI defense. Members of the subcommittee discussed an array of explanations as to why the JPSRB had not continued growing over the past decade. In addition, the subcommittee examined whether the implementation of Senate Bill 1008 (2019) (which terminated the automatic waiver of juveniles who committed Measure 11 crimes to adult court) could potentially lead to an increase or further decrease the JPSRB caseload. Several themes emerged to help explain the low caseload numbers:

- There continues to be a need for JPSRB. The Oregon Youth Authority has continued to serve young persons who would be a better fit for and largely benefit from the comprehensive mental health treatment program the JPSRB was developed to provide.
- There may be anecdotal beliefs about the JPSRB that prevent defense attorneys and probation officers from recommending JPSRB, namely that an individual who is adjudicated REI receives a longer sentence and is under monitoring and supervision far longer compared to pleading guilty.
- Several stakeholders may not be aware that REI/JPSRB are an option.
- The name of the defense, Responsible Except for Insanity, may serve as a deterrent and reinforce stigma of those suffering from a serious mental condition.
- The impact of SB 1008 is not clear at this time, particularly since it went into effect about the same time as the onset of the COVID-19 pandemic.
- There was a question as to whether expungement laws apply equally to those who are convicted of their offense versus those who are adjudicated REI.

Recommendations

- **Legislative Change:** Ensure there is parity among those adjudicated REI to expungement laws.
- **Legislative Change:** Change the name REI—title it differently with the same legal meaning. This was presented to the work group; however, consensus was not achieved. The agreement was that there were more significant reasons individuals were not using the defense and that additional discussion was needed. Caution was raised on how the name change could inadvertently impact interpretation of the defense and prior case law.
- **Practice Change:** Consider JPSRB handling all PSRB cases through age 25 to match brain science with the legal approach. This is unlikely to have an

immediately large impact and would only result in a handful of individuals transferring to JPSRB. This could also have logistical barriers, as the JPSRB would need to be versed in the laws that apply to those who are adjudicated GEI and REI.

- **Practice Change:** Target youth who may have initially come under OYA, but following a subsequent crime, consider REI. There could be problems of dual jurisdiction.
- **Training:** Increase outreach/communication with juvenile probation officers. Target counties who formerly used the REI defense more often.
- **Other Change:** OADC should redistribute a survey to public defenders to gain additional data related to defense attorneys' understanding of REI and JPSRB. This survey was originally distributed to approximately 350 juvenile attorneys in September 2020, with only one response.

DATA COLLECTION AND ANALYSIS

The work group planned to discuss data collection and analysis as a separate topic. While the PSRB has expansive data, much of it is paper based. The goal was to examine what types of data are necessary to assist the legislature and stakeholders in decision-making and ways the PSRB could improve its research. Data was mentioned throughout the work group, but no separate work group developed.

LAW ENFORCEMENT COORDINATION

This area of discussion was moved to a small subcommittee of law enforcement partners as well as community providers who had specialized expertise and experience with the problem areas. The overarching goal of this subcommittee was to examine the statutory roles and responsibilities of law enforcement in the PSRB system of care.

Background

ORS 161.336(4) (2019), provides the statutory authority for law enforcement where a person on conditional release has absconded, has had a significant change in their mental health, is in violation of their conditional release plan, or is being revoked to the Oregon State Hospital. The subcommittee identified four major problem areas to consider for legislative change or other solutions.

Issue 1: There is a lack of clarity related to law enforcement's authority, and even where the law is clear, there is a significant lack of resources that interfere with law enforcement's ability to fulfill its duties, particularly related to transport.
This issue was the main focus of the work group's law enforcement coordination discussion. Members discussed that the authority granted for law enforcement to take PSRB clients into custody, specifically when the Board has not issued a written revocation order, may be legally questionable from the law enforcement point of view.

The participants discussed a lack of clarity regarding their authority and provided an example. A person who was under PSRB jurisdiction and on conditional release was granted a pass to visit family. During the pass period, the person went to a different location where he had police contact due to a domestic disturbance. After police ran this person's name in the law enforcement database, the PSRB case manager was contacted. Law enforcement did not believe they had authority to take the person into custody for the purposes of transporting the person to OSH because it was after hours and there was not a written order. Law enforcement believed their only option was to release the person. Although the PSRB case manager attempted to set up a plan for the person to return to his facility, the person did not return. Instead, the person remained on unauthorized leave, and ultimately murdered the person with whom he was living.

Although this situation was the worst-case scenario, it is not uncommon for law enforcement to question their authority to take a person into custody for the purposes of transport in the absence of a written revocation order. Following is a summary of the two most likely situations in which this could occur:

- ***After business hours***: PSRB is a small agency and the Executive Director is the only person expected to be available 24 hours per day. Although available, the Executive Director does not have access to a LEDS (Law Enforcement Data System) terminal after business hours; has limited access to files (located in the business office); and is not able to generate an affidavit (which is the support for the revocation and requires notarization).
- ***During business hours***: There are limited situations where a person on conditional release may be missing from their residence, but where a revocation to the Oregon State Hospital is premature or inappropriate. A person may be missing because of symptoms related to disorganization. In another example, a person may have been discharged from a local hospital whose staff did not coordinate the discharge with the person's PSRB treatment team. The team may report the person is missing, but not support a revocation based on particular evidence. In those cases, the team may require the opportunity to assess the missing person prior to making any further decisions about placement; therefore, the PSRB may hold off on issuing a revocation order until the appropriate placement is identified.

The PSRB's position is that in the absence of a written revocation order, law enforcement has the authority to take a person under PSRB's jurisdiction into custody for the purposes of transport pursuant to ORS 161.336(b) (2019). This statute (as interpreted by the PSRB) grants those professionals responsible for the monitoring and supervision of a PSRB client on conditional release the ability to request that a peace officer take that client into custody if there is reasonable cause to believe the person is a substantial danger to others because of a qualifying mental disorder and the person is in need of immediate care, custody or treatment. The PSRB emphasizes that the statute does not require "probable cause," which is the standard required for a Director's Hold or Peace Officer Hold under ORS 426.228 (2019). This statute serves to authorize the professionals responsible for the monitoring and supervision of the PSRB client to take

immediate action and request law enforcement to transport the person to a facility in the absence of a written Board order. Although technically, a written order from the PSRB is not necessary to execute this process, the reasonable cause standard is not clear or well-understood, and in the absence of observing that the person is a "substantial danger to others" in that moment, the authority for transporting the person under this provision of the statute is questioned.

The subcommittee identified that ORS 133.310 (2019) (authority of peace officer to arrest without warrant) is the statute that law enforcement most frequently uses when taking a person into custody. Whereas the legal authority for law enforcement to take a person into custody is more descriptive and precise when an individual commits an offense, the statutes governing civil and criminal commitments are less clear. Moreover, officers tend to be less familiar with those statutes or have less experience working with this population. The subcommittee considered whether adding the language from ORS 161.336(4) (2019) to this section of the statute could help to clarify law enforcement's authority. However, this ultimately appeared to be problematic because this statute governs arresting individuals, and the clients taken into custody pursuant to transport are not under arrest.

The subcommittee also discussed that, even where law enforcement clearly had authority to take a person under PSRB jurisdiction into custody for transport, a lack of resources can be an additional barrier to transporting an individual to the Oregon State Hospital in a timely way. Most routinely, this impacts those law enforcement agencies located in rural counties, particularly rural counties that are distant from the Oregon State Hospital; however, it can also impact more urban areas that may have competing public safety matters to prioritize. The subcommittee discussed that an alternative to law enforcement transporting individuals to OSH is the use of secure transport. However, the subcommittee also recognized the inherent challenges of using secure transport, most significantly, those companies typically require 24-hour advance notice for transporting clients.

Issue 2: The PSRB lacks access to the LEDS terminal during non-business hours. The work group discussed the challenges related to after-hour crises. Presently, the PSRB's Executive Director (ED) is on-call 24/7 to take crisis calls. When these calls come in after business hours, the ED lacks access to the LEDS terminal and cannot submit a revocation order into the system.

Issue 3: There is a lack of protocol, policies, and procedures related to missing persons and extradition situations. This issue focused on the response of the PSRB and law enforcement agencies when an individual under PSRB's jurisdiction and on conditional release crosses state lines. The inherent challenge in these situations is the authority of an outside state to have the person returned to Oregon. The current process requires the PSRB to partner with the DA's office in the county where the individual resides to determine whether the individual can be indicted on Escape II charges. This is typically not a quick process, and the subcommittee explored a recent example that occurred illustrating the extensive resources that law enforcement

expended not only to support the Escape II charge, but also in securing the return of the individual from the other state and then to OSH.

Recommendations

- **Legislative Change**: Integrate the language of 161.336 into ORS 133.310 (2019) (authority of peace officer to arrest without warrant) or other area of the law that law enforcement more regularly uses that establishes their authority to take a person into custody (e.g., ORS 426.228 (2019) authority of peace officers); or specifically establish an "authority of peace officers" section under ORS 161.336 (2019). Note: this is not to change any actual authority; the goal is to clarify current authority. Consensus was not achieved due to lack of necessary information and time to examine whether this would be an effective change.
- **Administrative Rule or Process Change:** Develop a form to be used by a community supervisee as the "written order" when an individual on conditional release absconds from treatment, modeled after the Director's Designee. The PSRB is actively working with community mental health providers to design this form. Final approval of this form should be solicited from PSRB, OHA, law enforcement agencies, and community mental health programs at a minimum.
- **Practice Change:** Outreach with OHA regarding secure transport options. Develop local protocols to address transportation issues.
- **Best Practices:** Local community and local law enforcement develop protocols and contingencies to ensure timely responses to PSRB-related crises, revocations and law enforcement responses to clients who are missing.
- **Best Practices:** PSRB, law enforcement, and Governor's Office should develop extradition protocols tailored to individuals under the jurisdiction of the PSRB. The protocol would include expectations related to roles and responsibilities as well as fiscal responsibilities and reimbursements.
- **Practice Change:** PSRB should further examine options to access the LEDS terminal remotely, particularly following the launch of LEDS 20/20.[85]
- **Practice Change:** PSRB should further develop the conditional release handbook for case managers, particularly the protocol for when a person has absconded, but a revocation is not the identified outcome.

[85] Criminal Justice Information Service, *About the LEDS 20/20 Project* (n.d.) <https://www.oregon.gov/osp/programs/cjis/Pages/About-LEDS-20/20-Project.aspx> (last visited December 20, 2021).

Appendices

Oregon
Kate Brown, Governor

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March 7, 2019

Senator Floyd Prozanski
900 Court Street NE, S-413
Salem, Oregon 97301

Dear Senator Prozanski,

Earlier this year, I shared some of the challenges our agency faces and our interest in working toward solutions. As a small agency, impacted by several larger systems across the State, one idea we discussed was to form a collaborative workgroup to examine these challenges in more depth. We believe that a legislator/committee-led or supported workgroup would be the most successful approach to achieving this goal and we hope that you might assist us in this endeavor. Our goal is to develop comprehensive, system fixes and avoid piecemeal legislation that might have unintentional, negative consequences and/or a burdensome fiscal impact.

Over the past several months, I have been listening to various stakeholder perspectives not only on the challenges faced in our forensics system, but also potential solutions. These conversations have enabled me to outline 3 general areas that could be targeted by a future workgroup. In addition, to this general overview, I have included a list of legislative concepts for further consideration and discussion.

Pre-jurisdiction/Front Door

Some individuals found Guilty Except for Insanity are later determined to solely have a non-qualifying mental disorder and, by law, ***must*** be discharged from PSRB. Solutions would focus on further reducing the risk of inappropriate cases that are adjudicated GEI that lead to these types of early discharges. House Bill 3100 (2011) went a long way to reducing this risk with the creation of the Certified Forensic Evaluator as well as other requirements of the criminal courts; however, there are opportunities to further examine the “front door” to the PSRB.

Discharge/Back Door

One category of discharges is those that occur due to a client no longer meeting jurisdictional criteria. In the worst case scenario, this would be a discharge that occurs because the individual no longer has a qualifying condition, but is still deemed to be a substantial danger to others due to a non-qualifying condition (e.g. substance use, personality disorder). Solutions would focus on ways for our agency to maintain monitoring and supervision, transfer jurisdiction, or otherwise increase public safety.

A second category of discharges is those that occur because a client has completed their sentence. In some cases, individuals who are at the end of their sentence continue to pose a substantial danger to others because of their qualifying condition. The worst case scenario would be a person who was never able to live successfully on conditional release during their jurisdiction (or who could only live in a highly monitored placement), but who would not meet criteria for a civil commitment. Solutions would focus on identifying ways to extend jurisdiction and/or reduce the threshold for a civil commitment based on the history of dangerousness (e.g. GEI instant offense).

Post-jurisdiction

The Board has limited resources and also lacks the access to databases to meaningfully track clients post-jurisdiction. However, we hypothesize there are opportunities for program improvement through the study of those who recidivate following Board jurisdictions. Solutions would focus on developing ways to track and better understand what contributes to positive and negative outcomes.

Thank you for taking the time to review this correspondence. We recognize we are in the middle of a busy and long legislative session and that creating this type of workgroup would require time and resources. We are open and appreciative of any further discussion and ideas you have about the possibilities of this venture.

Sincerely,

Alison Bort
PSRB Executive Director

This handbook is intended to serve as a guide for Oregon State Hospital Staff, community providers, partnering agencies, Board Members and staff

2019 PSRB HANDBOOK

Oregon
Kate Brown, Governor

Psychiatric Security Review Board
610 SW Alder Street, Suite 420
Portland, Oregon 97205
Phone: (503) 229-5596
Fax: (503) 224-0215
psrb@oregon.gov

April 10, 2019

Dear PSRB Partners,

On behalf of the Psychiatric Security Review Board, I would like to extend our gratitude to all of your, our valued partners! As executive director, I am committed to supporting you in the daily challenges of this work. You are an integral part of our agency's ability to carry out our mission and ensure that individuals under the PSRB are receiving the services needed to live safely in the community.

This handbook was originally designed and recently updated as one way to support our partners. Enclosed is an abundance of resources related to our policies, procedures and practices. In updating this handbook for 2019, we provided updates to statutory changes and made concerted efforts to incorporate frequently asked questions we receive from you, our partners. Whether you provide direct services or supervise programs that serve the PSRB, I hope you find this handbook to be an informative guide.

Please note we have several other resources to support you such as our PSRB website at http://www.oregon.gov/prb, where you can find updated information, sample templates, and references. In addition, PSRB staff is here to help Monday through Friday during business hours. If you are in need of a more in-depth or tailored training for your agency, I am available to travel to any Oregon county to provide technical assistance to meet your needs. Please feel free to contact our office at (503) 229-5596 for more information about training opportunities.

I look forward to our future collaborations and invite feedback on ways we can further strengthen our partnerships and equip you with the resources you need to effectively manage your programs. My door is always open, so please do not hesitate to contact me directly at Alison.Bort@oregon.gov.

Sincerely,

Alison Bort
Executive Director

Psychiatric Security Review Board

Conditional Release and Community Treatment Facilities

Background

When someone commits a crime and is found by the Courts to be "guilty except for insanity," he or she is placed under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB).

Individuals found guilty except for insanity are typically placed under the jurisdiction of the PSRB for the maximum sentence length provided by statute for the crime. Depending on the offense, that is 5 years, 10 years, 20 years, or life.

Historically, PSRB authority over an individual has lasted longer than Department of Corrections' system authority.

While under PSRB jurisdiction, an individual can be housed in the Oregon State Hospital or in a variety of residential treatment settings, ranging from Secure Residential Treatment Facilities to independent living. The PSRB determines what kind of facility is appropriate based on the level of treatment, care and supervision the individual requires.

Mission of the Psychiatric Review Board – Public Safety

Oregon State law is explicit that PSRB must put public safety first. ORS 161.336(10) states: 161.336(10) states: "In determining whether a person should be committed to a state hospital or secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society."

Conditional release under PSRB authority – Proven Public Safety Record

The PSRB has been successful in carrying out its mission. From January 2011 through 2017 (the most recent year for which recidivism figures are currently available), only 15 people out of the 896 who were living in the community on conditional release have been convicted of new felonies or misdemeanors.

The cumulative recidivism rate for the PSRB from 2011 to 2017 is 0.46 percent. By comparison, the most recent recidivism rate for individuals on Parole or Post-Prison Supervision is 18% and on Probation is 14% (CJC, 2019) after being on parole or probation for three years.

Most PSRB clients begin their treatment at the Oregon State Hospital. When clients are conditionally released they are carefully monitored by the PSRB. They are subject to immediate return to the state hospital if they violate the terms of their conditional release order.

PSRB SNAPSHOT (as of January 1, 2019)

575	Number of people currently under PSRB jurisdiction.
205	Number of people under PSRB jurisdiction in Oregon State Hospital.
364	Number of people under PSRB jurisdiction who are on conditional release from the state hospital.

SAFETY RECORD (January 1, 2011 to December 31, 2016)

896	Number of people on conditional release during the intervening 6 years.
15	Number of those 896 people who committed a felony or misdemeanor while on conditional release and were subsequently convicted of that crime.
0.50%	Cumulative annual recidivism rate for GEI clients since 2011.
99.4%	Percent of adult conditional releases maintained in the community per month in 2018.

Psychiatric Security Review Board

Address: 610 SW Alder St.
Suite 420
Portland, OR 97205
Phone: 503-229-5596
Fax: 503-224-0215
Email: psrb@oregon.gov
Website: www.oregon.gov/prb

FAQs

Are people who have been found GEI ever sentenced to the Oregon State Hospital?
No. The GEI statute calls for individuals to be placed under the jurisdiction of the PSRB..The hospital is a secure place for psychiatric treatment, not for punishment.

How is the length of time at the Oregon State Hospital established?
The period of time PSRB clients stay at OSH varies by individual. The PSRB makes its decision to conditionally release someone based on a clinical assessment of the individual's mental status, progress in treatment at the hospital and risk assessments as to dangerousness as well as the availability of the appropriate resources in the community. If it is determined that a person can be safely managed and treated in a community setting, the PSRB attempts to find an appropriate placement.


OSH Hearings Room

Are PSRB adult clients ever discharged before their sentence is completed?
By law, the PSRB retains jurisdiction over clients who have a qualifying mental disorder that renders them a substantial danger to others when the disorder is active. In rare cases, a client found guilty except for insanity may be discharged early from the Board's jurisdiction. The 5 year average of these types of discharges by the PSRB is 13.6 per year, with 6 in 2017 and 3 in 2018. The overwhelming majority of clients complete their full sentence under the PSRB.

Is the state trying to move PSRB clients out of the state hospital and into the community, and what kind of impact will that have on public safety?
Because of additional funding from the Oregon Legislature since 2005, an increased number of PSRB clients have been moved into a variety of new community placements, including Secure Residential Treatment Facilities (SRTFs). Since more of these facilities have opened, there has not been any increase in the recidivism rate.

Is it safe to move people who have committed violent crimes into the community?
State law prohibits the Board from putting anyone on conditional release who is determined to be presently dangerous to others. Additionally, before individuals are released, they go through a comprehensive screening process that includes four levels of review. In all cases, including person-on-person crimes, victims who want notification are contacted in advance, as is the District Attorney's office that first prosecuted the case.

Conditional release is not a new policy. Most states in the US have some type of conditional release program. The PSRB has supervised clients in the community on conditional release since its inception in 1978. Over the past 20 years, more than 1960 conditional releases have been granted to people who have transitioned into community placements throughout Oregon. Some of these clients remain under supervision for decades or even life.

Who is notified when someone is being considered for conditional release?
By law, the district attorney from the committing county is notified along with the judge who signed the judgment order. Also, the victim(s), if they requested such notification. The Attorney General's office, the client's attorney and the client's case manager are also notified.

For more information contact Alison Bort, Executive Director of the Psychiatric Security Review Board at (503) 229-5596.

WHERE PSRB CLIENTS LIVE (as of January 1, 2018)

Oregon State Hospital (35.7%)

- 205 individuals
- Locked 24/7, secure perimeter
- 24-hour supervision
- Off-site privileges based on public safety and level of care needed

Secured Residential Treatment Facility (12%)

- Locked 24/7
- Egress controlled by staff
- Off-site privileges based on public safety and level of care needed
- 6-16 individuals per facility

Residential Treatment Facility/Home (24.2%)

- Unlocked
- 24-hour awake supervision
- Up to 16 individuals per facility

Adult Foster Home (3.1%)

- Unlocked
- 24-hour staff
- Up to 5 individuals
- Some clients with state variance allow for four hours home alone

Semi-Independent/Supported Housing (7%)

- Varies from individual apartments to shared housing
- Staff part time at the site

Intensive Case Management (3.1%)

- Independent living
- Staff contacts at least twice per day with at least one contact at residence
- Case management team

Independent Living (self, with family) (13.4%)

- In regular apartments or houses
- Frequent home visits by case manager

Other (Department of Corrections) (1.6%)

QUESTIONS?

For General questions about PSRB resources in the community:

- Psychiatric Security Review Board
  610 SW Alder St. Ste. 420
  Portland, OR 97205
  (503) 229-5596
  psrb@oregon.gov

For General questions about community resources for clients diagnosed with a Developmental/Intellectual Disability:

- **Juvenile PSRB Developmental Disability community placement:**
  Lou McDonough
  Department of Human Services: Service Coordinator / SPD
  11826 NE Glisan St.
  Portland, OR 97220
  (971) 673-2986
  lou.m.mcdonough@state.or.us

- **Adult PSRB Developmental Disability community placement**
  Matt Bighouse
  State of Oregon Department of Human Services /ODDS
  500 Summer Street NE, #E09
  Salem, OR 97301-1064
  (503) 945-6976
  Matt.L.Bighouse@dhsoha.state.or.us

For general questions about community resources for clients who need referrals to or are eligible for Aging and People with Disabilities services:

- Beth Lee
  APD Branch 5510 Lead
  500 Summer St NE
  Salem OR 97301 971-719-3459
  beth.lee@state.or.us

For General questions about community resources for clients with a psychiatric diagnosis:

- **Juvenile PSRB community placement:**
  Alex Palm
  JPSRB Coordinator
  Oregon Health Authority
  500 Summer Street NE, E86
  Salem, OR 97301
  Alex.J.Palm@state.or.us

- **Adult PSRB community placement:**
  Anna Dyer
  Oregon Health Authority
  500 Summer Street NE, Y34
  Salem, OR 97301
  (503) 779-9814
  anna.e.dyer@state.or.us

Many facilities in Central Oregon and Eastern Oregon are run by Greater Oregon Behavioral Health, Inc. (GOBHI).

- Greater Oregon Behavioral Health, Inc.
  401 E 3rd Street, Suite 101
  The Dalles, OR 97058
  (541) 298-2101
  1-800-493-0040
  Fax: (541) 298-7996; info@gobhi.net
  Click here for a list of GOBHI Facilities.

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2019-2024
Strategic Plan

Psychiatric Security Review Board

Due Process - Research - Recovery - Partnership

Mission

The Psychiatric Security Review Board protects the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest, and person-centered care.

Values

The PSRB's values are rooted in our legislative mandate to protect the public. We achieve maximum levels of public safety through:

Due Process

Observing individuals' legal rights and adhering to principles of procedural fairness.

Research

Decision making and organizational practices driven and influenced by the best available data.

Recovery

Clients understand and receive treatment for the psychiatric and comorbid conditions that contributed to their past criminal offenses and have opportunities to achieve health, home, purpose, and community.[1]

Partnership

Promoting active communication and collaboration within and between the systems serving PSRB clients and the community at large.

1 PSRB endorses the Substance Abuse and Mental Health Administration's (SAMHSA) definition of recovery.

5-Year Vision

In 2024, the Psychiatric Security Review Board (PSRB) maintains a positive reputation with the public, the legislature, and the legal community and serves as a model for local and national agencies working to enhance the recovery of justice-involved individuals with mental health challenges. We define public safety in terms, not only of reduced recidivism, but also in terms of the PSRB's ability to enhance the health, well-being, and re-connection of the individuals under our jurisdiction with their natural supports and communities. Healthier clients and confidence in PSRB monitoring help victims in their own recovery process.

The Board uses the "problem-solving" philosophy promoted by specialty courts—such as mental health and drug courts—and the most recent research to address recidivism and promote long-term recovery. Consistent with this philosophy, the PSRB develops a best practice guide to support our valued community and hospital treatment providers and conditional release monitors. The professionals working with individuals under the PSRB are adept at using forensically oriented, evidence-based assessment and treatment practices and are equipped with the tools necessary to identify and address the underlying biopsychosocial issues and criminogenic factors that contributed to an individual's instant offense. They use an inclusive, multi-disciplinary, and team-oriented approach to decision making. Providers feel they can communicate candidly with the PSRB and consult with the Board's staff to address issues that might enrich a client's current or potential conditional release or prevent an unnecessary revocation.

Principles of trauma-informed care and procedural fairness are ingrained in PSRB culture and apply to our interactions with clients, victims, and the public, minimizing the stress associated with hearings and maintaining confidence that the justice system is trustworthy and fair for individuals under PSRB jurisdiction and the victims of their instant offenses. Individuals under the PSRB have a clear understanding of how to progress, and the Board's decision making process is perceived as fair and consistent. Due to the PSRB's open communication channels with the Department of Justice's victims' advocate, victims feel heard and safe. Victim-centered programs are established and made available to victims interested in alternative opportunities for healing and recovery.

A mental health peer-alumni group exists, enhancing long-term community support and providing several types of opportunities for individuals who have completed their PSRB jurisdiction (or are in advanced phases of their treatment) to inspire hope and share their successes, challenges and recommendations with individuals who are still under the PSRB. The PSRB maintains other opportunities to hear peer voices, such as during PSRB's rule-making process.

The PSRB has expanded its outreach to the legal and law enforcement communities around the state, routinely providing trainings regarding laws, programs, and best practices concerning people under the PSRB. Law enforcement better understands its role in supporting the PSRB when an individual under our jurisdiction is in crisis and needs to be returned to the Oregon State Hospital. The legal community understands the consequences of a GEI plea, allowing for effective representation of and communication with defendants, victims, and the state. The judicial community better understands the laws, procedures, and potential outcomes related to adjudicating an individual Guilty Except for Insanity, conditionally releasing individuals they find GEI directly into the community, and effectively uses the PSRB's clear and streamlined civil commitment process.

The PSRB, in collaboration with stakeholders, is actively engaged in the legislative process to educate lawmakers and propose legislation that advances our mission and repairs deficiencies in the forensic system. Legislative changes may also serve to decriminalize and destigmatize individuals challenged by mental health and substance use issues.

The public is well-versed on the PSRB's conditional release program, diminishing the fear associated with PSRB clients' placement in their communities. An informed legislature and public have improved the funding and development of housing and treatment resources in the community setting, providing greater flexibility in conditional release decision making and eliminating costly and unnecessary commitments to the State Hospital. By the time individuals reach the end of their jurisdiction, they have reintegrated into the community, have attained permanent housing, and are well-connected to the treatment and other resources necessary to sustain their recovery, leading to a reduction in post-jurisdiction recidivism.

The public and our partners have increased awareness of PSRB's Gun Relief and Sex Offender Reclassification and Relief programs. Potential petitioners of these programs are not blocked unnecessarily from access due to financial limitations, logistical obstacles, or other unintended, oppressive practices.

A workplace using trauma-informed care principles promotes a culture of trust, inclusion and teamwork that optimizes both staff and Board effectiveness and addresses the impact of secondary trauma and burnout. PSRB staff work in a collaborative environment,

where opportunities for teamwork strengthen morale and distribute the workload fairly. PSRB staff are comfortable sharing their ideas and actively participate in problem-solving and agency improvements. Management, the public, and other staff acknowledge and value staff's contributions. PSRB staff endorse high rates of job satisfaction and ample opportunities to grow professionally.

The PSRB has clear policies and procedures that simplify work, improve workflow, and enable our valued staff members to provide excellent customer service to our stakeholders and clients and support to our Board members. The documentation the PSRB expects of our providers is manageable, reducing unnecessary paperwork and increasing the quality of information the Board receives to make informed decisions. Technological advances such as an integrated client database, case tracking, and other mature software streamline our docketing and hearings processes, secure document sharing with our stakeholders, and enhance workload efficiencies. Increased efficiency further promotes procedural fairness for both the individuals under our jurisdiction and victims.

New Board members receive a comprehensive onboarding module and all Board members receive ongoing training consistent with the principles outlined in this vision. The Board's administrative rules are updated, clarified, and ultimately, manualized into a practice guide that enhances decision making and ensures the Board's accountability to the public. The Board is regularly briefed on applicable laws to ensure consistency of decision making.

The PSRB continues to improve by proactively soliciting feedback from the current and former clients we serve, our direct partner organizations, affected stakeholders, and the public. PSRB leadership provides education to these groups on a routine basis through trainings, system/community meetings, our website, handbooks, or through other methods that enhance opportunities for informed and constructive feedback. The PSRB has also improved itself by establishing partnerships with academic and other institutions that can develop research questions, analyze our available data, and publish professional papers that evaluate and inform our approach to this valuable work.

Five-Year Initiatives and Goals

Initiative 1: Use research and best practices to develop legislative and program changes that improve and standardize how clients enter and lapse or discharge from the PSRB system and how the PSRB system treats victims.

Goal 1.1: Form a collaborative legislative workgroup to examine system challenges and make comprehensive, system-fixing recommendations.

Outcomes Endorsing Success[2]—PSRB has:

- Developed a scope document for the workgroup that addresses:
  - Pre-jurisdiction/Front Door: Issues related to inappropriate GEI adjudications
  - Discharge/Back Door: Issues related to clients who are still deemed to have a qualifying mental disorder and are a danger to others at their discharge date or clients who no longer meet jurisdictional criteria, but are nevertheless deemed dangerous by virtue of a non-qualifying mental disorder.
  - Post-jurisdiction: Examining data related to recidivism post-PSRB jurisdiction
- Developed and maintains a document that captures potential legislative and rules changes that may refer to other workgroups.

Goal 1.2: Examine procedural fairness and implement trauma-informed practices for victims of those adjudicated GEI/REI.

Outcomes Endorsing Success—PSRB has:

- Established a victim-centered process toward healing consistent with our legislative mandate under ORS 161.398.
- Partnered with the Attorney General's Victim Task Force to develop clearer policies and procedures related to victim impact statements, victim requests, no-contact orders, and fair treatment for both victims and clients.

Goal 1.3: Streamline policies and procedures associated with the PSRB Civil Commitment.

Outcomes Endorsing Success[2]—PSRB has:

- Developed legislative concepts to fix challenges associated with PSRB Civil Commitments.
- Developed a protocol to approach PSRB Civil Commitment cases systematically and consistently.
- Hired new staff to lead the PSRB Civil Commitment program.
- Examined the OARs associated with the PSRB Civil Commitment program and recommended rule changes.
- Improved information-sharing process to assist with initiating PSRB Civil Commitment petitions.

Goal 1.4: In February 2020, present to the Legislature revised Key Performance Measures that measure agency effectiveness accurately.

- PSRB has examined and adopted Key Performance Measures.

2 A more extensive list of legislative concepts and goals will be incorporated into this goal.

Initiative 2: Influence identification and adoption of best practices for working with PSRB clients across the State.

Goal 2.1: Examine Oregon's Specialty Court Standards, other criminal justice/behavioral health models, and research to strengthen standards of practice for monitoring, supervising, and treating PSRB clients.

Outcomes Endorsing Success—PSRB has:

- Developed a key component guide for community-based PSRB programs.
- Revised and kept current its Conditional Release Handbook for case monitors.

Goal 2.2: Ensure that all case monitors and treatment providers servicing GEI clients have a basic minimum competence in the areas of risk assessment and forensic mental health.

Outcomes Endorsing Success—PSRB has:

- Developed an onboarding training manual—to be completed within 6 months of hire—that includes training on the following key topics:
  - Key Components for a successful PSRB program (once developed in Goal 2.1)
  - Trauma-Informed Care
  - Criminogenic Factors
  - Risk Needs Responsibility Model
  - Correct Use and Interpretation of START and Other Risk Instruments
  - Feedback-Informed Treatment
- Developed webinars on advanced training topics.
- Completed annual site visits (director, deputy, key partners from Oregon Health Authority) to provide site training and support leading to shared understanding, application of best practices, and strengthened partnerships.
- Developed a training handbook, and also coordinates collaboration opportunities (e.g. with OSH prescribers) for community prescribers.
- Held annual or biannual PSRB forensic conferences for OSH and community providers.

***Goal 2.3*:** Enhance opportunities for feedback, collaboration, and understanding of program practices across the State.

Outcomes Endorsing Success—PSRB has:

- Regularly highlighted, featured, or acknowledged (via website or statewide meetings) positive program accomplishments or practices happening in PSRB programs and/or the state hospital.
- Established a voluntary "open hours" consultation group for providers to enhance shared learning, problem-solving, and support.
- Established a peer-alumni group or other resource for the Board to obtain feedback from the clients it oversees.
- Revised and expanded the Conditional Release Guide to include more information about community-based residences and programs.
- Collaborated with the Oregon State Hospital to put on a conditional release fair for clients to learn more about conditional release placements.
- Developed bench cards for judicial officers.
- Increased JPSRB admissions[3] and petitions of relief.

3 PSRB will be examining the significant decreases in admissions for JPSRB over the past 5 years.

Initiative 3: Equip Board members with the tools, training, and support to help them make consistent, reasoned decisions while promoting procedural fairness and due process in a trauma-informed environment.

Goal 3.1: Formalize Board member on-boarding and create opportunities for ongoing professional development.

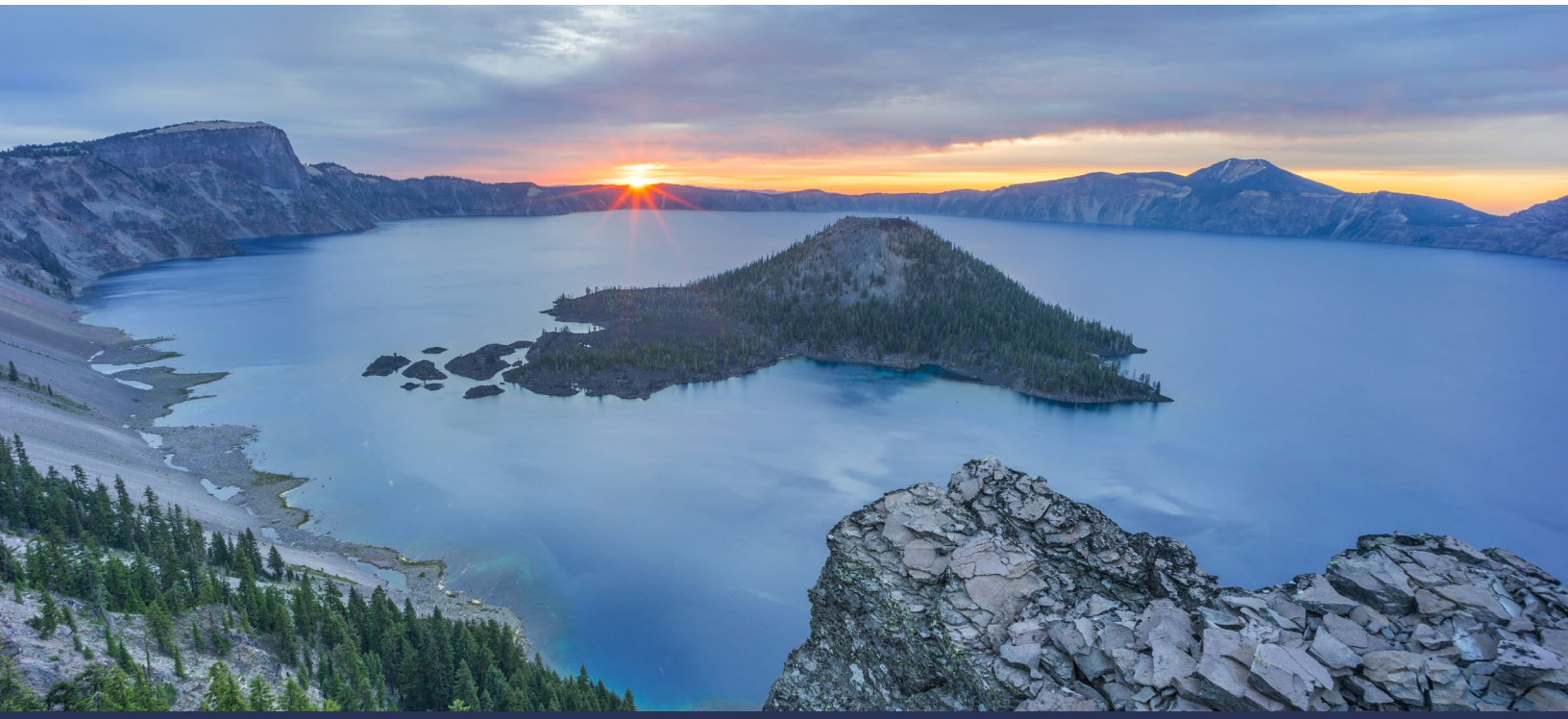
Outcomes Endorsing Success—PSRB has:

- Developed a comprehensive onboarding protocol for new Board members.
- Developed, deployed, and kept current a comprehensive practice manual that incorporates past legal advice.
- Developed, deployed, and kept current a policy handbook for hearings that incorporates both statutes and applicable case law.
- Provided periodic (at least annually) Board refreshers and new topic trainings including, but not limited to: new laws, judicial ethics, unconscious bias, and case law updates, as needed by the Board.
- Developed a peer mentor program connecting newer Board members with more experienced Board members.

Goal 3.2: Integrate Trauma-Informed Care principles into hearing proceedings.

Outcomes Endorsing Success—PSRB has:

- Engaged Board members and staff in trauma-informed care training.
- Used a Trauma Informed Care screening tool to assess and establish a baseline from which to make improvements to PSRB hearings and other agency practices.
- Identified changes that will increase Board and staff trauma-informed care practices and develop a timeline for implementation.



Initiative 4: Help stakeholders/partners (e.g. counties, law enforcement, district attorneys, local criminal courts, local hospitals) understand their rights and roles when working with PSRB clients.

Goal 4.1: The executive director or designee will establish a systematic approach to reach out routinely to legal communities and law enforcement across the State to strengthen collaboration and provide updated information, education, or other training related to agency operations.

Outcomes Endorsing Success—PSRB has:

- Identified venues, conferences, or other settings to provide PSRB 101 trainings to legal professionals.
- Developed a contact list of statewide legal professionals to which to send important legal updates, fact sheets, or other information relevant to the PSRB and legal community partnership.
- Revised and kept current templates, fact sheets, and handbooks for use by those in the legal community.
- Developed inter-agency protocols to enhance effective communication with law enforcement and the legal communities.
- Established a protocol to enhance communication and better collaborate with the criminal courts to ensure that new clients are effectively transitioned to PSRB's jurisdiction.

Goal 4.2: Increase understanding of PSRB's "revocation of conditional release" protocol among our community providers, law enforcement, county crisis teams, and local hospitals.

Outcomes Endorsing Success—PSRB has:

- Developed accessible, routinely reviewed and updated inter-agency protocols.
- Developed contingency plans for when a client's immediate transportation to a specified placement cannot be executed.

Initiative 5: Provide PSRB staff with an inclusive, collaborative, and safe office environment, where they have the training, resources, and communication necessary to effectively perform their job duties; receive timely, constructive feedback and praise; and have opportunities for professional development and growth.

Goal 5.1: Develop, deploy, and keep current internal policies and procedures.

Outcomes Endorsing Success—PSRB has:

- Compiled a table of contents of all current internal policies and procedures.
- Examined the need for additional internal policies and procedures and developed a plan for creating those deemed necessary.
- Developed a timeline for reviewing, updating, adding, and removing policies and procedures.
- Created and maintained a shared office binder that can be easily accessed and used (e.g. in staff meetings, workgroups) by all staff.

Goal 5.2: Implement a PSRB succession plan.

Outcomes Endorsing Success—PSRB has:

- Developed a succession planning strategy that assesses and forecasts workforce needs by identifying critical positions and developing competencies to meet those needs.[4]

Goal 5.3: Provide timely, constructive feedback about employee performance from supervisors, opportunities for professional development, and clear expectations about their job duties.

Outcomes Endorsing Success—PSRB has:

- Examined and revised the agency's performance appraisal process to improve opportunities for goal setting, constructive feedback, praise, and training/skill building needs.
- Identified and used a (not yet identified) tool periodically to assess employee satisfaction and provide management with employee feedback.
- Employees provide feedback via a (not yet identified) tool indicating that they are satisfied and have the tools necessary to do their jobs well.

Goal 5.4: Promote wellness, self-care, and safety in the PSRB 's office environment.

Outcomes Endorsing Success—PSRB has:

- Team building and self-care/wellness integrated into weekly staff meetings.
- A Trauma-Informed Care (or similar) tool it uses to assess the workplace environment and determine what changes could improve workplace comfort and safety.
- An employee wellness committee that is actively represented at team meetings.

4 The PSRB will develop a succession plan consistent with the State of Oregon's Secretary of State's Audit Division's 2017 Report and Department of Administrative Services recommendations.

Initiative 6: Expand, streamline, and make the PSRB's programs, research, and business needs more efficient by adopting secure, mature technology that is consistent with the State Chief Information Office's vision and adheres to requisite compliance standards.

Goal 6.1: Develop and implement an agency-specific Information Technology Plan.

Outcomes Endorsing Success—PSRB has:

- Completed a technological needs assessment.
- Developed a timeline and budget proposal for purchasing and implementing new technology.
- Implemented the use of secure email in its regular business practices.
- Developed, deployed, and kept current a process for ensuring compliance with security/confidentiality mandates and best practices.

Goal 6.2: Streamline the PSRB hearings process by identifying and implementing hearings management software.

Outcomes Endorsing Success—PSRB has:

- Automated our docketing process.
- Streamlined our witness identification and coordination efforts.
- Set up a process that allows us to complete the majority of orders within 48 hours of Board decisions.

Goal 6.3: Invest in software that increases efficiencies, uses secure and electronic storage and communications, and reduces waste.

Outcomes Endorsing Success—PSRB has:

- Implemented ORMS (Oregon Records Management Solution) technology.
- Implemented remote access to the shared network, reducing reliance on email, use of flash drives, and printing otherwise-available files; increased efficiency by working on/saving documents to one place.
- Centralized electronic storage systems to eliminate superfluous programs (e.g. Document Mall) and reduced costs.
- Reduced on-site space required for storing paper files.
- Provided electronic interfaces with partners to simplify and speed up document sharing.

Goal 6.4: Modernize our database to allow for more complex system communications, case tracking capabilities, and streamlining/more effective preparation for hearings.

Outcomes Endorsing Success —PSRB has:

- Completed a cost-benefit analysis of our current Access database and other comparable systems.
- Expanded data that can be used to recommend legislative and programmatic changes.
- Decreased emails from providers through a centralized, electronic method of submitting monthly reports, incident reports, and other documentation.

Goal 6.5: Establish partnerships with academic or other institutions to expand opportunities for data analysis and system improvements.

Outcomes Endorsing Success—PSRB has:

- Established a shared vision, mutual goals and objectives with an academic institution.
- Developed a research plan that outlines our research interests, action plan, and timelines for action.
- Integrated research interests and research findings into PSRB presentations.
- Submitted posters, papers, or panel presentations to professional conferences.

Psychiatric Security Review Board

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Psychiatric Security Review Board

Conditional Release and Community Treatment Facilities

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While under PSRB jurisdiction, an individual can be housed in the Oregon State Hospital or in a variety of residential treatment settings, ranging from Secure Residential Treatment Facilities to independent living. The PSRB determines what kind of facility is appropriate based on the level of treatment, care and supervision the individual requires.

Mission of the Psychiatric Review Board – Public Safety

Oregon State law is explicit that PSRB must put public safety first. ORS 161.336(10) states: 161.336(10) states: "In determining whether a person should be committed to a state hospital or secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society."

Conditional release under PSRB authority – Proven Public Safety Record

The PSRB has been successful in carrying out its mission. From January 2011 through December 2019, the PSRB placed individuals on conditional release 1,032 times. During that same time frame, those individuals who were living in the community on conditional release were convicted of new felonies or misdemeanors only 35 times.

The cumulative recidivism rate for the PSRB from 2011 through 2019 is less than one percent. By comparison, the most recent recidivism rate for individuals on Parole or Post-Prison Supervision is 18% and on Probation is 14% (CJC, 2019) after being on parole or probation for three years.

Most PSRB clients begin their treatment at the Oregon State Hospital. When clients are conditionally released they are carefully monitored by the PSRB. They are subject to immediate return to the state hospital if they violate the terms of their conditional release order.

PSRB SNAPSHOT (as of January 1, 2021)

620	Number of people currently under PSRB jurisdiction.
238	Number of people under PSRB jurisdiction in Oregon State Hospital.
375	Number of people under PSRB jurisdiction who are on conditional release from the state hospital.

SAFETY RECORD (January 1, 2011 to December 31, 2019)

1,032	Number of people on conditional release during the intervening 8 years.
35	Number of times those 984 people committed a felony or misdemeanor while on conditional release and were subsequently convicted of that crime.
0.83%	Cumulative annual recidivism rate for PSRB clients since 2011.
99.4%	Percent of adult conditional releases maintained in the community per month in 2019.

Psychiatric Security Review Board

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FAQs


OSH Hearings Room

Are people who have been found GEI ever sentenced to the Oregon State Hospital?
No. The GEI statute calls for individuals to be placed under the jurisdiction of the PSRB. The hospital is a secure place for psychiatric treatment, not for punishment.

How is the length of time at the Oregon State Hospital established?
The period of time PSRB clients stay at OSH varies by individual. The PSRB makes its decision to conditionally release someone based on a clinical assessment of the individual's mental status, progress in treatment at the hospital and risk assessments as to dangerousness as well as the availability of the appropriate resources in the community. If it is determined that a person can be safely managed and treated in a community setting, the PSRB attempts to find an appropriate placement.

Are PSRB adult clients ever discharged before their sentence is completed?
By law, the PSRB retains jurisdiction over clients who have a qualifying mental disorder that renders them a substantial danger to others when the disorder is active. In rare cases, a client found guilty except for insanity may be discharged early from the Board's jurisdiction. The 5 year average of these types of discharges by the PSRB is 6.4 per year, with 3 in 2018, 2 in 2019, and none in 2020. The overwhelming majority of clients complete their full sentence under the PSRB.

Is the state trying to move PSRB clients out of the state hospital and into the community, and what kind of impact will that have on public safety?
Because of additional funding from the Oregon Legislature since 2005, an increased number of PSRB clients have been moved into a variety of new community placements, including Secure Residential Treatment Facilities (SRTFs). Since more of these facilities have opened, there has not been any increase in the recidivism rate.

Is it safe to move people who have committed violent crimes into the community?
State law prohibits the Board from putting anyone on conditional release who is determined to be presently dangerous to others. Additionally, before individuals are released, they go through a comprehensive screening process that includes four levels of review. In all cases, including person-on-person crimes, victims who want notification are contacted in advance, as is the District Attorney's office that first prosecuted the case.

Conditional release is not a new policy. Most states in the US have some type of conditional release program. The PSRB has supervised clients in the community on conditional release since its inception in 1978. Over the past 20 years, more than 1,950 conditional releases have been granted to people who have transitioned into community placements throughout Oregon. Some of these clients remain under supervision for decades or even life.

Who is notified when someone is being considered for conditional release?
By law, the district attorney from the committing county is notified along with the judge who signed the judgment order. Also, the victim(s), if they requested such notification. The Attorney General's office, the client's attorney and the client's case manager are also notified.

For more information contact Alison Bort, Executive Director of the Psychiatric Security Review Board at (503) 229-5596.

WHERE PSRB CLIENTS LIVE (as of January 1, 2021)

Oregon State Hospital (37.9%)

- 238 individuals
- Locked 24/7, secure perimeter
- 24-hour supervision
- Off-site privileges based on public safety and level of care needed

Secured Residential Treatment Facility (11.3%)

- Locked 24/7
- Egress controlled by staff
- Off-site privileges based on public safety and level of care needed
- 6-16 individuals per facility

Residential Treatment Facility/Home (22.4%)

- Unlocked
- 24-hour awake supervision
- Up to 16 individuals per facility

Adult Foster Home (3.1%)

- Unlocked
- 24-hour staff
- Up to 5 individuals
- Some clients with state variance allow for four hours home alone

Semi-Independent/Supported Housing (6.9%)

- Varies from individual apartments to shared housing
- Staff part time at the site

Intensive Case Management (1.9%)

- Independent living
- Staff contacts at least twice per day with at least one contact at residence
- Case management team

Independent Living (self, with family) (14.2%)

- In regular apartments or houses
- Frequent home visits by case manager

Other (Department of Corrections) (1.8%)

PSRB Legislative Workgroup Work Plan

Meeting #	Date/Time	Issues	Subtopics	Relevant Background
1	**9/19/19**	**Identifying Scope of WG** **Discussion Issues**		
2	**10/25/19**	**Court Ordered Conditional Release** **Stipulations to GEI**	• Process for Court Ordered CR • Resources for Court Ordered CR	• Relevant statutes • PSRB Handbook • Basic Data (to be gathered) • Data on these occurrences • Survey of state statutes on GEI stipulation
3	**11/21/19**	**Evaluations (GEI; 426; CMHP)**	• Content • Consistency • Quality • Training/Qualifications • Oversight • Resources Access (LEDS)	• Relevant statutes • Information on current training and qualifications • Overview of current oversight program
4	**12/13/19 (9-11a) Portland**	**Evaluations** **Number of evals required for GEI finding**	• See above	• Research on other state practices

		Definition of a Qualifying Mental Health Disorder	• Substance Abuse Induced Qualifying Mental Health Disorder	• Social Science Research on Relevant Mental Health Disorders • Social Science Research on Substance Abuse induced disorders
5	**1/16/20 (2-4p) Salem**	**Community Resources**	• Resource continuum • Resource location • After care for clients ○ Discharge plans • Housing • Transportation • Law Enforcement notice • Peer Support • Oversight/Ombudsman	• Resource Maps • Sample Contract • Presentation
(CANCELED)	**2/14/20 (9-11a) Salem**	**JPSRB** *JPSRB Moved to Small Group* **Clients who Malinger/Fraudulent pleas** *Rescheduled to October 9, 2020*		
(CANCELED)	**3/20/20 (9-11a) Portland**	**Early Discharge** *Rescheduled to June 26th*		

(CANCELED)	**4/16/20 (9-11a) Salem**	**Early Discharge Cont.** *Rescheduled below* **Data** *Canceled Topic*		
(CANCELED)	**5/15 Portland (9-11a)**	**421 Civ Commitment** *Rescheduled to August 21*		
(CANCELED)	**6/26/20 (Zoom)**	**Early Discharge** *Rescheduled to 7/24/20*		
6	**7/24/20 (Zoom)**	**Workgroup Update on Process and Small Groups** **Early Discharge** **Length of Jurisdiction** **Determination of continued jurisdiction at every hearing** **Early Discharge Topics Continued**	• Burden of Proof • Nexus between Danger and QMHD • Evidentiary Requirements • Notice Requirements • Who should have jurisdiction to make this decision (PSRB or en banc PSRB or Circuit Court) • Should Board have deliberation time • Should this be permitted directly from OSH • Type of sentencing/Indeterminate sentencing	• Presentation • National Insanity Laws • Report Draft Distributed

7	**8/21/20**	**421 Commitments** **Report Discussion**	• Hold provisions • 6 mo hearing standards • Transitions • Venue • Moving forward with Report Writing	• Presentation • Draft of Report
8	**10/9/2020**	**Malingering/Fraudulent Pleas** **Planning Future Work**	• How do we deter or disincentivize? • Should this be a crime? • Is there a way to resentence (w/in the due process/double jeopardy clauses of the constitutions?) • Subcommittee update	• Example legislation on Malingering/Fraudulent pleas • Malingering Presentation
10	**12/11/20**	• **Person-Centered Language & Board Oversight/Composition** **Court Conditional Release** **421 Civil Commitments**	• Does the Board require additional oversight? • How to implement more person-centered language. • Should the Board be expanded/specify public member credentials? • LC 1672: Needed amendments • LC 1647—Update from 12/4 subcommittee	• Summary of current and potential oversight strategies. • Statutes with "adequately controlled" • LC 1672 (Court conditional release) • LC 1647 (Civil Commitments)

		Early Discharge **Report Writing** **Wrap-Up**	• Should we introduce a concept addressing the inconsistencies of the PSRB Discharge Statutes, update from 10/2 subcommittee • Drafting the remainder of the report process. • Next steps, future of the Workgroup, appreciations and gratitude	• Review of previous distributed materials • Draft report available now

SMALL GROUPS				
JPSRB	**10/5/2020**		• Viability of JPSRB • Resources under JPSRB	• OCDLA Research re: JPSRB
PSRB-Law Enforcement Partnership	**10/5/2020**		• Law Enforcement transport • Law Enforcement role during contact with PSRB individual • Law Enforcement communication	• ORS 161.336 • Revocation Protocol • Revocation FAQ
421 Civil Commitment	**10/5/2020**		• Developing a legislative concept	• Drafted leg concept
Early Discharge	**10/2/2020**		• Developing a legislative concept	• Comparative State Statutes • CT Discharge Statute

				• BOPPPS Evaluation Authority • Review of presentation
Court Conditional Release	**10/30/2020**		• Developing a legislative concept	• Draft of Report on Court Conditional Release • Drafted leg concept
421 Civil Commitment	**12/4/2020**		• Review of LC 1647	• LC 1647

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13	Elaine Sweet		
14	Elie Steinberg		

PSRB Workgroup, 11/21

Table with Links to Relevant Materials

Evaluations (GEI; 426; CMHP) **Number of evals required for GEI finding**	• **Content** • **Consistency** • **Quality** • **Training/Qualifications** • **Oversight** • **Resources Access (LEDS)**	• **Relevant statutes** • **Information on current training and qualifications** • **Overview of current oversight program**

This document includes all of the listed materials as well as links to electronic versions, where applicable

- **Issue List for PSRB workgroup (previously sent)**
- **Certified Forensic Evaluations in General**
  - **House Bill 3100**
  - **OAR 309-90:** Forensic Mental Health Evaluators and Evaluations
- **Criminal Responsibility Evaluations**
  - **ORS 161.309:** Notice and report prerequisite to defense
  - **OAR 309-90-0025:** Content of Written Evaluations Assessing Competency and Criminal Responsibility
- **CMHP Evaluations**
  - **PSRB Community Evaluation Handbook**
  - **OAR 309-019-0160:** OHA-HSD rules related to PSRB evaluations
  - **OAR** 859-070-0020: PSRB rules related to GEI CR evaluations
    OAR 859-200-0205: PSRB rules related to Civil Commitment CR evaluations
- **Civil Commitment Evaluations**
  - **ORS 426.701, 426.702**
  - **Initial Evaluation for PSRB Civil Commitment**
    - **ORS 426.120 Examination report; rules**
    - **ORS 426.110 Appointment of examiners; qualifications; costs**
  - **Certification process for subsequent PSRB Civil Commitment**
    - **ORS 426.702**
- **National Analysis of Evaluations Required for a GEI Defense (attachment)**

An Argument for/against Court-Appointed Psychiatric Evaluations
Prepared in Consideration for the 2019-21 PSRB Legislative Workgroup (12/2020)

Elie Steinberg, PSRB Extern

Although only a small percentage of felony prosecutions result in a successful insanity claim, this area of law garners a lot of attention because of its highly contested nature and inconsistency among states. Because of the Insanity Defenses "popularity," the lack of authority on the subject of court-appointed psychiatric evaluations was surprising.

In California, when a defendant pleads not guilty because of insanity, the court will select psychiatrists or licensed psychologists to examine the defendant and investigate his or her mental status. These court-appointed evaluations are paid for by the county where the indictment was found or in the county where the trial was held.[1]In Oregon, when a defendant pleads not guilty because of insanity, the court will order a psychiatric evaluation. Unlike California, a financially eligible individual—instead of the court—is subject to the cost of a psychiatric evaluation. Alternatively, the executive director of the public defense services can pay a reasonable fee for the evaluation collected from the appropriate defense funds.[2] The State and the Oregon State Hospital can also provide psychiatric evaluations for the defendant on their own financial terms.

If an individual cannot afford the cost of an attorney or psychiatric evaluation to plead the Insanity Defense, they have the right to a court-appointed attorney and a court-appointed psychiatric evaluator as guaranteed by the Sixth Amendment of the Constitution. [3] Therefore, on a case by case basis, Oregon does pay for court-appointed evaluations like California. A major difference is that when Oregon provides an indigent defendant with a court-appointed attorney, the State may still provide a psychiatric evaluation for the defendant as well. In California, the State is not subject to provide an evaluation—the court-appointed evaluation is the sole evaluation.

A significant reason that Oregon may not want to adopt California's court-appointed evaluation approach boils down to cost. Oregon would be paying for every court-appointed evaluation instead of only those for indigent individuals asserting the Insanity Defense. To determine if paying for each court-appointed evaluation would be overly burdensome on Oregon, it would be essential to identify how many individuals could have paid for this evaluation but were not subject to in California. The PSRB can obtain these statistics and answer these questions by reaching out to different attorneys and specialists working with the Insanity Defense in California. If the cost is high for Oregon, there is an argument that, like all defenses, an individual is subject to pay for any expert witnesses and the Insanity Defense is no exception. I would also be curious if private health insurance or Medicaid costs ever cover psychiatric evaluations.

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[1] Cal. Penal Code § 1027
[2] ORS 161.309 5B
[3] U.S. Const. amend. VI

One argument for court-appointed evaluation appears in *Verdin v. Superior Court*. In this case, the plaintiff, Mr. Verdin, was charged with premeditated and deliberate attempted murder, assault with a firearm, willful discharge of a firearm in a grossly negligent manner, corporal injury on a spouse, and felony child endangerment. After Mr. Verdin pleads guilty except insanity, the prosecution requested access to Mr. Verdin for purposes of mental examination. The defense objected to Mr. Verdin's participation in an evaluation by the prosecution's expert and the Trial court granted the prosecution's request. The question of whether Mr. Verdin was subject to an examination of his mental state by the prosecution's expert ultimately made it to the Supreme Court of California for review. The Supreme Court of California reversed and remanded the case.[4]

The Supreme Court instructed the Court of Appeals to issue a writ of mandate to the district court, requiring the court to vacate the defendant's previous order to participate in the evaluation.[5] Under California's criminal discovery statutes and the Constitution, there is no mandate providing that a defendant be subject to an examination by the prosecution's expert.[6] The court identifies that allowing the prosecution to choose an expert to examine the defendant while simultaneously subjecting the defense to the court-appointed expert may unequally assist the prosecution in disproving the defendant's mental state claim.[7]

An argument in favor of Oregon adopting court-appointed psychiatric evaluations for individuals pleading the Insanity Defense is that it will provide a uniform approach that preserves the rights of indigent defendants in mental health cases. Oregon's current psychiatric evaluation standard creates the type of evidentiary imbalance that the California Supreme Court in *Verdin* was trying to avoid. [8]By allowing the prosecution to retain its expert when the indigent defendant is appointed a psychiatric evaluator, the prosecution is given an unfair advantage in disproving the defendant's mental state claim. By adopting California's court-appointed evaluation approach and not allowing the prosecution to retain its own expert, Oregon would preserve every defendant's rights, no matter their socioeconomic background.

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[4] Verdin v. Superior Court, 43 Cal. 4th 1096, 183 P.3d 1250 (2008)
[5] Section 1054 of Proposition 115,
[6] (Cal. Penal Code § 1054 et seq.)
[7] Diminished Capacity and the Right to Refuse Mental Examination, Martha S. Smith, Rachel Kalbeitzer, Ira K. Packer, Journal of the American Academy of Psychiatry and the Law Online Sep 2009, 37 (3) 401-404;
[8] *Id*

PSRB Legislative Workgroup
December 13, 2019
Qualifying Mental Disorder (QMD)

Basic facts

- QMD is the baseline to establish a GEI verdict
- Legislature has not provided a definition
    - Comes from OARs, case law
- QMD is a legal term, not a clinical one
- No definitive framework about which clinical conditions are a QMD
- A person can have a QMD and not satisfy either of knowledge/conforming conduct prongs

QMD definitions

- PSRB OAR 859-010-0005
    - (a) A developmental or intellectual disability, traumatic brain injury, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of the defendant's or youth's functioning and is defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association.
    - (b) Any diagnosis of a psychiatric condition which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of the defendant's or youth's functioning and is defined in the DSM-5.
    - QMD includes
        - A disorder in a state of remission which could with reasonable medical probability occasionally become active; or
        - A disorder that could become active as a result of a non-qualifying mental disorder.
    - Non-QMD is defines as a mental disorder in which the condition is
        - A diagnosis solely constituting the ingestion of substances (e.g., chemicals or alcohol), including but not limited to alcohol-induced psychosis;
        - An abnormality manifested solely by repeated criminal or otherwise antisocial conduct; or
        - An abnormality constituting a personality disorder

- OHA OAR 309-090-0005(25): Definition of QMD
    - (a) A developmental or intellectual disability, traumatic brain injury, brain damage or other biological dysfunction that is associated with distress or disability causing symptoms or impairment in at least one important area of the defendant's or youth's functioning and is defined in the current Diagnostic and

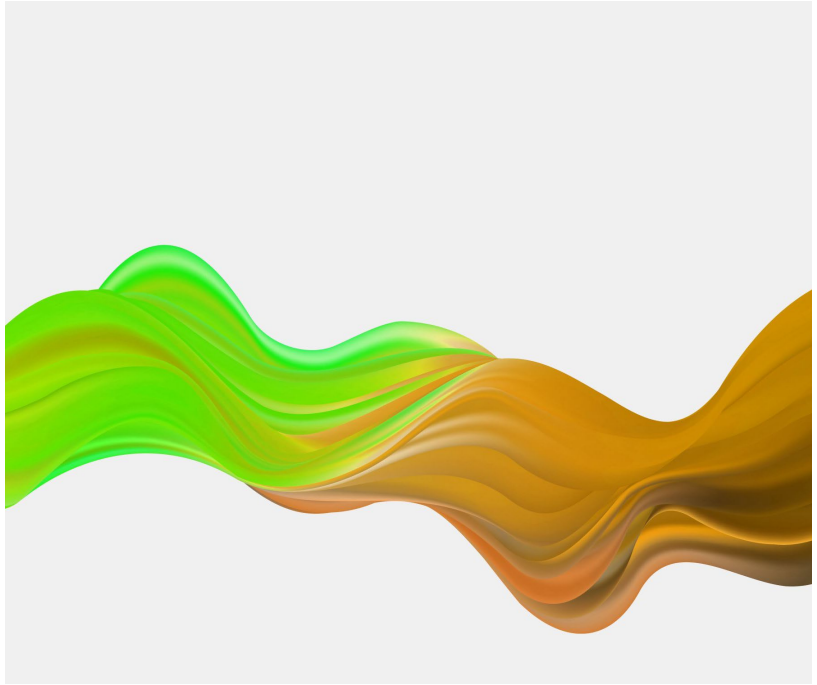
Statistical Manual of Mental Disorders (DSM-5) of the American Psychiatric Association.
    - (b) Any diagnosis of a psychiatric condition which is a significant behavioral or psychological syndrome or pattern that is associated with distress or disability causing symptoms or impairment in at least one important area of the defendant's or youth's functioning and is defined in the DSM-5.
    - (A) A diagnosis solely constituting the ingestion of substances (e.g., chemicals or alcohol), including but not limited to transitory, episodic alcohol or drug-induced psychosis;
    - An abnormality constituting a personality disorder; or
    - Constituting solely a conduct disorder for a youth.

- Excluded from QMD
    - Sexual misconduct disorder (*Beiswenger v PSRB*, 1998)
    - Combination of mental disease and voluntary intoxication (*State v Peverieri*, 2004)
    - Substance dependency (*Tharp v PSRB*, 2005)
    - Alcohol dependence (*Ashcroft v PSRB*, 2005)

Questions for discussion (in no systematic order):

- Can drug-related disorders and cooccurrence of drug use and QMD be better clarified given the complexity these present?
- Should severe and persistent personality disorders be considered as potential QMD?
- Should there be legislative input about what a QMD is?
- How can we provide better guidance in understanding QMD and allow for diagnostic (DSM) changes over time?
- Should QMD be the same in fitness to proceed (competency) and GEI cases, or are there areas where they should/could differentiate?

Malingering and the assessment of response style



A PRESENTATION FOR THE PSRB LEGISLATIVE WORKGROUP

MICHELLE R. GUYTON, PH.D. ABPP

NORTHWEST FORENSIC INSTITUTE

OCTOBER 9, 2020

Assessment of Response Style

“A consideration of malingering must be present in every evaluation.” (OAR 309-090-0060)

What is the ultimate purpose of assessing response style?

- To determine if the other data obtained from the examinee are valid. (Boone, 2007)

Feigned symptoms of pathology is important, but other types of response style have been neglected (Otto, 2008).

Prevalence of malingering in FTP evaluations

- 8% of criminal defendants in 314 FTP or GEI evaluations in Michigan Center for Forensic Psychiatry identified by clinicians as malingering (Cornell & Hawk, 1989)
- 29% of 154 defendants referred for forensic evaluation in federal penitentiary identified as malingering using the SIRS (Boccaccini et al., 2006)
- 21% of FTP assessments, using SIRS (Vitacco et al., 2007)
- 17% of IST admissions at Napa SH possibly malingering; 94% of these confirmed using more extensive, multiple measures (McDermott et al. (2017)

Categories of Response Style

Negative Impression Management

- Exaggeration/help-seeking – “cry for help”
- Feigning – deliberate fabrication or gross exaggeration of symptoms, regardless of motivation
- Malingering – deliberate fabrication/exaggeration of symptoms to fulfill an external goal
  - “The distortion must be *intentional,* the distortion must be *gross,* and the distortion must be directed towards something tangible ...” (Rubenzer, 2020)

Positive Impression Management

- Defensiveness – opposite of malingering; deliberate denial or gross minimization of symptoms to attain external goal

Disengagement

- Suboptimal effort due to internal states, comorbidity, or malingering

Costs and Benefits of a Malingering Label
(Rubenzer, 2020)

Costs

- May exceed scope of court order
- May require disclosure that assessing malingering is part of the exam
- Creates legal jeopardy for the examinee
- May be more prejudicial than simply reporting low effort
- May require "excessively long" assessments
- Risk of a false dichotomy

Benefits

- In many cases, a label of malingering or feigning is probably accurate and most informative to the court.
- Provides the Court with a means to punish feigning or malingering, potentially reducing its prevalence
- Facilitates proper punishment if guilty and lessens burden on forensic mental health system

Why do people malinger?

Fear/avoidance of negative consequences

- Going to court/facing charges
- Going to prison
- Work
- Military service

Obtaining

- Medication
- Housing/benefits
- Financial compensation

Malingering as an adaptation strategy

Who malingers?

No one type of person or condition predisposes a person to malinger

Conditions/situations that elevate the possibility:

- Legal setting (criminal/civil)
- Antisocial personality disorder

Malingering is dynamic

How do we assess for malingering: Interview

- Look for (in)consistency:
  - Comparing multiple sources of data
    - Self-report – observation
    - Self-report – record data
  - Across time
- Compare with known phenomenology of mental illnesses
  - Odd symptom co-occurrence
  - Endorsing all the symptoms
  - Atypical presentation of the symptoms
- Endorsement pattern

How do we assess for malingering: Testing

SYMPTOM VALIDITY TESTS

Mental health symptoms

Assess for unusual symptoms, rare combinations, high severity

Compare to scores developed from genuine and feigning groups

Common tests: M-FAST, SIRS-2, SIMS, validity scales of personality tests

EFFORT TESTS

Cognitive abilities

Assess for good effort, trying hard

Compare to known rates

Common tests: TOMM, WMT, 21-item test, embedded measures

Fitness to proceed and GEI specific considerations for malingering

In fitness to proceed (FTP) evaluations:

- Is there a history of prior adjudicative in/competence?
- What is the level of cooperation (too revealing vs. noncooperative)?
- Does examinee claim ignorance of basic information?

In guilty except for insanity (GEI) evaluations:

- Consider all of the FTP criteria
- Does current alleged criminal conduct mirror prior patterns of behavior?
- Does person report sudden inability to understand basic right from wrong?
- Does person report sudden inability to control impulses?
- Was there a partner in the crime?
- Is there an alternative, nonpsychotic motive for the crime?
- Is there simultaneous denial of responsibility and attribution of crime to mental illness?

Early Discharge/ Length of Jurisdiction

Presented to PSRB workgroup to provide overview of relevant legal authority and issues to consider for legislative or other change

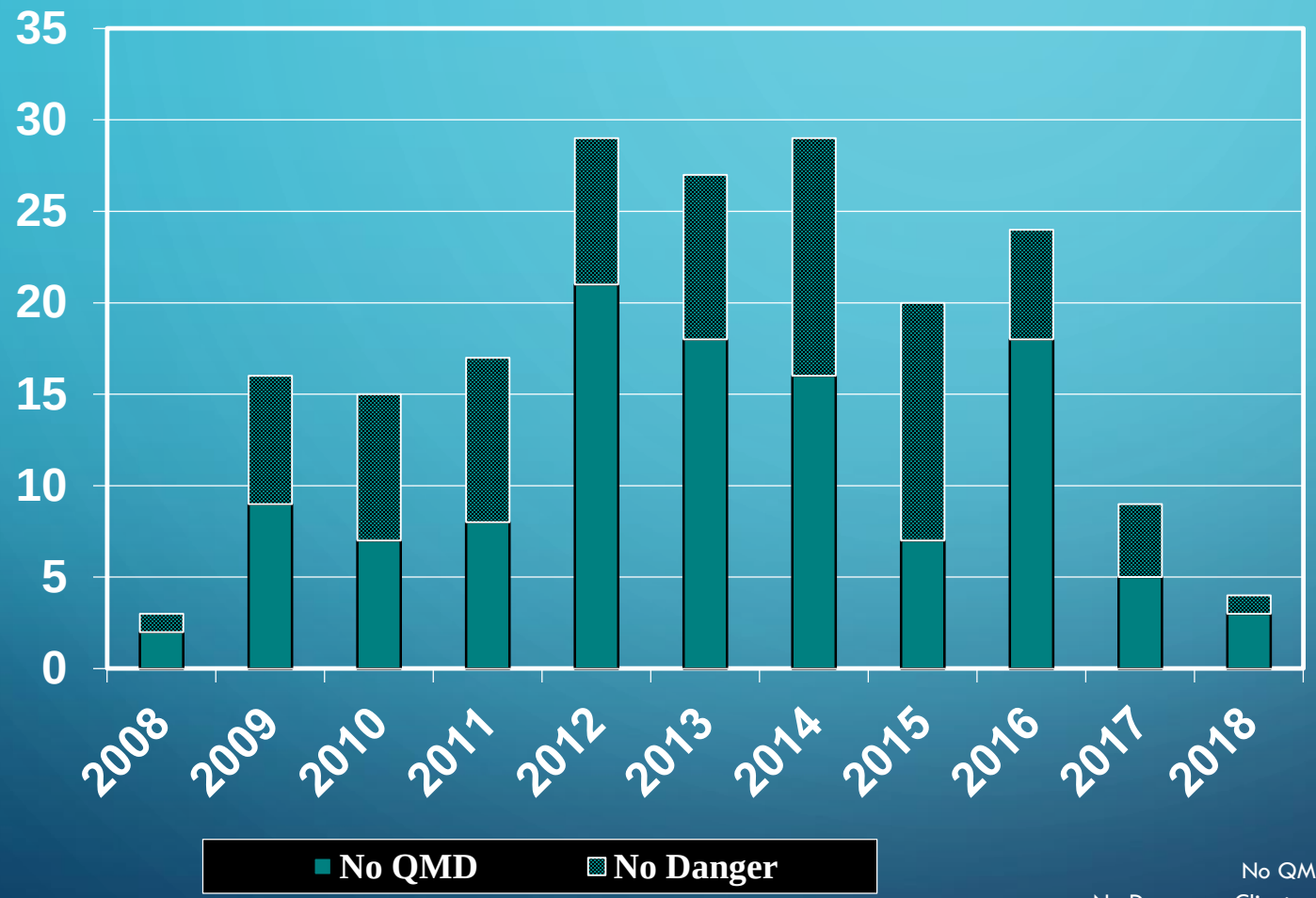
At every hearing, PSRB must determine whether:

- The individual has a qualifying mental illness;
- The individual is a substantial danger to others; and
- If yes to both of the above, is the qualifying mental illness connected to the dangerousness.

- **If the answer is “no” to any of the above 3 criteria, the PSRB must discharge the individual for lack of jurisdiction**

GEI EARLY DISCHARGES

(BY YEAR)



2018* (MD=3) (D=1)

2017* (MD=3) (D=5)

2016* (MD=18) (D=6)

2015* (MD=7) (D=13)

2014* (MD=16) (D=13)

2013* (MD=18) (D=9)

2012* (MD=21) (D=8)

2011 (MD=8) (D=9)

2010 (MD=7) (D=8)

2009 (MD=9) (D=7)

2008 (MD=2) (D=1)

No QMD = Client has no qualifying mental disorder

No Danger = Client no longer poses a substantial danger to others

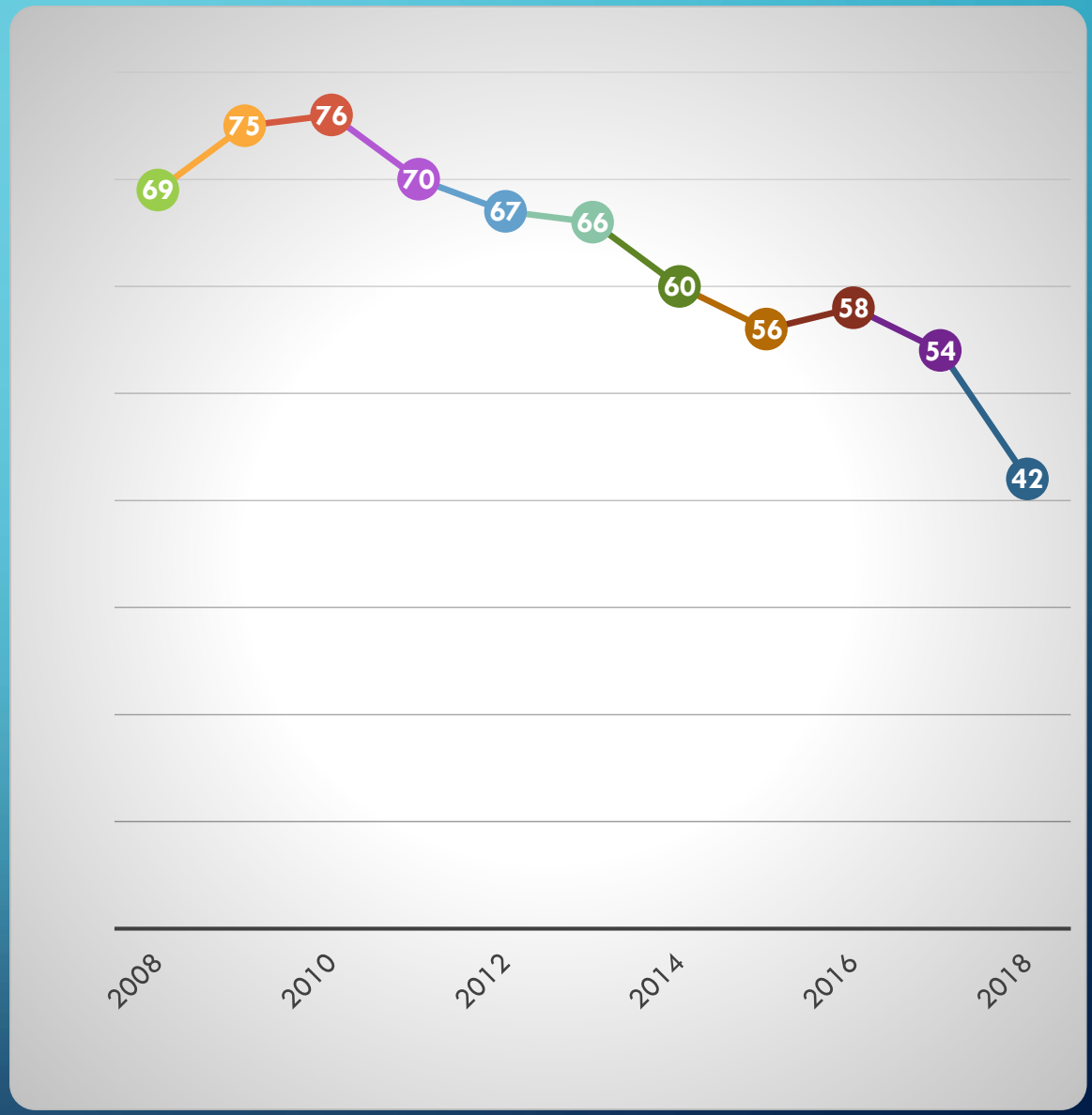
*Includes SHRP discharges

1/1/2012 - GEI clients split between PSRB and SHRP

6/30/2018 - All GEI clients returned to PSRB jurisdiction

TOTAL ADULT PSRB DISCHARGES (CLIENTS, BY YEAR)

- 2018 42
- 2017 54
- 2016 58
- 2015 56
- 2014 60
- 2013 66
- 2012 67
- 2011 70
- 2010 76
- 2009 75
- 2008 69



Benefits of an Early Discharge and Max Sentencing Statute

Jurisdictional Discharge No Longer Dangerous

- Jurisdictional discharge based on resolved or managed QMD ***and*** finding that the person is no longer a substantial danger even when that disorder is active.

Jurisdictional Discharge No MDD or No Nexus

These are cases where everyone one in the room, even the defense in some cases, agrees the client is dangerous. The issue is whether they have a QMD or whether that QMD is sufficiently connected to that dangerousness.

- The person will receive no supervision whatsoever
- Re-traumatizing to Victims
- Public perceptions - “gets away with a crime”
- Puts Public Safety at Risk (likely to re-offend)
- Microscope and tort liability claims for the PSRB if/when that person offends in the future

Jurisdictional Lapse/End of Jurisdiction

- These are cases were the person has reached their end of jurisdiction, but continue to have a qualifying mental disorder and are regarded as substantially dangerous. Examples:
  - Refuse to engage in any discharge planning
  - Describe plans for post-jurisdiction of great concern to public safety (e.g. stopping medication and treatment; starting substances or pre-offense behaviors)
  - Have had little to no time on conditional release during their period of jurisdiction
  - Fall short of civil commitment criteria

Jurisdictional Lapse/End of Jurisdiction

- These can also be cases where the person was psychiatrically stable at the time jurisdiction ends. Examples:
  - Does not meet criteria for particular services due to they type of mental disorder or behavioral issues that require ongoing treatment (e.g. TBI, Sex Offender Treatment)
  - Do not meet criteria for the level of care they were in under PSRB
  - Unable to access housing
  - The case of Mr. D: https://www.eastoregonian.com/news/pendleton-man-accused-of-assaulting-16-year-old-girl/article_a2f51f12-a518-11ea-9888-93e0edfd0d2d.html

The primary concern is protection of society

- PSRB's decisions related to discharge, conditionally release, or committed to the state hospital, emphasize that the "primary concern is the protection of society."
  - ORS 161.327(2)
  - 161.327(3)(c)
  - 161.366(1)(a)
- Also consider:
  - Ore. Const. Art. I § 15 "Laws for the punishment of crime shall be founded on these principles: protection of society, personal responsibility, accountability for one's actions and reformation."
  - ***Drew v. PSRB*, 322 Ore. 491 (1996)** Protection of society does not outweigh the need for PSRB to ensure there is substantial evidence supporting its findings.
  - ***Newton v. Brooks*, 246 Ore. 484, 489 (1967**) (commitment under former GEI statute "is intended to protect the public from the premature release of a dangerous offender who has been acquitted of criminal liability under the *M'Naghten* test. If a mental disorder makes the person's freedom a hazard to society, public safety may require his detention."
  - ORS 161.025(d, f, g) Purposes; principles of construction.

CRIMINAL COURT DISCHARGE STATUTES

ORS 161.327(1)

COMMITMENT / CR OF PERSON FOUND GEI OF FELONY

(1) After the defendant is found GEI, if the court finds by a preponderance of the evidence that a person found guilty except for insanity of a felony is affected by a qualifying mental disorder and *presents a substantial danger to others*, the court shall order as follows:

(a) Commitment to OSH

OR

(b) Conditional release

ORS 161.329(1)

ORDER OF DISCHARGE

After the defendant is found GEI, the court shall order that the person be discharged from custody if:

(1) The court finds that the person is no longer affected by a qualifying mental disorder, or, if so affected, no longer *presents a substantial danger to others and is not in need of care, supervision or treatment*;

BOARD DISCHARGE STATUTES

ORS 161.346

APPLICATION FOR DISCHARGE OR CR

(1) …If the board finds that a person under the jurisdiction of the board:

(a) Is no longer affected by a qualifying mental disorder, or, if so affected**, no longer *presents a substantial danger to others*,** the board shall order the person discharged from commitment and conditional release.

ORS 161.351

DISCHARGE BY BOARD

(1) Any person placed under the jurisdiction of the PSRB shall be discharged at such time as the board, upon a hearing…[when] that the person is no longer affected by a qualifying mental disorder or, if so affected, ***no longer presents a substantial danger to others that requires regular medical care, medication, supervision or treatment.***

(2) [Remission]. A person whose qualifying mental disorder may, with reasonable medical probability, occasionally become active ***and when it becomes active will render the person a danger to others*** may not be discharged.

ORS 161.336

CONDITIONAL RELEASE BY AGENCY; TERMINATION OR MODIFICATION OF CR; HEARING

(5)(a) Any person conditionally released under this section may apply to the board for discharge from…an order of conditional release on the ground that the person is no longer affected by a qualifying mental disorder or, if still so affected, ***no longer presents a substantial danger to others and no longer requires supervision, medication, care or treatment***.

TIMING OF DANGEROUSNESS

GEI DEFENSE ORS 161.295

- A person is guilty except for insanity if, as a result of a qualifying mental disorder at the time of engaging in criminal conduct, the person lacks substantial capacity either to appreciate the criminality of the conduct or to conform the conduct to the requirements of law.

PSRB JURISDICTION—HISTORICAL, PRESENT, FUTURE

- OAR 850-010-0005(7) "Danger"; "Substantial Danger"; or "Dangerousness" means a demonstration or previous demonstration of intentional, knowing, reckless or criminally negligent behavior which places others at risk of physical injury because of the person's qualifying mental disorder.
- But also ORS 161.351(2) A person affected by a qualifying mental disorder in a state of remission is considered to have a qualifying mental disorder. A person whose qualifying mental disorder may, with reasonable medical probability, occasionally become active ***and when it becomes active will render the person a danger to others*** may not be discharged.

“Substantial Danger”

Determinations of future dangerousness suffer from inherent uncertainty, because future human action is inherently uncertain. Such a decision, involving (as it necessarily does) evaluation and weighing of a person's character, capabilities, mental health, and personal history, is akin to parole decisions in the traditional criminal law arena.

***Drew v. PSRB*, 322 Ore. 491 (1996)**

- Trial court stipulation over the crime of forgery in the 1st degree resulting in GEI adjudication and court conditional release, which resulted in a revocation 3 weeks later.
- Discharge request at next hearing based on no substantial danger to others.
- Court of Appeals: It would have been permissible for PSRB to infer that petitioner's condition, so recently adjudicated, persisted in light of a dangerousness to others finding seven weeks prior.

OAR 859-010-0005(7)

"Danger"; "Substantial Danger"; or "Dangerousness" means a demonstration or previous demonstration of intentional, knowing, reckless or criminally negligent behavior which places others at risk of physical injury because of the person’s qualifying mental disorder.

LENGTH OF/END OF JURISDICTION

- **161.328 Commitment of person found guilty except for insanity of misdemeanor** (2) The total period of commitment under this section *may* not exceed the maximum sentence provided by statute for the crime for which the person was found guilty except for insanity.
- **SB 420 (2011)**: Provided discretion for the judge to sentence less than the maximum sentence.
- **HB 2556 (2015)**: Proposed that maximum period of commitment or conditional release of person found guilty except for insanity of felony is equal to presumptive sentence person would have received under sentencing guidelines of Oregon Criminal Justice Commission (failed).

Overview of Early Discharge Issues

- **Burden of proof at discharge-** is preponderance sufficient?
- **Nexus between danger and QMHD for early discharge-** should we clarify whether a nexus between the QMHD and danger is necessary to continue jurisdiction? This is required to establish GEI but less clear when I comes to early discharge
- **Should specific evidence be required?** (Eval? Violence risk assessment? No active symptoms/acuity of symptoms? Specific level of care?)
- **Should there be a notice requirement for early discharge requests?**
- **Should the board be given additional time to deliberate?** When and how much?
- **Should the PSRB retain authority to grant early discharge? Should this be a circuit court decision? Should it require the full board or an "en banc" decision?** What do other states do?
- **Currently jurisdiction of the PSRB must be established at every hearing, should this change?** This leads to "surprise" discharges and discharge requests. Should there be a notice provision if a client seeks to challenge jurisdiction or make a request for discharge?
- **How should "substantial danger" be defined, particularly in relation to future dangerousness?** Increased clarity to assist treatment providers and persons under the PSRB with where to focus treatment goals.
- **Early discharging directly from the hospital can be problematic-** should this be prohibited? Should stepping down be required or considered formally? Should jurisdiction be extended until an individual is living in the community?
- **People sometimes discharge without formal plans-** Should there be Mandatory end of jurisdiction hearings 1 year and/or 6 months prior to end of jurisdiction discharge?

Substantial Danger to Others
Prepared in Consideration for the 2019-21 PSRB Legislative Workgroup (12/2020)
Elie Steinberg, PSRB Extern

From what I have looked at thus far, I did not find any statutes, administrative rules, or case law that would help to clarify "substantial danger to others" or that I would recommend adopting in Oregon. Section 859-010-0005 of Oregon's Administrative rules is more descriptive than rules or statutes from most other states.

Using the nine states that provided information, I identified three categories to better understand how different states define "substantial danger to others" related to retaining/discharging a person who successfully asserted the insanity defense before a supervising authority.

Categories

Totality of the Evidence
Connecticut, Arizona, Mississippi, and Wisconsin

Within this category, the states present very brief definitions of "substantial danger to others" or do not expand on the meaning at all. Instead, each state identifies that the best practice to determine a client's future dangerousness is through a balancing test by trial court judges/ PSRB.

These states consider the *totality of the evidence* when determining whether an acquittee would or would not present danger to himself or others if discharged from the Psychiatric Security Review Board's or another governing body's jurisdiction.

For example, Arizona's *Danger to Others* standard solely addresses severe physical harm that does not need to be intentional (A.R.S Title 36). The statute leaves it to the Board to consider the client's entire criminal history and determine from those facts whether the individual has a propensity to re-offend.

Similarly, in Wisconsin, to determine if the client poses a significant risk of bodily harm to himself, herself, others, or of serious property damage, the court considers the nature of the client's crime, their mental history, where they live, how the person will support themselves, what future arrangements they have set up, etc. (Wis Stat 971.17(4)(d)(d)).

Connecticut case law argues that the determination of dangerousness in the context of a discharge hearing reflects a societal, rather than a medical judgment (*State v. Dyous*). Therefore, in deciding if a client is dangerous in these states, the Board or governing jurisdiction may reference the legislation—but ultimately comes to a legal decision based on the totality of the evidence.

Some Legislative Guidance
New York and Virginia

These statutes (especially New York's statute) were comprehensive and workable. Both New York and Virginia supply guidelines for assessing the future dangerousness of a client who is petitioning or appealing for discharge from the jurisdiction.

The Virginia statute provides the court with questions on how to assess the likelihood in the foreseeable future that the client will "engage in conduct, presenting a substantial risk of bodily harm" to himself or others. The statute also confronts the likelihood that an outpatient program can control the client upon discharge. (VA ST § 19.2-182.3).

Similarly, New York's statute provides guidelines for assessing the speculation of dangerousness by requiring the court and psychiatry team to automatically measure the clients' level of dangerousness after the trial verdict. New York also uses this level of dangerousness to determine the track or degree of supervision necessary to treat the insanity acquittee's condition; therefore, safeguarding both the acquittee and the public. This system seems unique to insanity acquittees, employing a step-down process from secure confinement to discharge and, therefore, a higher judicial and prosecutorial involvement throughout the process.

No Legislative Guidance
Ohio, Missouri, and Tennessee

These state's statutes do not provide any helpful clarification of "substantial danger to others."

In Tennessee**,** discharge occurs for acquitees when they no longer meet the standards for admission. The admission standards include that a person (1) has a mental illness, and (2) the person poses a substantial likelihood of serious harm because of the mental illness or serious emotional disturbance. Tennessee does not provide any further clarification on the "substantial likelihood of serious harm."

Missouri and Ohio do not mention anything regarding dangerousness to others when it comes to discharging.

Table of Relevant Materials

This document includes all of the listed materials as well as links to electronic versions, where applicable

- **Issue List for PSRB workgroup**

- **PSRB Attorney-Judge Handbook, select excerpts**
  - Full handbook can be accessed here

- **PSRB Conditional Release Handbook, select excerpts**
  - Full handbook can be accessed here

- **Relevant Oregon Revised Statues**
  - **ORS 161.327**
    - Commitment or conditional release of person found guilty except for insanity of felony; appeal
  - **161.336**
    - Conditional release by board; termination or modification of conditional release; hearing.
  - **161.341**
    - Application for discharge or conditional release; release plan; examination; right to hearing.

- **PSRB Administrative Rules**
  - 859-070-0015
    - Elements of Conditional Release Order
  - 859-070-0030
    - Evaluation and Reports
  - 859-070-0035
    - Out-of-State Conditional Release Order

- **OHA Administrative Rules**
  - OAR 309-019-0160
    - Psychiatric Security Review Board and Juvenile Psychiatric Security Review Board

- **Templates**
  - Court conditional release evaluation order
  - Court Conditional Release and Placement under PSRB

ISSUE LIST: Court Ordered Conditional Release

- **Process** needs to be standardized, and systemwide coordination needs to be enhanced (specifically communication with the PSRB and community providers)
    - Specifically C felonies

- **Resources** no process for reimbursing community resources, lack of community resources

- **Evaluations** no standard requirement, no reimbursement

ISSUE: Court Conditional Releases (Follow-up)

1. **Number of Court CRs we have per year since 2008.**

Court Conditionally Released Clients
as a Percentage of all New GEI Cases

	Ct CR's	Total Number of New Terms Received	Percentage
2018	5	43	12%
2017	9	54	17%
2016	14	55	25%
2015	3	39	8%
2014	6	43	14%
2013	11	39	28%
2012	10	58	17%
2011	14	63	22%
2010	9	63	14%
2009	13	82	16%
2008	9	70	13%

2. **Court CRs between 2012-October 2019 n=60**
    a. Successful Results (31 or 51.66%)
        i. 21 remained in original placement (Range 92-2,596 days)
        ii. 10 stepped down from original
    b. Less Successful Results (29 or 48.33%)
        i. 13 stepped up (Range 28 – 735 days)
        ii. 16 revoked (Range 2 – 730 days)

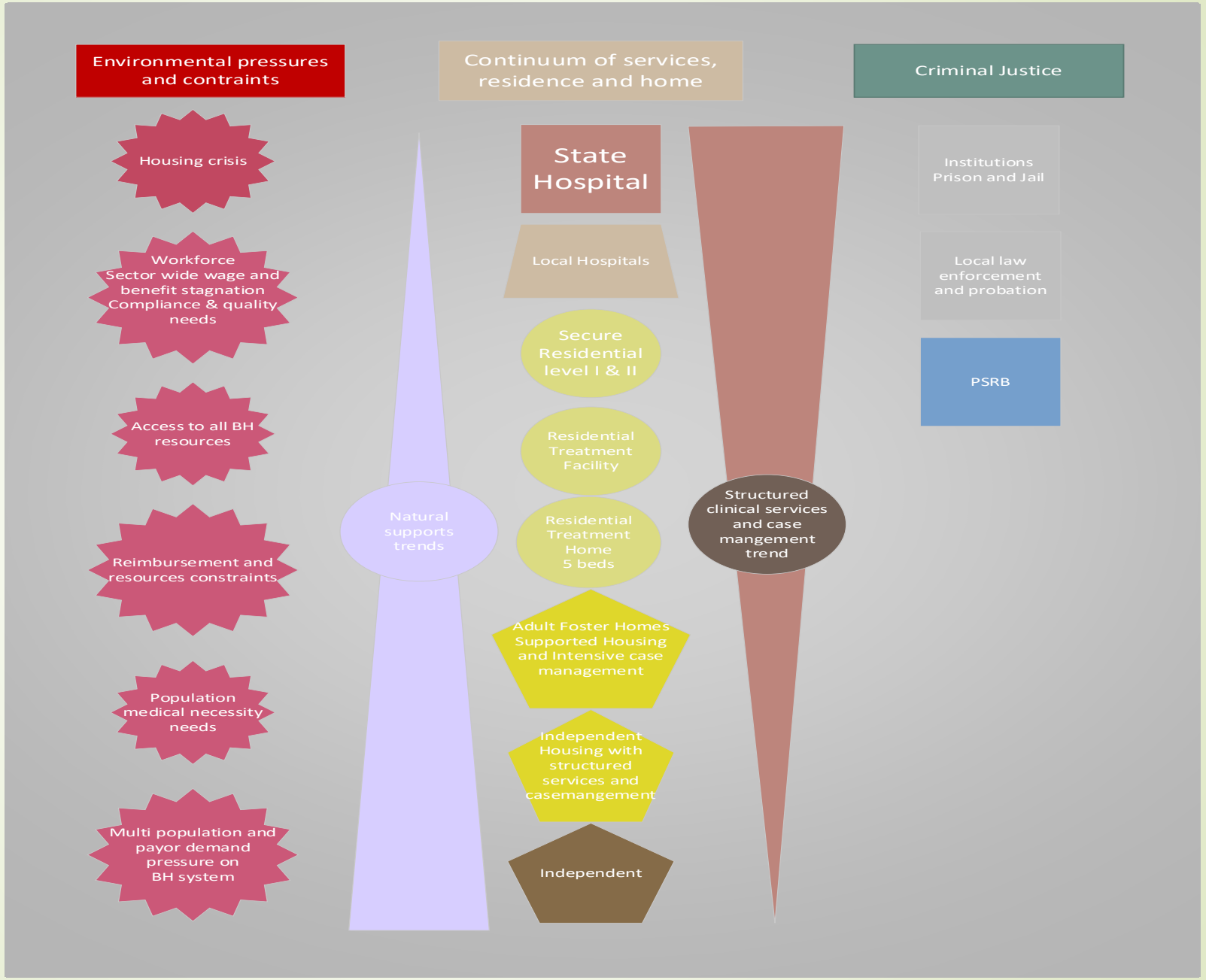
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Totals
Year 1	9	6	3	2	20 (33%)
Year 2	3	2	1	0	6
Year 3+	2			1	3

    c. ***TAKE HOME: 25% of Court CR's fail within the first 6 months***
        i. Fail =stepping up or revoked

3. ARTICLE: Statewide Survey of Living Arrangements for Conditionally Released Insanity Acquitees
4. ARTICLE: Conditionally Release Placements of Insanity Acquittees in Oregon: 2012-2014

OCBH

A discussion from a BH providers lens


Environmental pressures and contraints
Continuum of services, residence and home
Criminal Justice
Housing crisis
Workforce Sector wide wage and benefit stagnation Compliance & quality needs
Access to all BH resources
Reimbursement and resources constraints
Population medical necessity needs
Multi population and payor demand pressure on BH system
Natural supports trends
State Hospital
Local Hospitals
Secure Residential level I & II
Residential Treatment Facility
Residential Treatment Home 5 beds
Adult Foster Homes Supported Housing and Intensive case management
Independent Housing with structured services and casemangement
Independent
Structured clinical services and case mangement trend
Institutions Prison and Jail
Local law enforcement and probation
PSRB

A window into Behavioral Health providers
Mission, service, operations and compliance
Why do we do what we do?

Mission; A Board or Owner frames the services based on mission of creating health in the community

Service; every service has best practices, quality and effeciencies that are standards

Operations; Non-profits and private providers must pay employees and keep the lights on to deliver care. They are different on taxes, community input, who we are accountable too and tax requirements. Reserves, cash flow and many daily operations are more similar in need than not similar.

Compliance is central to operations and guided by Federal, State and payors both public and private. In BH compliance also includes clinical and licensure standards of the workforce.

The nonprofit & private MH residential and outpatient care continuum that serves individuals experiencing SMI is;

Predominantly governed by the constraints and requirements of Medical Necessity

This means a general MH population is the primary and largest utilizer, incuding public and privately insured

This shapes programing, clinical training, and many other delivery aspects, just like physical health

Specialist Behavioral has them too!

Different populations need different services a primary care doctor may or may not refer out based on training and skill level MH is no different.

Unfortunately BH payment scales and equity are not similar to Physical Health payment. Specialty BH rates are rare and woefully outdated.

Some examples; IDD, Mulit system involved persons such as Aid and Assist, child welfare, Forensic such as PSRB, Acute disorder such as polydipsia, Disorders of eating, to name a few.

Definitions of levels

Residential Treatment Homes (RTH), Residential Treatment Facilities (RTF), and Secure Residential Treatment Facilities (SRTF) provide housing and treatment services to adults diagnosed with a qualifying mental illness and are staffed 24 hours a day.

The capacity of an AFH and RTH is up to five residents and the capacity of an RTF and SRTF is 6-16 residents, though there are few contracted facilities that provide services for 16 or more residents.

From: https://www.oregon.gov/oha/HSD/AMH-LC/Pages/RT.aspx

- **Rate Standardization**

Overview

- As required by the budget note in House Bill 5026-A (2017), the Oregon Health Authority established a plan for standardization of Oregon's reimbursement rates for adult mental health residential services. This page provides information about that plan, also known as the Rate Standardization Project.

……..

- **Background**

- Historically, OHA negotiated provider rates on an individual basis, based upon provider-submitted costs, with little connection to resident acuity. In 2007, a partial rate standardization effort resulted in two groups of providers, each paid according to a different rate methodology.

- 50 percent had their individually negotiated rates rebased.

- The remaining 58 providers continue under a bundled personal care (PC)/habilitation rate from pre-2007.

- Neither rate methodology is risk-adjusted nor tied to patient acuity. Meanwhile, some providers get biennially updated operating budgets through the OHA county pass-through contracts, which may include cost of living adjustments.

- From: https://www.oregon.gov/oha/HSD/OHP/Pages/MH-Rates.aspx

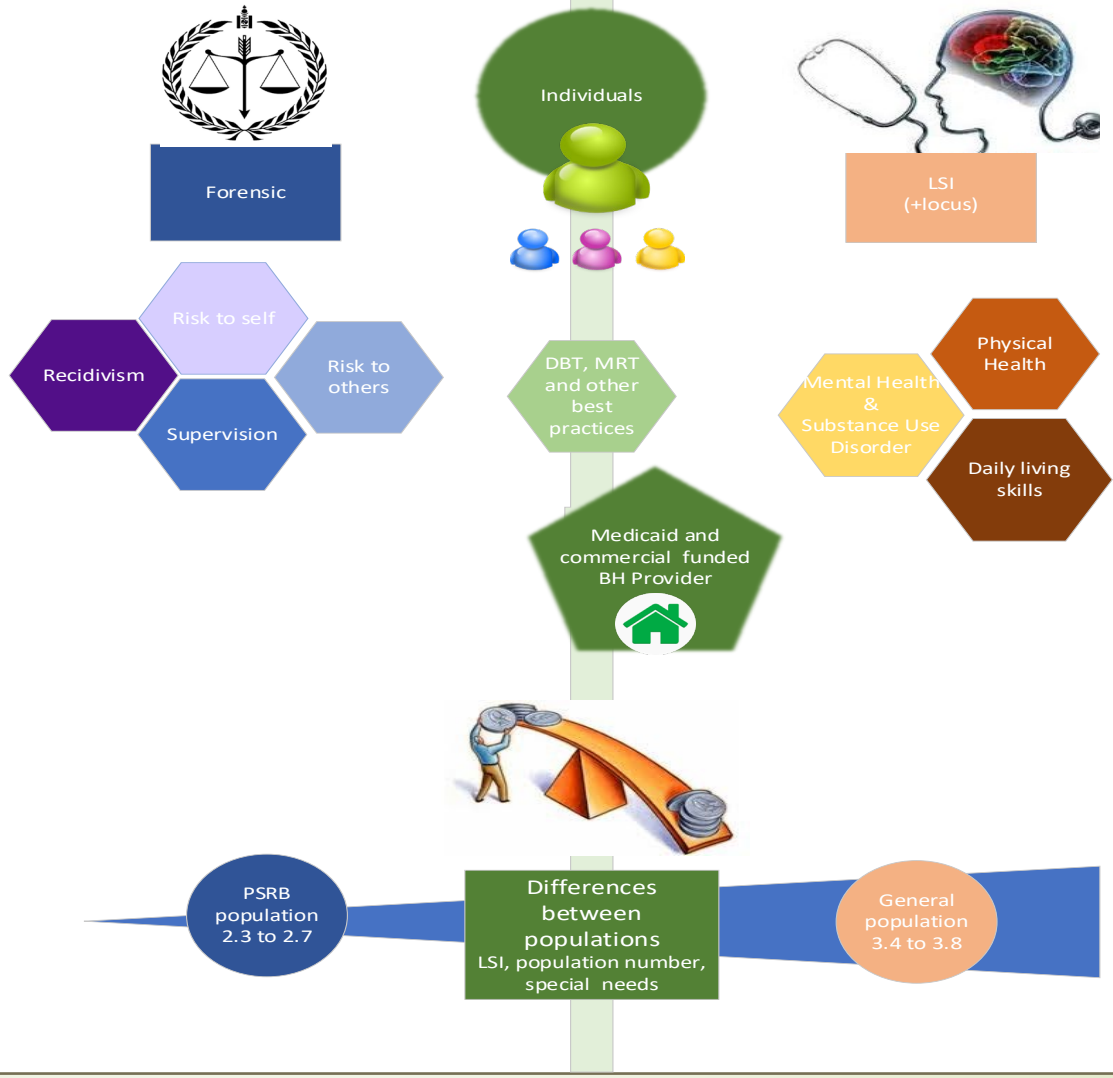
Rate standardization

Context from the provider lens

Change was needed

All payment change impacts systems operations

Change pain is happening; moving from individual uncoordinated contracts to a Medicaid acuity base model



Commitment of “Extremely Dangerous” Mentally Ill Persons

ORS 426.701, 426.702

ORS 426.701: Commitment of "extremely dangerous" person with mental illness; requirements for conditional release; rules.

. . . the court shall order the person committed [to the PSRB] for a maximum of 24 months if the court finds, by clear and convincing evidence, that:

(A) The person is **extremely dangerous**;

(B) The person suffers from a mental disorder that is **resistant to treatment**; and

(C) Because of the mental disorder that is resistant to treatment, the person committed **one of the [listed] acts**.

(a) A person is "extremely dangerous" if the person:

(A) Is at least 18 years of age;

(B) Is exhibiting symptoms or behaviors of a mental disorder substantially similar to those that preceded the act described in subsection (3)(a)(C) of this section; and

(C) Because of a mental disorder:

(i) Presents a serious danger to the safety of other persons by reason of an extreme risk that the person will inflict grave or potentially lethal physical injury on other persons; and

(ii) Unless committed, will continue to represent an extreme risk to the safety of other persons in the foreseeable future.

(c) A mental disorder is "resistant to treatment" if, after receiving care from a licensed psychiatrist and exhausting all reasonable psychiatric treatment, or after refusing psychiatric treatment, the person continues to be significantly impaired in the person's ability to make competent decisions and to be aware of and control extremely dangerous behavior.

(C) Because of the mental disorder that is resistant to treatment, the person committed one of the following acts:

(i) Caused the death of another person;

(ii) Serious physical injury with a dangerous weapon;

(iii) Physical injury with a firearm or an explosive;

(iv) Oral-genital contact with a child under 14;

(v) Forcibly rape, sodomy or sexual penetration;

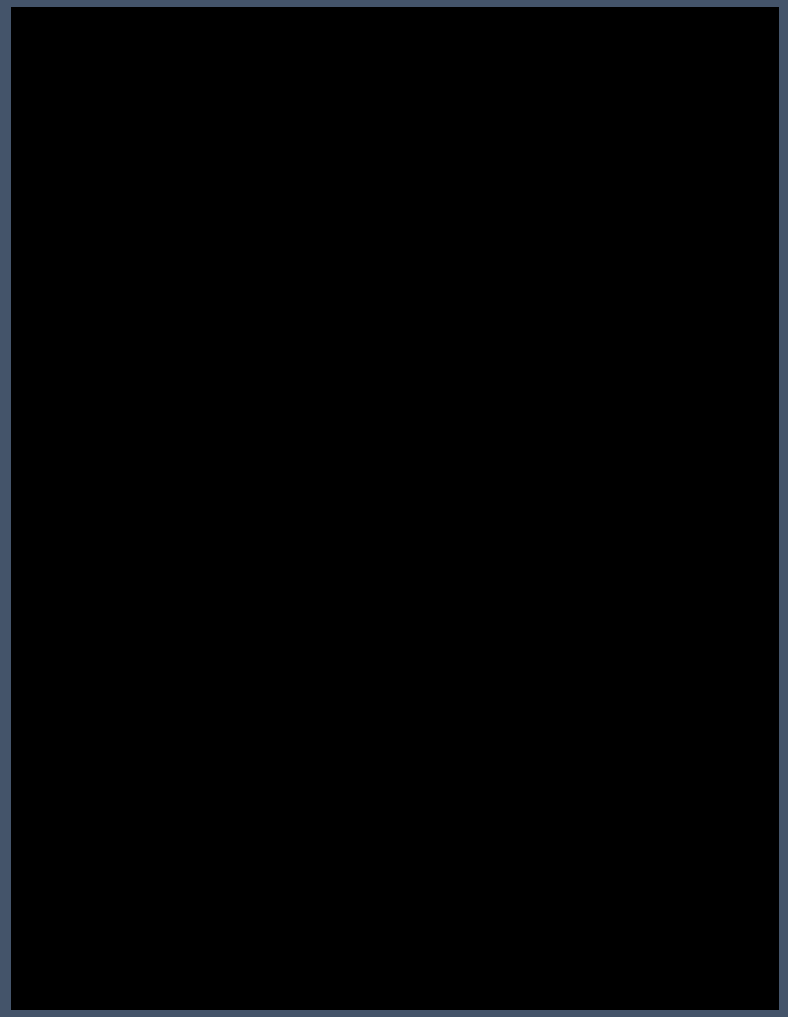
(vi) Caused a fire or explosion that damaged property or placed another person in danger, and it was not the incidental result of normal and usual daily activities.

Where did this statute come from?

Senate Bill 421 (2013)
Sponsored by Senator Prozanski
(at the request of the Kilcullens)

Officer Christopher Kilcullen

- Eugene Police Officer
- Killed on April 22, 2011 by Cheryl Kidd
- Was a 12 year veteran at the time of his death
- Survived by a wife and two children



Cheryl Kidd

- 53 years old at the time of the shooting
- History of mental illness- Schizophrenia
- Charged with Aggravated Murder
- Determined to be Unfit to Proceed

The Numbers

Number of total persons committed since the law passed in 2013: 21

Number of current persons committed: 18

Placement- OSH: 13

SRTF/SACU: 3

ECF: 1

RTH: 1

AFH: 1

.

Discharges

Number of Discharges: 3

Death: 1

No longer met criteria: 2

*Both were on conditional release and living in an RTH level of care at discharge. Neither were re-indicted

Positive Impacts

- Commitment to the PSRB for extremely dangerous individuals
  - Access to PSRB resources
- 24 months in duration, with a hearing before the Board at 6 months
- Victim notification provisions
- Right to a competency evaluation
- Statute of limitations tolled during a period of commitment
- Conditional release provisions
- Right to protest further commitment
- Judicial notice of findings related to underlying act

Room for Improvement

- Hold provision is needed
- Attempted murder/Physical injury with a dangerous weapon
- Venue for initial and recommitment hearings
- Evaluations done by certified forensic examiners
- Expert witnesses appearing via teleconference
- Content of reports
- Timeline for recommitment hearings
- Timing of dismissals/Tolling of the statute of limitations
- Six month hearings following recommitment

PSRB Legislative Workgroup:

JPSRB Subcommittee

Monday, October 5, 2020

Agenda

1. Overview—Where to go from here?
2. Issue List
    a. Sunset versus Expansion of JPSRB
3. Relevant Materials
    a. SB 1008
    b. JPSRB Demographics
    c. JPSRB Community Resources/Contracted Placements
    d. JPSRB Statutes

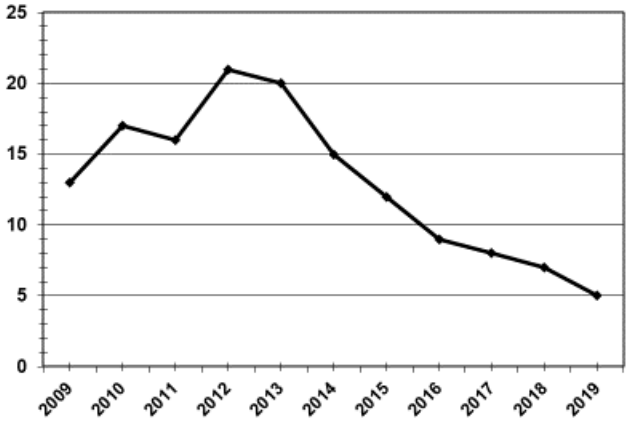
Juvenile Client Demographics

(as of 1/1/2020)

Clients:	Secure Inpatient	3
	Conditional Release	2
Gender:	Male	5
	Female	
Average Age:	21.1 years old	
Ethnicity:	Asian	
	Black	
	Hispanic	
	Native American	
	White	5
Sex Offenders:	3	
Eligible for DD Services:	3	
Primary Diagnoses:	Mood Disorders	
Secondary Diagnoses:	Developmental / Intellectual Disabilities	

Juvenile Clients under PSRB

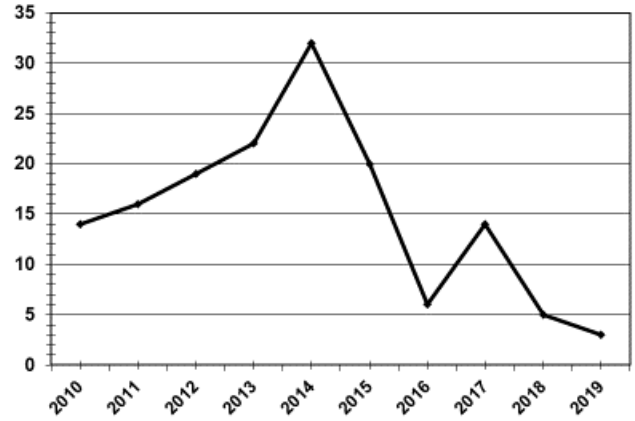
(as of 12/31 of given year)



2019	5
2018	7
2017	8
2016	9
2015	12
2014	15
2013	20
2012	21
2011	16
2010	17
2009	13

Juvenile Panel Full Hearings Scheduled

(by Year)



2019	3
2018	5
2017	14
2016	6
2015	20
2014	32
2013	22
2012	19
2011	16
2010	14
2009	13

Oregon's Juvenile Psychiatric Security Review Board

Stewart S. Newman, MD, Mary Claire Buckley, JD, Senia Pickering Newman, JD, and Joseph D. Bloom, MD

In 2005, the Oregon Legislature passed a bill modifying the existing Psychiatric Security Review Board (PRSB) statute, creating a juvenile panel for management of juvenile insanity acquittees. Dubbed the Juvenile PSRB (JPSRB), it borrows heavily from the 30 years of experience of its adult predecessor. Statutory language was also modified to create a plea of "responsible except for insanity" for juveniles in Oregon. The authors discuss the similarities of the JPSRB to the adult PSRB system and highlight the differences that take into account the unique needs of juvenile defendants. They go on to discuss potential problems foreseen with implementation of the JPSRB system and to recommend possible solutions.

J Am Acad Psychiatry Law 35:247–52, 2007

There is very little professional literature regarding the use of the insanity defense in the juvenile justice system.[1] National trends show that the number of juvenile offenders has decreased since the recent peak in 1994. Similarly, the number of juveniles who enter the adult criminal system by judicial waiver is decreasing, consistent with fewer juveniles entering the overall justice system. The percentage of juveniles who are waived into the criminal courts has also been decreasing since the mid-1990s.[2] Despite this, legislators in Oregon recognized that juveniles continue to enter the legal system and were aware of the role that mental illness plays in many offending behaviors. Psychiatrically based legal defenses that negate criminal responsibility are playing an increasing role in the juvenile justice system, given the move toward a more retributional system. Until now, the small number of juveniles in Oregon who have asserted successful insanity defenses were usually placed under the guardianship of the Department of Human Services until they reached the age of majority, with their care managed at the discretion of the courts.

The 1977 Oregon Legislature created the adult Psychiatric Security Review Board (PSRB).[3] The PSRB was charged with the task of supervising insanity acquittees committed to its jurisdiction by the courts after insanity verdicts. The PSRB has been described in detail in the literature, and it has functioned well over the past 30 years without major attempts to modify its role by either the legislature or the Oregon appellate courts.[4–8] This successful record most likely stems from the fact that there is something in this system for all interested parties and that it balances protection of the public with treatment for insanity acquittees. Over its 29 years, the PSRB has monitored approximately 2,250 insanity acquittees, with a current caseload of approximately 700 clients. Approximately half of these clients are held in a forensic hospital, and the other half are on conditional release in the community. The fact that the PSRB has been in existence for close to 30 years and has been viewed as successful, no doubt led to its being considered as a potential model for an approach to problems in the juvenile mental health and correctional systems.

With assistance from the Oregon Law Commission, created in 1997 by the Oregon Legislative Assembly to conduct a continuous program of law reform, legislators crafted a bill to expand the PSRB system to include juveniles. It took many years for the idea of extending the PSRB to juveniles to gain acceptance, but in 2005 the state legislature passed a bill to create a second panel of the PSRB to address mental health problems relating to children and ad-

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olescents. The statute established the juvenile panel of the PSRB (JPSRB), which closely resembles its adult progenitor. There are important differences, however, taking into account the unique challenges that arise for juveniles in the justice system. This commentary will first describe the statute creating the JPSRB and then discuss some of the concerns that may arise as the JPSRB begins to function.

The Statute

Because of the uniqueness of the statutory model and to facilitate the analysis of this scheme, the text of the statute is reproduced in full.

Oregon Revised Statutes (ORS) 419C.529 Finding of mental disease or defect; jurisdiction of Psychiatric Security Review Board; conditional release or commitment.

(1) After the entry of a jurisdictional order under ORS 419C.411, (2) if the court finds by a preponderance of the evidence that the young person, at the time of disposition, has a serious mental condition or has a mental disease or defect other than a serious mental condition and presents a substantial danger to others, requiring conditional release or commitment to a hospital or facility designated by the Department of Human Services, the court shall order the young person placed under the jurisdiction of the Psychiatric Security Review Board.

(2) The court shall determine whether the young person should be committed to a hospital or facility designated by the department or conditionally released pending a hearing before the juvenile panel of the Psychiatric Security Review Board as follows:

(a) If the court finds that the young person is not a proper subject for conditional release, the court shall order the young person committed to a hospital or facility designated by the department for custody, supervision and treatment pending a hearing before the juvenile panel in accordance with ORS 419C.532, 419C.535, 419C.538, 419C.540 and 419C.542 and shall order the young person placed under the jurisdiction of the board.

(b) If the court finds that the young person can be adequately controlled with supervision and treatment services if conditionally released and that necessary supervision and treatment services are available, the court may order the young person conditionally released, subject to those supervisory orders of the court that are in the best interests of justice and the young person. The court shall designate a qualified mental health treatment provider or state, county or local agency to supervise the young person on release, subject to those conditions as the court directs in the order for conditional release. Prior to the designation, the court shall notify the qualified mental health treatment provider or agency to whom conditional release is contemplated and provide the qualified mental health treatment provider or agency an opportunity to be heard before the court. After receiving an order entered under this paragraph, the qualified mental health treatment provider or agency designated shall assume supervision of the young person subject to the direction of the juvenile panel. The qualified mental health treatment provider or agency designated as supervisor shall report in writing no less than once per month to the juvenile panel concerning the supervised young person's compliance with the conditions of release.

(c) For purposes of determining whether to order commitment to a hospital or facility or conditional release, the primary concern of the court is the protection of society.

(3) In determining whether a young person should be conditionally released, the court may order examinations or evaluations deemed necessary.

(4) Upon placing a young person on conditional release and ordering the young person placed under the jurisdiction of the board, the court shall notify the juvenile panel in writing of the court's conditional release order, the supervisor designated and all other conditions of release pending a hearing before the juvenile panel in accordance with ORS 419C.532, 419C.535, 419C.538, 419C.540 and 419C.542.

(5) When making an order under this section, the court shall:

(a) Determine whether the parent or guardian of the young person is able and willing to assist the young person in obtaining necessary mental health services and is willing to acquiesce in the decisions of the juvenile panel. If the court finds that the parent or guardian:

(A) Is able and willing to do so, the court shall order the parent or guardian to sign an irrevocable consent form in which the parent agrees to any placement decision made by the juvenile panel.

(B) Is unable or unwilling to do so, the court shall order that the young person be placed in the legal custody of the Department of Human Services for the purpose of obtaining necessary mental health services.

(b) Make specific findings on whether there is a victim and, if so, whether the victim wishes to be notified of any board hearings concerning the young person and of any conditional release, discharge or escape of the young person.

(c) Include in the order a list of the persons who wish to be notified of any board hearing concerning the young person.

(d) Determine on the record the act committed by the young person for which the young person was found responsible except for insanity.

(e) State on the record the mental disease or defense on which the young person relied for the responsible except for insanity defense.

New Provisions

Organization of the Board

The addition of the JPSRB required a revision of the original PSRB statute to establish two distinct panels, one for adults and one for juveniles. Modeled after the adult board, the juvenile board members include one child psychiatrist, one psychologist with specialized training in child psychology, one attorney with experience in juvenile law, one juvenile probation officer, and a member of the general public.[3]

"Responsible Except for Insanity"

Oregon's insanity verdict was changed in 1983 from "not responsible due to mental disease or defect" to "guilty except for insanity."[9] This language was adopted in response to the verdict in *United States v. Hinckley*, to clarify public confusion regarding whether individuals were responsible for an act that they had clearly committed.[10] Oregon is currently the only state to use this legal designation. In the 2005 statute creating the JPSRB, the Legislature termed the insanity verdict for juveniles "responsible except for insanity," in keeping with the concept that the juvenile justice system is separate from the adult criminal system and is a system that is intended to regard juveniles in a noncriminal framework.[11]

Qualifying Diagnoses

To be placed under the jurisdiction of the JPSRB after pleading insanity, a juvenile must have either a "serious mental condition," or "a mental disease or defect and [present] a substantial danger to others." The statute defines "serious mental condition" to include "psychotic disorders, bipolar disorders, and major depression."[12] The adult statute is a derivative of the American Law Institute Test, excluding from the definition of "mental disease or defect" those abnormalities manifested only by repeated criminal or otherwise antisocial conduct.[9] The juvenile statute follows suit, specifically excluding these categories and adding conduct disorder to the exclusions.[12] In addition, the juvenile statute includes one amendment made in 1983 to the adult statute that excluded conditions "constituting solely a personality disorder."[9] The 2005 Legislature, however, faced a major problem as to how to define mental defect for the purposes of this statute. It was faced with a political dilemma of how to deal with individuals who are developmentally disabled. There was concern in the legislative assembly that including mental defect would lead to an overwhelming number of mentally retarded and developmentally disabled individuals being placed under the jurisdiction of the JPSRB, leading to an untenable budgetary situation. The legislature chose a temporary measure of excluding "mental defect" which was defined as "manifesting in significantly subaverage general intellectual functioning that is accompanied by significant limitations in adaptive functioning in at least two areas or characterized by severe and pervasive impairment manifested during the developmental period."[12]

Further scrutiny of the legislation, however, has led to the realization that this exclusion creates uncertainty as well as significant legal problems. First, the language of the statute is unclear as to who might be excluded. For example, a juvenile with a diagnosis of Asperger's disorder, who has average intelligence, may or may not be excluded from being placed under the jurisdiction of the JPSRB (depending on whether the juvenile poses a substantial danger to others). The statutory language is simply unclear on this point. Furthermore, the exclusion creates a situation in which juvenile offenders who are mentally retarded or developmentally disabled and who successfully plead insanity are in a legal "purgatory" of sorts. There is no clear statutory guidance as to the appropriate disposition of these individuals—only the admonishment that they will not be placed under JPSRB jurisdiction. This deficiency leaves these individuals in the very situation that the legislation expanding the PSRB to include a juvenile panel was tasked to resolve.

The Oregon Law Commission recognized the difficulties that will inevitably develop from the exclusion of mental retardation and developmental disorders and plans to introduce a bill to the 2007 Oregon Legislative Assembly that creates amendments to the JPSRB statutes.[13] The amendments will provide for the removal of the exclusion of mental retardation from the definition of "mental disease or defect." Further, it will specify the inclusion under "serious mental conditions" of a mental deficiency manifested as "mental retardation," if the deficiency exists concurrently with qualitative deficits in "activities of daily living." The definition of mental retardation is taken from the *Manual on Terminology and Classification in Mental Retardation*.[14] Activities of daily living are defined to include bathing and hygiene, eating, mobility, toileting, and communication. The deficits in activities of daily living cannot be a result of mental illness, substance abuse, or situational trauma.

Thus, there is confusion about which diagnoses qualify for an insanity defense for juveniles. Qualifying diagnoses include "serious mental disorders" (psychotic disorder, bipolar disorder, and major depression). Nonqualifying diagnoses include antisocial behavior, personality disorders, conduct disorders, and a confusing mixture of developmental disorders. Finally, there is the provision for inclusion of all youth with a "mental disease or defect" other

than "a serious mental condition" who also present as a "substantial danger to others." It would not be too much speculation to say that this array of those qualifying and nonqualifying diagnoses will lead to great confusion in the trial and appellate courts unless clarified soon by the legislature.

JPSRB Process

If the court finds that juvenile has a "serious mental condition, or a mental disease or defect and presents a substantial danger to others," it orders the juvenile placed under the jurisdiction of the JPSRB.[15] As with the adult system the court also makes a determination of the initial placement of the juvenile either in a secure treatment facility or on conditional release in the community. Once these determinations are completed, the JPSRB takes over the management of the juvenile up to the limits of the JPSRB's jurisdiction. As with the adult board, the JPSRB controls movement of the juvenile by making determinations regarding commitments to a treatment facility, conditional release into the community, revocation of conditional release, or early discharge from the jurisdiction of the board. The JPSRB has the authority to have parents of juveniles sign an irrevocable consent form in which the parents agree to any placement decision made by the PSRB. If the parents are unwilling to consent, the court can order the juveniles placed in the custody of the Department of Human Services to obtain mental health treatment.[15]

It is important to note that juveniles under the jurisdiction of JPSRB must remain segregated from adults for the provision of treatment services in secure settings. Because the child and adolescent unit at the state hospital was eliminated several years ago, juveniles under JPSRB jurisdiction will be placed in a separate secure adolescent inpatient treatment facility run by a private nonprofit agency.

Length of JPSRB Jurisdiction

The time served under the jurisdiction of the board cannot exceed the maximum sentence for the charges had the individual been convicted of the crime. In the state of Oregon, the sentences are up to 1 year for a misdemeanor, 5 years for a Class C felony, 10 years for a Class B felony, and 20 years for a Class A felony.[16,17] However, the period of any disposition may not extend beyond the date on which the youthful offender becomes 25 years of age, except for individuals charged with murder or any aggravated form of murder. The placement of those individuals under the jurisdiction of the panel continues for life. Juveniles who become adults (age 18) during their time under JPSRB jurisdiction can be transferred to the jurisdiction of the adult panel for the remainder of the supervisory period.[18]

In 1994, Oregon voters approved Ballot Measure 11, which created mandatory sentence terms for 16 violent and sex-related offenses, to which an additional five offenses have since been added.[19] Measure 11 also provides for mandatory waiver of youthful offenders 15 years of age or older into the adult criminal court system who commit any of the now 21 offenses covered by the law.[20] The PSRB statute specifies that any juvenile offender who is charged with a Measure 11 crime, receives the mandatory waiver to adult criminal court, and successfully mounts an insanity defense is placed under the jurisdiction of the adult panel of the PSRB, regardless of his or her age at that time. Similarly, any juvenile who is judicially waived to adult court and is found guilty except for insanity would be placed under the jurisdiction of the adult panel.

In effect, this creates the confusing situation of four distinct populations of insanity acquittees within the juvenile legal system. The first is any juvenile offender 15 years of age or older, charged with a Measure 11 offense, or juveniles waived to adult court. They are placed under the adult panel jurisdiction. The second is juveniles younger than 15 who are charged with murder or aggravated murder. They are placed under the juvenile panel's jurisdiction for life (though it is likely that their management will be transferred to the adult panel upon their 18th birthday). The third is juveniles younger than 15 years not waived to adult court but charged with a Measure 11 offense. They are placed under the jurisdiction of the juvenile panel, but, at most, until they are 25 years of age. The fourth is juveniles of any age charged with a non-Measure 11 crime; they also are placed under the jurisdiction of the juvenile panel, but, at most, until they are 25 years of age.

As with the adult PSRB, if while under the jurisdiction of the juvenile panel the juvenile either no longer has a serious mental condition or has a mental disease or defect other than a serious mental condition but no longer presents a substantial danger to others, that juvenile must be discharged from PSRB jurisdiction.[21] Juveniles discharged in this way are no

longer under the control of the PSRB, and as noted earlier, have been acquitted of their crimes. They become free citizens without further restrictions placed on them. To address the concept of mental illness in remission, the 2005 statute adopted the statutory definition from the adult statute that specifies that a juvenile is still considered to have a mental disease or defect if it may, with reasonable medical probability, occasionally become active and cause him or her to be dangerous.[21]

Conditional Release

Again, as with the adult program, the primary method of insuring community protection is through institutionalization, with the safeguards in the conditional release program requiring monthly monitoring of those on conditional release and a mechanism for prompt revocation of conditional release when indicated. The primary concern for the determination of qualification for conditional release by the PSRB remains the protection of the community.[15] The JPSRB is required to hold a variety of hearings on a regular basis, including hearings requested by the juveniles or by the facility director in which conditional release may be requested. The criteria for conditional release are specified in the statute and include being adequately controlled with proper available supervision and treatment services. The juvenile panel also has the power to require the juvenile to comply with treatment as a condition of release. Failure to do so could result in revocation of the conditional release status.[15]

The procedure for revocation of conditional release status is handled entirely by the JPSRB. If the juvenile violates the conditions of release or it appears to treatment providers or supervisors that the mental health of the juvenile is deteriorating such that the youth could pose a substantial danger to others, the juvenile panel or the chairperson of the panel can order revocation. Furthermore, in emergent situations, any supervisor of the juvenile within the community can request that the juvenile be taken into custody if he or she believes that the juvenile presents a substantial danger to the community. If conditional release status is revoked, a written order of the JPSRB is sufficient to act as a warrant and allow police to detain the juvenile and transport him or her to a designated facility. The juvenile must be transported to the treatment facility and may not be brought to jail unless charged with a new crime. A hearing by the juvenile panel must occur within 20 days of revocation, and the state has the burden of proving the unfitness of the juvenile to remain on conditional release. As with any determinations made by the JPSRB, the burden of proof is always by a preponderance of the evidence.[21]

Legal Protections

Juveniles under the jurisdiction of the JPSRB have a multitude of civil liberty protections afforded to them throughout the supervisory period. As mentioned, juveniles have the right to periodic hearings to review their progress and current status. At these hearings, they have the right to be present with legal counsel, to have counsel appointed if they are unable to afford an attorney, to call witnesses to testify, to cross-examine witnesses, and to review any and all information available to the board for the purpose of making decisions.[21] The decisions of the board can also be appealed to the Oregon appeals courts.

The original PSRB statute provided for mandatory periodic reviews of the status of an individual placed under the jurisdiction of the PSRB. Recognizing the limited time that juveniles might be under the jurisdiction of the PSRB (no longer than the 25th birthday unless transferred to the adult panel), the statute compresses the timeline for required hearings and review. Juveniles under the jurisdiction of the PSRB are entitled to a minimum of one hearing yearly to determine if they should be considered for discharge from supervision or conditional release. Adults are entitled to hearings every two years. Having spent three years on conditional release, juveniles are entitled to a hearing within 30 days of the expiration of the three-year period to determine whether they should be discharged from the jurisdiction of the JPSRB.[22] For adults, the individual must spend five years on conditional release before a mandatory review.[23]

The Future of the JPSRB

The JPSRB was appointed by the governor and began to organize on January 1, 2007. The panel is to begin to receive clients on July 1, 2007. The juvenile panel will not "inherit" jurisdiction over any juveniles who have previously successfully asserted an insanity defense. The JPSRB thus starts with a "clean slate," with an initial budget built on an estimate of up to 10 juveniles being placed under the juvenile panel's jurisdiction annually. However, there re-

mains uncertainty regarding the actual number of juveniles for which the panel will become responsible. Amendments to the PSRB legislation may create the opportunity for individuals with mental retardation to be placed under the JPSRB's jurisdiction. Some critics have voiced concern that this will lead to a flood of placements, even up to 100 or more juveniles annually. History tells us that only four juveniles who were waived into adult court have been remanded to the jurisdiction of the adult panel. Yet most in Oregon acknowledge that the juvenile justice and mental health systems are in crisis and that the JPSRB may provide a much needed opportunity for some juveniles to receive treatment services. We believe that we have seen this happen with the adult PSRB, with diversion of some mentally ill individuals into the criminal justice system when community mental health and hospital services have had severe budgetary problems.

The creation of the JPSRB is an innovative approach to an area that is much in need of attention: the interface between the juvenile mental health and criminal justice systems. As is evident from this report, there are many areas that need further clarification in the statute, not the least of which are the criteria for inclusion in the system. How this complicated statute will be viewed by lawyers and judges is yet to be determined, as is the accuracy of the prediction of 10 cases per year. In an environment where treatment needs of children often go unmet, we can envision the frequent use of this statutory mechanism. Another question is whether this statute will stand up over time in the way that the adult system has persisted with few changes. There certainly have been problems on the adult side, especially with the number of individuals who have become the responsibility of the adult PSRB. The caseload has placed a strain on Oregon's forensic mental health system, as both the forensic hospital and the community treatment systems have had to provide the budget to treat a very large number of insanity acquittees. The number of cases seems to be the greatest problem for the treatment resources of the state of Oregon. Given that fact, it may be that the number of young individuals committed to the jurisdiction of the JPSRB determines its ultimate future and acceptance.

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21. Or. Rev. Stat. § 419C.532 (2005)
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23. Or. Rev. Stat. § 161.351 (1989)

PSRB REVOCATION GUIDE
AUTHORITY FOR LAW ENFORCEMENT CUSTODY AND TRANSPORT

Under what circumstances can a PSRB client's conditional release be revoked?			
Person has violated the terms of their conditional release.	161.336(4)(a)(B)(i)	Absconding from treatment, commitment of a new crime, gross violation of conditional release terms.	
The mental health of the person has changed such that the Board, ED, or community provider reasonably believes that the person may no longer be fit for conditional release.	161.336(4)(a)(B)(ii)	Medication refusals, symptomatic and not agreeing to treatment recommendations, refusal to increase levels of support or local hospitalization.	
Inadequate/unavailable supervision and treatment in the community setting.	161.327(1)(b)	Requires a higher level of care or particular resource that is not available in the community setting.	
What mechanisms would allow the police to take a client into custody to be <u>transported</u> to a treatment facility?			
Written or electronic order signed by a Board member or the ED.	161.336(4)(a)(A)(i)	Order for Revocation	Board notified during *business hours*.
Written or electronic order signed by the PSRB Deputy Director if it is part of a written policy.	161.336(4)(a)(A)(ii)	Order for Revocation	Board notified during *business hours*, no Board member available and ED on leave.
Written or electronic order signed by the community mental health program director if the person has absconded from conditional release.	161.336(4)(a)(A)(iii)	PSRB Form*	Client has absconded from supervision after hours/weekend.
A peace officer if there is <u>reasonable</u> cause to believe the person is a substantial danger to others because of a mental disorder and that the person is in need of immediate care, custody or treatment.	161.336(4)(b)		Law enforcement encounters client and LEDs verifies PSRB jurisdiction. Communicates with LEDs contact for further information but is unable to reach anyone. May or may not occur during business hours.
A peace officer if the director of the facility providing treatment to a person on conditional release *or* any person responsible for the client's supervision requests the peace officer due to their <u>reasonable</u> cause to believe the person is a substantial danger to others because of a mental disorder and that the person is in need of immediate care, custody or treatment.	161.336(4)(b)	PSRB Form*	Treatment provider or Executive Director are in communication with law enforcement. May occur during business hours before an order can be generated or where an order for revocation is not necessary.
A peace officer if the officer has <u>probable</u> cause to believe the person is dangerous to self or to any other person and is in need of immediate care, custody or treatment for mental illness.	426.228(1)	Peace Officer Hold (POH)	Most likely used if a client has committed a new crime.
A peace officer when a community mental health program director, pursuant to ORS 426.233, notifies the peace officer that the director has <u>probable</u> cause to believe that the person is imminently dangerous to self or to any other person.	426.233(1)(a)(A) 426.228(2)	Director's Designee Custody Hold	Most likely used if a client meets criteria to be placed at a local hospital.

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PSRB REVOCATION GUIDE
AUTHORITY FOR LAW ENFORCEMENT CUSTODY AND TRANSPORT

Where should the client go once they are in custody?		
If taken into custody by law enforcement pursuant to a revocation order, the client *shall* be transported to the facility designated by the Board.	161.336(c)	Order for Revocation
If taken into custody by law enforcement pursuant to the community mental health program director if client has absconded, the client *shall* be transported to the facility designated by the program director.	161.336(c)	Written document from provider
If taken into custody by law enforcement under the reasonable cause criteria in ORS 161.336(b), the client *shall* be transported to the facility designated by the program director.	161.336(c)	Verbal instruction from provider or PSRB ED
If taken into custody based on a director's designee custody hold, the provider may direct the officer to take the person to an OHA approved facility.	426.233(1)(b)(A)	County Form—DD
If taken into custody based on a director's designee custody hold, the provider may authorize any individual to provide custody and secure transportation services for a person in custody (i.e. law enforcement is not involved in transport).	426.233(3)	County Form—DD

- "PSRB Form"--PSRB is developing a form to provide additional information and increase a law enforcement officer's confidence is using this procedure.