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6.17.2025

Dear Co-Chairs Prozanski and Kropf, Co-Vice Chair Mannix, and members of the committee:

I am a resident of Salem, Oregon, and a licensed psychologist, licensed attorney (in Nebraska), and certified forensic evaluator. I am writing to you in support of the declaration for mental health treatment (DMHT; i.e., mental health advance directives or psychiatric advance directives) provisions present in HB 2005-1. Although I work full-time at Oregon State Hospital as a psychologist and am one of three DMHT subject matter experts for OHA, in this letter, I am representing only my own views, as a researcher and clinician familiar with DMHTs.

In April 2025, I submitted written and in-person testimony regarding HB 2488-4, in which I voiced support of the DMHT provisions contained therein and provided general information about the usefulness of DMHTs. HB 2005-1 contains those same provisions, and I continue to encourage the committee to support those provisions. During yesterday's opportunity for public testimony, most concerns raised about HB 2005-1 were unrelated to DMHTs; however, a few were raised specific to the DMHT provisions, and I will address those below.

One concern raised was that the language in section 15, paragraph 3(a) allowing "any person, including the person whose capacity is being determined, who is interested in the affairs or welfare of a respondent may file a petition for a determination of capacity" is too broad. However, it is noteworthy that the language reflected there is substantively the same as the language under the law currently. Currently, ORS 127.700(6) states that an individual may be determined to be "incapable" for the purposes of using a DMHT if that is the opinion of a court "in a protective proceeding under ORS chapter 125." According to ORS 125.010, "any person who is interested in the affairs or welfare of a respondent may file a petition"; the language in HB 2005-1 was purposefully written to mimic the language under the current state of the law. Although there may be a helpful and meaningful conversation to have about whether these provisions should change in the future, this concern is not a reason to not pass HB 2005-1, as that concern will exist either way.

Another concern raised was that there are no provisions for the appointment of attorney for an individual who has a DMHT. I wholeheartedly agree that an attorney should be appointed for an individual whose DMHT is being opined upon by a court; however, as there are no current provisions in the law that require the appointment of an attorney, the continued lack of such provisions in this bill is not a reason to not pass it. Similarly, concerns were raised about the lack of a central repository for DMHTs. I again wholeheartedly agree that a central repository would

be a crucial improvement to our current system; however, that is lacking now, and this bill's passage does nothing to change the continued lack of a central repository, for better or worse.

The last concern raised is the concern that even when a DMHT is known to clinicians, they often ignore it and substitute their own judgment. I agree this is a serious concern, one that often renders DMHTs functionally useless. Fortunately, the DMHT provisions in HB 2005-1 were specifically tailored to provide individuals with a DMHT more options to enforce their DMHT, both in general and in the context of civil commitment. By clarifying the petition filing process and allowing any person (including the individual with a DMHT!) to request a court opine on the alleged incapacity, individuals with DMHTs and their loved ones have a clear process by which to ensure they are not ignored. Uncertain clinicians have a process by which they can receive reassurance that moving forward with a DMHT is legally appropriate. Therefore, while I agree with this concern, I respectfully disagree that HB 2005-1 aggravates this concern in any way; on the contrary, it was written to address this issue in particular, as the idea for many of the proposed changes were inspired by a young woman who was ultimately successfully diverted from civil commitment when her public defender learned of her DMHT and advocated for its appropriate implementation.

Finally, I would like to note that the conversation about the provisions in this bill have been replete with concerns about the aid and assist population, the state hospital constantly being overwhelmed, and the serious, long-term consequences of someone being channeled through either the criminal justice system or civil commitment process. The DMHT provisions in this bill are unique in that they represent the opportunity for people at risk for involuntary mental health treatment to proactively protect themselves by providing informed consent in advance for treatment they may need in a crisis. Unlike many of the provisions of this bill, even the ones I would consider to be helpful and necessary, the DMHT provisions exist solely to give power, agency, and autonomy back to the individuals who would like to plan ahead to hopefully never (or never again) become part of either process (i.e., aid and assist or civil commitment).

The bill overall may not be perfect, and I agree wholeheartedly so much more work needs to be done in Oregon to make DMHTs a truly useful tool for consumers of mental health services, providers of mental health services, their loved ones, and even the general public. However, the bill is an important and meaningful step forward in DMHT implementation in Oregon. It clarifies how DMHTs can be used in general and in the context of a potential civil commitment. It is consistent with the best available research on how DMHTs can be used to improve the lives of people at risk for involuntary treatment.

Therefore, I ask all members of the committee to consider supporting the DMHT provisions in the forthcoming amendment to improve access to self-defined, recovery-oriented care for the most vulnerable among us – people at risk of involuntary psychiatric treatment. Also, I invited anyone interested in the promotion of DMHTs in Oregon (e.g., politicians, organizations who testified regarding these DMHT provisions, consumers of mental health services, providers, their loved ones, *anyone*) to reach out to me for future collaborations.

If you have any questions regarding the information presented in this letter or about DMHTs in general, please do not hesitate to contact me. I am currently in the process of starting a non-profit organization, MyMHAD, that will exist solely to promote the use of DMHTs in Oregon. The website for the organization will be located at www.myMHAD.org as soon as its construction is completed, and it is intended to be a resource to all who might want to learn more about DMHTs. Thank you for reading this written testimony, and thank you for your consideration.

Respectfully submitted,

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