Oregon Psychiatric Physicians Association

March 12, 2021

To: Chair Prozanski, Vice Chair Thatcher
Members of the Senate Judiciary Committee

From: Dr. Maya Lopez, Oregon Psychiatric Physicians Association

RE: SB 187, Definition of "Danger to Self or Others"

Chair Prozanski, Vice Chair Thatcher, and members of the Senate Judiciary Committee:

For the record, I am Dr. Stephanie Maya Lopez and I'm here today on behalf of the Oregon Psychiatric Physicians Association in support of SB 763, which clarifies the definition of a "danger to self or others."

The role of civil commitment in society demands careful balance. Civil commitment is a life-saving clinical tool, but it is a tool of last resort. In most cases, civil commitment never occurs and never needs to occur. This is how it should be.

Nevertheless, for some members of our communities who suffer from the most serious forms of mental illness, civil commitment can also be a necessity and a path to healing. For the person who is suffering a severe mental health crisis, and where all other options have failed, such treatment may be the only alternative to severe outcomes such as homelessness, incarceration, serious and permanent injury to self or others, and death. Our system must strive to find balance within this complicated reality.

Our current civil commitment law fails to strike such a balance and therefore fails the people who need it most. The standard for commitment in Oregon requires a person, due to a mental disorder, to be "dangerous to self or others" or to be "unable to provide for basic personal needs." However, without such concepts being defined in the law, they have been interpreted by courts as to only apply when such dangers are "imminent." This standard of "imminence," which manages to be both narrow and vague, is ineffective, failing to allow for reasonable clinical prediction or to provide clear guidance to the court as to what evidence should be considered.

The all too common result is that someone in crisis is unable to get treatment when they need it most. Doctors, law enforcement, families, and patients know this message all too well: "we understand your concern, but it's not imminent enough for us to do

anything." The results are often tragic if predictable: left without improvement in a clinical setting, these crises follow a different path – towards homelessness, arrest, incarceration, or worse. In the meantime, conditions that often can be better managed if they are treated early are left to deteriorate.

This bill would allow persons in crisis to be treated without an arrest and incurring the burden of a criminal record. It would allow more people to receive treatment in their community instead of ending up in jail and then being sent to the state hospital as an "aid and assist" patient. And it would allow clinicians to intervene in severe cases prior to serious harm coming to that person or someone else. Over the last several years, there has been much talk in Oregon about "decriminalizing mental illness" but let us be clear: <u>if a person can be dangerous enough to go to jail, but not dangerous enough for treatment, efforts to shift treatment away from jails and prisons will fail.</u>

In testimony for a previous version of this bill in 2018, Dr. Wil Berry described a case involving a young woman in the early stages of schizophrenia who developed delusions that her mother was involved in a plot to murder her and sell her organs. Despite the availability and use of intensive, patient-centered services in her community, she could not be persuaded to take medication and her condition worsened.

This woman attacked her mother repeatedly, which she perceived as self-defense because she thought that her mother was attempting to harvest her organs. Police and crisis teams were called each time. They shared the team's concern, but the decision was a familiar refrain: she was not an "imminent" risk. Their hands were tied. The team knew commitment was needed and her mother expressed shock that these attacks were not enough for her daughter to get treatment. After a tense period of several weeks, a more serious assault occurred, sending her mother to the hospital. Finally, she did get civilly committed, but only after an arrest and serious charges to face upon her psychiatric hospital release.

The purpose of civil commitment is to provide treatment after all other clinical options have failed but before something terrible happens. As it stands now, we must wait to treat some people until severe harm is imminent by waiting for disaster to strike and then trying to pick up the pieces. Such a system does not protect the freedom, health, and lives of those people and the people around them. Instead, it simply pushes the problem back to our emergency rooms, our streets, and our jails.

The woman whose story was told by Dr. Berry did well after she was civilly committed. She did not want to be hospitalized or receive treatment initially, but she returned to live in her community, she took her medications willingly, her delusions resolved, she was in a stable housing situation, and she got a job. She worked with her public defender to address the charges. She and her mother reconciled but both will live with the traumatic memories of the violence between them for the rest of their lives.

In my work, I have seen many patients for whom civil commitment would have prevented a tragedy from occurring. I know of one case in my work in the community setting in which the individual became increasingly symptomatic and aggressive but was not civilly committable under the appellate court definitions of "dangerousness." This person then committed a very serious crime with grave, permanent consequences. He was then placed under the supervision of the Psychiatric Security Review Board. This person has spent many years trying to atone for his act, an act that may very well have been prevented if civil commitment had been possible. I relate this case to you here because increasing access to voluntary forms of treatment is essential, but it will not be enough to prevent tragedies like this in cases where the person is unable to recognize that they have an illness and refuses early interventions even when those services are person-centered and recovery oriented. I will also share with you that this person wrote me a note of deep gratitude for the care that I provided to him, despite the fact that he was initially compelled to get involuntary treatment and that he was still under compulsory treatment.

I believe this bill is a step towards balance. It will not make civil commitment common; our system of checks and balances, with doctors, investigators, and the court all playing a part, remains intact. And the threshold for commitment remains high, ensuring that community-based, recovery-oriented, voluntary treatment remains the cornerstone of care in our state. But for those in the most severe crises, it allows us to push for quality treatment and shift the burden away from criminalization.

Thank you.