To: Representative Grayber, Senator Taylor, Representative Nelson, Bowman, Fahey, Munoz, Valderrama, Senator Jama, Patterson, Pham, Wagner and members of the House Committee on Labor and Workforce Standards

Submitted by: Chris Ligterink, DSP

Regarding: HB 3838

I write this as I have come home from work for the evening. I work as a Direct Support Professional in Corvallis, OR. My shift today was 10-8, but I did not leave work until about 9:30 due to a staff emergency and my relief having a meeting at another facility before their shift at 9:00 started. I was the only one working from 5 pm until 9 pm when relief arrived.

I work in a facility with five residents, one of which requires constant 1-1 care. While making dinner, this resident informed me that they "Had an accident" and needed my assistance. I had to encourage them to go into the bathroom and start the process themselves, as I can not walk away from dinner cooking on the stove. Between this interaction and finishing dinner, I had to redirect them to the bathroom 2 times, as they were walking around the home. When dinner was finished, I had to ask a resident to inform others, as I stepped into the bathroom with the resident (At their request) to help them clean themselves up. This put me, the only worker at that time, in the bathroom with them for about 30 minutes. With dementia, Comagine training specified that you cannot leave someone with dementia alone in the bathroom.

This is not a rare occurrence. Whenever something happens and I am asked to work alone, my manager tries to rally me. I always respond with the same comment: "This isn't the first time, and it won't be the last." Each time, I must make choices that could impact the safety of my residents, or my own. I have always argued for two staff for months, simply because of safety. That of my residents, as well as staff's. This should be a standard, for the company I work for holds a mission statement that people served always come first. This is not a standard.

We have argued for over a year that this resident be moved to a higher level of care. We have requested dementia training, which was only provided when a peer of mine suggested that we utilize Care Oregon trainings. Those were never made standard. They spent time this week in the ER, where the physician was added to the growing list of people who claim they need more care than we can provide. Just about a year ago, we were told by the mental health director that we DSP do the work of a QMHA. We were encouraged to keep trying to do that work without any support from management. The DSP have fought for

over a year for this resident to receive adequate support. Numerous complaints to State of Oregon officials have gone ignored.

While the housing director claimed that we do the work of a QMHA, I write this as someone who has filed all paperwork required of MHACBO to begin my work as a QMHA; I only need an interview assessment to start my hours. But this is not provided where I work. There is no opportunity to make that progress, no vision of the future, or desire to promote individuals who could accomplish more for the individuals we already serve.

These are the standards that we have allowed these companies to set. Oregon was rated 49/51 in mental healthcare and, in the last 2 years, has only moved to 47/51. When left to these companies to decide, the standards have not produced the much-needed results that are claimed in other testimony theirs would create. At what point do we say we have had enough? Reading through the testimonies, I have read many claims that passing this bill will stop progress. I do not see any commitment to make that progress on their own. There is almost no plan; it is just a plea to oppose this bill for the promise of something they cannot define or have not completed on their own.

Many mention already existing standards or reporting agencies, however I have made complaints myself that were never followed through. On November 3rd, 2023, I wrote an email to OHA directors that included my supervisors and county leadership. I detailed neglect, A) For the purposes of these rules, Neglect means the active or passive failure to provide the basic care or services necessary to maintain the health and safety of an adult (411-020-0002 (1)(b)), as one of my residents had not seen their case manager in over a year. OHA reached out to my director of mental health who told them there was nothing wrong. He told me this, as he admonished me for "Souring relations with the county." A mandatory reporter, took my report of neglect, and decided he alone had the authority to decide there was no neglect. This resident saw his case manager 2-3 times after that and then not again for about a year until just recently.

This profession is in dire need of standards: Training standards, that allow staff to be trained regarding any new change in care they face. Staffing standards, that require an adequate level of staffing in comparison to the needs of those they serve. Advancement standards, for companies to be required to provide staff with the ability to advance in a career in mental health if they should so choose. Pay standards, that allow the workers to be able to make claims instead of being told there will be no cost-of-living adjustment (While the CEO increases their pay). Investigation standards, for when staff file a complaint, there can be real change that will better the lives of those served.

I have set out a goal to better Oregon's mental health, and I have found that those who should stand with me have only done their best to stand in front of me. I have sought collaboration to reach a goal but have only been retaliated against because I challenge the failures of our system. I write you today as a DSP. I notice the lack of DSP testimony on this bill. I humbly request that this committee ask every administrative worker that has submitted testimony a simple question: Did you inform your DSP of this bill and your testimony to encourage or even allow them to submit their own? If they did not, as my own company has submitted testimony having not informed the DSP staff, to my knowledge, of this bill, I argue that their testimony be stricken from the record, as it was only given in bad faith.

While I have my reservations about the board makeup listed in this bill, I wholeheartedly believe that we can no longer allow these companies to prove to us that they will not create effective standards on their own. I ask that you push this bill through, signaling today as the start of effective standards that will provide Oregon with a ground floor for which mental healthcare can finally progress.