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Dear Co-Chairs Prozanski and Kropf, 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 that I anticipate will be in the fourth and forthcoming amendment to HB 2488. 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.

The forthcoming amendment is anticipated to have provisions allowing a person with a DMHT to use their DMHT as an "off-ramp" from a pending civil commitment if other parties, including the treating provider, agree that the DMHT allows for treatment that would render the pending civil commitment no longer necessary. This is not only consistent with the constitutional requirement to impose the least intrusive option that is sufficient and available, it is also consistent with the best available research on how DMHTs can be used to improve the lives of people with serious mental illness (SMI). In case you are unfamiliar with DMHTs, these are advance directives that allow people to plan ahead for the type of care they would like to receive in the event of an incapacitating psychiatric crisis, similar to how medical advance directives allow people to plan ahead for the type of care they would like to receive in the event of an incapacitating medical event. In Oregon, they are possible under ORS 127.700-127.737.

Research on DMHTs and their outcomes have shown that:

- People with SMI have an overwhelming preference to have a DMHT-type document, but few reported having such a document in place (Swanson et al., 2006).
- In particular, consumers of mental health services have noted that it was meaningful to be viewed as a responsible agent for future crises, to purposefully and thoughtfully determine what they wanted for themselves in future crises, to have power over future crises, and to be believed by providers (Amering et al., 2005).
- Content analyses on DMHTs noted 94% contained clinically useful information and 91-95% were feasible to implement (Swanson et al., 2006; Srebnik et al., 2005).
- People with DMHT-type documents in place have been shown to have reduced compulsory hospital admissions (Tinland et al., 2022), reduced coercive interventions in general (Swanson et al., 2008), lower utilization of intensive healthcare services, and lower healthcare costs (Loubiere et al., 2023).

- Unfortunately, most providers are unfamiliar with DMHTs, do not understand the laws and regulations that control them, and consequently, do not think of them even in situations where DMHTs would be an ideal fit (Avila & Leeper, 2022).
- When providers are aware of DMHTs, they often voice general support for them, but note that unfamiliarity, discomfort, and concerns about legal and ethical implications can limit their confidence in using them (Avila & Leeper, 2022; Quinlan & Coffey, 2015; Elbogen et al., 2006; Swanson et al., 2006; Van Dorn et al., 2006).
- Even brief education on the laws about DMHTs can increase provider interest and confidence in using DMHTs to help families that would benefit (Avila & Leeper, 2022).

Overall, DMHTs are a relatively simple idea that is consistent with relevant legal principles, best available research, and recovery-oriented practice by clinicians. In addition to explicitly outlining how they can be used to avoid potentially unnecessary civil commitments (replaced by treatment as outlined by a DMHT), the forthcoming amendment to HB 2488 will also clarify some of the vague provisions in ORS 127.700-127.737 to better guide courts and clinicians interested in using DMHTs to help the people they interact with every day. **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.**

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, if that information would be helpful to members of the committee. Thank you for reading this written testimony, and thank you for your consideration.

Respectfully submitted,

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