BEHAVIORAL HEALTH

ACCESS TO SERVICES

Bills in the 2021 Legislative Session sought to increase consumer access to behavioral health services and access to prescription drugs.

In Medicaid, coordinated care organizations (CCOs) are required to provide and prioritize specified behavioral health services, however, mental health wellness appointments were not required by statute. House Bill 2469 adds mental health wellness appointments to the list of behavioral health services a CCO must offer its members.

In 2020, the National Suicide Hotline Designation Act was signed into law to increase access to emergency mental health services. House Bill 2417 establishes a program to provide grants to cities or funding to county community mental health programs to support mobile crisis intervention teams. The bill also requires the Oregon Health Authority (OHA) to report to the legislature its recommendations on policies and legislative changes needed to implement the National Suicide Hotline Designation Act of 2020 (also known as the 9-8-8 line) and establish a statewide coordinated crisis services system.

The Governor's Behavioral Health Advisory Council (Council) was established by Executive Order in October 2019 to develop recommendations aimed at improving access to effective behavioral health services and supports for all Oregon adults and transitional-aged youth with serious mental illness or co-occurring mental illness and substance use disorder. Based on the recommendations of the Council, House Bill 2086 appropriates moneys to OHA programs that provide culturally specific services that are directly responsive to and driven by people of color, tribal communities, and people with lived experience.

Peer respite centers are voluntary, short-term programs where people seeking help for mental health struggles or substance use disorder can get help from trained peers who have lived experience with mental health and substance use disorder challenges. House Bill 2980 requires OHA to provide funding to peer-run organizations in the Portland metropolitan area, southern Oregon, Oregon coast, and eastern and central Oregon regions to operate peer respite centers to provide services to individuals with mental illness or trauma response symptoms. The bill also requires that at least one peer respite center receiving funding participate in a pilot project designed specifically to provide culturally responsive services to historically underrepresented communities. Finally, the bill directs OHA to adopt criteria for operating peer respite centers that receive funding and to monitor compliance.

Consistent and affordable access to prescription mental health drugs for those who need them is recognized as an important piece of effective mental health treatment. The Mental Health Clinical Advisory Group was created in 2017 to "develop evidence-based algorithms for mental health treatments, including treatments with mental health drugs." House Bill 3045 changes the sunset date requiring OHA to reimburse the cost of a mental health

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See the **2021 Legislative Summary Report** for Behavioral Health, which highlights policy measures that received a public hearing during Oregon's 2021 Regular Legislative Session.

drug prescribed to a Medicaid enrollee from January 2022 to 2026. The measure prohibits OHA from requiring prior authorization for any mental health drug prescribed for a Medicaid enrollee if the claims history available to OHA shows the individual has been in a course of treatment with the drug during the last year.

CIVIL COMMITMENT AND JUDICIAL PROCEEDINGS

Civil commitment is a process in which a judge decides whether a person alleged to be mentally ill should be required to accept mental health treatment. Other judicial proceedings in behavioral health include a guilty except for insanity (GEI) verdict, and "aid and assist." Aid and assist orders allow a judge to order a defendant who is not able to participate in their trial because of the severity of their mental illness to receive restoration treatment so that they can aid and assist in their own defense.

The "extremely dangerous person" standard is a specific classification for individuals subject to a civil commitment proceeding. The basis for the extremely dangerous person standard is a previously adjudicated or pending allegation of criminal conduct along with a "mental disorder that is resistant to treatment." Under the previous law, ORS 426.701 (2019), the courts did not have the authority to detain an individual who is alleged to be extremely dangerous while the civil commitment petition was pending. The Legislative Assembly changed this with the passage of Senate Bill 205 which allows the court to order an individual to be committed to Oregon State Hospital or other secure mental health facility while a petition is pending.

In 2019, the Legislative Assembly passed Senate Bill 24 (SB 24), which modified the fitness to proceed processes delineated in ORS 161.365 (2019) and ORS 161.370 (2019). Fitness to proceed is an examination of the defendant's present capacity to understand the proceedings against them and their capacity to assist in their defense. Currently, courts are required to consider ordering rehabilitation services in the least restrictive setting possible or, when appropriate, find an alternative disposition for a defendant who does not require a hospital level of care. On passage of SB 24, courts were also prohibited from committing to the state mental hospital individuals charged with violations, and individuals who committed misdemeanors to be admitted to a hospital level of care, only when necessary. The measure created the requirement for review hearings where the court must consider alternative placements and dispositions at seven-day intervals for any individual found to be unfit and placed in custody while awaiting services at the state mental hospital or in the community. In order to implement SB 24, the Legislative Assembly enacted Senate Bill 295, which restructures the aid and assist statutes to effectuate the intent of SB 24, increasing the use of community-based services for competency restoration.

A declaration for mental health treatment allows a person to express their preferences for mental health treatment should the person become unable to communicate or effectively understand information to the extent that the person is unable to consent or object to mental health treatment. A person executing a declaration for mental health treatment can also appoint a health care representative to make decisions for them.

Previously, a physician or mental health provider could act contrary to the instructions in the declaration if the person had been civilly committed and treatment was done in accordance with state law. However, Oregon law did not include a provision for this under the extremely dangerous person standard. Senate Bill 72 expanded this ability to allow a physician or mental health provider to act contrary to the treatment indicated in a declaration of mental health treatment for a person committed under the extremely dangerous person standard. The act requires the same criteria be met as for treatment of a person civilly committed and includes the cost of outpatient services within the calculation of current cost of care for persons who are or were at the Oregon State Hospital.

Several bills looked at the process of exiting a court-ordered hold. Senate Bill 206 modifies the court-conditional release process by increasing required communication between parties, agencies, and organizations involved in the process. The act modifies requirements for the court in determining whether a person should be conditionally released,

specifying when mental health consults and evaluations must be ordered by the court, and directs the Psychiatric Security Review Board to establish, by rule, standards for mental health consultations and evaluations. In an effort to clarify the adjudication of GEI cases, Senate Bill 200 requires the district attorney in each county to develop and adopt written policies regarding cases involving a GEI defense.

STATE SYSTEMS

Oregon's behavioral health system is housed across multiple agencies and boards: OHA, Oregon Housing and Community Services, Oregon Department of Human Services, and the Oregon Department of Education. A 2020 audit from the Secretary of State's office identified data limitations and system fragmentation as challenges facing Oregon's behavioral health system. Several bills in the 2021 session looked at statewide systems that impact behavioral health.

In 2017, the Legislative Assembly passed Senate Bill 860 which required that the Oregon Department of Consumer and Business Services report on commercial insurance pay parity between physical and mental health care services. The report found many insurers were out of compliance with payment parity. House Bill 3046 requires commercial insurers to report on mental health parity requirements and specifies the types of behavioral health services that must be provided by CCOs and covered by group health insurance and individual health plans.

The Oregon Consumer Advisory Council (OCAC), housed in OHA, is comprised of consumers of mental health care who advise the Director of OHA on the provision of behavioral health services. Currently, members are appointed by OHA. Senate Bill 721 (*vetoed*) would have authorized existing members of OCAC to select new members or to convene a seven-member subcommittee of current members to select new members. This bill was vetoed by Governor Brown in August 2021.

SUBSTANCE USE DISORDER RECOVERY AND PREVENTION

Substance use disorders (SUD) are a major public health concern for Oregon, particularly SUD treatment and prevention. Opioid addiction is an SUD issue for seniors. Senate Bill 698 conditions an opioid treatment center's ability to legally operate based on their acceptance of Medicare reimbursement via rules adopted by OHA. Previously, there was no requirement that opioid treatment centers accept Medicare reimbursement, which prevented many older adults from accessing treatment.

The Alcohol and Drug Policy Commission (ADPC) was created by the Legislative Assembly in 2009 and charged with planning to fund and deliver effective drug and alcohol treatment and prevention services. In 2020, the ADPC released its strategic plan, which includes a goal of identifying processes and resources to create, track, fund, and report on strategies for systems integration, innovation, and policy development. House Bill 2313 (*not enacted*) would have directed OHA and the ADPC to inventory statewide resources available to address the inadequate recovery support resources available to prevent and treat substance use disorders. House Bill 3377 A (*not enacted*) would have established the Task Force on Substance Use with the goal of fully funding the addiction, prevention, and recovery plan for the ADPC through new and existing revenues.

Recovery Community Organizations, which are peer-operated and governed by local community members, are another tool for substance use recovery and are non-medical services. House Bill 3111 (*not enacted*) would have required OHA to contract with at least four Recovery Community Organizations in different counties.

SUICIDE PREVENTION

According to OHA, suicide was the second leading cause of death among Oregonians age 10-24 in 2018. Over the last several years there have been a number of reports of suicides in children under the age of 10, however, the law defined youth suicide to only include those 10-24 years of age. The legislature changed this with Senate Bill 563, which modifies laws relating

to youth suicide intervention and prevention to include children 5 to 10 years of age.

Oregon law allowed physical and behavioral health providers to disclose health information of youths to parents or guardians when the risk of harm was serious; however, the law did not specify the conditions under which a disclosure was allowable. House Bill 3139 clarifies the conditions and imposes requirements on providers to disclose certain health information to parents or guardians without a minor's consent to engage in critical safety planning when the risk of harm is serious and imminent.

Historically, there were no statutory requirements for health care and behavioral health professionals to complete suicide prevention continuing education. To increase the amount of on-going training providers and other professionals receive in suicide prevention, House Bill 2315 requires licensees of certain regulatory boards and OHA to complete continuing education in suicide prevention.

An important public health practice for communities who have experienced a youth suicide is post suicide interventions. Local mental health authorities (LMHAs) have been required to engage in post suicide interventions, including working with community partners for information sharing and response since 2015. House Bill 3037 now requires medical examiners and death investigators to notify LMHAs of suicides involving individuals 24 years of age or younger. The measure also allows these individuals to identify a decedent's educational institution or extracurricular activities if necessary, to protect public health. Lastly, the bill clarifies that OHA is responsible for developing uniform, statewide post suicide response protocols to be implemented at the local level in the aftermath of a youth suicide.

WORKFORCE

In 2018, OHA contracted with the Farley Health Policy Center to assess the behavioral health workforce in Oregon. They found that minority populations are underrepresented in all segments of the behavioral health workforce compared with the racial and ethnic demographics of the state's population. The report also found that unlicensed providers are the most racially and ethnically diverse segment of the workforce as compared to licensed providers and licensed prescribers. More recently, a 2021 workforce report from OHA shows that people of color comprise 13 percent of the licensed behavioral health provider workforce, and clinical social work associates are the most racially or ethnically diverse, with 26 percent being people of color.

To increase the behavioral health workforce and improve workforce diversity, House Bill 2949 establishes a number of funding opportunities including: (1) incentives to increase the recruitment and retention of providers in the behavioral health care workforce who can provide culturally competent services; (2) grants to licensed behavioral health providers to provide supervised clinical experience to associates; and (3) grants to public or private organizations that employ licensed behavioral health providers to provide supervised clinical experience to associates.

House Bill 2361 (*not enacted*) would have prioritized access to Oregon's health care provider incentive program for behavioral health providers serving Latino, Latina, and Latinx providers in Morrow, Malheur, Hood River, and Umatilla counties. House Bill 2370 (*not enacted*) would have directed the Higher Education Coordinating Commission to assess mental health provider education programs in Oregon for the purpose of mapping the behavioral health programs in Oregon and identifying gaps in the workforce pipeline.

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