

This handbook is intended to serve
as a guide for Oregon State Hospital
Staff, community providers,
partnering agencies, Board Members
and staff

2019 PSRB HANDBOOK



Oregon

Kate Brown, Governor

Psychiatric Security Review Board

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April 10, 2019

Dear PSRB Partners,

On behalf of the Psychiatric Security Review Board, I would like to extend our gratitude to all of you, our valued partners! As executive director, I am committed to supporting you in the daily challenges of this work. You are an integral part of our agency's ability to carry out our mission and ensure that individuals under the PSRB are receiving the services needed to live safely in the community.

This handbook was originally designed and recently updated as one way to support our partners. Enclosed is an abundance of resources related to our policies, procedures and practices. In updating this handbook for 2019, we provided updates to statutory changes and made concerted efforts to incorporate frequently asked questions we receive from you, our partners. Whether you provide direct services or supervise programs that serve the PSRB, I hope you find this handbook to be an informative guide.

Please note we have several other resources to support you such as our PSRB website at <http://www.oregon.gov/prb>, where you can find updated information, sample templates, and references. In addition, PSRB staff is here to help Monday through Friday during business hours. If you are in need of a more in-depth or tailored training for your agency, I am available to travel to any Oregon county to provide technical assistance to meet your needs. Please feel free to contact our office at (503) 229-5596 for more information about training opportunities.

I look forward to our future collaborations and invite feedback on ways we can further strengthen our partnerships and equip you with the resources you need to effectively manage your programs. My door is always open, so please do not hesitate to contact me directly at Alison.Bort@oregon.gov.

Sincerely,

Alison Bort
Executive Director



Psychiatric Security Review Board

Conditional Release and Community Treatment Facilities

Background

When someone commits a crime and is found by the Courts to be “guilty except for insanity,” he or she is placed under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB).

Individuals found guilty except for insanity are typically placed under the jurisdiction of the PSRB for the maximum sentence length provided by statute for the crime. Depending on the offense, that is 5 years, 10 years, 20 years, or life.

Historically, PSRB authority over an individual has lasted longer than Department of Corrections’ system authority.

While under PSRB jurisdiction, an individual can be housed in the Oregon State Hospital or in a variety of residential treatment settings, ranging from Secure Residential Treatment Facilities to independent living. The PSRB determines what kind of facility is appropriate based on the level of treatment, care and supervision the individual requires.

Mission of the Psychiatric Review Board – Public Safety

Oregon State law is explicit that PSRB must put public safety first. ORS 161.336(10) states: 161.336(10) states: “In determining whether a person should be committed to a state hospital or secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society.”

Conditional release under PSRB authority – Proven Public Safety Record

The PSRB has been successful in carrying out its mission. From January 2011 through 2017 (the most recent year for which recidivism figures are currently available), only 15 people out of the 896 who were living in the community on conditional release have been convicted of new felonies or misdemeanors.

The cumulative recidivism rate for the PSRB from 2011 to 2017 is 0.46 percent. By comparison, the most recent recidivism rate for individuals on Parole or Post-Prison Supervision is 18% and on Probation is 14% (CJC, 2019) after being on parole or probation for three years.

Most PSRB clients begin their treatment at the Oregon State Hospital. When clients are conditionally released they are carefully monitored by the PSRB. They are subject to immediate return to the state hospital if they violate the terms of their conditional release order.

PSRB SNAPSHOT (as of January 1, 2019)

- 575** Number of people currently under PSRB jurisdiction.
- 205** Number of people under PSRB jurisdiction in Oregon State Hospital.
- 364** Number of people under PSRB jurisdiction who are on conditional release from the state hospital.

SAFETY RECORD (January 1, 2011 to December 31, 2016)

- 896** Number of people on conditional release during the intervening 6 years.
- 15** Number of those 896 people who committed a felony or misdemeanor while on conditional release and were subsequently convicted of that crime.
- 0.50%** Cumulative annual recidivism rate for GEI clients since 2011.
- 99.4%** Percent of adult conditional releases maintained in the community per month in 2018.

Psychiatric Security Review Board

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Portland, OR 97205

Phone: 503-229-5596

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Website: www.oregon.gov/prb

FAQs

Are people who have been found GEI ever sentenced to the Oregon State Hospital?

No. The GEI statute calls for individuals to be placed under the jurisdiction of the PSRB. The hospital is a secure place for psychiatric treatment, not for punishment.

How is the length of time at the Oregon State Hospital established?

The period of time PSRB clients stay at OSH varies by individual. The PSRB makes its decision to conditionally release someone based on a clinical assessment of the individual's mental status, progress in treatment at the hospital and risk assessments as to dangerousness as well as the availability of the appropriate resources in the community. If it is determined that a person can be safely managed and treated in a community setting, the PSRB attempts to find an appropriate placement.

Are PSRB adult clients ever discharged before their sentence is completed?

By law, the PSRB retains jurisdiction over clients who have a qualifying mental disorder that renders them a substantial danger to others when the disorder is active. In rare cases, a client found guilty except for insanity may be discharged early from the Board's jurisdiction. The 5 year average of these types of discharges by the PSRB is 13.6 per year, with 6 in 2017 and 3 in 2018. The overwhelming majority of clients complete their full sentence under the PSRB.

Is the state trying to move PSRB clients out of the state hospital and into the community, and what kind of impact will that have on public safety?

Because of additional funding from the Oregon Legislature since 2005, an increased number of PSRB clients have been moved into a variety of new community placements, including Secure Residential Treatment Facilities (SRTFs). Since more of these facilities have opened, there has not been any increase in the recidivism rate.

Is it safe to move people who have committed violent crimes into the community?

State law prohibits the Board from putting anyone on conditional release who is determined to be presently dangerous to others. Additionally, before individuals are released, they go through a comprehensive screening process that includes four levels of review. In all cases, including person-on-person crimes, victims who want notification are contacted in advance, as is the District Attorney's office that first prosecuted the case.

Conditional release is not a new policy. Most states in the US have some type of conditional release program. The PSRB has supervised clients in the community on conditional release since its inception in 1978. Over the past 20 years, more than 1960 conditional releases have been granted to people who have transitioned into community placements throughout Oregon. Some of these clients remain under supervision for decades or even life.

Who is notified when someone is being considered for conditional release?

By law, the district attorney from the committing county is notified along with the judge who signed the judgment order. Also, the victim(s), if they requested such notification. The Attorney General's office, the client's attorney and the client's case manager are also notified.

For more information contact Alison Bort, Executive Director of the Psychiatric Security Review Board at (503) 229-5596.



WHERE PSRB CLIENTS LIVE (as of January 1, 2018)

Oregon State Hospital (35.7%)

- 205 individuals
- Locked 24/7, secure perimeter
- 24-hour supervision
- Off-site privileges based on public safety and level of care needed

Secured Residential Treatment Facility (12%)

- Locked 24/7
- Egress controlled by staff
- Off-site privileges based on public safety and level of care needed
- 6-16 individuals per facility

Residential Treatment Facility/Home (24.2%)

- Unlocked
- 24-hour awake supervision
- Up to 16 individuals per facility

Adult Foster Home (3.1%)

- Unlocked
- 24-hour staff
- Up to 5 individuals
- Some clients with state variance allow for four hours home alone

Semi-Independent/Supported Housing (7%)

- Varies from individual apartments to shared housing
- Staff part time at the site

Intensive Case Management (3.1%)

- Independent living
- Staff contacts at least twice per day with at least one contact at residence
- Case management team

Independent Living (self, with family) (13.4%)

- In regular apartments or houses
- Frequent home visits by case manager

Other (Department of Corrections) (1.6%)

QUESTIONS?

For General questions about PSRB resources in the community:

- Psychiatric Security Review Board
610 SW Alder St. Ste. 420
Portland, OR 97205
(503) 229-5596
psrb@oregon.gov

For General questions about community resources for clients diagnosed with a Developmental/Intellectual Disability:

- **Juvenile PSRB Developmental Disability community placement:**
Lou McDonough
Department of Human Services: Service Coordinator / SPD
11826 NE Glisan St.
Portland, OR 97220
(971) 673-2986
lou.m.mcdonough@state.or.us
- **Adult PSRB Developmental Disability community placement**
Matt Bighouse
State of Oregon Department of Human Services /ODDS
500 Summer Street NE, #E09
Salem, OR 97301-1064
(503) 945-6976
Matt.L.Bighouse@dhsosha.state.or.us

For general questions about community resources for clients who need referrals to or are eligible for Aging and People with Disabilities services:

- Beth Lee
APD Branch 5510 Lead
500 Summer St NE
Salem OR 97301 971-719-3459
beth.lee@state.or.us

For General questions about community resources for clients with a psychiatric diagnosis:

- **Juvenile PSRB community placement:**
Alex Palm
JPSRB Coordinator
Oregon Health Authority
500 Summer Street NE, E86
Salem, OR 97301
Alex.J.Palm@state.or.us
- **Adult PSRB community placement:**
Anna Dyer
Oregon Health Authority
500 Summer Street NE, Y34
Salem, OR 97301
(503) 779-9814
anna.e.dyer@state.or.us

Many facilities in Central Oregon and Eastern Oregon are run by Greater Oregon Behavioral Health, Inc. (GOBHI).

- Greater Oregon Behavioral Health, Inc.
401 E 3rd Street, Suite 101
The Dalles, OR 97058
(541) 298-2101
1-800-493-0040
Fax: (541) 298-7996; info@gobhi.net
[Click here for a list of GOBHI Facilities.](#)

TABLE OF CONTENTS
(Ctrl+ click to follow links)

1. [PSRB Overview](#)
 - [Mission](#)
 - [History and Functioning of the PSRB](#)
 - [Board Members and Staff](#)
 - [PSRB Staff](#)
 - [Cost and Performance Measures](#)
 - [National Acclaim](#)
 - [Adult Panel](#)
 - [Juvenile Panel](#)
 - [Civil Commitments](#)
 - [Gun Relief Program](#)
2. [Hearings](#)
 - [Types of Hearings](#)
 - [Hearings FAQ](#)
 - [Media at Hearings](#)
 - [Evidence Required at a Psychiatric Security Review Board Hearing](#)
 - [Hearings for Inpatients](#)
 - [Full Hearings for Outpatients](#)
 - [Hearings for Clients Already on Conditional Release](#)
 - [Community Evaluations](#)
3. [Case Manager Responsibilities](#)
4. [Residential Staff Responsibilities](#)
5. [Revocation of Conditional Release](#)
6. [Passes while on Conditional Release](#)
7. [Alcohol and Drug Screening](#)
8. [Medical Cannabis](#)
9. [Victims](#)

PSRB Overview

Mission

The Psychiatric Security Review Board's mission is to protect the public by working with partnering agencies to ensure persons under its jurisdiction receive the necessary services and support to reduce the risk of future dangerous behavior using recognized principles of risk assessment, victims' interest, and person-centered care.

History and Functioning of the Psychiatric Security Review Board

On January 1, 1978 the Board assumed jurisdiction over all persons found guilty except for insanity (GEI) who posed a substantial danger to others. "Guilty Except for Insanity is Oregon's insanity defense, and the Board has retained jurisdiction over GEI clients as its responsibilities have grown over the last four decades. For example, in 2007, the Legislature expanded the Board and its responsibilities to include a juvenile panel to oversee youth who were found responsible except for insanity (REI) of a crime.

The 2009 Legislature again expanded the Board's duties; adding responsibility for restoration hearings for individuals previously barred from purchasing or possessing a firearm due to a mental health determination, and who petition to have that right restored.

In 2013, the Legislature again expanded the Board's duties to include supervising and monitoring the civil commitments of those individuals considered extremely dangerous due to a persistent mental illness that is resistant to treatment. That same year, the legislature also mandated that the Board assign risk ratings to its GEI clients who are required to register as sex offenders, and that the Board create a procedure to allow those clients to apply for reclassification to a lower level, or relief from the sex offender registration process, depending on their circumstances. The Board completed its necessary sex offender designations in 2018.

Board Members and Staff

By statute, the Board has 10 Members, each appointed by the governor and confirmed by the Senate for a four-year term. The adult PSRB panel consists of a psychiatrist and a psychologist experienced in the criminal justice system, an experienced parole and probation officer, an attorney experienced in criminal trial practice, and a member of the general public. Similarly, the juvenile PSRB Panel is comprised of a child psychiatrist, child psychologist, an attorney experienced in juvenile law, a juvenile parole or probation officer, and a member of the general public. Each panel elects a chair, who serves a one-year term.

Current Adult Panel

Psychiatrist: Scott Reichlin, M.D., originally appointed 5/22/2015; current term expires 6/30/2021. Dr. Reichlin is the Adult Panel's current chair.

Psychologist: Pamela Buchanan, Psy.D., originally appointed 07/01/2019; current term expires 06/30/2023

Attorney: Anne Nichol, J.D., originally appointed 7/1/2017; current term expires 6/30/2021

Parole and Probation: Trisha Elmer P.P.O., originally appointed 9/22/2016; current term expires 6/30/2020

Public Member: John Swetnam, originally appointed 3/9/15; current term expires 6/30/2021

Current Juvenile Panel

Psychiatrist: Bennett Garner, M.D., originally appointed 3/15/2017; current term expires 6/30/2020

Psychologist: Catherine Miller, Ph.D., originally appointed 1/2/2015; current term expires 6/30/2022.

Attorney: Charles Kochlachs, J.D., originally appointed 2/17/2016; current term expires 6/30/2020

Parole and Probation: Kathryn Kuenzi, J.C.C., originally appointed 1/2/2015; current term expires 1/1/2022

Public Member: Shelly Casteel, originally appointed 3/1/2014; current term expires 6/30/2021. Shelly is the Juvenile Panel's current chair.

The staff supporting the Board and agency operations consists of an executive director, deputy director, three paralegals, three administrative assistants, a deputy director, a research analyst, an administrative assistant and an executive secretary. The executive director oversees the overall operations of the agency, including monitoring PSRB clients on conditional release, preparing orders resulting from Board hearings and affidavits and orders for revocation of conditional release. In addition, the executive director prepares and presents the budget and other matters before the legislature. She serves as agency spokesperson, maintaining a collaborative partnership with multiple agencies within Oregon's forensic mental health system and beyond.

PSRB Staff

| Name | Position | Email | Phone |
|----------------------------|-----------------------------------|--|--|
| Alison Bort, J.D.,Ph.D. | Executive Director | alison.bort@oregon.gov | Direct: (503) 229- 5596 Cell: (503) 781-3602 |
| Sid Moore, J.D. | Deputy Director | sid.moore@oregon.gov | Direct: (503) 229- 5032 Cell: (503) 709-8861 |
| Jane Bigler | Executive Secretary | psrb@oregon.gov | Direct: (503) 229- 5596 |
| Shelley Banfe | Research Analyst | shelley.banfe@oregon.gov | Direct: (503) 229- 5596 |
| Laura Moeller, J.D. | Hearings Coordinator | laura.moeller@oregon.gov | Direct: (503) 229- 5596 Cell: (503) 568-9882 |
| Nola Borland | Hearings Scheduler | nola.borland@oregon.gov | (503) 229-5596 |
| Jeanne Schaefer | Hearings Specialist | jeanne.schaefer@oregon.gov | (503) 229-5596 |
| Matthew Berndt, J.D. | Conditional Release Monitor | matthew.berndt@oregon.gov | (503) 229-5596 |
| Jeff Hanson | Conditional Release Monitor | jeff.hanson@oregon.gov | (503) 229-5596 |
| Karen Bull | Case Summarizer | karen.bull@oregon.gov | (503) 229-5596 |
| Ashley Wilsey | Office Specialist | ashley.wilsey@oregon.gov | (503) 229-5596 |

Cost and Performance Measures

The Psychiatric Security Review Board is a State agency that is funded by the Oregon Legislature. The agency's budget for the 2019-21 biennium is approximately \$3.2 million for Board operations, hearings and 11 staff members. Please click [here](#) to access the 2019-21 Legislatively Adopted Budget, Containing Annual Performance Measures.

National Acclaim

The Psychiatric Security Review Board has been the focus of international attention and study. An NBC white paper on "Crime and Insanity," shown on television in April 1983, focused on Oregon as a model system. In addition, the American Psychiatric Association statement on the insanity defense in December 1983 recommends the model system presently in operation in the State of Oregon under the aegis of the Psychiatric Security Review Board. The APA was impressed that:

Confinement and release decisions for acquittals are made by an experienced body that is not naive about the nature of violent behavior committed by mental clients and that allows a quasi-criminal approach for managing such persons. Psychiatrists participate in the work of the Oregon Board, but they do not have primary responsibility. The Association believes that this is as it should be since the decision to confine and release persons who have done violence to society involves more than psychiatric considerations. The interest of society, the interest of the criminal justice system and the interest of those who have been or might be victimized by violence must also be addressed in confinement and release decisions.

A report of the National Commission on the Insanity Defense issued in March 1983 and entitled "Myths and Realities", sponsored by the National Mental Health Association, recommends the adoption of a special statute to address the disposition of the acquitted after a finding of not responsible by reason of insanity of a violent crime. In that report, the National Commission also discusses the Oregon code creating the Psychiatric Security Review Board.

In 1989 the National Alliance for the Mentally Ill set goals and priorities which included passing statutes that provide improved systems for insanity acquittees, citing the Oregon Psychiatric Security Review Board as a model for such a statute.

In 1994, the Psychiatric Security Review Board was named the APA's Hospital and Community Psychiatry's Gold Achievement Award winner. The award was given in recognition of the program's commitment to improved integration of mental health services within the criminal justice system and its responsibility to individual, community and societal values.

Oregon remains one of the states currently in the forefront of legal process in this area. Connecticut and Arizona have similar agencies, with Connecticut having adopted the Oregon model years ago and Arizona just achieving their sunset clause in 2018. Most recently, in 2010, Washington State created and enacted a version of this model. Other states, including Florida, Kentucky, Michigan, New Hampshire, and South Carolina have expressed an interest in this successful approach.

The insanity defense population will continue to be a part of our society. Oregon has chosen to create the Psychiatric Security Review Board, offering a multidisciplinary method of decision-making. By statute, the Board's primary concern is the protection of society. The system works well because of the Board's ability to respond quickly to community emergencies and because the system balances the public's concern for safety, the treatment of persons in the community and the rights of the clients.

There have been several articles and books written and research studies performed on the insanity acquittee population. Please visit our website for a snapshot of publications on this topic.

Adult Panel

When an adult commits a felony and is found by the courts to be Guilty Except for Insanity (GEI), the judge is likely to place the individual under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB). Typically, courts place these individuals under the Board's jurisdiction for the maximum period they could have received had they been found guilty of the offense. When an individual successfully pleads GEI, sentencing guidelines do not apply.

The Psychiatric Security Review Board's statutory functions are to protect the public by:

1. Accepting jurisdiction over Guilty Except for Insanity clients;
2. Balancing the public's concern for safety with the client's rights;
3. Conducting hearings, making findings, and issuing orders;
4. Monitoring the progress of each client under its jurisdiction;
5. Revoking conditional release, when necessary, if clients violate their conditional release terms;
6. Maintaining up-to-date histories on all clients.

The Board carries out these functions by conducting hearings and monitoring clients on conditional release. In making decisions, the Board's primary concern is the protection of the public.

While under the Board's jurisdiction, an adult can be committed to the Oregon State Hospital or conditionally released to a lower level of care, ranging from secure residential treatment facilities to independent living. The majority of clients placed under the PSRB under a GEI plea begin their PSRB term at Oregon State Hospital, with the goal of conditional release as the progress through treatment. The Board determines what type of facility is appropriate based on both clinical and risk assessments, including the level of treatment, care and supervision required by the client. Conditional release is granted to a client once the Board determines that he or she can be adequately controlled with supervision and treatment in the community and that the necessary supervision and treatment are available.

The Board assesses readiness for conditional release planning by:

1. Reviewing the exhibit files containing reports and evaluations by the client's providers of various disciplines;
2. Listening to witness testimony, including cross examination when the Board needs additional information; and;

3. Cross examining witnesses to obtain additional information; and
4. Considering the risk to society that the client may pose if returned to the community, using:
 - a. Clinical judgment of professional staff;
 - b. Results of psychological testing and risk assessments
 - c. Recommendations of the Oregon State Hospital's Risk Review Panel; and
 - d. The availability of resources in the community to compensate for any residual risk.

When release is appropriate and the Board approves a verified plan, the Board orders the client released from the state hospital subject to the Board's specific conditions. An overview of these conditions includes:

1. An appropriate housing situation;
2. Mental health treatment and supervision;
3. The designation of a person who agrees to report on a monthly basis to the Board concerning the released person's progress and who also agrees to notify the Board's director immediately of any violations of the release conditions; and
4. Any other special conditions deemed appropriate and/or necessary such as abstaining from alcohol and drugs or submitting to random drug screen tests.

The efficacy of the Board's decision-making and the ability of those treated and supervised persons to succeed on conditional release are evidenced by the fact that in 2018, more than 99% remained in the community on a monthly basis. However, in accordance with ORS 161.336, a change in mental health status that causes a client to pose a risk of substantial danger to others or a violation of the terms of conditional release may result in immediate revocation of the conditional release and return to Oregon State Hospital. Members of the treatment team typically intervene at the earliest stages possible to mitigate risk and create safety plans to avoid a revocation if possible.

Grounds for revocation include:

1. Violation of the terms of the conditional release plan
2. A significant change in mental health status
3. Absconding from supervision

4. Loss of the availability of appropriate community resources

Juvenile Panel

When a juvenile is found by the courts to be Responsible Except for Insanity (REI), the judge places the individual under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB) if:

1. The court finds that the juvenile has a serious mental condition (defined as major depression, bipolar disorder or psychotic disorder); **or**
2. The court finds that the young person has a qualifying mental disorder other than a serious mental condition and represents a substantial danger to others, requiring conditional release or commitment to a hospital or facility.

Individuals found REI are placed under the jurisdiction of the Board for the maximum sentence they could have received if found guilty of the crime. As with the adult panel, sentencing guidelines do not apply.

With respect to juvenile clients, the Psychiatric Security Review Board's statutory functions protect the public by:

1. Accepting jurisdiction over REI clients;
2. Balancing the public's concern for safety with the client's rights;
3. Conducting hearings, making findings, and issuing orders;
4. Monitoring the progress of each client under its jurisdiction;
5. Revoking conditional release, as necessary, if the client violates his or her terms;
6. Maintaining up-to-date histories on all clients.

While under the Board's jurisdiction, juveniles can be committed to the Secure Adolescent Intensive Program (SAIP) for those with a mental illness or Secure Children's In-client Treatment Program (ITP) for those with developmental disabilities. When juvenile clients turn 18 years old, they are transferred from SAIP/ITP to the Oregon State Hospital for care and treatment if the Board determines they need hospital level of care. Individuals can also be conditionally released and placed at a variety of lower levels of care, ranging from residential treatment facilities to independent living. The Board determines what type of facility is appropriate based on both clinical and risk assessments, including the level of treatment, care and supervision required by the client. Conditional release is conferred on a client once the Board determines that he or

she can be adequately controlled with supervision and treatment in the community and that the necessary supervision and treatment are available.

The Juvenile Panel assesses a juvenile's readiness for conditional release planning using the same methods used by the Adult Panel. Similarly, the conditions of release for juveniles as well as the grounds for revocation are substantially similar to those used for adults.

PSRB Civil Commitments

All people charged with a crime have the constitutional right to assist in their own defense. If a court believes a mental disability may prevent someone from assisting in their own defense, the court puts the criminal case on hold while an evaluation is completed to determine the person's competency and whether they need treatment to restore competency. In some cases, a court may find, in light of an evaluation conducted under ORS 161.370, that there is no substantial probability that, in the foreseeable future, the defendant will gain or regain the capacity to stand trial.

In response to this finding, a court or district attorney may dismiss the charges and/or initiate commitment proceedings. ORS 426.701 is known as a PSRB Civil Commitment, and is available when there is reason to believe that a person is extremely dangerous due to a qualifying mental disorder that is also resistant to treatment. This requires the judge to appoint a qualified examiner to evaluate the individual. Commitment under this statute is for two years, and the individual is under the jurisdiction of the PSRB for the commitment period. The individual may be recommitted indefinitely, every two years if the court finds he or she continues to meet jurisdictional criteria. Conditional Release is permitted under the Civil Commitment program.

In some limited circumstances, a district attorney may initiate a PSRB Civil Commitment in cases where the individual's GEI or prison sentence is coming to an end, but there is evidence that supports the necessary criteria for this statute.

Gun Relief Program

The Gun Relief Program was established as a direct result of the investigation arising from the Virginia Tech tragedy. It revealed that a majority of states, including Oregon, were not sending the names of people barred from purchasing firearms to the federal National Instant Criminal Background Check System (NICS) database. All federally licensed firearm dealers and law enforcement agencies use NICS to conduct background checks when individuals apply to purchase firearms.

Congress passed legislation requiring states to provide those names for inclusion in the federal database or risk losing some federal criminal justice grant funding. To address various concerns, Congress included a provision requiring states to establish "relief" programs whereby individuals previously barred from purchasing or possessing firearms

could petition to have that right restored and their names removed from the NICS database.

As a result, the 2009 Oregon Legislature enacted HB 2853 which, in part, directed the Oregon State Police to submit the names of firearm-disqualified individuals to the NICS database. HB 2853 also directed the Psychiatric Security Review Board to conduct relief hearings, given the mental health expertise of its Board members. The Board will only hear relief hearings from individuals who are barred from possessing a firearm due to an Oregon mental health determination, including civil commits, persons found guilty except for insanity (GEI) and persons who were found unable to aid and assist in a criminal proceeding. Persons are barred from purchasing or possessing firearms if they have received one of these mental health determinations.

Persons who previously received judicial relief under ORS 166.274 remain barred from possessing a firearm under federal law. However, the PSRB's relief program is certified by the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and is recognized under federal law as having the authority to lift a federal mental health prohibitor.

Hearings Overview

Statutory Timing of Hearings

The PSRB conducts hearings at intervals as required by Oregon Law. Hearings regarding inpatients (individuals committed to the State Hospital) are held more frequently and the focus is primarily on release from the hospital. Individuals on conditional release (outpatients) have hearings less regularly and the primary focus of these hearings is on the conditions of the outpatient's supervised release.

Scheduling the Hearing

Approximately 1 to 3 months prior to the statutory due date, a PSRB staff member will reach out to the client's treatment team at the hospital or in the community with a proposed hearing date. If there are any requests regarding a specific time within a given hearing date, these should be discussed at this time to ensure that it is feasible given the docket as a whole. The week of the hearing, a PSRB staff member will provide a proposed schedule or hearing plan for the hearing day and note any witnesses expected to be available.

By statute, for good cause, an attorney may seek a continuance of a hearing to be held before the Board. If approved, the continuance allows parties an additional 60-days within which to prepare before the matter comes before the Board.

Full Hearings versus Administrative Hearings

The PSRB holds two types of hearings: (1) Full Hearings and (2) Administrative Reviews. Both types of hearings require notice to parties, updated exhibit files, and all hearings are documented using a formal Board Order detailing the decision. Full hearings are held on the record with attorneys and clients present. Usually there is

testimony at these hearings, and a decision is delivered at the conclusion of the hearing.

Findings Required at a Hearing

At all full hearings, the Board must make a finding on whether the client is appropriate for ongoing PSRB jurisdiction. Specifically, the Board must determine whether (1) the individual suffers from a qualifying mental condition and (2) when this condition is active the client poses a risk of substantial danger to others. The Board must also make a finding regarding the appropriateness of the client's current placement – at the hospital or in the community.

Notice of Hearing

Once a hearing is scheduled, notice will be sent to interested parties (typically 3 weeks in advance of the hearing date). The Department of Justice, defense attorney, district attorney, and all interested parties and victims who request it receive prior notice of all hearings by the Board.

Types of Hearings

Initial Hearings ORS 161.341(6)(a)

Initial Hearings must occur within 90 days of commitment by court order to PSRB if in the hospital or a secure intensive inpatient facility. When an adult client is conditionally released by the court, there is no statutory requirement for that client's initial hearing to occur within a specified time. However, the Board's policy is to set those clients' hearings within 90 days to mirror hospital clients' timelines. All initial hearings are full hearings.

2-Year/1-Year Hearings ORS 161.341(7)(b)

Adult clients committed to the OSH (inpatients) are required by statute have hearings at least once every two years. Individuals who are committed to a hospital under the JPSRB are required to have hearings at least once every year. The Board will conduct these hearings even if a client voluntarily refuses to attend. Consistent with the Board's policies, immediately before the hearing, the client's attorney confers with the client to confirm for the record that the client has been informed of the hearing and is knowingly and voluntarily refusing to attend. All 2-year (or 1-year) hearings are full hearings.

Hospital Request for Conditional Release (CR) or Discharge ORS 161.341(1)

When a person is committed to a state hospital or secure intensive community inpatient facility and the superintendent of the hospital or director of the facility is of the belief that the person no longer meets jurisdictional criteria or no longer needs hospital level of care, the statute indicates that the superintendent or director shall apply for an order of discharge or conditional release. The application must be accompanied by a report setting forth the facts supporting the review. The PSRB is required to hold a hearing on the application within 60 days (30 days if the person is a juvenile) of its receipt. Not fewer than 20 days (10 days in the case of a juvenile) prior to the hearing, the report is to be sent to the Attorney General.

At conditional release hearings, it is the State's burden to establish that jurisdictional criteria exist and to establish suitability for the client to the proposed placement. Typically, the client's treating prescriber in the hospital testifies as well as the social worker. If the hearing is for conditional release, the community evaluator, prospective conditional release monitor, and prospective prescriber are asked to listen to the hearing via conference call so they are able to ask questions of the hospital treatment team on their client's behalf. If the State meets its burden, it is likely that the client will be conditionally released into the community with placement at the facility that evaluated him/her.

All conditional release or discharge hearings are full hearings.

5-Year/3-Year Hearings ORS 161.336(6)

After an individual is placed on conditional release, the Board will hold a hearing at the five-year mark (three years, if client is a youth) to consider the progress of the client in the community. All 5-year (or 3-year) hearings are full hearings.

Client/Outpatient Requested Hearing ORS 161.336(4)(c) & 161.336(5)(a)

By statute, individuals committed to the State Hospital may request a hearing every six months to consider the issues of discharge, conditional release, and conditional release evaluations. Similarly, outpatients may request a hearing every six months to consider the issues of discharge and/or to consider modifications to their current conditional release plan. Hearings where the issue of jurisdiction is contested are always full hearings; however, most hearings scheduled to consider modifications of a client's conditional release may be reviewed administratively.

Supervisor request for outpatient hearing ORS 161.336(5)(b)

A case monitor who supports a modification to the conditional release or an early discharge from jurisdiction may request a hearing for either of those purposes on the outpatient's behalf. Hearings where the issue of jurisdiction is contested are always full hearings; however, most hearings scheduled to consider modifications of a client's conditional release may be reviewed administratively.

Revocation Hearings ORS 161.336(4)(c)

Revocation hearings occur within 20 days (10 days, if a youth) after a client is admitted to the hospital on a revocation order. Revocations are typically used when a client in the community violates the conditions of their release and must be returned to the State Hospital for the safety of the community. Revocation hearings are full hearings.

Hearings FAQs

What Can I expect at a PSRB Hearing?

Hearings are run like miniature trials. Typically, three Board Members sit for any given hearing date. The Board sits in the front of the room with the representative from the Attorney General's office and defense attorney facing them. The client typically sits

next to his defense attorney. Witnesses, members of the public, and in some limited cases, the media, may be present in the courtroom. The Board leads the proceedings, inviting parties to make opening statements, call witnesses, and make closing arguments. The Board may also question witnesses who are called.

The Board expects courtroom decorum throughout the proceedings. All hearings are recorded and there should be no talking among individuals in the courtroom unless they are speaking directly to the Board. Cell phones should be off or, at a minimum, on vibrate. Hats are not allowed.

Who Decides the Outcomes of the Hearings?

The PSRB is composed of ten Board members: five for the Adult Panel and five for the Juvenile Panel. The Board Members sitting for any particular hearing decides the outcome of the hearing. A quorum of three is required to decide the outcome of each hearing, so three members are assigned for each hearing day. In instances where conflicts of interest exist and one of the sitting Board members is not allowed to render a decision on a case, PSRB staff arrange for a fourth board member to also hear the case, review the exhibit file, and render a decision.

How do Case monitors find out the Hearing outcome?

Case monitors may call the PSRB office after Noon on the Thursday following the hearing for the verbal hearing result. The Board order will be mailed within 30 days of the hearing.

When does the PSRB need Prescriber Progress Notes and Case monitor Progress Notes for PSRB Clients who have upcoming Hearings?

The PSRB staff needs both up-to-date Prescriber Progress Notes and Case monitor Progress Notes at least three weeks prior to a client's scheduled hearing. It is imperative that there be at least one progress note in the client's record that is dated within 30 days of their hearing. This must be received from the treating prescriber so that the Board will know that the client has recently been seen and assessed. The notes should include information summarizing the client's psychiatric status since the last hearing. Please refer to our policy online that outlines the timelines and information to be included in prescriber progress notes.

Will a hearing still happen if the client's prescriber is not available to testify at the hearing?

Possibly, depending on the type of hearing and whether or not there are stipulations, but usually, no. In some situations it is possible to have a supervisor testify on behalf of a doctor who is absent, however, the strong preference of the Board is that the client's treating prescriber be available for testimony at the hearing. In situations where a client is on conditional release, it is permissible to have the client's case monitor testify in lieu of the treating prescriber so long as no discharge or major modifications to the terms of release are being sought.

How soon will a client be released from the hospital following a conditional release hearing?

It depends on when the bed is available at the placement where the client will be residing, but typically the hospital processes these requests as quickly as possible following the Board's decision.

What if a Treatment Team does not believe a client meets jurisdictional criteria?

ORS 161.341 *requires* OSH to submit an Early Discharge Hearing Request when OSH believes a client no longer meets jurisdictional criteria. Prior to requesting a hearing for a client's discharge, it is the hospital's policy to have its internal Risk Review Board weigh in on the matter. The Risk Review opinion represents the official position of the State Hospital regarding whether a client should be discharged. The matter will be set for a full hearing.

Community providers *may* request a discharge on behalf of the client if they believe the client no longer meets jurisdiction. To set this hearing, the treatment team shall provide the PSRB with a letter including the team's opinion as to why discharge is appropriate and what factors were considered in making this determination. Prior to the hearing, the treatment team must also submit a psychological/psychiatric evaluation assessing jurisdictional criteria and an opinion regarding whether or not the client should be discharged from the PSRB.

Media at hearings

Clients, victims and witnesses sometimes ask the PSRB whether or not there will be media present at hearings and whether or not media is allowed to be present at hearings held at the Oregon State Hospital. Hearings conducted by the PSRB are open to the public. Board deliberations are not open to the public. For details, see PSRB's rules about public records including deliberations (OAR 859-040-0015) and about media (OAR 859-050-0105). Although there is no statutory right to keep the media from publishing the likeness of a client or participants in a case, preferences to remain anonymous or to not have one's likeness published are usually able to be accommodated. So long as Board staff is aware in advance of the participant's preference, it is usually possible to work out an arrangement with members of the media to honor the participant's request to not have their likeness published.

Evidence Required at PSRB Hearings

For All Full Hearings

At every full hearing, whether the client is committed to the Oregon State Hospital or on Conditional Release, the Board must determine whether a client is appropriately placed under the PSRB's jurisdiction. The Board requires that a Licensed Psychologist, Psychiatrist, or Psychiatric Mental Health Nurse Practitioner evaluate the psycho-legal questions associated with PSRB jurisdiction. These questions include:

1. Does the person suffer from a qualifying mental disorder? A current psychiatric diagnosis must be provided.
2. If so affected, is the client's qualifying mental disorder active or in remission?
3. May this person's qualifying mental disorder, with reasonable medical probability, occasionally become active, and when active, render the person a danger to others?

The Board will further require that the prescriber/psychologist who performed the evaluation be available to testify at the hearing, either in person or by telephone, so that counsel and the Board members have an opportunity to cross-examine. If the client stipulates to jurisdiction and provides the PSRB notice in advance, the Board may waive this requirement.

Hearings for Inpatients (i.e. Clients committed to OSH)

Documentation

The client's treatment team shall ensure the following documents have been submitted to the Board a minimum of **12 days** prior to the scheduled hearing:

1. A Progress Note Update, authored by the treating prescriber dated within 30 days of the scheduled hearing date. In addition to the psycho-legal questions related to jurisdiction, the note should also reflect a recent interview with the client and a detailed account of the client's progress in treatment since the last note. Significant medications changes and incidents relating to instability or potential dangerousness during the relevant time period must be included. Please refer to our "Drafting a PSRB Progress Note Update" memorandum for additional details.
2. START dated within the past 90 days (i.e. not expired)
3. Violence Risk Assessment (or an updated VRA if one was generated)
4. Specialty Risk Assessments, if applicable, such as Sex Offender Risk Assessment, Stalking Risk Assessment or Arson Risk Assessment
5. If the client is seeking a conditional release, these additional documents are required:
 - Official Request for Hearing
 - Signed Summary of Conditional Release Plan
 - Signed Agreement to Conditional Release

- If victim wants contact with client, a letter from victim noting the desire for contact.

Witnesses

It is the Board's expectation that the client's treating prescriber or a prescriber designated by the Clinical Director be available to testify at PSRB hearings. Typically, at least 30 days prior to a hearing, PSRB staff send out the monthly docket to the designated OSH staff liaison. Since revocation hearings must be done within 20 days of a client's return to the hospital, notice for those types of hearings will be shorter than the typical 30 days. The Board expects OSH staff to promptly inform PSRB staff if a treating prescriber has a schedule conflict or if a different prescriber is expected to testify than originally indicated.

Testimony is not restricted to the treating prescriber. If any OSH provider (e.g. social worker, psychologist, specialty provider) believes he/she has relevant testimony for the hearing, please inform PSRB staff no later than 1 week prior to the scheduled hearing so the witness list can be finalized. Last minute witnesses can be a basis for a continuance so it is critical to identify necessary participants as early as possible.

Topics expected to be questioned during the hearing include:

1. Psycho-legal questions related to jurisdiction (see above).
2. Familiarity with the client's psychiatric history, including prescribed medications.
3. Familiarity with the client's instant offense.
4. Awareness of the progress the client has made while residing at the hospital.
5. Awareness of significant risk factors and behavioral incidents that have occurred during the course of the client's hospitalization.
6. Recommendations for ongoing monitoring and supervision, evaluation, treatment, and level of care (including conditional release)
7. If client requests to act as his or her own attorney, the prescriber's opinion as to whether the client is competent to represent him/her self.

Full Hearings for Outpatients

Full hearings are typically not necessary for clients unless there jurisdictional criteria is being challenged. The only exception is that after a client has been on conditional release for five years, the Board *must* hold a full hearing per statute, even if there is no modification requested. See: ORS 161.336(6). Board staff will support community providers in preparing for the 5-year hearing by sending a letter to the case monitor 90-days before the hearing must take place. The letter will detail what documents are

required and provide scheduling information for the full hearing. See sample Document Request correspondence and sample scheduling.

The Board requires personal appearance of all clients on conditional release at a 5-year hearing. The Board will not consider exceptions to this policy unless the client is physically incapacitated and cannot be transported to the hearing due to failing health or if the hearing would be detrimental to the client's psychiatric stability. The Board has video and conference call capabilities.

Documentation

In preparation of any full hearing, the client's treatment team shall ensure that the following documents have been submitted to the Board a minimum of 12 days prior to the scheduled hearing:

1. All prescriber progress notes, with at least one that has been dated within 60 days and includes the client's current diagnoses and psychotropic medications. In addition to the psycho-legal questions related to jurisdiction, the note should also reflect a recent interview with the client and a detailed account of the client's progress in treatment since the last note. Significant medications changes and incidents relating to instability or potential dangerousness during the relevant time period must be included.
2. All assessments and progress reports/polygraph results from specialty providers (i.e. sex offender or DBT).
3. START dated within the past 90 days
4. All monthly conditional release progress reports detailing what the client has been doing for a given month and whether they have been meeting the conditions of their release.
5. The client's most recent Annual Assessment.
6. The client's current Treatment Service and Support Plan.
7. In addition to the above documents, if the client's Case monitor is recommending a modification to the client's conditional release plan, the following documentation should also be submitted to the Board as early in advance of the hearing as possible:
 - A letter from the case monitor or other members of the client's treatment team detailing the team's position on Board jurisdiction and any modifications that will be sought at the hearing.

- Signed Updated Summary of Conditional Release Plan which includes the changes recommended by the treatment team and supported by the case monitor's letter.

Witnesses

It is the Board's expectation that the client's treating prescriber, case monitor, and any independent evaluators be available to testify at PSRB hearings. Telephonic testimony of psychiatrists or other witnesses is permissible if there is no objection by the State or client's attorney. Case monitors and psychiatrists should notify Board staff immediately if they are not available to testify on the scheduled hearing date. Testimony is not restricted to the treating prescriber. If any provider (e.g. therapist, psychologist, specialty provider) believes he/she has relevant testimony for the hearing, please inform PSRB staff no later than 1 week prior to the scheduled hearing so the witness list can be finalized. Last minute witnesses can be a basis for a continuance so it is critical to identify necessary participants as early as possible.

Topics expected to be questioned during the hearing include:

1. Psycho-legal questions related to jurisdiction (see above).
2. Familiarity with the client's psychiatric history, including prescribed medications.
3. Familiarity with the client's instant offense.
4. Awareness of the progress the client has made while in the community.
5. Awareness of significant risk factors and behavioral incidents that have occurred during the course of the client's conditional release.
6. Recommendations for ongoing treatment, evaluation, and level of care.

Hearings for Persons Already on Conditional Release¹

At any time a case monitor can request a modification of conditional release. Most requests for modifications may be handled through an administrative hearing. Housing step-down, driving privileges, pass privileges (secure facility clients), a reduction in treatment, and reduction in home visits are all examples of conditions typically reviewed at an administrative hearing. However, given the nature of the instant offense or the client's history, some modifications may be handled at a full hearing.

When a case monitor or client wants to make a modification, the first step is to review the client's current conditions of release. Typically, providers are expected to review the

¹ Please refer to the [Case Monitor Responsibilities](#) section of this handbook for additional information regarding requests for modifications of conditional release orders.

conditions once per month and determine if the conditional release requirements are sufficient to adequately manage the client safely in the community setting.

Once the case monitor identifies all of the modifications that need to be changed, the next step is to draft a letter that describes the clinical benefit and associated risk with each request. Letters should also address how the associated risk will be mitigated. Case monitors are encouraged to utilize the templates available on our website and to employ the principles of the Risk-Need-Responsivity model.

In addition to the letter, the case monitor must also submit a Signed Updated Summary of Conditional Release Plan which includes the changes recommended by the treatment team and supported by the case monitor's letter.

More significant reductions in monitoring and/or supervision or increases in privileges should have more robust clinical justifications and risk assessment. It is highly recommended that the treatment team utilize the START instrument or other objective tool to support these more significant requests.

Once the Board receives the letter and Updated Summary of Conditional Release Plan, a hearing date will be set to review the modification request. Verbal results of administrative hearings are available no earlier than Noon following the hearing date. Official orders will be mailed within 30 days.

Community Evaluations

Individuals under the jurisdiction of the Psychiatric Security Review Board (PSRB) live in the community at various levels of care, including licensed residential, semi-independent, ICM (Intensive Case Management), and independent. PSRB clients are only conditionally released after the designated mental health agency has completed a Community Evaluation and accepted them for placement. At a minimum, this evaluation entails a review of the exhibit file, consultation with the current providers, and an interview with the prospective PSRB client. Evaluators are encouraged to access other relevant documents and or individuals who may provide additional, collateral information. In accordance with OAR 309-019-0160, the community evaluation *must* be conducted by a QMHP.

The purpose of the Community Evaluation is to provide the Board with an independent, objective opinion that a PSRB client can be safely managed in a particular community setting. This evaluation is the foundation of any subsequent conditional release plan and provides an attestation that the designated mental health agency is familiar with the court exhibit file and has considered the relevant information in developing its recommendations. The Board encourages community evaluators to be familiar with the principles of the Risk-Need-Responsivity model and expects the evaluation to address the criminogenic and protective factors that will enhance or destabilize the client's ability to thrive while on conditional release. The evaluation should not be a repetition of information (i.e. evaluators should refrain from copy/pasting from other exhibits), but

rather an integration of information that identifies the goodness of fit between a client's risk profile and clinical needs and the resources the mental health agency's program can provide to ensure good outcomes for the client and public safety.

Templates of sample community evaluations can be found on our website. In addition, in 2018, the Board established a community evaluation workgroup to better identify and target the information necessary for these evaluations to improve efficiencies and further enhance Board decision-making. The Executive Director will announce any changes that are made to the Community Evaluation content consistent with the recommendations of the workgroup.

Outcomes of Community Evaluations

Each Community Evaluation will have one of three outcomes: Acceptance, Contingent Acceptance, or Denial.

Acceptance: The Community Evaluator determines that the agency has the treatment, monitoring, and supervision resources necessary to safely manage a client on conditional release.

Contingent Acceptance: The Community Evaluator determines that the agency has the treatment, monitoring, and supervision resources necessary to safely manage a client on conditional release. However, before the client can move into the placement, specific circumstances must be met (e.g. County Mental Health must approve, a Residential Screening must take place, a bed is not currently available, additional time must pass from a particular event (e.g. medication change, traumatic anniversary date). In most of these cases, some sort of addendum will be required once the contingency has been overcome.

Denial: Community Evaluators must sometimes make a decision to deny a client into the program. A denial does not usurp the Community Evaluator's duty to complete the evaluation. Rather, the focus of this evaluation is to provide the client and his/her treatment team with specific feedback as to why the client is being denied as well as recommendations about what resources or changes in circumstances would be needed in order to accept the client at a future date. Further, denials are not viewed negatively by the PSRB, but rather, as important feedback that can communicate helpful recommendations to the client, current treatment providers, prospective treatment providers, and the PSRB about what will help the client succeed and live safely while on conditional release.

Types of Community Evaluations

Community evaluations are completed any time a client under the PSRB transitions from one program to another or when the client is being considered to be court conditionally released upon GEI adjudication. Community evaluations are not required

when a client changes his or her level of care within the same treatment program and county.

Oregon State Hospital Requesting Community Evaluation

At any time, State hospital staff can ask the Board to order that a client be evaluated for conditional release. The request for evaluation should be in writing and should specify which county mental health or developmental disability agency is preferred. Additional information regarding the recommended level of supervision and/or specific facility being requested assists with this process. Prior to processing such requests, the PSRB will need to have previously received:

- The most recent Risk Review minutes showing “conditional release ready” was approved;
- A psychiatric update from OSH completed within 60 days of date of request
- A START completed in last 90 days;
- A valid Violence Risk Assessment (amended if out of date);
- Specialty risk assessments if applicable (Sex Offender Risk Assessment; Arson, Stalking, Neuropsychological, Substance Use-specific).

Once the request letter and the above-noted documents have been received, the PSRB’s Executive Director (ED) will review the request for approval. The exception to ED review would be for clients whose underlying GEI offense was murder. Per Board policy, those evaluation requests will be reviewed by the Board during an administrative hearing.

Initially, the PSRB will refer requests only to facilities with current or anticipated vacancies. In accordance with OAR 309-035-0163(1)(d), the Board will not refer to providers with full waitlists. In addition, the PSRB will coordinate with the hospital social workers and community providers to prioritize requests to multiple community programs in terms of vacancies and timing of bed availability.

Criminal Court Judge Requesting Community Evaluation for Possible Court Conditional Release

Generally, the PSRB does not get involved in a GEI case until the judge has found a person GEI and determined whether he/she will be committed to OSH or placed on conditional release. However, PSRB staff can assist attorneys, judges and county mental health agencies in processing a court conditional release. ORS 161.327 requires that a mental health agency, designated by the Board, conduct a conditional release evaluation before a court is permitted to place a GEI defendant in the community. The court may order evaluations, examinations and compliance per ORS 161.327(3)(a).

In accordance with ORS 161.327(3)(b), the criminal court *must* order a community evaluation, to be completed by a local mental health program designated by the Board, if the a defendant found GEI solely of a Class C felony. This does not mean the individual must be placed on conditional release, but rather, that the individual has the opportunity to be evaluated. Criminal Court Judges *may* order community evaluations in any case, not just Class C felonies.

If you are a community provider who receives an order from a criminal court to complete a Community Evaluation, please notify the PSRB office immediately.

Case Manager Request for Community Evaluation:

At any time, a case manager can request a community evaluation to assess a client's goodness of fit for a different program in the community. Prior consultation with the Executive Director may be appropriate to determine residential availability and appropriate level of care for a particular client. A Request for Evaluation should be submitted writing and should include a justification for the request. Additionally, all documentation, including monthly progress reports should be up to date and received by the Board.

Client Request for Community Evaluation:

If a client requests a community evaluation, the Board will treat the request as a request for a hearing and set the hearing once the Board receives the required documents. If the case manager supports the client's request for evaluation, the case manager should submit a Request for Evaluation as noted above as this will likely expedite the evaluation process and remove the need for a hearing.

Community Evaluations Timelines

OAR 309-019-0160 sets forth the timelines for completion of the community evaluation—even if a bed is not currently available. The expectation is that providers schedule the interview with the prospective client within 15 days of receiving the order and that the evaluation be completed no later than 30 days after the provider has interviewed the prospective client. Clients can be transported to the proposed residence or county for the in-person interview if that is expected to expedite the evaluation process and assist in transitioning the client from his/her current placement to the new placement. Community providers are expected to actively communicate with the prospective client's social worker to facilitate interviews and this process.

Conditional Release Planning

In determining whether an order of conditional release is appropriate, the Board shall have as its goals the protection of the public, the best interests of justice, and the welfare of the individual. Chapter 859, Division 70 of the Oregon Administrative Rules outlines the rules related to the conditional release of adults. OAR 859-070-0020 provides that the mental health or developmental disability community provider will prepare the conditional release plan.

OAR 859-70-0015 provides the elements that all conditional release plans require. These elements are embedded in the PSRB's template, Proposed Conditional Release Plan, which can be found on our website. That document outlines the types, dosages, and frequencies of monitoring, supervision and treatment as well as special conditions that are supported by the community evaluation. It must be signed by the client, the client's current provider, the client's prospective community provider, and the client's prospective prescriber. A summary of these elements includes:

- Name and contact information for the PSRB conditional release monitor with contact information.
- Placement details and level of care of where the client will live.
- A list of the conditions the client must follow (including, but not limited to: individual therapy, group therapy, psychiatric treatment, medications, groups required, curfew, specific treatment for sex offenders, AA/NA/DDA groups, passes, dietary, etc.)
- Special conditions deemed appropriate given the specific risk associated with the client. The community evaluator and OSH treatment team are expected to assess clients' risk and include special conditions in plans submitted to the Board. See sample special conditions at the end of this handbook and on our website. Sometimes, the Board will add special conditions as a result of the Conditional Release hearing.

Pulling it All Together: Hospital Request for Conditional Release Hearing

The following guidelines provide the steps taken by OSH and Community Providers toward setting a conditional release hearing.

1. The OSH treatment team recommends the client go before the OSH Risk Review for conditional release planning approval.
2. The OSH treatment team works with the client to identify an appropriate community placement. Available resources to assist with identifying a potential placement include:
 - OSH treatment providers may contact community providers to ask questions about their programs and available resources.
 - Arrangements can be made for clients to tour potential programs.
 - The PSRB Conditional Release Guide, available on our website, provides information about community placements across the state.
 - OSH Social Workers may contact community providers

3. After identifying an appropriate placement, the OSH Social Worker requests the PSRB to order a community evaluation. Occasionally, the Board will order the community evaluation at a full hearing and will direct OSH to identify a program within 30 days of the order, in which case OSH will need to notify the Board of the desired placement. Under these circumstances, the actual Order for Evaluation will not be issued until the PSRB receives such a designation from OSH.
4. The Community Provider completes the Community Evaluation, and if accepted, completes the Proposed Summary of Conditional Release Plan.
5. The OSH Social workers complete an Application for Hearing and client's signed Agreement to Conditional Release, which triggers the PSRB to schedule a Hospital Request for Conditional Release Hearing.
6. The PSRB Hearings Specialist will coordinate with all parties to ensure that the necessary documentation and witnesses are available prior to setting a hearing date.
7. The PSRB staff will coordinate with providers to ensure the client has legal representation, special accommodations, and/or interpretive services for the hearing.
8. Once a hearing date is identified, notices will be distributed, including notice to any victims.

Case Monitor Responsibilities

A case monitor (a.k.a case manager) is the individual who has been designated in a Board order to provide the monitoring and supervision necessary to ensure a client is in compliance with a conditional release order and is able to be safely managed in the community setting. The Board relies on the case monitor to speak on behalf of the treatment and residential staff working with a client and to represent the team's recommendations for modifications to or a revocation of a client's conditional release order.

Community providers are encouraged to be familiar with OAR 309-019-0160, which prescribe the minimum service delivery standards for services and supports provided to adults and juveniles under the PSRB. In addition, community providers should be familiar with the Monitoring, Security, and Supervision Services for Individuals Under the Jurisdiction of the Adult and Juvenile Panels of the Psychiatric Security Review Board agreement. Lastly, all case monitors should be familiar with the Board's policy regarding major changes in PSRB client's psychiatric stability, medication regimen and serious incidents for those on conditional release. Please contact our office for questions about these documents.

Agreement to Conditional Release

Case monitors need to ensure that the Agreement to Conditional Release is signed by each of their clients. This document is crucial in the event the client violates one of the standard conditions and the Board contemplates revocation. It also can be used to extradite a clients who have left the state and have a pending Escape 2 charge. Clients should sign these forms when they are placed on conditional release from OSH. If the client is on a court conditional release, the case monitor is responsible for ensuring that the client signs and returns the forms to the PSRB prior to the conditional release.

Photograph of Client

Case monitors are responsible for ensuring there is a current photograph of the client on file. This photograph may be utilized in emergency situations where a client is missing or has absconded from a conditional release placement. In some cases, the photograph may be used for a press release where a client who has absconded is deemed to be a substantial danger.

Monthly Progress Reports

The bare minimum communication required by the PSRB is through the submission of PSRB monthly progress reports. Case monitors are responsible for submitting these reports for each client they supervise to the Board on the 10th of each month. A current form-fillable template of this report is available on the Board's website and should not be modified. Prescriber and specialty progress notes should accompany these reports.

Monthly reports provide the Board with important information about how a client is progressing while on conditional release and can be especially helpful when the Board or the Board's Executive Director are reviewing and making decisions related to conditional release modifications and pass requests. Case monitors are strongly encouraged to use the comments section to communicate both client progress as well as the challenges a client experiences over the course of the month. If a client is not meeting a particular conditional release requirement, the case monitor should use the comments section to explain why it was not met and what the team plans to do to support the client in meeting that condition in the future. If appropriate, the case monitor should pursue a modification to the conditional release plan to reflect the conditions required to manage the client safely in the community.

When completing reports, it is expected that providers are using multiple sources to verify that clients are meeting their conditional release requirements and not solely relying on a client's self-report. The information provided in the report should be consistent with other documentation submitted to the Board (e.g. prescriber progress notes, incident reports). Case monitors should completely fill out the report and only use a "not applicable" designation when a condition is not ordered. If there are errors on a progress report, case monitors should notify Board staff immediately and resubmitted a corrected version of the report.

Serious Incidents

In addition to monthly reports, case monitors are responsible for keeping the executive director or PSRB staff apprised of all serious incidents regarding a client. *Immediate* communication through a *phone call* is required in these types of circumstances, which include:

- Absconion
- Arrest
- Positive UA
- Refusing medications
- Psychiatric or medical hospitalization
- Need for revocation due to violent or dangerous behaviors
- Other circumstances deemed to be serious

If serious incidents occur after business hours, program staff can reach the executive director at cell number is 503-781-3602.

Case monitors are responsible for following up their verbal communications to the Board staff with written documentation such as an incident report or letter that will be placed in the client's record. The documentation should describe the serious incident or conditional release violation and lay out any safety plan, relapse prevention plan, behavior support plan, and/or other recommended changes in placement, monitoring, supervision, or treatment to ensure the client can continue to live safely in the community setting.

Case monitors are strongly encouraged to communicate with the Board as frequently as needed when they have safety concerns related to their PSRB clients. In less emergent circumstances, they may submit written documentation of incidents that are relevant to a client's conditional release without the need of a phone call. Early contact with the Board's staff about changes to a client's mental health or risk behaviors can help prevent an unnecessary revocation. Our staff is available to support you!

Major Medication Changes

The Board has adopted [a formal policy](#) that all non-emergency major medication changes, including adjustments to mood stabilizers and anti-psychotic medications be initiated only after the case monitor communicates the potential risks of these changes and the safety plan, including whether a higher level of care is required, in a written

document. [A sample of this letter can be found on our website](#) and should be consistent with our policy regarding major changes in PSRB client's psychiatric stability, medication regimen and serious incidents for those on conditional release. The case monitor is responsible for ensuring that all relevant treatment professionals working with the client have been given a copy of this letter and are familiar with the safety plan.

Conditional Release Order Modifications

Case monitors are responsible for regularly reviewing their clients' conditional release orders. Case monitors are encouraged to request modifications to these orders that are commensurate with their clients' progress and ability to safely manage themselves with increased independence and responsibilities. Modifications can be requested by the case monitor at any time and most often require Board approval through an administrative hearing.² However, in the interest conserving judicial resources, it is best practice for case monitors to request modifications no more than every three months and in doing so, consider the entire conditional release order to avoid piecemeal requests and the need for multiple hearings.

When requesting a modification to a conditional release order, the case monitor must minimally include a letter that outlines each requested modification, the risks associated with that modification, the interventions that will mitigate that risk, and the clinical benefits of the requested change. In addition, the case monitor must submit a Summary of Conditional Release Plan that reflects the modifications requested in the letter. Lastly, all of the client's monthly progress reports must be up to date, including prescriber or specialty service progress notes. Case monitors are encouraged to utilize the templates available on our website³ and to employ the principles of the Risk-Need-Responsivity model⁴.

Depending on the nature of the modification request, case monitors should consider submitting additional, supporting documentation. For requests that have higher inherent risk (e.g. stepping down to a lower level of care, driving privileges, eliminating therapy), case monitors should consider utilizing an actuarial risk tool to ensure that it supports such requests (e.g. the START). In addition, case monitors may want to consider asking the prescriber to address risk factors associated with the requested modification in an additional progress note.

Clients under the PSRB have the right to request changes to their conditional release plans, even if it is not supported by the case monitor and other treatment team

² Increases in treatment, monitoring or supervision or other special conditions can be approved immediately by the PSRB Executive Director to mitigate a client's risk of dangerousness.

³ Ctrl + Click to follow links: [Sample Request for Modification - Change Multiple Conditions](#); [Sample Request for Modification - Step Down](#); [Sample Request for Modification - SRTF Pass Level](#)

⁴ Ctrl + Click to follow links: [Successfully Implementing Risk-Need-Responsivity Principles in Your Treatment Program](#); [GAINS Webinar- Risk-Need-Responsivity Applications across Behavioral Health and Criminal Justice](#)

members. The client should understand that it is highly unlikely that the Board would approve such changes in these circumstances. Rather, the best practice/approach is to communicate to the client what would need to happen in order for the treatment team to support the client's requested change. If a client persists in the request without the team's support, case monitors are encouraged to contact the Board's staff for further consultation on additional options the client might want to consider before setting a hearing.

Request for a Client's Change in Placement

A change in placement is a specialized type of modification. Changes in placement may be requested for a variety of reasons including:

- Crisis requiring an increased level of care or respite placement
- Client wants to move closer to a support system or resources (e.g. treatment services, educational or employment opportunities, cultural activities, family) in a particular community
- Client is ready to step down to a lower level of care
- Client has reached a maximum benefit or progress has plateaued with the current provider

When a change in placement is requested, the case monitor takes the following steps:

1. Case monitor submits a request for a community evaluation. The request should include the bases for the evaluation and identify the requested placement. Case monitors are encouraged to review the conditional release placement guide or consult the PSRB's conditional release monitor(s) with questions about programs and/or current vacancies.
2. Case monitor partners with the potential incoming provider to facilitate a face-to-face interview with the client.
3. The incoming provider completes the community evaluation and, if the client is accepted, develops a new summary of conditional release plan and submits these to the Board.
4. If the client agrees to and signs the new conditional release plan, the current case monitor requests in writing that the Board authorize the move.
5. The prescriber from the current placement and the prospective placement must engage in a consultation specifically regarding issues related to medication. This consult must be documented in writing and submitted to the Board.

6. The change in placement is set for an administrative hearing or, in the case of a crisis situation or a lateral transfer (e.g. changing placement without any other changes to the conditional release plan), may be approved by the PSRB Executive Director.
7. A client may not change residences until the Board approves the transfer.

Other Case Monitor Responsibilities

- Comply with all conditions in a Board order.
- Inform the Board whenever there is a change in a client's case monitor.
- Complete and submit pass requests (please refer to our Pass Policy in this handbook).
- Inform the Board whenever there is a change to a client's residence/address. If prior authorization was granted for a client to move, immediately notify Board staff of the new address and date of move. Unless it is an emergency, such as fire or flood in or substantially near the facility, changes in residence require prior authorization from the PSRB.
- Inform the Board immediately if you are aware the client had contact with law enforcement.

Communications with the PSRB

Please include the following for all email communications from HIPAA entities to the PSRB:

The information in this email is privileged and confidential. It is for the intended recipient. Any dissemination, distribution or copying of this communication received in error is strictly prohibited

This helps the Board classify public versus confidential information when the Board receives Public Records Requests. If your agency does not have secure email, please use initials or other non-identifying information concerning clients while communicating via email.

Residential Staff Responsibilities

Each licensed residential placement housing PSRB clients is required to follow Division 35 or Division 40 of the Oregon Administrative Rules as well as the policies and procedures required by their agencies and counties. Placements must also coordinate with the PSRB and the Oregon Health Authority to identify and address how to

approach any inconsistencies between Home and Community-Based Services (HCBS) rules and conditional release plans.

The PSRB expects proactive communication between residential staff and a client's case monitor and other treatment team members to ensure that all residential staff are familiar with the client's risk profile, conditions of release, effective strategies to build rapport and support the client, and privileges (e.g. pass privileges, level system).

The PSRB Executive Director and other staff members are available to conduct on-site training for employees anywhere in the state.

Document all incidents: The Board expects to receive a copy of incident reports that describe significant behavioral or mental health changes, violations of conditional release requirements, psychotropic medication refusals or any other information that is relevant to a client's ability to be safely managed in the community setting. Residential staff may send these incident reports directly to the PSRB office or through the client's case monitor.

Procedures for client going out on a pass or escorted trip: A QMHP should consult with the client prior to a pass/escorted outing outside the facility and determine whether there are any signs of instability of mental health or noticeable risk factors. Additionally, staff should have an established communication protocol so that previous shift staff can report to subsequent shifts regarding the psychiatric stability or conditional release compliance of the client.

Secure Facilities/Clients with any condition requiring "Supervised by Staff"

"Supervision": Unless otherwise noted in the Order of Conditional Release, "supervised" means arms-length, not line of sight.

Client incidents occurring outside the facility should be cause for staff to immediately return to the facility with the client. This includes "getting away" from the group or refusing to comply with staff directives or the client's conditions of release.

Staff ratio on escorted outings should be appropriate so that if needed, one staff member can leave the group safely to follow a client who absconds or refuses to comply with staff directives. Staff should have cell phones on their person in the event they need to call for back-up assistance.

It is appropriate for staff to call 911 immediately if a PSRB client leaves the group or fails to comply with staff's directives to return. It is appropriate for staff to follow the client, reporting to police the client's whereabouts to aid in his or her apprehension.

Communications with the PSRB: For all e-mail communications from HIPAA entities to the PSRB, the following should be included:

The information in this email is privileged and confidential. It is for the intended recipient. Any dissemination, distribution or copying of this communication received in error is strictly prohibited

This helps the Board classify information that is public versus confidential when there are requests from the public for information. If your agency does not have secure email, please use initials or other non-identifying information concerning clients while communicating via email.

Revocation of Conditional Release

A revocation is the legal action taken to terminate or suspend a client's conditional release plan. Accordingly, it is considered the most severe and restrictive legal response to a client who can no longer be safely managed in the community setting. Pursuant to ORS 161.336(4), the Board has the authority to revoke a client's conditional release under the following circumstances:

- The person has violated conditional release³ terms; or
- The person's mental health has changed such that the person is no longer fit for conditional release⁴; or
- The community supervision and treatment is inadequate or unavailable⁵; or
- There is reasonable cause to believe the person is a substantial danger to others because of a mental disorder and that the person needs immediate care, custody or treatment⁶

Revocations require a case-by-case analysis of the client's historical and current risk to public safety. They are done after considering less restrictive alternatives. Historically, reasons for revocations have included:

- Commission of a new person-on-person crime or other serious law violation;
- Serious threatening behavior toward others, coupled with a history of violence;
- Significant medication change accompanied by concerning behavior like that caused by increased mental health symptoms;

³ See ORS 161.336(4)(a)(B)(i)

⁴ See ORS 161.336(4)(a)(B)(ii)

⁵ See ORS 161.327(1)(b)

⁶ See ORS 161.336(4)(b)

- Repeated medication refusal;
- Absconding from supervision;
- Repeated substance abuse relapses accompanied by increased mental health symptoms.

The Board relies on case monitors to inform our staff of early warning signs, critical incidents, changes in mental status, changes in medications or other issues that might jeopardize a client's conditional release to avoid unnecessary revocations. Prior to considering a revocation, the Board expects case monitors to explore less restrictive interventions that would similarly serve to protect the public and maintain client safety. Consultation with the Forensic Utilization Coordinator and Board staff is strongly encouraged to examine statewide vacancies, resources, and funding for interventions. Examples of less restrictive interventions include:

- Heightened supervision (e.g. 15 minute checks)
- Increased staffing
- Restriction of privileges or passes
- Step-up to a higher level of care
- Using crisis-respite placement
- Placing client on a hold at a local hospital (i.e. Director's Custody)

Paperwork Required to Initiate a Revocation

In almost all circumstances, a revocation requires a written or electronic order signed by a Board Member or the Executive Director.⁷ However, there are certain situations in which it will be impossible to obtain such an order or doing so will take an extended amount of time to coordinate.⁸ This section explains when a written or electronic order for revocation is required and identifies the exceptions to that rule. Understanding these exceptions becomes especially important when trying to coordinate a revocation with your local law enforcement agency. Please note that PSRB staff are available to provide additional training to your local law enforcement agencies to strengthen your partnership with them during the revocation process.

Written or Electronic Board Order Required

⁷ See ORS 161.336(4)(a)(A)(i) and (ii)

⁸ **At a minimum, the PSRB Executive Director must be consulted prior to initiating a revocation.**

A written or electronic Board Order for revocation will be **required** when the revocation request takes place during business hours and is based on a violation of the person's conditional release agreement or on a change in the person's mental health that makes the person no longer fit for conditional release.

Written or Electronic Community Order Exception

Under the conditions outlined in the above paragraph **and** when a client has absconded from supervision, the community health program director may sign a written or electronic order to revoke that client (e.g. Director's Hold).⁹ This type of revocation should only occur in consultation with the PSRB Executive Director or after several attempts to reach the Executive Director have been made without a response. The PSRB office is currently working to adopt a form that can be used to better facilitate this process (e.g. for those who are not Director Designees or when criteria for a Director's Hold are not met).

Peace Officer or Responsible Community Supervisor Exception

Emergency mental health crises can take place at any time. Providers responsible for the monitoring and supervision of clients under PSRB jurisdiction are permitted to use the statutes for placing a person on a Director's Hold and into the custody of a peace officer for transport to a designated facility, typically a local psychiatric hospital¹⁰ This mechanism will require the provider to be certified in that particular county and to complete a Director's Written Report Regarding Peace Officer Custody of an Allegedly Mentally Ill Person.

In some circumstances, a PSRB client may need immediate care, custody or treatment, but will not meet the criteria for a Director's Hold (under ORS 426.228). In these cases, the law grants those professionals responsible for the monitoring and supervision of a PSRB client the ability to request that a peace officer take that client into custody if there is reasonable cause to believe the person is a substantial danger to others because of a mental disorder and that the person is in need of immediate care, custody or treatment.¹¹ Please note that the statute does not include the word "imminently," providing a relatively low threshold for requesting law enforcement to take the client into custody. This statute serves to authorize the professionals responsible for the monitoring and supervision of the PSRB client to take immediate action in the absence of a written or verbal Board order where the client may not otherwise meet criteria for peace officer custody. The PSRB office is currently working to adopt a form to better facilitate this process.

Revocation Placement Options

⁹ See ORS 161.336(4)(a)(A)(iii)

¹⁰ See ORS 426.228

¹¹ See ORS 161.336 (4)(b)

Historically, all revocations resulted in an admission to the Oregon State Hospital. In April 2018, the Oregon Legislature passed legislation that modified ORS 161.336 and allowed for the PSRB to revoke adults under its jurisdiction to either the Oregon State Hospital or “other facility” designated by the Board.¹² Although this provides statutory authority to revoke a PSRB client to a local hospital, the law is not well-known and the Board is taking a conservative approach to using this alternative until it is better established with community stakeholders. PSRB staff will explore this as an alternative to a revocation to the Oregon State Hospital.

Revocations During Business Hours

Revocations require a multi-system coordination that includes the community provider(s), law enforcement, secure transport, the Oregon State Hospital, PSRB staff, and at least one Board member. Under some circumstances, coordination might also include legal counsel, a local hospital, a local jail, residential staff, and other professionals. Therefore, it is best practice that revocations take place during business hours. If it puts neither the public nor the client’s safety at risk to do so, the best practice is to develop a short-term safety plan (Director’s Custody hold, respite bed, step-up to a higher level of care) and process the revocation during the next business day. In almost all cases, a revocation will require the client to be admitted to the Oregon State Hospital, Salem Campus; however, there can be exceptions. The following provides the steps taken toward revoking a client to OSH during business hours.

1. Case monitor (or responsible party) contacts the PSRB office to report the need for a revocation. If no less restrictive option is identified, PSRB staff initiate our PSRB revocation protocol.
2. Case monitor (or responsible party) provides a written and verbal summary of the incident(s) giving rise to the revocation.
3. PSRB staff complete an Affidavit in Support of Revocation that summarizes the jurisdiction history and describes the bases for revocation as reported by the case monitor’s written and verbal communications. Persons with additional information may be contacted by PSRB staff to further support the affidavit.
4. PSRB staff formally alerts the Oregon State Hospital of the revocation and provide OSH with the case monitor’s contact information to assist with the admission process¹³.
5. The Oregon State Hospital admissions department contacts the case monitor (or responsible party) directly to request documentation and other information to

¹² See ORS161.336(4)(a)(A)

¹³ PSRB staff will make every effort to notify OSH as soon as possible that a revocation may be needed.

coordinate the client's admission and ensure he/she/they is/are placed on the appropriate unit. OSH admissions can be reached at (503) 947-4247. At a minimum, admission documentation includes:

- a. Current medication orders
 - b. Current assessment
 - c. Current Individualized Services and Support Plan (Treatment Plan)
 - d. Recent progress notes or incident reports that might be relevant to the client's decompensation and/or need for revocation
 - e. Any medical conditions or specialty treatment equipment considerations (e.g. oxygen tank, C-PAP, insulin)
6. PSRB staff generates a revocation order and a member of the Board reviews it along with the Affidavit in Support of Revocation¹⁴.
 7. PSRB staff uploads the client's exhibits for OSH to review.
 8. A Board member signs the revocation order, which PSRB staff uploads into LEDS and faxes/emails to the case monitor and OSH.
 9. Case monitor (or responsible party) coordinates with law enforcement and/or secure transport to transport the client to OSH.
 10. Case monitor (or responsible party) communicates with OSH about expected transport dates and estimated times of arrival.

After-Hours Revocations

If a business-hour revocation is not feasible, the Executive Director of the PSRB will assist the community provider with coordinating an after-hours revocation.

1. Case monitor (or responsible party) calls the PSRB Executive Director immediately to consult at (503) 781-3602, and leaves a voicemail if there is no answer.
2. If the PSRB Executive Director cannot be reached, the case monitor should consider either placing a Director's Hold and having the client transported to the local emergency room or implementing an appropriate safety plan (1:1 staffing,

¹⁴ The PSRB Executive Director has authority to sign these orders; however, will only do so after making several attempts to reach out to Board members.

house restriction, etc.) and waiting until the next business day at which time PSRB staff will complete the revocation process.

- 3.** If the case monitor cannot achieve the above, he/she/they may initiate revocation in the following manner:
 - a.** Call OSH Communications Center (503) 945-2800: inform OSH that you are initiating a revocation. If you do not communicate with them ahead of time, OSH staff will not provide any information to law enforcement/secure transport personnel and that will further delay the admission.
 - b.** Email/Fax Documentation: Provide OSH with the following documentation (or verbal information if documentation is not available).
 - i.** Current medication orders
 - ii.** Current assessment
 - iii.** Current Individualized Services and Support Plan (Treatment Plan)
 - iv.** Recent progress notes or incident reports that might be relevant to the client's decompensation and/or need for revocation
 - v.** Any medical conditions or specialty treatment equipment considerations (e.g. oxygen tank, C-PAP, insulin)
 - c.** Call local law enforcement/secure transport and inform them that you are "placing a Director's Custody hold" on the client and ordering a revocation to the Oregon State Hospital in accordance with 2018 Or. Laws, Chapter 120, §5 (which modified ORS 161.336(4)(b)). Ask them to transport to the local hospital to get medical clearance (or jail).
 - d.** Get medical clearance: Oregon State Hospital is not equipped to treat individuals whose mental status deterioration or rule violation behaviors are related to alcohol or substance use intoxication and/or withdrawal or to an unstable medical condition. As such, prior to contacting OSH, please ensure that the client has been medically cleared at the closest medical facility and that communication between the admitting psychiatrist at OSH and the professional providing medical clearance has taken place.
 - e.** Law enforcement is required by law to transport to OSH without any paperwork or confirmation from the PSRB; however, they may require the agency to complete paperwork, such as a Director's Written Report Regarding Peace Officer Custody of an Allegedly Mentally Ill Person, later.

- f. It is possible the front-line officer will be unfamiliar with the statute and authority to place the client into custody. If the peace officer refuses, request to speak to his supervisor and continue to cite the statutory authority (from Oregon Laws). Sometimes, law enforcement will want to confirm with OSH that the revocation is authorized. Ensure you have completed step 3a above.

Post-Revocation Responsibilities

Continuity of Care

Often, a revocation can be traumatic not only to the PSRB client, but also to the treatment team and other participants of the treatment or residential program. The revocation itself may come with some relief from what are often extended and exhausting crisis situations. Although it may be challenging, we encourage community providers to remain as engaged as possible with the client's OSH treatment team following a revocation. This ensures stronger continuity of care, provides OSH with the community provider's perspective on the client and the incident(s) leading to revocation, and may reduce the trauma the client experiences by offering a potential path back to the community placement. At a minimum, we recommend that the case monitor coordinate a consultation between the community prescriber and the OSH prescriber shortly after the client's admission. A consultation between the conditional release monitor and OSH social worker is also highly recommended.

Revocation Hearing and Letter

Each revocation requires the PSRB to set a hearing for the client within 20 days. The PSRB staff will send the conditional release monitor a letter within several days of the revocation requesting details about what led to it, the team's opinion about clinical and treatment recommendations, and whether the agency/facility is willing to consider the client for placement again. For some clients, a relatively fast stabilization can occur and the client can return to the same bed at the facility at the revocation hearing. To hold the bed for up to 30 days, you may contact the Forensic Utilization Coordinator to request funding through from the Oregon Health Authority's Health Systems Division.

Community providers are not required to attend revocation hearings, but we strongly recommend that you call. These hearings may offer after-the-fact information that the client was unable or unwilling to report or an increased understanding of the client's experience. In addition, it may provide opportunities to clarify things that were not clear from the record and ensure that the provider's account of the incident is accurate. If you are interested in attending this type of hearing, please contact our staff.

Passes While on Conditional Release

CR Handbook
Pass Policy – Updated 3/12/19

Community integration and connection are important aspects of recovery. The PSRB encourages case managers to approve opportunities for clients to take passes that promote recovery so long as those passes are consistent with the conditional release plan, the level of privileges within a program, and account for specific risk factors and public safety. The following provides a guide on the PSRB's pass notification and/or approval process. Please note, not all passes require approval, but may require notification to the PSRB office. If you are unclear about whether approval is required or have a more atypical pass request, please call our office to consult. Exceptions to the timeframes in this policy can be considered for emergency situations such as a death in the family or a medical situation.

A) **Supervised Passes** (within Oregon)

- a. No notification or approval is needed for single-day passes within Oregon where the client will be supervised at all times by staff, **unless** the conditional release (CR) order or pass privilege states otherwise (see Section D) or the pass is out of state (see Section E).

B) **Single Day Trip** (within Oregon, unsupervised by staff)

- a. The client's case manager may approve single day passes within Oregon, **unless** the CR order or pass privilege states otherwise (see Section D).
- b. [Pass Notification Form](#) is not required.

C) **Overnight Passes** (within Oregon, supervised or unsupervised by staff)

- a. The client's case manager may approve overnight passes within Oregon of up to 2 weeks in duration, **unless** the CR order or pass privilege states otherwise (see Section D).
- b. [Pass Notification Form](#) must be submitted to the Board at a minimum of 48 hours prior to the requested departure date/time.
- c. Overnight passes should not be used to circumvent the Board-approved level of care for the client.

D) If a client's CR condition or pass privilege level requires the PSRB to approve the pass in any of the above situations, a [Pass Request Form](#) must be submitted:

- a. ED approval:
 - i. [Pass Request Form](#) submitted a minimum of 7 days prior to the requested departure date.

b. Board approval:

- i. Pass Request Form submitted a minimum of 30 days prior to the requested departure date.
- ii. Letter of Support (see below) to be submitted with the form.

E) Out of State

a. Unless the client's conditional release order states otherwise, all out of state passes must be approved in advance by the ED or the Board.

b. Documents required for an out of state pass include:

- i. Pass Request Form;
- ii. Signed Waiver of Extradition (for all states s/he will be entering) prior to the client's departure;
- iii. Letter of support (see below)

c. Timelines:

- i. If CR states case manager may approve out of state passes, the case manager must submit documentation a minimum of 48 hours prior to the requested departure date/time.
- ii. If ED approval is required, the case manager must submit documentation at a minimum of 14 days prior to the requested departure date/time.
- iii. If Board approval is required it will be considered at either an administrative or full hearing. The case manager must submit the following at a minimum of 30 days prior to the requested departure date.

F) Out of Country

a. Out of Country passes MUST be approved by the Board and the matter will be set for an administrative or full hearing. The following must be submitted at least 30 days prior to the requested departure date:

- i. Pass Request Form;
- ii. Signed Waiver of Extradition (for all states s/he will be entering) prior to the client's departure; and
- iii. Letter of support (see below)

G) Letter of Support¹

- a. Some passes require a letter of support. The goal of this letter is to provide the Board with additional information to assist with the pass approval process. The following information should be addressed when a letter is required:
 - i. Mental status
 - ii. Risks associated with the travel
 - iii. Clinical benefits of the travel
 - iv. Detailed itinerary
 - v. Plan for meeting CR plan and taking medications as prescribed
 - vi. Information about travel companions, host, authorized others²
 - vii. Recent incidents or violations of conditions of release
 - viii. Victim concerns
 - ix. Safety plan, plan for checking in with client while on pass
 - x. Payment and financial obligations
 - xi. Any requirements or concerns of the state/country being visited

¹ The depth of the letter of support should reflect the extensiveness of the pass as well as the client's risk (i.e. the more extensive and the higher the risk, the more detailed the letter of support).

² The treatment team must verify the details of the pass with these individuals and have a Release of Information on file

Alcohol and Drug Screening

All clients under the jurisdiction of the Psychiatric Security Review Board and on conditional release agree not to use or possess substances, including non-prescribed and other substances that might otherwise be legal (e.g. alcohol, cannabis, Kratom, Tylenol). Alcohol and drug screening tools are frequently used to monitor compliance with this condition, to detect and deter substance use, and to improve the safety and recovery of the clients we serve. In addition, this tool may also ensure proper use of prescribed and over-the-counter medications.

Frequency of Alcohol and Drug Screens

The recommended frequency of alcohol and drug screens should be individually tailored to mitigate factors associated with the individual's risk of substance use and danger to others. These factors include, but are not limited to the presence of a substance use diagnosis, history of substance use, the extent substances were related to past dangerous behaviors and the instant offense, past criminal charges, and current level of care.

At a minimum, case monitors are authorized to direct clients on conditional release to provide a specimen (e.g. saliva, urine) for a drug screen at any time. Case monitors or other staff for supervising a client should immediately direct a drug screen when they observe significant changes in behavior (e.g. erratic behavior; incoherent, staggering or disoriented demeanor, slurred speech, glassy eyes, dilated pupils) or other evidence of substance use.

Since the frequency of drug screens is based on both risk and clinical factors, it is possible that not all of the recommended drug screens will be covered by a client's insurance (e.g. the recommended frequency is not deemed medically necessary). A denied authorization should not be a basis for requesting a reduction in drug screens where the treatment team otherwise believes they are necessary for the client to live safely in the community. Rather, the case monitor should consult with the Forensic Utilization Coordinator and seek alternative funding for those additional drug screens.

Random, Observed

To be an effective monitoring tool, alcohol and drug screens are expected to be random and observed.

Specimen Collection Procedures

Providers responsible for collecting specimen samples should be familiar with the best practices related to urine collection and testing procedures.¹⁷ Providers are encouraged

¹⁷ Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 47.) Appendix B. Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64092/>

to establish a drug screening policy and procedure consistent with those practices to ensure consistency, accuracy and integrity with this monitoring tool.

Providers should be familiar with the chosen drug screen panel and add additional substances to the panel as necessary (e.g. when a substance of concern is not included in the general panel). In addition, providers should be familiar with the sensitivity, detection times, benefits, and risks of various collection methods (e.g. urine vs. saliva) and the common reasons associated with false positives. Providers should have access to and make use of the analyst/toxicologist at the laboratory testing the specimen to discuss concerning test results. Some basic differences between urinalysis and saliva testing include:¹⁸

| Urinalysis | Oral fluid/Saliva Testing |
|--|--|
| <ul style="list-style-type: none"> • Typically detects use that has occurred up to 3 days prior to the test • The exception is cannabis use, where occasional use can be detected for up to 6 days and more regular use can be detected for up to several weeks • The main disadvantages of urinalysis are that it may not detect very recent use (past 2-6 hours) and urine specimens can be adulterated or substituted relatively easily. | <ul style="list-style-type: none"> • Has a much shorter window of detection compared to urinalysis • For most drug types it detects use that has occurred in the previous 1-3 days • Compared to urinalysis, oral fluid/saliva specimens are less easily adulterated or substituted • The main disadvantage of oral fluid is that pH levels can affect drug concentrations in oral fluid/saliva. |

A Word About Poppy seeds

Research shows that morphine and codeine can sometimes be detected in urine up to 48 hours after an individual ingests poppy seeds from some pastries such as bagels, muffins, and cakes.¹⁹ When a client's drug screen returns a positive result for morphine and codeine, the case monitor should not suggest that the result could have been poppy seeds; however, case monitors are encouraged to consult with the laboratory toxicologist and rule this out when there is no other evidence of heroin or opiate use. Clients with a history of opiate abuse should be encouraged to refrain from ingesting poppy seeds, especially where there are repeated positive results and concerns of substance use.

¹⁸ http://nceta.flinders.edu.au/files/7915/1209/0979/Drug_Testing_Rationale_Utility_and_effectiveness_9_Nov_17.pdf

¹⁹ Thevis M, Opfermann G, Schänzer W. Urinary Concentrations of Morphine and Codeine After Consumption of Poppy Seeds. J Anal Toxicol (January-February 2003) 27(1): 53-56.
URL: <http://www.ncbi.nlm.nih.gov/pubmed?term=morphine%20and%20codeine%20on%20poppy%20seeds%20thevis>

Substance Use and Relapse

Client substance use, as evidenced by a client's self-report, observations of others, or a positive drug screen, must be reported to the Board as soon as possible. Substance use or relapse will not necessarily result in an immediate revocation of a conditional release. Case monitors, in consultation with other treatment team members, including the prescriber, should recommend to the Board staff, in light of the use and other risk factors, what treatment, monitoring and supervision interventions should be implemented to enable the client to continue living safely in the community.

Dilute and Missed Drug Screenings

Dilute results from a urinalysis are uncommon when following best practice procedures and may indicate that a client has altered the specimen and/or has been using substances. When results are consistently dilute, a client should be provided feedback to limit their fluid intake and eat something the hour before providing the urine specimen. If results continue to be dilute, the case monitor may want take additional measures such as increasing the frequency of the drug screens, adding an oral test, directing a room search for substances or paraphernalia, and consulting with the lab toxicologist. Consulting with a medical provider to rule out a medical condition for the dilute results is also advised. Ongoing, unexplained dilute results may result in placing that client at a higher level of care.

As mentioned, drug screens are expected to be random. Missed drug screens are considered positive, unless excused by a case monitor for good cause. When drug screens are regularly missed by the client, the case monitor should take additional measures to investigate whether this is due to substance use or better explained by other situational factors.

Medical Cannabis

Pursuant to [Oregon Ballot Measure 91](#) (codified at [Oregon Revised Statutes 475B.005-548](#)), on July 1, 2015, cannabis possession, consumption, and manufacturing became legal in the State of Oregon under certain circumstances. These circumstances are defined as the "recreational use" of cannabis. The PSRB would like to make it explicit that this law **does not** affect the Board's policy on cannabis use, recreational or otherwise.

Consistent with the Agreement of Conditional Release that all PSRB clients sign and the conditional release order, consuming/possessing cannabis or products containing cannabis in any form is prohibited. A violation of this condition is serious and jeopardizes a client's conditional release placement.

The Board will find a violation of conditional release for any possession or use of cannabis even if the client has a medical cannabis card or if it has been prescribed by a licensed professional. The Board will not sanction a client for having a medical cannabis

card. Rather, the Board's focus will be on possession and consumption (i.e. ingestion, sublingual, topical and inhalation) of cannabis-related products.

Research has confirmed a positive association between cannabis use and the risk for mental health symptoms. The DSM-V outlines these risks:

- Cannabis may increase the risk of developing psychotic disorders like schizophrenia and can worsen symptoms in individuals who already experience psychosis.
- Following immediate use, cannabis can cause mental health symptoms like psychosis, anxiety, depression, and sleep disturbances.
- Adults who have been diagnosed with cannabis use disorder have high rates of mental health disorders including anxiety, depression, PTSD, and ADHD.

The Federal Drug Administration has not approved cannabis as a safe and effective drug for any indication with three exceptions. Two synthetic forms to treat nausea and vomiting from chemotherapy and a specific cannabidiol to treat seizures associated with rare forms of epilepsy (<https://www.fda.gov/news-events/public-health-focus/fda-and-marijuana>).

CBD, which is short for cannabidiol, is considered a non-psychoactive compound found in a cannabis plant. The FDA has issued several warning letters to firms that market unapproved new drugs that allegedly contain CBD (<https://www.fda.gov/news-events/public-health-focus/warning-letters-and-test-results-cannabidiol-related-products>). Consuming (i.e. ingestion, sublingual, topical and inhalation) and/or possessing products containing CBD is also prohibited by the Board.

Questions related to a client's request to use cannabis should be directed to the Board.

Victims

Victim Information

Under Oregon law, when a person is found guilty except for insanity (GEI) or responsible except for insanity (REI), the judge is required to ask the victim whether he or she wishes to be notified of future hearings or releases relating to the defendant and if so, include victim contact information in the court order that places a defendant under PSRB jurisdiction. The Board then is required to provide notice in advance of any hearing regarding that individual. Generally, this notice is done via U.S. Mail when a hearing is scheduled.

In 2009, the Oregon Legislature expanded victims' rights to include post-conviction proceedings. This legislation explicitly put into law the right for victims or representatives to have the opportunity to be heard and to make a victim impact statement at the end of

a PSRB hearing. It is helpful for anyone wishing to make a statement to coordinate this with the [Oregon Department of Justice Victim Advocate](#).

Additionally, a victim can assert or decline victim rights at any time.

Patients Contacting Victims

While under the Board's jurisdiction, patients should not attempt to contact directly or indirectly victims of the GEI/REI offense. This includes asking family members or case managers to talk to victims on a patient's behalf (even if it would benefit patient or is part of his/her therapeutic work). If a victim directly or through the DOJ Victim Advocate contacts OSH or a provider to initiate contact, contact will require approval by the PSRB. If you have reason to believe that a patient has contacted a victim or intends to contact a victim, inform PSRB staff immediately and inform the patient he/she may not do so until the Board has approved contact after a hearing.

Victims' Participation in the PSRB Process

Victims will be allowed to be heard at all full hearings. Victims may elect to listen to the hearing via teleconference without making a verbal statement and/or to submit a written victim impact statement. Victims may also give a verbal, unsworn statement to the Board. Victims of patients' non-PSRB crimes will not be permitted to give victim impact statements. However, either party may call such victims as witnesses, if the testimony is determined by the Board Chairperson to be relevant. If victims provide advance notice, the Board will attempt to accommodate special requests such as seating arrangements, additional security, etc.

The PSRB will consider requests from victims who wish to request restorative justice services. Participation is contingent upon the patient's ability to participate and other requirements as adopted by the PSRB by administrative rule.

Providers should communicate with PSRB hearing staff to determine if victims will be participating. Victim impact statements can be highly emotional and graphic. This can often increase anxiety and staff may need to provide additional support prior to, during, and after the hearing.

Additional resources:

Oregon Department of Justice – Appellate Advocacy Program:

Kamaile Luke
Appellate Victim Advocate
Crime Victim and Survivor Services Division
Oregon Department of Justice
Appellate Advocacy Line: 503.378.4284 (messages can be left 24/7)
Email: CrimeVictimsServices@doj.state.or.us