Draft Report

Task Force on the Intersection of Tribal and State Forensic Behavioral Health

Cover Sheet

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Need to seek permission to use the flag of all nine tribes in cover page, plus OJD and OHA, list of Task Force members

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I: Introduction

House Bill 2005

House Bill 2005 (Oregon Laws 2025, chapter 559) was enacted in the 2025 legislative session. HB 2005 made a number of modifications to Oregon's civil commitment and fitness to proceed statutes. Section 39 of the measure established the Task Force on the Intersection of Tribal and State Forensic Behavioral Health (Task Force). The charge of the Task Force is:

> (3) The task force shall examine tribal and state interactions relating to involuntary hospitalization and mental or behavioral health treatment of tribal members in the state civil and criminal systems and:
>
> (a) Identify data sharing needs between tribal service providers, tribal courts and non tribal service providers, the Oregon Health Authority and Oregon courts, and identify methods for resolving barriers to data sharing;
>
> (b) Examine mental and behavioral health care services provided within tribal lands and to tribal members and identify barriers to providing care to tribal individuals;
>
> (c) Determine barriers to tribal members receiving care at the Oregon State Hospital pursuant to competency restoration orders or civil commitment;
>
> (d) Examine models for tribal and state interactions relating to mental or behavioral health;
>
> (e) Examine the results of the study described in section 38 of this 2025 Act; and
>
> (f) Develop recommendations concerning tribal court needs that intersect with state services and barriers to services.

While completing this charge, the legislation also requires that the Task Force to "invite and consider perspectives involving forensic or mental health matters before tribal courts, including prosecutors, defenders, people with lived experience, family members of persons with unmet behavioral needs and members of tribal governments."

Task Force Membership

HB 2005 outlined a 17-member Task Force with representatives from all nine federally recognized tribes of Oregon, the Governor's Office, the Oregon Health Authority, the Department of Justice, community mental health providers, tribal service providers, and

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the Oregon Judicial Department. Members appointed by the Chief Justice are non-voting members. The membership of the Task Force is:

Chair

Hon. Naomi Stacy, Judge, Confederated Tribes of the Umatilla Indian Reservation

> *Appointed by*: Governor, in consultation with the Commission on Indian Services
>
> *Role*: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Oregon

Vice Chair

Hon. Denise Keppinger, Judge, Columbia County Circuit Court

> *Appointed by:* Chief Justice of the Supreme Court
>
> *Role:* Judge with expertise in the competency to proceed process

Members

First Lady Aimee Kotek Wilson, MSW

> *Appointed by:* Governor
>
> *Role:* Represent the Office of the Governor

Lisa Nichols, Manager, Intensive Forensic Services, Oregon Health Authority, Behavioral Health Division

> *Appointed by:* Governor
>
> *Role:* Represent the Oregon Health Authority

Leslie Wu, Policy Advisor, Department of Justice

> *Appointed by:* Governor
>
> *Role:* Represent Department of Justice

Kimberly Lindsay, Executive Director, Community Counseling Solutions

> *Appointed by:* Governor
>
> *Role:* Represent community mental health providers

Hon. Karen Costello, Chief Judge, Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians

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Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Oregon

Hon. Gayleen Adams, Chief Judge, Confederated Tribes of Warm Springs

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Oregon

Hon. Melissa Cribbins, Chief Judge, Coquille Indian Tribe

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Orego

Hon. Ronald Yockim, Chief Judge, Cow Creek Band of Umpqua Tribe of Indians

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Oregon

Hon. Patrick Melendy, Chief Judge, Confederated Tribes of Grand Ronde

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Tribal court judges or staff or other individuals designated by an Indian tribe and representing one of the nine federally recognized Indian tribes located in Oregon

Sharon Stanphill, Chief Health Officer, Cow Creek Band of Umpqua Tribe of Indians

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Represent tribal service providers

Cindy Cecil, Clinical Director of Behavioral Health, Yellowhawk Tribal Health Center

Appointed by: Governor, in consultation with the Commission on Indian Services

Role: Represent tribal service providers

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Adrea Korthase, Indian Child Welfare Act Analyst, Office of the State Court Administrator

Appointed by: Chief Justice of Supreme Court

Role: Represent the Tribal, State, and Federal Court Forum

The Task Force was not able to obtain official appointment of representatives from the Klamath Tribes, the Burns Paiute Tribe, or the Confederated Tribes of the Siletz Indians.

Finally, because the unique insights and qualifications provided by the Office of Tribal Affairs within the Oregon Health Authority, the Task Force gladly welcomed the additional agency support from Angie Butler, Siletz, Med, Senior Tribal Policy & Program Analyst, Tribal Behavioral Health Continuum of Care Advisor, Oregon Health Authority

Task Force Meetings

The Task Force met seven times from June through December of 2026. The initial meeting convened in person in Salem, Oregon and subsequent meetings were held remotely. Each meeting recording and minutes are available within the Meeting Archives of the Task Force's webpage.

Each meeting was at least two hours long and provided an opportunity for public comment.

II: Background

Tribal Courts

Tribal Courts

The United States recognizes 574 Tribes as "domestic dependent nations." Nine of these are located in Oregon. Each Tribe is a unique nation with its own cultures and customs. Each has a unique relationship with the federal government, the State of Oregon, and the Oregon courts. Oregon has long embraced the government to government relations with each of the federally recognized tribes in Oregon.

Each of listed federally recognized Tribes in Oregon have structured its courts according to its needs and customs:

- Burns Paiute Tribe
- Confederated Tribes of Siletz Indians

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- Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians
- Confederated Tribes of Grande Ronde
- Coquille Indian Tribe
- Confederated Tribes of Warm Springs
- Confederated Tribes of the Umatilla Indian Reservation
- Cow Creek Band of Umpqua Tribe of Indians
- Klamath Tribes

Behavioral and Mental Health

Behavioral and mental health disorders[1] touch every segment of our society, regardless of race, ethnicity, religion, or economic status. According to a nationwide survey completed in 2025 by the nonprofit Mental Health America, over 23 percent of adults in the U.S. are experiencing a mental illness, with 5.6 percent of the population experiencing a serious mental illness[2]. That same report detailed that over 46 million people, or nearly 18 percent of the population, had a substance use disorder (SUD).

For Oregon, the study found that 30 percent of Oregonians reported having a mental illness, giving Oregon the highest prevalence of mental illness of any state. The study also found that over 22 percent of Oregon's population reported to be adults with SUD, making it the fourth highest in the nation.

State Courts and Behavioral Health

When a person is experiencing a mental health disorder and the state becomes involved in their mental health care, that involvement can come through several different channels.

Civil Commitment

A person with a mental illness who has or is at risk of hurting themself or others may be held in a hospital for involuntary mental health treatment and placed in the **civil**

[1] The terms "behavioral health" and "mental health" continue to evolve as our understanding of the human brain advances. As used in this report, "mental health" describes the status of a person's wellbeing, with a "mental health disorder" being a condition with a biological basis that affects a person's mood, thinking, or behaviors. Common mental disorders include depression, anxiety, schizophrenia, and bipolar disorders. This report will also reference "behavioral health," which includes substance use disorders as well as mental health disorders.

[2] Reinert, M, Nguyen, T & Fritze, D., Mental Health America, *The State of Mental Health in America 2025*. pg. 14, Mental Health America (2025)

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commitment process. If an investigation by the local community mental health provider (CMHP) finds that the person is a danger to themself or others, or unable to meet their basic needs, the person has a hearing before a judge. If evidence is presented and the court finds that a person has a mental illness and is a danger to themself or others, or unable to meet their basic needs, the person may be committed to involuntary care for a period of up to 180 days. Opportunities arise in the commitment process for the person to voluntarily receive care or to be diverted into a short hospital stay. In 2024, Oregon saw 7,826 cases filed for commitment with only 474, or 6 percent, resulting in a commitment.[3]

Fitness to Proceed/Aid and Assist

If a person is facing criminal charges, that person has a right to be able to understand the proceedings against them and assist their legal counsel with their defense. If the person is unable to understand the proceedings or assist their attorney in their case because of a mental illness, that person is found not **fit to proceed**. Upon a finding that a person is not fit to proceed, or "unable to aid and assist" in their own defense, the court may order a person to participate in treatment to restore them to competency. Services to restore a person to competency may be provided in the community or at the Oregon State Hospital (OSH). The court may also order a person who is not competent to proceed to be released if held in custody, to be assessed for civil commitment, to be placed in an emergency guardianship, or to have the charges against the individual dismissed. In the first nine months of 2025, 1,159 defendants were found not competent to proceed with their case or cases due to a mental illness. Of those, 734 (63 percent) were ordered to OSH for restoration services as their initial placement.

Guilty Except for Insanity

When a person with a criminal charge is competent to proceed with their case but experienced a mental illness at the time of the offense, the person may bring a defense that the person is "guilty except for insanity" or **GEI**. GEI is a defense to a criminal charge. In order to be found GEI, the evidence must show that as a result of a qualifying mental disorder at the time of engaging in the criminal conduct, the person lacked substantial capacity to either appreciate the criminality of the conduct or to conform the conduct to the requirements of the law. A defendant who is GEI is placed under the jurisdiction of the Psychiatric Security Review Board (PSRB) and placement is fact dependent. In 2024, 40 defendants were found GEI by a court. Of the 40 defendants found GEI in 2024, 30 were committed to OSH, five were conditionally released, and five were discharged.

[3] Oregon Judicial Department Civil Commitment Dashboard, 2024.

Treatment Courts

Treatment courts are court programs that address the specific needs of groups. Often, these are probation programs after a person has plead guilty to a crime. These courts utilize a multi-disciplinary team to provide support to participants and often include heightened judicial interaction with individual participants. Treatment courts can be drug treatment courts, mental health courts, veterans' courts, and can include broader subjects, such as family treatment courts or juvenile drug courts.

III: Charges and Recommendations

By design, the charge to the Task Force found in HB 2005 was both narrowly focused on specific issues ripe for problem solving and broadly written to allow discussion and recommendations on larger issues. HB 2005 charges the Task Force with six specific issue areas for recommendation within the broader scope of the intersection of state and tribal interactions in the state civil and criminal systems. Below are each of those charges and the Task Force's recommendations for further action.

1) Identify data sharing needs between tribal service providers, tribal courts and non- tribal service providers, OHA, and Oregon Courts and identify methods for resolving barriers to data sharing

Understanding the data sharing needs of tribal courts, tribal behavioral health providers, and the individuals they serve requires understanding and acknowledging the abuse and discrimination against tribal people and their data.

While the day-to-day operations of state and tribal behavioral health and courts may be improved and individuals better served if data related to that individual and their tribal status were shared between systems, any efforts that would result in sharing of tribal membership must be led by the Tribes and approached with care for the privacy rights of the individuals and the experiences of the individual Tribes.

Within this report, membership in a Tribe means that an individual is an enrolled member of a tribe. The tribe itself is the only entity that knows who its members are. There is no list of currently enrolled tribal members at the state or federal levels. Each Tribe sets its own membership criteria[4] and maintains its own lists of current and past members. Enrollment criteria are often found in a tribal government's constitution or ordinances and are unique

[4] Tribal Enrollment Process | U.S. Department of the Interior

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to each Tribe. Tribal connections can also be complex and nuanced: a person may be connected to several different tribes and have enrollment options at more than one; a person may identify as belonging to a particular tribe and be an enrolled member in a different tribe; a person who is eligible for enrollment in a tribe may not wish to enroll; a person who is not eligible for enrollment in a tribe may identify as being a member of that community; or a person may be an enrolled member of one tribe and reside on the reservation of a different tribe.

Membership in a tribe is also distinct from racial data in which a person may identify as American Indian/Alaska Native or Native American.

Several layers of complexity exist when identifying the data sharing needs and barriers of these partners. First, Tribes, as sovereign nations, may have laws governing how and what data is collected and how that data may be shared. Federal laws, such as the Health Insurance Potability and Accountability Act of 1996 (HIPAA), provide the base layer of protection for safeguarding individual medical information across the nation. These law apply to tribal service providers, community mental health providers, hospitals, and the Oregon State Hospital. State law also provides greater specific protections for certain information, such as prohibiting public disclosure of the record of a civil commitment process, ORS 426.160, or restricting disclosure of information in a fitness to proceed case, ORS 161.362(3).

Recommendation #1: Explore Methods for State Notice to Tribe for Care Coordination

As noted, Oregon state systems have no means to verify a person's enrollment status with a Tribe, nor would it be appropriate for Tribes to provide their enrollment information to the state.

The Task Force recommends that when a person receiving services in the state system and provides information that they are a member of a Tribe, the various state systems be legally authorized to act upon that information and contact the appropriate Tribe.

For instance, if a person is being detained at a hospital for a civil commitment investigation, and the investigator (CMHP) or hospital learns that the person might be a member of a particular Tribe, the CMHP or hospital would be authorized to contact the specific Tribe with limited information about the person it is serving. If the Tribe verifies that the person is in fact a tribal member, state law should not act as an impediment to care coordination for that individual. Any information learned by or disclosed to the CMHP, hospital, or Tribe must be limited in scope and protected from inappropriate disclosure.

Likewise, if a defendant is receiving restorative treatment at the Oregon State Hospital or in Community Restoration, and OSH or the CMHP learns that the defendant may be a

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member of a Tribe, the Task Force recommends that OSH or the CMHP be allowed to contact the Tribe with limited information for the purpose of care coordination for that individual.

As this topic is a complex area of law and involves several different types of laws in different jurisdictions, the Task Force recommends further research with experts on privacy laws and tribal sovereignty.

Recommendation #2: Increase Training and Coordination Between Tribal, Local, and State Partners

Throughout the Task Force's meetings, the topic of education, collaboration, and coordinated training surfaced many times. Through ongoing collaboration and communication, state and local system partners can learn more about their counterparts within Tribes and form relationships that will lead to greater familiarity with the workings of each system.

The Task Force recommends that OHA lead regional trainings in coordination with the Tribes of those regions on topics of mutual interest. These topics can include hospital processes for crisis response and emergency treatment, the civil commitment process, the efforts of local CMHPs, and hospital protocols in behavioral health.

2) Examine mental and behavioral health care services provided within tribal lands and to tribal members and identify barriers to providing care to tribal individuals

Throughout its meetings, the Task Force shared information about health care services available on tribal lands and to tribal members. Each Tribe has a long history of developing and providing their own traditional healthcare and medicine to their communities. Despite colonization and efforts by the US government to eradicate traditional practices, including those related to healthcare and medicine, today many tribal health providers incorporate traditional treatments and services alongside their modern counterparts. Additionally, various US laws and treaties now guarantee health care for tribal members. For some Tribes, those health care services on tribal lands are administered by the Indian Health Services (IHS).

People living within tribal jurisdiction remain eligible to the rights and services available for all Oregon citizens. Tribal membership does not divest them of such rights, and is true regardless of whether that individual chooses to access tribal or IHS services.

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IHS operates two health care facilities in Oregon to serve tribal members. The Wester Oregon Service Unit is located in Salem, Oregon. While that facility provides behavioral health care services, the services do not include intensive or inpatient services. IHS also operates a medical and dental facility in the Warm Springs Service Unit in Warm Springs, Oregon. That facility does not provide behavioral health services. That's because the Confederated Tribes of the Warm Springs acts as the Community Mental Health Program (CMHP) for the Tribe, overseeing and administering local behavioral health services.

Tribes may also use IHS funding to operate their own health care programs[5]. Some Tribes provide health care through a tribal non-profit organization. The Confederated Tribes of the Umatilla Indian Reservation, for example, operates Yellowhawk Tribal Health Center, a non-profit organization owned and governed by the CTUIR that takes the place of Indian Health Services in that service unit. Yellowhawk provides outpatient Mental Health care, Substance Use Disorder treatment, and crisis response, but does not provide in patient behavioral health services. Yellowhawk works with the CMHP when coordinating necessary care for tribal members and individuals on the tribal land.

[Other examples!]

[General information here about how Tribes establish their own clinics]

[Need guidance on OHP/Tribal Member Pathway]

If a tribal member meets income and eligibility requirements, the member may be eligible for Oregon's Medicaid program, called the Oregon Health Plan. Tribal facilities are authorized to bill Medicaid for services provided to enrolled tribal members who would be eligible for IHS services[6]. Additionally, since 2016, Medicaid policy has been that "IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal providers to furnish certain services for their patients who are [American Indian and Alaska Natives] AI/AN Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching authorized under section 1905(b) of the Social Security Act at a rate of 100 percent[7]." As such, even when a tribal member is receiving services on

Commented [CN2]: I would like to include a brief description of each Tribe's set up related to health care and behavioral health care, if they are willing.

Commented [CN3]: Can tribes each provide info on this?

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[5] According to Medicaid.gov, "Tribes may contract with the IHS through self determination contracts and annual funding agreements under Title I of the ISDEAA or may enter into self-governance compacts and funding agreements under Title V. Approximately half of the Tribes elect to operate their Indian health care programs and administer the IHS funding and resources through ISDEAA contracts and compacts, while the remaining Tribes have determined to receive health care directly from the IHS."

[6] Department of Health and Human Services, CMS, Tribal Protections in Medicaid and CHIP Managed Care Oversight Toolkit, page 7, accessed Nov 17, 2026. Medicaid Managed Care Toolkit

[7] SHO #16-002, Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-eligibleMedicaid-EligibleAmericanIndiansandAlaskaNativesisavailableat,

tribal land, the state of Oregon may have a financial connection to that individual and their care.

Barriers to Providing Care

Tribal behavioral health providers encounter a number of barriers to providing a continuum of behavioral health care for individuals on tribal lands. These barriers include non-existing funding for in-patient or residential behavioral health services, few treatment beds available in rural locations, a lack of behavioral health providers statewide and notably in rural locations, historic communication obstacles between CMHPs, the state, the federal government, and Tribes, and a state behavioral health system that developed without taking into account the rights of tribal citizens as Oregon citizens to a continuum of care that includes for serious mental health treatment in a hospital level of care or secure residential treatment facility.

Beds:

A 2024 study[8] by the Public Consulting Group, LLC for the Oregon Health Authority examined the bed capacity of Oregon's residential behavioral health system and found that treatment beds of all types were needed across the state to meet the demand for these services. Task Force member reported [_] in-patient behavioral health beds were available on tribal lands.

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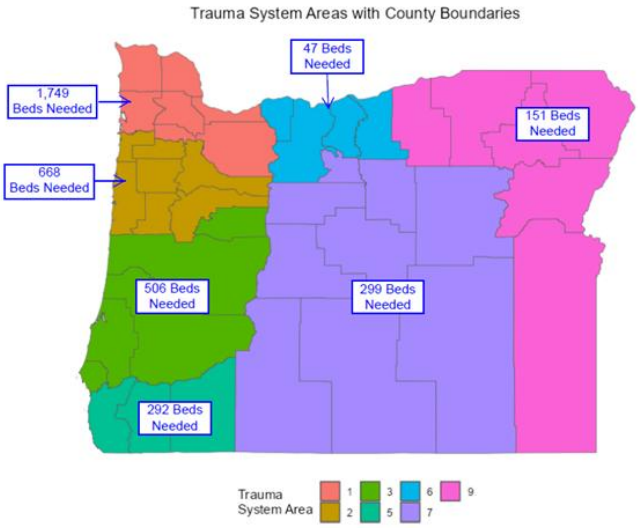
https://www.medicaid.gov/sites/default/files/Federal-Policy Guidance/Downloads/sho022616.pdf. 16 The published 2023 All-Inclusive-Rate

[8] PCG Report Template Blue



Oregon Behavioral Health Residential+ Facility Study-Final Report: Figure 31. Total Capacity Needed for Each Trauma System Area[9]

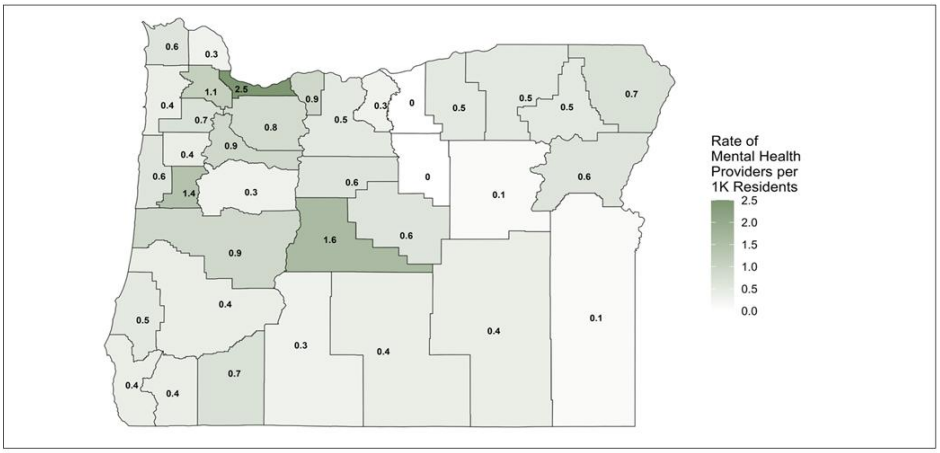
Recommendation # X: Specific Plans to Build Capacity:

The Task Force recommends that in consultation and collaboration with tribal behavioral health providers, that the Oregon Health Authority, and CMHPs create a plan to target specific bed capacity to provide medically necessary behavioral health care to individuals subject to tribal court orders. As each Tribe has different structures, resources, and community needs, it is important that each plan be developed individually with each Tribe. The Task Force recommends each plan to be developed within [X] months of this report and that each plan include a recommendation for number of beds, the type of beds, the funding stream necessary to build and maintain the beds, and a plan to recruit and retain the workforce necessary to maintain capacity.

Workforce:

While behavioral health professionals are in short supply across Oregon, the supply shortage is most acute in rural and frontier counties. The [date needed] Oregon Behavioral Health Talent Assessment found that 32 of 36 Oregon counties have fewer than one provider per 1,000 residents.

[9] Id at Page 111, figure 31.



Citation: Graphic 4, Rate of Mental Health Providers Per 1,000 Residents.[10]

The same assessment found that fewer than two percent of current mental health providers working in Oregon identify as American Indian or Alaska Native.

Recommendation X: Regional Workforce Development Plans:

The Task Force recommends that OHA regularly consult with tribes regarding efforts to develop region-specific behavioral health career roadmaps aligned with community cultural values and local service needs, as recommended by the Behavioral Health Talent Council[11]. The Task Force encourages tribes to partner with the state to build a culturally responsive workforce that best meets the needs of each Tribe.

Communication:

Another barrier that was raised by the Task Force is the barrier of communication some Tribes experience with their local CMHPs, hospitals, or other care providers. This historic lack of communication can take shape in many ways: a county crisis worker not knowing whom to call when a tribal member is experiencing a mental health crisis outside of the tribal land; the percieved inability for a tribal court to initiate a civil commitment proceedings for a tribal member transported to a local hospital; a hospital not being sure of what services a tribal member can access on tribal lands; [other examples].

Commented [CN6]: Would like to include other examples that other TF members have experienced.

Recommendation X: Ongoing Collaborative Trainings

[10] Oregon Behavioral Health Talent Assessment, Oregon Behavioral Health Talent Assessment.
[11] W00082508_GOV_Behavioral Health Talent Council Report_2026_web.pdf RR3.1

The Task Force recommends that OHA, CMHPs, hospitals, behavioral health providers, and public safety partners meet regularly in joint education and training sessions to build relationships and exchange information. The Task Force recognizes that it is crucial for local non-tribal providers and tribal providers to build connections to best serve the community.

3) Determine barriers to tribal members receiving care at the Oregon State Hospital pursuant to competency restoration orders or civil commitment

The Oregon State Hospital (OSH) is Oregon's public psychiatric hospital. It is run by the OHA and serves individuals who are ordered to OSH by a court, whether through the Guilty Except for Insanity (GEI) process, Aid and Assist process, or civil commitment process[12]. OSH is divided between two campuses and can serve a total of 703 individuals at any given point in time. According to the November 2026 OSH census, 309 individuals were at OSH for restoration services or evaluation under a court order in a criminal case, 295 were within the jurisdiction of the PSRB, and 36 individuals were civilly committed.

The vast majority of cases that result in a defendant being committed to OSH for restoration services originate in a state court, with a handful of individuals are sent to OSH by a municipal court. Admission to OSH is restricted due to a federal court order in ongoing litigation[13]. These restrictions apply to admissions in both civil commitments and in fitness to proceed cases, regardless of the jurisdiction that is sending the individual.

Barriers to Tribal Members Receiving Care at OSH

Tribal courts have authority over individuals on tribal lands that originate with the sovereign power of the tribe. Tribal courts operate as provided by the constitution of the Tribe and the treaties with the US government. While each Tribe has taken on different authority in different areas of law, when a Tribal court makes an order in an area of law for which it has jurisdiction, that order has the effect of a foreign court order within the state system and is given full faith and credit within the state, with one significant exception: commitment of individuals from Indian Country.

Civil Commitment:

Chapter 24 of the Oregon Revised Statutes outlines how Oregon courts acknowledge and interact with orders and judgments that originate in a different jurisdiction. ORS 24.105 outlines that a foreign judgment means a judgment, decree or order of a court of the United

[12] Oregon Health Authority : About Us : Oregon State Hospital : State of Oregon
[13] See Oregon Health Authority : Oregon State Hospital Mink-Bowman Order Compliance : Oregon State Hospital : State of Oregon

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States or of any other court which is entitled to full faith and credit in this state; and "[a]ny judgment, decree or order of a tribal court of a federally recognized Indian tribe, except when another Oregon statute provides a different process to enforce a tribal judgment, decree or order, or as provided in ORS 426.180 (Emergency commitment of individuals in Indian country)."

The process outlined in ORS 426.180-.210 outlines a process for transportation of an individual over whom a tribal court has jurisdiction when a tribal court finds that a person is a danger to self or others and is in need of immediate care, custody or treatment for mental illness. Through this process, the individual is taken to a local hospital or nonhospital facility, not OSH, and the director of that hospital or facility makes a determination about whether to admit or deny the individual for emergency treatment. If admitted, the CMHP then commences a civil commitment proceeding in state court and notifies the tribe. The statute is silent as to the process if the director refuses to admit the individual.

Additionally, the statute provides a process in which a tribe can agree to cover the expense of transportation and commitment of an individual who is committed from the reservation, or by the CMHP. See ORS 426.180(8) and 426.250(6).

The exclusion of commitment orders from the full faith and credit provisions of Oregon's statutes are a significant barrier to individuals needing emergency care and treatment from receiving that service in local hospitals or OSH.

Recommendation X: Provide Full Faith and Credit to Tribal Court Orders on Behavioral Health

The Task Force recommends that full faith and credit be given to any order related to behavioral health that originates from a Tribal court. This recommendation would include removing the reference to ORS 426.180 within ORS 24.150. By removing the requirement that the process in ORS 426.180 be followed, Tribes will be empowered to work with local hospitals, CMHPs, and OHA to develop pathways so that individuals in need of care and treatment can access such care and treatment when needed, regardless of where the individual originates. This would include the possibility of admission to OSH when individuals need the highest levels of care.

Of note, this recommendation does not require modification of the federal court order or other state statutes and policies. It provides a clear pathway for Tribes to access care for individuals and recognizes the power and authority inherent in Tribal courts to order such care.

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Aid and Assist

Not all tribal courts exercise authority over criminal cases. Some Tribes may exercise authority over violations of fish and game regulations and corresponding violations, or of gaming regulations, while other Tribes have developed a criminal code and exercise authority over criminal acts occurring within its jurisdiction. Co-existing authority with federal law enforcement may also exist. For certain categories of major crimes, the federal government may prosecute a crime that originated within the jurisdiction of a tribal court. When a defendant is subject to federal prosecution and fitness to proceed concerns are raised, that individual's competency and potential restoration are handled within the federal system. When a defendant is prosecuted in a state-originated case, Oregon statutes and rules, subject to the federal court order, control the defendant's competency and potential restoration process. But when a criminal case is charged in a tribal court, it is not clear whether federal resources or state resources are available to a defendant who may lack competency. For individuals who are facing criminal charges in a tribal court of one of the Tribes of Oregon, defendants found to be unable to aid and assist in their own defense have not been able to access that right to treatment in facilities that operate under state jurisdiction.

Recommendation X: Provide Full Faith and Credit to Tribal Court Orders on Behavioral Health

The Task Force recommends that full faith and credit be given to orders for evaluation, commitment, and community restoration when a defendant's fitness to proceed is questioned in tribal courts. This is likely to be a limited number of individuals sent to OSH for evaluation or commitment by tribal courts exercising criminal jurisdiction and does not require modification of the federal court order or other state statutes and policies.

The Task Force recommends that the Tribes who are exercising criminal jurisdiction or who anticipate exercising criminal jurisdiction work with OHA, CMHPs, and state courts to develop agreements or memorandums of understanding to timely facilitate restoration services for defendants coming from tribal courts.

4) Examine models for tribal and state interactions relating to mental or behavioral health

Throughout the course of its meetings, the Task Force had the opportunity to examine the models of interactions utilized by other states and tribes. Of particular note was a presentation on September 4, 2026, from the American Indian Health Commission on Washington State's Tribal Behavioral Health Model. Within that presentation, the Task

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Force learned about legislation in Washington State that may serve as a model for certain changes in Oregon statutes.

The measures, Senate Bill 6259, 2020 (CH. 256, Washington Laws of 2020) and House Bill 1877, 2024 (CH. 209, Washington Laws of 2024) both passed unanimously through the House and Senate chambers. Together, the laws do important work to provide recognition of the tribal behavioral health systems and coordination with state systems.

The Task Force learned about six important reforms that were made through these bills:

- Indian Health Care Provider was defined in statute and woven through the state statutes related to authority and regulations of providers of behavioral health services.
- Tribes must be notified and copied on all inpatient treatment and assisted outpatient treatment petitions and orders, notices of discharge from facilities, and other procedural steps related to civil commitment in the state system.
- State statute explicitly recognized the authority of tribes to act as public health authorities to provide for the health and safety of community members who are experiencing behavioral health crises. Further, Tribal mental health providers were authorized to be appointed "designated crisis responders" under statute and those "State Certified Tribal Designated Crisis Responders" were authorized to conduct involuntary civil commitment processes in both state and Tribal court.
- State statute recognized a Tribal government's attorney "Right to Intervene" in certain court proceedings related to civil commitment.
- Statute specifically requires behavioral health providers to accept the orders of tribal courts. "Behavioral health service providers shall accept tribal court orders from tribes located within the state on the same basis as state court orders issued under this chapter." RCW 71.05.337(2).
- Indian Health Care Providers were provided a specific exception to confidentiality rules for mental health records when those records are necessary to conduct or provide crisis or involuntary treatment services.

The Task Force also learned about processes in other states for recognition of Tribal court orders and communication between the various states and Tribes. A list of those states and their processes is provided here. (link when available).

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Recommendation X: What recommendations would the TF like to make from what it learned about WA or other states?

Commented [CN7]: Question for TF

5) Examine the results of the data study required by HB 2005

Section 38 of House Bill 2005 went into effect on July 24, 2025, and directed the Oregon Judicial Department (OJD) to study "tribal and state interactions relating to the involuntary hospitalization and mental or behavioral health treatment of tribal members in the state civil or criminal justice systems." The study was completed and reported to the interim committees of the Legislative Assembly related to the judiciary and behavioral health in December of 2025. The completed report can be accessed here.

To complete the data study, OJD gathered data from several sources and sought information on four specific areas of data collection. OJD asked for data relating to individuals who identify as American Indian or Alaska Native, or Native American, as well as data relating to members of one or more federally recognized tribes who are involved in (1) civil commitment proceedings; (2) competency (aid and assist) proceedings in criminal cases; (3) findings of guilty except for insanity in criminal cases; and (4) participation in treatment courts.

The data reflected what many suspected: data reporting on race or ethnicity can be difficult to obtain without relying on a reporter's perception of race, while the data that is collected may be incomplete or categorized in a different way. These challenges are reflected in the numbers that were able to be obtained.

Specifically, most OJD race data is collected through entry of racial data provided by district attorneys or other system partners into the court record system. Race data provided by district attorneys is likely to be based on the officer's perception of the defendant's race rather than information from the defendant.

OJD has no race data for most civil commitment cases, but what race data OJD was provided for 2024 shows that one percent of individuals civilly committed are perceived to be "Indian." OHA reports that 6 percent of civilly committed individuals identify as American Indian/Alaska Native or Native American. These terms are misaligned, and one is based on self-reported race and the other is based on perceived race. Importantly, neither data set reflects an individual's membership in a tribe.

For aid-and-assist cases, OJD data shows 1.5 percent of those for who fitness concerns are raised are perceived as "Indian", but OHA reports that nearly 10 percent of individuals found unfit identify as American Indian/Alaska Native or Native American. As the prior data point reflects, this difference may be due to the difference between self-reported race and

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perceived race. Neither OJD or OHA data tells us how many individuals are members of a tribe or their tribal affiliation.

Recommendation # X: Designation of tribal status in court system

Currently, courts and district attorneys can modify charging instruments in limited circumstances to indicate that a case is eligible for a particular program or has a particular status. These designations must be mutually agreed upon and may come from local court rules. Additionally, race data can be entered into the court system in certain circumstances.

The recommendation of the Task Force is to encourage Oregon Judicial Department to work with local courts and system partners to provide a designation on cases in which a person or defendant has provided information that they are a member of a tribe. This information could come from a defense attorney, the district attorney, the person, or by the court from its own questions. Courts and system participants would not be required to ask this information or to provide it if the person or defendant objected to their tribal membership being shared. Absent objection, however, allowing for a designation within the system would allow for greater insight into the number of tribal members interacting with the state court system.

Recommendation #X: Continue advocating for change of racial terms within the Odyssey platform.

The Oregon Judicial Department utilizes a case management program called Odyssey. Odyssey has limited options for racial categories within its program. It does not have a category for Native American or American Indian/Alaska Native. Instead, Odyssey has a designation for "Indian," which does not correlate to persons who self-identify as Native America, or American Indian/Alaska Native, nor does it allow an opportunity to specify a tribal membership. The lack of tribal data is not unique to Oregon alone. In ___, the National Counsel on State Courts recommended that "[c]ourts should actively collect and review race and ethnicity data in order to identify inequitable practices and to monitor progress in achieving equity. This analysis should extend to diversion to treatment placements."

The Task Force recommends OJD continue to advocate with Tyler, the company who produces Odyssey, to provide a greater variety of racial categories and more descriptive categories in line with the US Census. Additionally, the Task Force recommends that a field for "Tribal Membership" be added and that this information be added whenever available. [Tribal membership is a matter of political classification based on the U.S. treatment of tribes as sovereigns, rather than a racially based use. Haaland v. Brackeen, 599 U.S. 255 at (2023), citing "*...the bedrock principle that Indian status is a "political rather than racial"*

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classification, Morton v. Mancari, 417 U. S. 535, 553, n. 24 (1974).]If necessary, the Task Force recommends that statutory directive be given that court filings reflect more accurate and descriptive tribal data.

6) Develop recommendations concerning tribal court needs that intersect with state services and barriers to service

That Task Force has made a number of recommendations for meeting tribal court needs when there is an intersection with state services and barriers to individuals accessing those services. Additionally, the Task Force recommends:

Recommendations X: Anything else the TF recommends that doesn't fit into a category above?

The totality of recommendations are outlined below, along with whether the recommendation is suitable for legislation in 2027, further examination or workgroup, or whether the recommendation can be developed outside of legislation.

[Insert table here when finalized]

IV. Conclusion

The Task Force appreciated the support of the Oregon Legislature in convening this group to provide an opportunity to closely examine the unique and consequential ties between Tribal courts, behavioral health providers, and state systems. The Task Force made meaningful progress in addressing the barriers to accessing service for individuals in need, no matter where they are located within the State.

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