

Thirty-Five Years of Working With Civil Commitment Statutes

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This commentary reflects my 35 years of working with civil commitment statutes, first in Alaska, then in Oregon, and on various committees on the national level. Coming from a background in community and public psychiatry, I have always considered civil commitment to be the most important forensic mental health statute, as the commitment process in any state greatly influences the lives of many severely mentally ill individuals. Over the course of the past 35 years, many changes have occurred in civil commitment law, resulting in the gradual de-emphasis of the importance of these statutes. The ability of clinicians to use these statutes effectively has diminished. Herein, I review some of the areas of conceptual and practical problems related to the use of these statutes and, in effect, make a plea for a re-examination of the importance of civil commitment and for an attempt to fix some of the problems that have led to the loss of effective and rational civil commitment laws.

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Civil commitment statutes are the most important forensic mental health laws. They affect the largest number of people of any of the law–mental health interactions. As a part of the civil law, these statutes provide a buffer between the voluntary mental health and criminal justice systems. This is a very important buffer, as entry into the criminal justice system carries significant negative connotations for the mentally ill. Yet, there has always been much controversy surrounding civil commitment statutes. Let me illustrate by quoting from the websites of two of the most important Washington-based national advocacy organizations that support programs for the mentally ill: the Judge David Bazelon Center for Mental Health Law and The Treatment Advocacy Center. First, from the website of the Bazelon Center:

The Bazelon Center is a nonprofit legal advocacy organization based in Washington, D.C. Our name honors Judge Bazelon whose landmark decisions pioneered the field of mental health law, and our advocacy is based on the principle that every individual is entitled to choice and dignity. For many people with mental disabilities, this means something as basic as having a

decent place to live, supportive services and equality of opportunity.¹

Their position statement on involuntary commitment reads:

The Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative. Civil commitment requires a meaningful judicial process to protect the individual's rights.²

Next, from the website of the Treatment Advocacy Center:

The Treatment Advocacy Center is a nonprofit organization dedicated to eliminating legal and clinical barriers to timely and humane treatment for millions of Americans with severe brain disorders who are not receiving appropriate medical care. Current federal and state policies hinder treatment for psychiatrically ill individuals who are most at risk for homelessness, arrest or suicide. As a result, 40 percent of the 4.5 million individuals with schizophrenia and manic-depressive illness (bipolar disorder), an estimated 1.8 million people, are not being treated for their illness at any given time.

The Treatment Advocacy Center is working on the national, state, and local levels to educate civil, legal, criminal justice, and legislative communities on the benefits of assisted treatment in an effort to decrease homelessness, jailings, suicide, violence and other devastating consequences caused by lack of treatment.³

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Each of these organizations is enormously influential. Each has far-reaching political connections. Both websites have many links, and each can mobilize opinion and advocacy very quickly. It is also quite clear that they do not agree on an approach to civil commitment.

This article is a personal retrospective on 35 years of my working with civil commitment statutes as a psychiatrist interested in both public mental health systems and forensic psychiatry. I will explore just some of the inconsistencies and controversies, both past and current, surrounding civil commitment statutes by examining certain features of the Oregon commitment statute as it evolved from the time of Oregon's entry into statehood to the present. Oregon's statute is similar to others in the country, and as such the discussion should apply to other jurisdictions. As this is a personal statement, I will also briefly review some of the empirical approaches that I and my colleagues have used over the years to try to understand the actual functioning of this and related statutes. Using the Oregon statute and the empirical data as a starting point, I will discuss some of the conceptual issues in civil commitment law in general, including the current controversy focused on outpatient civil commitment.

The Anatomy of the Oregon Civil Commitment Statute

Historical Development

The Oregon Territory was created in 1853. There were no provisions in the Territory for the commitment of mentally ill persons, although territorial statutes did call for the appointment of guardians who would be responsible for the care and custody of insane persons and their estates. In 1859, Oregon became the 33rd state to enter the Union. In a paper written to celebrate the 150th anniversary of the American Psychiatric Association, Bloom and Williams⁴ reviewed 140 years of change in the Oregon civil commitment statute. The following describes some of the statutory changes that have taken place over the years.⁴

1862: Commitment Standard

A county judge may order hospitalization based on a finding that a person "by reason of insanity or idiocy, as the case may be, is suffering from neglect, exposure or otherwise, or is unsafe to be at large, or is suffering under mental derangement."

The alleged insane person had to be examined by one or more competent physicians who had to "certify upon oath that the said person or persons are insane or idiotic."

No person can be committed if that person "has friends that can, or desire to provide for their safe keeping and medical treatment."

1913: Commitment Standard

To commit a person, a judge must find that the person "by reason of insanity is unsafe to be at large or is suffering from exposure or neglect."

1919: Voluntary Commitment

A person may apply for a 30-day voluntary hospitalization, but must be competent to make the application.

1941: Voluntary Commitment

The 1919 requirement that the applicant be competent to seek voluntary hospitalization is eliminated.

1943: Legal Representation

If an allegedly mentally ill person requests the assistance of counsel, the court shall give him the opportunity to obtain legal counsel.

1953: Community Treatment

Hospital superintendents may establish outpatient clinics to provide diagnostic services and treatment in lieu of civil commitment or for patients released from the hospitals.

1955: Legal Restoration of Competency

When the patient is discharged from a commitment, the superintendent of the hospital is required to certify whether the patient is competent.

1965: Competency

No one is deemed incompetent by virtue of a commitment.

1973: Major Revision of the Commitment Law

Definition: A mentally ill person is a person who, because of mental disorder, is either dangerous to himself or others or is unable to provide for his basic personal needs and is not receiving care that is necessary for his health and safety.

1. *Legal counsel:* an indigent person has a right to court-appointed legal representation.

2. *Precommitment investigation:* an investigation is conducted before the commitment hearing "to de-

termine whether there is probable cause to believe that the person is in fact a mentally ill person.”

3. *Burden of proof*: beyond a reasonable doubt.

4. *Limitation of commitment*: the period of commitment shall not exceed 180 days.

1979: Burden of Proof

The burden of proof is reduced to “clear and convincing evidence.”

1981: Restriction of Treatment

Psychosurgery may not be used as a treatment.

1987: Expanded Definition of Treatment

Deteriorating mental illness with previous hospitalizations is added as a criterion for commitment.

1993: Advanced Medical Directives

These directives can be used for chronic mentally ill persons to direct aspects of the treatment, should involuntary treatment be necessary.

These statutory changes mirror changes made over time in most jurisdictions and reflect the great controversies and compromises that are represented in current statutes, including those changes that come from case law. I will focus on several of these statutory questions, including the definition of a mentally ill person for the purpose of civil commitment, the question of civil competency, and the relationship of competency to voluntary hospital admission and to the right to refuse treatment. It is also obvious from this review that, over time, these statutes have become more rigorous in the protection of due process and the liberty interests of allegedly mentally ill persons. In Oregon, this evolution was reflected in the major changes enacted in 1973.

As in many other parts of the country, the changes in commitment statutes made in the late 1960s and early 1970s in Oregon reflected legislative and judicial reactions to the dire circumstances of the state hospitals in the 1950s and early 1960s.⁵ These statutory changes, along with many other factors, gave rise to the era of deinstitutionalization.

The Oregon Statute: Empirical Data

In the mid-1980s, Faulkner *et al.*⁶⁻⁹ (including the author) conducted a series of studies focused on how the Oregon civil commitment statute worked on an empirical basis. We divided the commitment process into three stages and constructed a research model focused on each of the stages. The three-step model consisted of (1) screening for entry into the

system, (2) the precommitment investigation, and (3) the commitment hearing itself. At each step, we focused on the key decision makers and the key determinations that were required at the particular phase in the process.

At screening, the key determination is whether the individual should be entered into the commitment process, most often with a five-day emergency hospitalization, and the identified decision makers were physicians, police officers, or mental health program workers who were responsible for determining whether an initial petition should be signed.

In Oregon, a precommitment investigator must review the initial petition and make a recommendation to the court as to whether there is probable cause to believe that the allegedly mentally ill person meets the statutory definition of mental illness. The investigators are employed by county mental health programs, but make their recommendations directly to the court. If the precommitment investigator finds that the allegedly mentally ill person does not meet the statutory definition of mental illness, the court, in most cases, dismisses the petition and, most often, the person is released. Finally, in the commitment hearing itself, the decision maker is the circuit court judge who conducts the commitment hearing.

Because of data available at the Oregon Mental Health Division, the three-step model enabled us to determine who was either released at a particular phase of the process or passed on to the next stage. The model allowed us to examine the civil commitment process from several vantage points, such as looking at statewide data⁶ or comparing results in urban versus rural counties,⁷ results in a single county over time, or results before and after significant changes in the county system.⁸ We were able to demonstrate that, during the study period, total commitments were 5.3 in 10,000 adults in Oregon per year and that there were significant differences in this rate when we compared six different counties. These differences ranged from 2.3 to 7.8 commitments per 10,000 in the population per year.

In regard to steps two and three of the model,⁹ the data demonstrated that 70 percent of releases occurred at step two, while 30 percent occurred at step three, the commitment hearing. These are meaningful data because, according to the statute, the investigation is supposed to pass the allegedly mentally ill person on to a commitment hearing if there is probable cause to believe that the person is mentally ill, a

low-level legal determination.¹⁰ The fact that more individuals are not passed on by investigators to a commitment hearing is an area of conflict between physicians in Oregon who often see these patients as severely ill, in need of treatment, and clearly meeting commitment criteria, as opposed to county mental health employees who make the determination based primarily on their assessment of dangerousness. There is also very little recourse to the trial court to question the recommendations of the investigators.

The overall point is that these statutes are susceptible to empirical study, and we have, over the years, developed empirical studies focused on the major legal provisions that affect severely mentally ill persons, including civil commitment, treatment refusal, and the management and treatment of insanity acquittees (these areas are discussed later in the article). On all these topics, there are relatively few longitudinal studies in the literature. There should be more, because empirical data are extremely important, if not always persuasive, in trying to move the public debate away from ideology and toward a focus on what happens to the people subject to the ramifications of these statutes.

Conceptual Issues in the Civil Commitment Statutes

Dangerousness

As noted in the Oregon statute, the term “dangerousness to self or others” did not appear in the statute until 1973.⁴ Prior to that, the 1913 standard stated that the person must be found “unsafe to be at large.” The evolution from “unsafe to be at large” to “danger to self or others” in Oregon or “imminent dangerousness” in many other states, represents the influence of many diverse interest groups on the development of civil commitment law. Many psychiatrists, however, believe that this evolution away from the focus on severe mental illness and deterioration has been antitherapeutic, representing the rejection of treatment models for civil commitment in favor of a move toward criminal justice models. The American Psychiatric Association (APA) reflected that viewpoint in the commitment criteria proposed in its 1983 model commitment statute.¹¹ In this document, the criteria for a 30-day commitment are as follows.

A person may be involuntarily committed for a period of up to 30 days if, after the hearing, the court

determines, on the basis of clear and convincing evidence that (1) the person is suffering from a severe mental disorder; (2) there is a reasonable prospect that his or her disorder is treatable at or through the facility to which the person is to be committed, and such commitment would be consistent with the least restrictive alternative principle; (3) the person either refuses to or is unable to consent to voluntary admission for treatment; (4) the person lacks capacity to make an informed decision concerning treatment; (5) as the result of the severe mental disorder, the person is likely to cause harm to himself or to suffer substantial mental or physical deterioration or is likely to cause harm to others.

Unfortunately these criteria have languished in the archives of the APA and have not been widely adopted in whole or in part, while “dangerousness” or “imminent dangerousness” remains the commitment criterion most often applied.

Civil Competency and the Right to Refuse Treatment

The question of civil competency in regard to civil commitment statutes is significant and has implications in the treatment of the mentally ill. Note that the question of competency first appeared in the Oregon statute in 1919 when the legislature required that an applicant for a voluntary admission be competent to make the application.⁴ This requirement was repealed in 1941. The 1955 legislature added the requirement that the state hospital superintendent determine a patient’s competency at the time of discharge from the hospital. Finally, in 1965, the legislature enacted the current statutory provision, that an involuntarily committed person be declared by statute to be competent in all aspects of civil competency.

It is evident from these changes that the legislature had difficulty in determining the best way to address the question of competency. By separating matters of commitment from competency, the current law recognizes trends in civil competency laws that reject blanket incompetencies for those who are committed. At the same time, separating competency and commitment, in Oregon and elsewhere, has had major policy implications in regard to the treatment of both voluntary and involuntary hospital patients in relation to the so-called “right to refuse treatment.”

The right to refuse treatment seems a natural derivative of this separation of commitment and com-

petency.¹² Once this separation is made, the now competent but committed patient has long-standing legal rights to provide informed consent for the treatment offered and has a clear right to refuse the treatment. The result of this “right” is the need for some type of procedure to review the treatment refusal and determine whether the refusal is competent. States have developed either judicial or administrative procedures to review refusal of treatment.¹³ A judicial model requires a return to court to determine whether the civilly committed person is competent to refuse treatment, while administrative models provide due process through procedures that are based on step-wise decision making within the hospital system, utilizing consultants who are not employed by the hospital.

Note that the APA model statute places a specific incompetency definition into the commitment standard itself by requiring that “the person lacks capacity to make an informed decision concerning treatment.” Utah has incorporated such a definition of incompetency into its civil commitment standard. The Utah statute, in addition to other criteria for commitment states: “c) [T]he patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of the treatment.”¹⁴

Both APA and Utah require incompetency for a commitment to take place. This is a controversial solution to the problem of competency and commitment. Those who oppose such a solution are concerned about the difficult question of the competent yet dangerous mentally ill person and the fact that these persons might harm others and/or end up within the criminal justice system. Those in favor of such statutory provisions generally argue that these provisions allow for the immediate institution of treatment following admission to hospitals, thus attenuating the morbidity suffered by patients and making the hospitals more functional and less dangerous environments for patients and staff.

There are also unanticipated consequences of the problems surrounding the right to refuse treatment. For example, in 1988 we reported¹⁵ on the influence of the right to refuse treatment on the precommitment phase of civil commitment. Does an individual have a right to refuse treatment during a precommitment emergency hospitalization? The Oregon stat-

ute allows physicians to hold a person for up to five judicial days when “the physician believes (the person) is dangerous to self or to any other person and is in need of emergency care or treatment for mental illness.”¹⁶ This hospitalization is related to steps one (screening) and two (precommitment investigation) in our Oregon commitment model. The five judicial days were originally designed for the emergency care of the acutely mentally ill person and for an investigation by a county mental health worker leading to a recommendation to the judge as to whether probable cause exists to hold a commitment hearing.

We learned anecdotally that several Oregon hospitals were recognizing a right to refuse treatment for precommitment patients who refused treatment, thus extending this right without any court cases or legislative determinations. This is an important matter because, if it is determined that a qualified right to refuse treatment exists in the precommitment time period, then the length of time that is needed for a precommitment investigation should be shortened to avoid wasting hospital resources and leaving seriously mentally ill persons untreated. No final determination of this question has yet been made in Oregon, although the right continues to exist, having evolved as a custom rather than as a law.¹⁷

Voluntary Hospital Admission

As noted, voluntary “commitment” first appeared in the Oregon statute in 1919. It is interesting to note that, during the 22 years that this statute was law, the individual had to apply for a 30-day voluntary admission and had to be “competent to make the application.” In 1941, this requirement for competency to seek voluntary admission was eliminated. By virtue of the 1965 statutory amendment noted earlier, all patients, voluntary or involuntary, were presumed to be competent. In 1990 the U.S. Supreme Court decided in the case of *Zinermon v. Burch*¹⁸ that a patient had been denied due process protections when he gave consent to be admitted to a Florida state hospital while he was incompetent. In Oregon, as in other states, it is not surprising that this has again played out in the area of consent-to-treatment. Oregon now requires that an incompetent-appearing person who agrees to treatment must be reviewed by the same treatment procedure as those who refuse treatment.

A Proposed Model for Dealing with Competency and Civil Commitment

It is clear from this review that the conflicts surrounding competency in civil commitment proceedings have been exceedingly difficult to reconcile. This is in contrast to the manner in which competency is handled in the criminal justice system, where a defendant's competency to stand trial is relevant at any phase of the trial process, from pretrial to sentencing. The government is not interested in prosecuting an incompetent defendant. Doing so undermines the conceptual framework of the criminal justice system. If a defendant is found incompetent to stand trial, the proceedings are suspended until such time as the individual regains competency, or if after a period of time the individual has not regained competency, the criminal charges are dropped.

There is an entirely different situation in civil commitment, in Oregon as well as most other states. In civil commitment, although the hearings are very complex, the allegedly mentally ill person is presumed, *a priori*, to be competent to participate in his or her trial. There is no procedure that is available to evaluate the person's competency to participate meaningfully in a commitment hearing, and it is not until the question of treatment refusal is brought up after commitment that the question of competency comes to the fore.

In 1987, Bloom and Faulkner¹⁹ presented an alternative commitment model focused on the question of competency. We proposed adding a requirement to the civil commitment process that would be analogous to competency to stand trial in a criminal prosecution. Using the three-step model outlined earlier, we proposed adding an evaluation to determine competency to stand trial for civil commitment. This determination would take place between the investigation (probable cause) and court hearing steps of the model (Fig. 1). In this model competency to stand trial for civil commitment would be the first question addressed by the judge in the commitment hearing. If the judge finds the person incompetent to stand trial, the person can be referred to a hospital for a specific length of time for competency restoration. Treatment refusal in such a hospitalization would not be at issue, because the question of competency would have already been addressed in the court hearing. When competency was restored, the full commitment hearing could then proceed, or the person

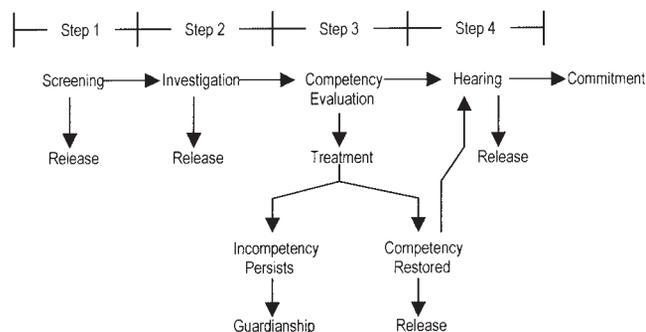


Figure 1. Proposed civil commitment process.

might be on the road to recovery and willing to continue in the hospital as a voluntary patient. If competency is not restored in a specific time, the judge could appoint a guardian for another interval before another review took place.

If in the early phase of the hearing, the judge found the person competent to stand trial, then the commitment hearing could go forward based on the definition of a mentally ill person, for the purposes of the commitment statute. A specific incompetency because of treatment refusal could be built into this hearing, or the usual postcommitment procedures could come into play once the person is committed and hospitalized.

Designing a commitment statute that addresses competency in the early phase of the commitment process should go a long way in producing a more meaningful and balanced hearing for all involved and should also help in defining the place of competency in various phases of the commitment process.

In summary, both the APA and the State of Utah have built specific competency criteria into their commitment standards. These are front-door solutions to the problem. The development of a determination of competency to stand trial for civil commitment hearings (Bloom and Faulkner¹⁹) is an example of an attempt to make the commitment hearing itself more meaningful. This approach has not been implemented in any jurisdiction. It seems that ultimately a solution to the problem of competency and commitment lies in changes in commitment statutes that recognize incompetency to refuse treatment at the trial level (a front-end solution), and at the same time recognize the need for procedures after commitment (a back-end solution) that can deal with incompetent assenters, including voluntary patients and those who appear competent at the commitment hearing but later refuse treatment. Ideally, the back-

end solutions would involve an administrative review rather than a return to a trial court for such an adjudication of competency.

The Current Battleground: Outpatient Commitment

There appear to be various conceptions of what is actually meant by outpatient commitment. Again using the Oregon statutes to illustrate, there are different statutory routes leading to an outpatient commitment. First, in the commitment hearing itself, a judge may find that an individual meets commitment criteria; but, instead of hospitalization, the judge may immediately place the individual in an outpatient setting on a type of conditional commitment.

Second, individuals in Oregon are committed to the jurisdiction of the Oregon State Mental Health Division rather than to a specific state facility. The Division then has the authority to place the individual in a setting of its choice. Over the years, the Division has placed a small percentage of those committed directly into an outpatient setting. Finally, state hospitals in Oregon may place hospitalized individuals on “trial visit” for the remaining time of their commitment, up to the 180-day limit. Trial visit is a release from the hospital into the community. It is a designation dating back many years to the time when there was no statutory limit to the length of commitment, and individuals were often on trial visit for extended periods. Now the term remains, but the 180-day limit to commitment applies to the length of the trial visit.

The current national controversy focuses on direct commitment to outpatient settings mostly designed for chronically mentally ill individuals who have been noncompliant with treatment and are deteriorating in their functioning. In Oregon, there are no separate criteria for these commitments. Instead, an individual must meet inpatient criteria. In many areas of the country, there are separate criteria for outpatient commitment. Oregon’s approach partially solves the problem of revocation of the outpatient commitment, because the committed individual has already met criteria for inpatient commitment.

It is this direct outpatient commitment that has generated the current controversy, and it is in this area that we see the most polarized views of the subject. The following describes two contrasting views of mandatory outpatient treatment.

In 1999 the APA published a document, “Mandatory Outpatient Treatment.”²⁰ The opening paragraph states:

Mandatory outpatient treatment refers to court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to be compliant with such treatment without a court order. Mandatory outpatient treatment is a preventative treatment for those who do not presently meet criteria for inpatient commitment. It should be used for patients who need treatment to prevent relapse or deterioration that would predictably lead to their meeting the inpatient commitment criteria in the foreseeable future [Ref. 20, p 3].

I cited earlier the Bazelon Center’s view on inpatient civil commitment. Here is their view on outpatient commitment:

The Bazelon Center also opposes all involuntary outpatient commitment as an infringement of an individual’s constitutional rights. Outpatient commitment is especially problematic when based on a: (1) prediction that an individual may become violent at an indefinite time in the future; (2) supposed “lack of insight” on the part of the individual, which is often no more than disagreement with the treating professional; (3) the potential for deterioration in the individual’s condition or mental status without treatment; (4) an assessment that the individual is “gravely disabled.”

These criteria are not meaningful. They cannot be accurately assessed on an individual basis and are improperly rooted in speculation. Neither do they constitute imminent, significant physical harm to self or others, the only standard found constitutional by the Supreme Court. As a consequence, these are not legally permissible measures of the need for involuntary civil commitment—whether inpatient or outpatient—of any individual.²

Again, there is a contrasting view from The Treatment Advocacy Center:

Perhaps the single most important reform needed to prevent the need for repeated hospitalization and to prevent the consequences of non-treatment is to encourage the use of assisted outpatient treatment. When appropriate, assisted outpatient treatment fosters treatment compliance in the community through a court-ordered treatment plan. Moreover, not only does the court commit the patient to the treatment system, it also commits the treatment system to the patient.²¹

In outpatient commitment, it appears that we have come full circle. We have in the outpatient commitment debate what appears to be a recapitulation of the earlier inpatient debate, with the new statutory provisions becoming political footballs between opposing interested parties. Those in favor of outpatient commitment see it as an important tool in a range of options that are potentially useful in managing severely mentally ill individuals in a community setting. Those who oppose outpatient commit-

ment see it as an infringement of liberty and as a financial drain on a mental health system already in crisis. They argue that dollars should be invested in proven intensive community treatment methods, not into further use of coercive approaches to treatment. This is the current state of affairs. Monahan *et al.*²² summarized the current situation: “In many states a take-no-prisoners battle is under way between advocates of outpatient commitment—who call this approach assisted outpatient treatment—and its opponents—who use the term ‘leash laws’ ” (Ref. 22, p 1198).

Discussion

The evolution of modern civil commitment statutes is the story of interactions over time among state legislatures, lay and professional interest groups, and courts. The result, a functioning civil commitment statute, is a political statement that reflects compromises that exist at a particular moment. There is little doubt that these statutes raise passions along a philosophical spectrum ranging from those who view mental illness as the free expression of ideas and involuntary commitment as equivalent to a prison sentence, to those who see mental illness as a serious brain disease and involuntary commitment as the only means of obtaining treatment for those whose insight and judgment are greatly impaired by their illnesses. Another aspect of this long-standing debate is a focus on the availability and expenditure of funds for treatment programs. The underlying policy question of whether it is best to invest precious mental health dollars in implementing laws that confine the mentally ill or in much-needed intensive and voluntary services is always part of the discussion. There appears to be little room for compromise for many in this debate, and the options are often presented as either/or choices, rather than compromises.

It should be a given that a focus on law alone is not sufficient. On the one hand, few can argue with the premise that civil commitment without decent hospital and community mental health services is a situation that should not be tolerated. On the other hand, commitment laws remain an absolutely necessary component of a mental health system, if only for the smallest number of mentally ill in the community.

Years ago, I had the opportunity to observe a self-contained Native American community where there were no effective commitment laws. I evaluated a

homicide offender from this community, which was governed by federal and tribal law, neither of which included a commitment statute. Prior to the homicide, the young man in question exhibited deteriorating mental functioning and was clearly becoming more violent. These facts were known to most everyone in his community. Significant attempts were made to have him enter voluntary treatment in an off-reservation psychiatric unit of a general hospital. All attempts failed, and the almost inevitable violent event, a homicide, occurred.

This experience led us to investigate more fully the legal situation that exists on many Native American reservations not covered by state law, where the option of civil commitment did not exist or where it only existed by informal agreement between tribal and local or state government.²³ This situation existed (and may still exist) in many reservation communities. Ultimately we were able to solve the situation in Oregon with a statutory change to state law that gave the tribal government authority to access the Oregon commitment statutes through a provision permitting rural counties in Oregon to use “emergency commitment” as a method of entry into the civil commitment system.²⁴

This experience demonstrated to me that, no matter what could be provided in the way of services, there still will inevitably be situations in which civil commitment laws are absolutely necessary. A responsible position would advocate an approach to civil commitment that recognizes the need for such statutes, yet aims to reduce the necessity for their use. I understand that few responsible people would argue with me about the need for such statutes for situations similar to the one described in the Native American community—a situation that was clearly one of imminent dangerousness. However, I also believe that, in less dramatic-appearing situations, credible arguments can be made for outpatient civil commitment when a person’s life history clearly demonstrates the individual’s incapacity to care for himself or herself in a community setting. This means having statutes that are not so narrowly drawn as to be limited to imminent dangerousness.

The gradual development of dangerousness as the main focus for commitment has, in my opinion, had very negative consequences. The standard, “gravely disabled,” has been recognized for many years as a legitimate reason for civil commitment. The original Oregon commitment statute of 1862 defined a men-

tally ill person for the purposes of commitment as one who “is suffering from neglect, exposure or otherwise, or is unsafe to be at large, or is suffering under mental derangement” (Ref. 4). Were we a more caring society than we are now? Probably not, although it is hard to argue against a statute that seeks to protect people from “suffering from neglect, exposure or otherwise.” The point is that society has long had an interest in protection of its vulnerable citizens, and there are few reasons to deviate from this long-held tradition.

Further, statutes that are written with broad language that allows holding allegedly mentally ill persons for a short time at the front end of the commitment process provide additional safeguards for individuals and for society. I have seen many situations in which individuals are in the midst of emotional crises and are hospitalized for short periods in precommitment status and in which these short hospitalizations have defused potentially inflammatory situations.

I have also seen the opposite. For example, I evaluated another homicide offender who, shortly after being informed by his wife that she was going to divorce him, was brought to an emergency room. He was very distraught but was not interested in voluntary admission, and, because of a strict interpretation of the statute, he was not considered appropriate for entry into civil commitment. Shortly after leaving the emergency room he killed his wife and attempted to kill himself. My point is that civil commitment statutes that are broadly drawn, at least at the front end, allow for the interplay of law and professional judgment, and it is this interplay of law and judgment that provides wider options and perhaps a better chance for good outcomes.

Outpatient commitment is now the major battleground in the civil commitment arena. Again, as this debate settles down, I hope we can come to view outpatient commitment more dispassionately—simply as another option, one among many available to psychiatrists and other mental health professionals.

Based on my experience and some of the empirical literature cited in this article, I argue for the usefulness of a well-structured approach to outpatient commitment. I have had personal experiences with several forms of structured outpatient treatment: a form of outpatient commitment related to the Oregon Psychiatric Security Review Board in its management of insanity acquittees²⁵ and the system of close

monitoring and supervision of drug- and alcohol-dependent physicians carried on by the Oregon Board of Medical Examiners.²⁶

These are obviously different programs conceptually but they are similar in regard to the principles that define structured outpatient programs. There are restrictions in regard to what an individual in each program can do in the community. There are consequences for failure to adhere to the program, and there are positive outcomes that have resulted from these programs. Outpatient civil commitment can be viewed as the same approach, with the particular rules governed by the controlling statutes. If interested parties approached the concept from a more neutral position—that outpatient commitment is neither inherently good nor bad—there would be situations in which having this legal option would be quite beneficial.

Conclusion

We appear to be living at a time when civil commitment statutes are losing or have lost much of their former prominence. There are multiple reasons for this, not the least of which is the loss of inpatient psychiatric beds in state and local facilities, resulting in the greatly increased use of the criminal justice system as a major repository for many seriously mentally ill individuals. Focus has now shifted in many areas of the country away from civil commitment to a focus on jail diversion and court clinics.²⁷ Aside from outpatient debate, reform in civil commitment statutes now seems stagnant. I believe that, as we attempt to rebuild our mental health system capacity, it will again be time to have a major focus on the design of effective, and more up-to-date commitment laws.

Over the years, I have come to believe that those who toil in civil commitment are like those who tried to build the Tower of Babel and were cast into the wilderness, condemned to wander and to be unable to communicate.

And the LORD said, “Behold, they are one people and they all have the same language. And this is what they began to do, and now nothing which they purpose to do will be impossible for them.”

“Come, let Us go down and there confuse their language, that they may not understand one another’s speech.”

So the LORD scattered them abroad from there over the face of the whole earth; and they stopped building the city.

Therefore its name was called Babel, because there the LORD confused the language of the whole earth; and they stopped building the city.²⁸

Perhaps we will have another chance.

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