Rural Civil Commitment

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In a recent article we examined civil commitment in Oregon's six most populous counties and reported significant local variations in how key decisions in the process are made.[1] This is consistent with other reports in the literature that identify considerable variability from one locale to another in the effects of new involuntary commitment statutes,[2] the morbidity and mortality of civil commitment processes,[3] and the arrest rates of psychiatric patients.[4] Most studies in the literature,[1,2,5-9] however, have analyzed data from entire states or from major urban areas, and little information is available concerning civil commitment in rural areas. We believe data pertaining to rural civil commitment are potentially valuable for several reasons. First, it would expand our basic knowledge of how civil commitment works in local communities, especially if analyzed in sufficient detail to illustrate specific steps in the process, important decisions that must be made, key decision makers, and factors that determine outcome. Second, rural data would enable comparisons to be made with urban counties, and significant differences might further underscore the importance of specific factors in civil commitment processes. Third, on a practical level, this data could provide considerable insight into local procedures and programs for involuntary patients. This type of information could be very valuable for local administrators charged with developing effective mental health programs. It also may be useful for state administrators concerned with public policy and the overall balance of mental health resources between state institutions and local programs.

This article examines civil commitment in Oregon's fourteen counties with populations less than 25,000 to more clearly elucidate characteristics of the process in rural areas. We begin with a brief review of Oregon's present statutes and the key decisions, decision makers, and determining factors at each step. Data presented from fiscal years 1977-78 to 1980-81 reflect the outcome of these decisions for the state as a whole and for the fourteen rural counties. In addition, data are provided that compare decision making in rural and urban counties. We conclude with a discussion of our results and consider important implications of this type of analysis for local and state mental health administrators.

Civil Commitment in Oregon

The Figure presents the stages in Oregon's civil commitment process, the key decisions and decision makers at each step, and what we believe to be the major factors that determine the outcome of these decisions in any area. This process

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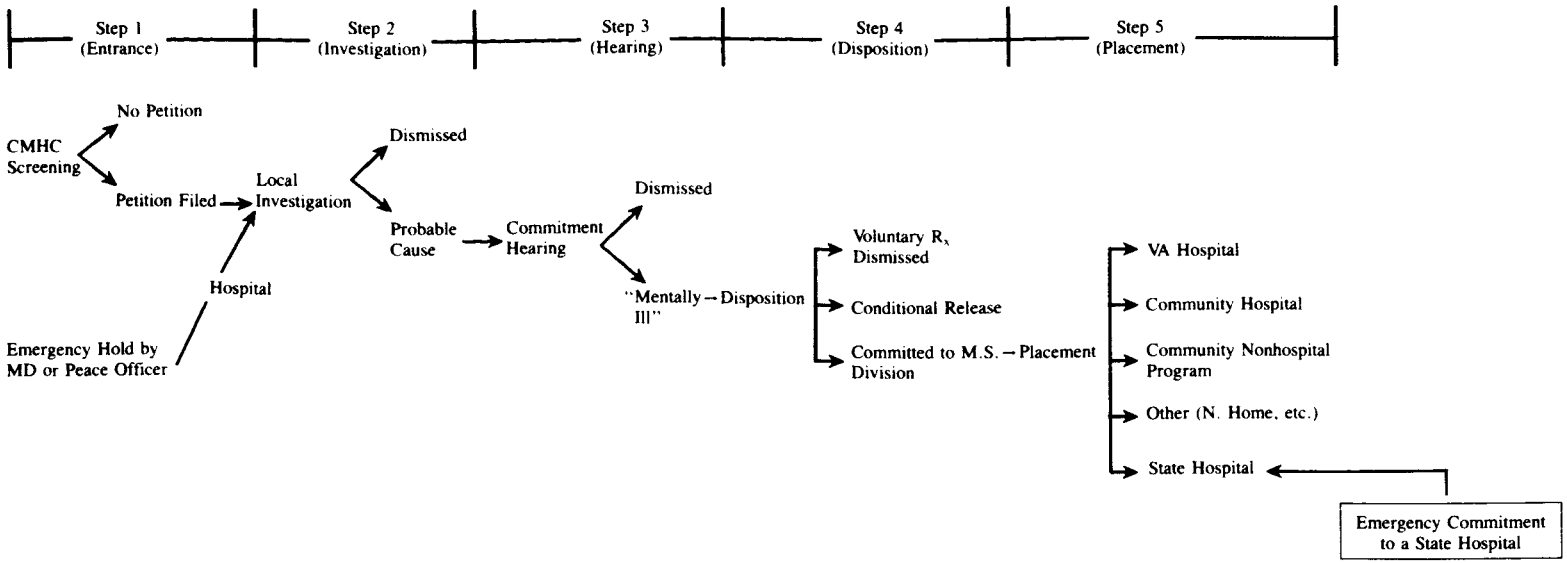
Figure. Steps in the Civil Commitment Process, Key Decisions, Decision Makers, and Determining Factors



Decision No. 1
Should a person enter the civil commitment process?

Decisionmakers:
(1) CMHC Staff
(2) MOs
(3) Peace Officers

Determining Factors:
(1) Community tolerance
(2) CMHC resources
(3) CMHC program philosophy
(4) Peace Officer attitudes
(5) MD attitudes

Decision No. 2
Is there probable cause of "mental illness"?

Decisionmaker:
(1) Local Investigator

Determining Factors:
(1) Local Investigator knowledge, skill, and attitude

Decision No. 3
Is there clear and convincing evidence of "mental illness"?

Decisionmaker:
(1) Judge

Determining Factors:
(1) Judicial knowledge, skill, and attitude

Decision No. 4
How should the "mentally ill" person be treated?

Decisionmaker:
(1) Court Examiners

Determining Factors:
(1) Condition of the patient
(2) Court Examiner knowledge and attitudes

Decision No. 5
Where should the committed person be treated?

Decisionmaker:
(1) CMHC Director

Determining Factors:
(1) Condition of the patient
(2) Alternate treatment resources
(3) CMHC Director attitudes
(4) Distance to a state hospital

Decision
Should a person be committed directly to a state hospital?

Decisionmakers:
(1) CMHC Director
(2) Local Psychiatrists

Determining Factors:
(1) CMHC Director attitudes
(2) Local psychiatrist attitudes

has been described in detail in a previous article,[1] and we provide only a brief overview here.

Step 1 (Entrance) indicates that patients enter the civil commitment process at the local level as a result of a petition filed by any two people or by an emergency "hold" of a peace officer or physician. The decision here is whether entrance should occur; the decision makers are the community mental health center (CMHC) staff who screen all local resident requests to file a commitment petition, physicians, and peace officers. Among major determining factors are community tolerance, CMHC resources and program philosophy, and the attitudes of individual peace officers and physicians.

In Step 2 (Investigation) an investigation is conducted by a mental health professional from the local CMHC, who makes recommendations to the circuit court judge concerning whether "probable cause" of "mental illness"* exists. The local investigator is the major decision maker in this step, and his/her knowledge, skill, and attitude are important determining factors.

In Step 3 (Hearing) the judge determines whether mental illness exists, using a standard of "clear and convincing" evidence. Two court examiners (at least one must be a physician) are appointed by the judge to conduct an in-court interview during the actual commitment hearing and to make written opinions, based solely on this interview, concerning the person's mental condition, recommendations for treatment, and whether they believe the person will cooperate with voluntary treatment. The judge then decides whether the standard of proof has been met; the determining factors are his/her knowledge, skill, and attitude regarding mental illness and involuntary treatment.[11]

How a mentally ill person should be treated is the decision in Step 4 (Disposition). Three dispositions are possible: voluntary treatment that results in dismissal; conditional release with supervision for up to 180 days; or commitment to the State Mental Health Division for up to 180 days. Although suggested treatment plans frequently are presented to judges by defense attorneys, judges usually rely on the opinions expressed by the court examiners who become the major decision makers in this step. The condition of the patient and the knowledge and attitude of the examiners about alternative treatments and community resources are the important determining factors here.

Step 5 (Placement) concerns where the committed person should be treated. The final decision is up to the State Mental Health Division, but it almost always accepts the recommendation of the local CMHC director, who then becomes the key decision maker in this step. Important determining factors include the condition of the patient, the presence of alternative community treatment resources, the attitude of the CMHC director toward local treatment for these types of patients, and simply the distance to the nearest state hospital.

In addition to these procedures it is possible to obtain an "emergency commit-

*In Oregon, a mentally ill person is "a person who, because of a mental disorder, is either (a) dangerous to himself or others; or (b) unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety."[10]

ment" directly to a state hospital at the request of two persons with the support of two physicians or the county health officer and the agreement of the state hospital that an emergency exists. This type of commitment lasts 15 days, after which the patient must sign into the hospital voluntarily, be discharged, or go through the usual commitment process. This option was included in the statute to accommodate rural areas of the state where a judge is not always available at a time of crisis. The decision to use an emergency commitment is almost always made in consultation with the CMHC director. The existence of community alternatives to emergency commitment also depends to a certain extent on the cooperation and involvement of local psychiatrists, especially in regards to caring for involuntary patients in local community hospitals. Therefore, the attitudes of CMHC directors and local psychiatrists are the important determining factors in this step.

Method of Study

Since 1977, each of Oregon's county mental health programs has been required to compile civil commitment statistics and to submit quarterly reports to the State Mental Health Division. The reporting forms are uniform from county to county and include detailed definitions of all the information requested. The data reported here were obtained from these forms for the four fiscal years (July 1 to June 30) 1977-78 to 1980-81 for the state as a whole and its fourteen counties with populations less than 25,000. The data reflect how key decisions in the commitment process are made in these rural counties. In addition, data also are presented comparing the decision making in these fourteen rural counties as a whole with Oregon's six most urban counties with populations greater than 100,000. The data in the tables represent the averages in the various categories for fiscal years 1977-78 to 1980-81 and are presented per 10,000 population. Small numbers in the various categories preclude detailed statistical analyses of most of the data on the fourteen rural counties. Since we are presenting data from an entire population, however, descriptive statistics (for example, percentages) do provide an adequate analysis of differences. More sophisticated techniques are possible when pooled urban and rural data are compared. To put the data in some perspective, the average annual number of civil commitments for 1977-78 to 1980-81 was 1,130 for the entire state of Oregon, 745 for its six urban counties, and 77 for its fourteen rural counties.

Results

Table 1 provides information pertinent to Step 1 (Entrance) in the civil commitment process (Figure). Marked differences exist among these rural counties in the numbers of screenings, petitions, peace officer holds, physician holds, and investigations. Statewide and in six rural counties the most frequent route to an investigation is by a peace officer hold, while in seven counties it is by petition, and in only one by a physician hold. For example, in county 6, 87 percent of the investigations are a result of petitions; in county 9, 76 percent are due to peace officer holds; and in county 8, 53 percent are secondary to physician holds. The

Table 1. Screenings, Routes to Investigation, and Investigations (Inv)
(Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Counties	Screenings	Routes to Investigation						Investigations	
		Petitions		PO* Holds		MD† Holds			
		Av	%Inv	Av	%Inv	Av	%Inv	Av	%Screen
1	29.1	6.6	75	1.8	21	0.3	4	8.7	30
2	9.5	3.2	47	1.4	21	2.2	32	6.8	71
3	12.8	3.6	72	1.1	22	0.3	6	4.9	39
4	21.1	2.6	32	5.4	68	0.0	0	8.0	38
5	19.6	9.5	53	6.6	37	1.9	11	18.0	92
6	13.0	9.9	87	1.1	10	0.3	3	11.4	87
7	11.2	1.2	19	3.3	52	1.9	30	6.3	56
8	12.4	2.5	41	0.4	6	3.2	53	6.0	49
9	16.0	2.2	24	7.1	76	0.0	0	9.3	58
10	19.7	6.2	56	4.4	39	0.5	5	11.1	56
11	15.3	5.3	37	6.4	44	2.7	19	14.4	94
12	10.3	2.7	56	2.0	42	0.1	2	4.8	46
13	18.5	1.4	21	3.8	58	1.4	21	6.6	36
14	8.1	1.3	33	2.5	67	0.0	0	3.8	46
State totals	27.5	3.5	25	7.2	51	3.5	25	14.2	52

*Peace Office Holds
†Physician Holds
Averages and percentages do not total correctly because of rounding.

Pearson Product Moment Correlation:

	r	p
Screening/Investigations	.43	Not Sig.

percentage of screenings that result in an investigation varies from a 30 percent in county 1 to 94 percent in county 11. This means that the percentage of screenings diverted from the commitment process varies from 6 percent in county 11 to 70 percent in county 1. The correlation between the number of screenings and the number of investigations is not significant, indicating factors other than just the number of screenings that occur are important in determining the number of investigations conducted.

Table 2 (next page) presents data concerning Step 2 (Investigation) and Step 3 (Hearing) as well as information on emergency commitments directly to a state hospital and "total" commitments (commitments plus emergency commitments). There are considerable county differences in the numbers of hearings, commitments, emergency commitments, and "total" commitments. There is a significant difference among the counties in the percentage of investigations (Table 1) that result in a commitment hearing, varying from 32 percent in county 9 to 89 percent in county 1. Similarly, the percentage of hearings resulting in a commitment varies significantly, from 37 percent in county 9 to 100 percent in county 13. There is an expected significant correlation between the number of investigations (Table 1) and the number of hearings as well as between the number of hearings and the number of commitments. While emergency commitments were included in the statutes to aid rural counties, they are rarely used except in counties 1, 9, 11, and 14 where they comprise respectively 33 percent, 63 percent, 23 percent, and 40 percent of the "total" commitments.

Table 2. Hearings, Commitments, Emergency Commitments, and "Total" Commitments (TC) (Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Counties	Hearings		Commitments			Emergency Commitments		"Total" Commitments*
	Av	%Inv	Av	%Hear	%TC	Av	%TC	
1	7.8	89	6.4	82	67	3.2	33	9.6
2	5.8	85	3.0	52	88	0.4	12	3.4
3	4.2	84	2.3	56	100	0.0	0	2.3
4	4.2	52	3.2	77	91	0.3	9	3.5
5	13.9	77	8.8	64	93	0.6	7	9.5
6	7.8	69	7.2	92	100	0.0	0	7.2
7	2.6	41	1.6	64	88	0.2	13	1.9
8	2.5	41	1.8	71	100	0.0	0	1.8
9	3.0	32	1.1	37	37	1.9	63	3.0
10	9.5	86	6.0	63	89	0.8	11	6.7
11	10.1	70	5.3	53	77	1.6	23	6.9
12	3.4	71	3.0	87	100	0.0	0	3.0
13	2.8	42	2.8	100	100	0.0	0	2.8
14	2.5	66	1.9	75	60	1.3	40	3.1
State totals	7.3	51	4.5	62	85	0.8	15	5.3

Average and percentages do not total correctly because of rounding.
*"Total" commitments = commitments + emergency commitments.

Pearson Product Moment Correlations:

	r	p<
Investigations/Hearings	.86	.001
Hearings/Commitments	.95	.001

χ^2

	p<
Inv. Leading to Hearings	.001
Hearings Leading to Commitments	.001

Table 3 (next page)contains information about Step 3 (Hearing) and Step 4 (Disposition). Data are available for only those hearings attended by CMHC staff. A few hearings in any county involve the private mental health sector and not county clinic staff. Information is not available for those hearings. Data in Table 3 also include results of hearings held to extend the period of commitment of a person already committed. For these reasons it is not possible to compare Table 3 with Table 2. Table 3 does illustrate differences in the number of hearings attended by CMHC staff and indicates that most persons arriving at the point of a commitment hearing are found mentally ill (75 to 100 percent). For those found to be mentally ill, most are committed (71 to 100 percent) except in county 9 where 71 percent receive voluntary treatment or conditional release.

Table 4 (next page) presents the data from Step 5 (Placement) and reveals that most committed patients are sent to a state hospital (60 to 100 percent). Some rural counties, however, do rely on community hospital and nonhospital programs for a few of their patients.

Tables 5 and 6 (page 366) compared pooled data from Oregon's six most populous counties (urban: greater than 100,000) and its fourteen least populous counties (rural: less than 25,000) on each of the steps in the civil commitment process. A number of findings are notable. There are fewer screenings, investigations, hearings, and commitments per 10,000 population in rural counties (Ta-

Table 3. Results of Hearings Attended (HA)
(Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Counties	Hearings Attended	Not Mentally Ill		Voluntary or Conditional Release			Committed		
		Av	%HA	Av	%HA	%MI	Av	%HA	%MI
1	7.2	0.8	11	0.8	11	12	5.6	79	88
2	4.0	0.4	10	0.8	20	22	2.8	70	78
3	3.7	0.5	13	0.9	25	29	2.3	62	71
4	3.8	0.0	0	0.6	17	17	3.2	83	83
5	12.3	1.0	8	2.5	21	22	8.8	72	78
6	7.3	0.2	2	0.0	0	0	7.3	98	100
7	2.3	0.5	20	0.2	10	13	1.6	70	88
8	2.5	0.4	14	0.4	14	17	1.8	71	83
9	3.0	0.4	13	1.9	63	71	0.7	25	29
10	7.4	1.2	16	0.8	10	12	5.4	74	88
11	8.3	1.1	13	2.1	25	29	5.1	61	71
12	3.1	0.1	3	0.0	0	0	3.0	97	100
13	2.8	0.0	0	0.0	0	0	2.8	100	100
14	2.5	0.6	25	0.0	0	0	1.9	75	100
State totals	6.5	1.5	23	0.8	12	16	4.2	65	84

Average and percentages do not total correctly because of rounding.

Table 4. Placement of Committed Patients
(Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Counties	State Hospital		VA Hospital		Community Hospital		Community Nonhospital		Other	
	Av	%TC	Av	%TC	Av	%TC	Av	%TC	Av	%TC
1	8.8	92	0.0	0	0.0	0	0.6	6	0.2	2
2	3.4	100	0.0	0	0.0	0	0.0	0	0.0	0
3	1.9	80	0.3	13	0.0	0	0.0	0	0.2	7
4	2.6	73	0.0	0	0.0	0	1.0	27	0.0	0
5	7.3	77	0.0	0	0.6	7	1.3	13	0.3	3
6	6.5	91	0.0	0	0.0	0	0.7	9	0.0	0
7	1.4	75	0.0	0	0.5	25	0.0	0	0.0	0
8	1.1	60	0.0	0	0.7	40	0.0	0	0.0	0
9	2.6	88	0.0	0	0.0	0	0.4	12	0.0	0
10	6.2	92	0.0	0	0.0	0	0.2	3	0.3	5
11	6.5	95	0.1	2	0.0	0	0.3	4	0.1	2
12	2.0	68	0.0	0	0.4	14	0.5	18	0.0	0
13	2.4	88	0.0	0	0.0	0	0.0	0	0.4	13
14	3.1	100	0.0	0	0.0	0	0.0	0	0.0	0
State totals	4.6	87	0.2	4	0.4	8	0.2	4	0.1	2

Averages and percentages do not total correctly because of rounding.
*%TC = % of "Total" commitments

ble 5). The pattern of routes to investigation is significantly different, with petitions most frequent in rural counties and peace officer holds most frequent in urban ones. In rural counties, significantly higher percentages of screenings result in investigations. Rural counties also have significantly higher percentages of investigations resulting in hearings and hearings resulting in commitments. The percentages of "total" commitments composed of regular commitments and emergency commitments are similar in rural and urban counties. The outcome of hearings attended by CMHC staff is significantly different in rural and urban

Table 5. Urban and Rural Comparisons
(Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Categories	Urban	Rural
Screenings	31.8	15.5
Routes to Investigation[1]		
Petitions	3.3	4.1
% Inv.	31	47
P.O. Holds	7.3	3.4
% Inv.	45	40
M.D. Holds	4.2	1.1
% Inv.	24	13
Investigations	14.9	8.6
% Screenings[1]	47	57
Hearings	7.4	5.7
% Inv.[1]	56	65
Commitments	4.9	3.9
% Hearings[1]	56	70
% T.C.[2]	86	85
Emergency Commitments	0.8	0.7
% T.C.[2]	14	15
"Total" Commitments	5.7	4.6

Averages and percentages do not total correctly because of rounding.
[1] χ^2: $p < .001$
[2] χ^2: $p > .05$

counties, with a smaller percentage of patients found not "mentally ill" and a higher percentage committed in rural counties (Table 6, next page). In hearings attended by CMHC staff, the percentages of mentally ill patients referred either for voluntary treatment or conditional release or commitment are similar in rural and urban counties. When data from the state and VA hospitals are pooled and compared to all other placements, rural and urban counties are similar, with the large majority of patients referred to the state hospital.

Tables 1-4 also reveal the characteristics of involuntary commitment in the state of Oregon as a whole. About half of all CMHC screenings lead to an investigation (about half diverted). About half of all investigations are the result of peace officer holds, while one quarter are initiated by physician holds and one quarter by local petitioners. About half of all investigations lead to a formal commitment hearing and about two-thirds of all hearings result in civil commitment. Therefore, about 16 percent of all patients who are screened and 32 percent of those who are investigated are ultimately committed. Fifteen percent of involuntary commitments are emergency commitments, and about 85 percent of all committed patients are placed in state hospitals. For the four fiscal years 1977-78 to 1980-81 the average statewide civil commitment rate is 5.3 per 10,000 population.

Discussion

The data in this study reconfirm our earlier findings[1] concerning the marked variability among counties at each step in the civil commitment process. There seems to be as much difference among rural counties as among urban in the outcome of key decisions. For example, in county 6, 87 percent of all screenings

Table 6. Urban and Rural Comparisons
(Averages for FY 1977-78 to 1980-81 per 10,000 Population)

Categories	Urban	Rural
Hearings Attended[1]	6.8	5.0
Not "Mentally Ill"	1.5	0.5
% H.A.	21	11
Voluntary/Cond. Rel.[2]	0.8	0.8
% H.A.	13	15
% M.I.*	16	17
Commitments — H.A.[2]	4.5	3.7
% H.A.	66	74
% M.I.	84	83
Placements[3]		
State Hosp.	4.08	3.25
% T.C.	72	69
V.A. Hosp.	0.12	0.03
% T.C.	2	1
Community Hosp.	0.38	0.16
% T.C.	8	6
Community Nonhosp.	0.28	0.35
% T.C.	4	7
Other	0.04	0.10
% T.C.	1	2

Averages and percentages do not total correctly because of rounding.
*M.I. = Mentally ill
[1] χ^2: $p < .001$
[2] χ^2: $p > .05$ for disposition of "mentally ill" between Vol./C.R. and Commit. — H.A.
[3] χ^2: $p > .05$ when data from State and V.A. Hosp. pooled and compared to all other placements

result in an investigation (13 percent diverted) (Table 1); 87 percent of investigations are the result of petitions; 69 percent of all investigations lead to hearings (Table 2); 92 percent of all hearings lead to commitments; emergency commitments do not occur; and 91 percent of committed patients are placed in the state hospital (Table 4). Therefore, in county 6, 55 percent of patients screened and 63 percent of those investigated are ultimately committed. By comparison, in county 9, 58 percent of all screenings result in an investigation (42 percent diverted) (Table 1); 76 percent of investigations are the result of peace officer holds; 32 percent of all investigations lead to hearings (Table 2); 37 percent of all hearings lead to commitments; emergency commitments compose 63 percent of the "total" commitments; and 88 percent of committed patients are placed in the state hospital (Table 4). Therefore, in county 9, only 7 percent of patients screened and 12 percent of those investigated are ultimately committed. The data from both counties 6 and 9 is considerably different from the average data for all rural counties (Table 5). County differences such as these underscore the importance of the identification of major decision makers and the elucidation of important determining factors in order to adequately understand civil commitment processes.

It appears that physicians and peace officers are somewhat less involved in initiating civil commitment in rural than in urban counties and that petitioners play a more important role (Tables 1 and 5). The exact reasons for this are unknown, but we suspect that the larger proportion of severely dysfunctional and troublesome patients found in Oregon's urban centers may provoke more active

peace officer involvement. Many of these patients are transients or residents of urban mental health ghettos without a close social network of concerned friends or families who would take the initiative to file a petition for commitment. Without concerned supervision, their dysfunctional behavior frequently goes unnoticed or is tolerated until it deteriorates to the point of a crisis requiring the assistance of peace officers for control. Closer family and social network ties might explain the larger proportion of petitions in rural counties. The lesser involvement of rural physicians might be due to limited manpower and the fact that most rural hospitals don't attempt to attract psychiatric patients, thereby limiting the necessity for physician holds.

Smaller numbers of screenings, investigations, hearings, and commitments in rural counties (Tables 1 and 5) might be explained by fewer severely disturbed patients per 10,000 population. It is possible, however, that the limited resources so typical of rural CMHCs[12] restrict the numbers of screenings that can be performed. In addition, it is well known that rural populations in the United States tend to use fewer psychiatric services than do urban ones.[13] The larger percentage of rural screenings that result in an investigation might mean that only the more disturbed patients are being screened, but it also may indicate that fewer CMHC resources are available for concerted diversion techniques. The larger percentage of investigations that result in a hearing and the larger percentage of hearings that result in a commitment could be due to less adversarial rural investigators, attorneys, and judges. These outcomes also could be influenced by the fact that anonymity is so hard to achieve in rural areas.[14] Rural patients and their psychiatric histories are frequently well known to everyone involved in the commitment process and this information may lead to less impartial decision making. In rural counties, 25 percent of all patients screened and 45 percent of those investigated are ultimately committed, while in urban counties these figures are 15 percent and 33 percent respectively.

The fact that the numbers of emergency commitments in urban and rural counties are about equal (Tables 2 and 5) seems somewhat surprising since this provision was put into the statutes to accommodate the needs of rural counties. In our previous report,[1] however, we indicated that one county accounted for the majority of the urban utilization of emergency commitments. If we eliminate that county, urban emergency commitments becomes 0.2 per 10,000 population compared to 0.7 for rural counties. However, a closer examination of rural emergency commitments (Table 2) reveals that county 1 accounts for a large proportion of them. Elimination of county 1 diminishes rural emergency commitments to 0.5 per 10,000 population. In addition, five rural counties report no emergency commitments over the four-year period of study. It seems to us that the utilization of this provision depends more on the specific idiosyncrasies of the individual counties than whether they happen to be rural or urban.

Lower percentages of patients found to be not "mentally ill" at hearings attended by rural CMHC staff (Tables 3 and 6) and higher percentages of these patients who are committed lend some credence to our impression that rural

judges may be less strict in their interpretation of the civil commitment statutes than are their urban counterparts and perhaps are more interested in removing dysfunctional patients from their communities.

The high percentage of "mentally ill" patients in both rural and urban counties who are committed rather than placed on voluntary treatment or conditional release (Tables 3 and 6) may reflect the serious dysfunction of the patients themselves as well as the reluctance of court examiners to recommend and judges to consider less structured forms of intervention.

Similar patterns of placement of committed patients in rural and urban counties (Table 4 and 6) with an emphasis on the state hospital again underscores the serious dysfunction of most of these patients; it also reflects the paucity of community resources directed toward their treatment. The data indicate there are some rural and urban counties attempting alternative forms of treatment for some patients.

Implications

We believe there are important implications for this type of analysis of rural civil commitment processes for both local and state mental health administrators. Local CMHC administrators are provided with data they can use to monitor their programs for involuntary patients. They can observe changes that occur over time and study the specific effects of any programs or policies they might implement. Comparison of data between rural counties might result in an investigation into possible explanations for any observed differences. For example, in our earlier comparison of counties 6 and 9, the data from step 2 (Investigation) and step 3 (Hearing) reveal that in county 6, 69 percent of all investigations lead to hearings and 92 percent of all hearings lead to commitments, while in county 9 these figures are 32 percent and 37 percent respectively. For the fourteen rural counties combined, these figures are 65 percent and 70 percent respectively (Table 5). These data seem to indicate that either the decision makers in step 1 (Entrance) and step 2 (Investigation) in county 9 are referring inappropriate patients to the next step or the decision makers in step 2 (Investigation) and step 3 (Hearing) are too conservative in their determinations of "probable cause" and "clear and convincing" evidence of mental illness. After a more thorough investigation, corrective efforts could be started, perhaps in the form of administrative shifts in local programs to develop diversion alternatives or consultation and education with decision makers in steps 1, 2, or 3. Similar analyses of major differences can be made throughout the commitment process. Knowing the important decision makers and determining factors at each step may suggest possible solutions for any problems that are identified.

Detailed analysis of rural civil commitment processes is of value to state administrators, especially since such high percentages of committed patients are placed in state institutions (Table 4). In the era of deinstitutionalization, there is considerable pressure to shift mental health resources from state institutions to community programs. This only becomes possible, however, if community pro-

grams are able to decrease referrals to state institutions. Detailed civil commitment data provide state administrators information on the efforts of local programs to divert patients from the commitment process and to develop innovative rural alternatives to institutional placement. For example, in counties 1, 3, 4, and 13, more than 60 percent of all screenings are diverted from the commitment process (Table 1), and in counties 8 and 12 more than 30 percent of committed patients are placed in community programs (Table 4). This type of information might be used to reward community programs whose efforts save the state a considerable amount of money. It also can identify effective rural models for the management of involuntary patients that might be shared with other communities.

It hardly needs to be emphasized that many of our conclusions about the data presented here are speculative and need to be substantiated by additional research. While it may be possible to identify general characteristics of civil commitment in rural areas that tend to be different from those in urban centers, we are more impressed by the differences that exist among the rural counties than by their similarities. As in urban counties, the key to understanding civil commitment in rural areas is to realize a "typical" rural county probably does not exist[15] and whatever is learned about the process in one jurisdiction may not generalize to another. Each community represents a unique laboratory with its own amalgamation of patient population, community tolerance, CMHC resources and program philosophy, judges, attorneys, peace officers, physicians, mental health professionals, political influences, and perhaps other factors we believe combine to ultimately determine how local civil commitment will occur. What is needed is more intensive research into the effects of these factors so we may understand more clearly their specific contributions to civil commitment processes.

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