Local Variations in the Civil Commitment Process

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In recent years involuntary commitment has been a topic of considerable controversy in the medical and legal professions. There have been divergent opinions concerning the rationale for or against civil commitment[1-4] and the merits or deficits of existing or proposed procedures.[5-7] A number of investigators have studied the effects of new commitment statutes on mental health systems. In a previous article[8] we reviewed some of their reports and noted variable and contradictory results from one location to another. Similarly, there have been investigations into the effects on patients of civil commitment processes. Shore, *et al.*[9] reviewed the literature and described variable morbidity and mortality statistics in several studies. Bloom, *et al.*[10] postulated a "regional specificity" for explaining variations in the reported arrest rates of psychiatric patients. It has been proposed that many factors in addition to the nature of the involuntary commitment laws themselves combine to ultimately determine the observed effects in any area.

In this article we examine local variations in the involuntary commitment process in Oregon to more clearly elucidate factors that might significantly influence such procedures. We begin with a brief history of civil commitment in Oregon, outline present statutes, and discuss several key decisions that occur during the process. Data are presented from fiscal years 1977-78 to 1980-81 that reflect the outcome of these decisions for the state as a whole and for its six most populous counties. We discuss our results, identify factors we believe are influential in determining how important decisions are made, and consider the implications of this type of analysis for mental health administrators at state and local levels.

Civil Commitment in Oregon—Steps in the Process

The evolution of Oregon's present civil commitment statute has been described in some detail by Shore,[11] Bloom, *et al.*,[12] and Shore, *et al.*[9] Change in the commitment process was initiated in 1971 by an appeals court decision[13] affirming the allegedly mentally ill person's right to representation by counsel. By 1973, civil commitments in Oregon's largest county had decreased by more than 50 percent.[11] In 1972, the Director of the Mental

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Health Division appointed a task force to revise the existing statute and a new law was passed by the state legislature in July 1973.[14]

The Figure presents the steps in the current commitment law. Step 1 indicates that patients enter the civil commitment process at the local level in three ways. Any two people may file a petition with a CMHC director, or emergency hospitalization and treatment for five days is possible under either a peace officer or physician "hold." In any case, an investigation (Step 2) is conducted by a local non-physician, mental health professional who makes recommendations to the circuit court judge concerning whether "probable cause" of "mental illness" exists.

The Oregon statute defines a mentally ill person as "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."[15] If the judge believes probable cause is present, a commitment hearing (Step 3) is held within three days (petition) or five days (emergency physician or peace officer) hold to determine whether there is "clear and convincing" evidence of mental illness. If mental illness is present, three dispositions are possible (Step 4): voluntary treatment that results in dismissal; conditional release with supervision for up to 180 days; or commitment to the Mental Health Division for up to 180 days. The Mental Health Division has final authority to determine where in the system a committed patient will be placed (Step 5). It is possible to extend the commitment for additional 180 day periods if the person remains mentally ill.

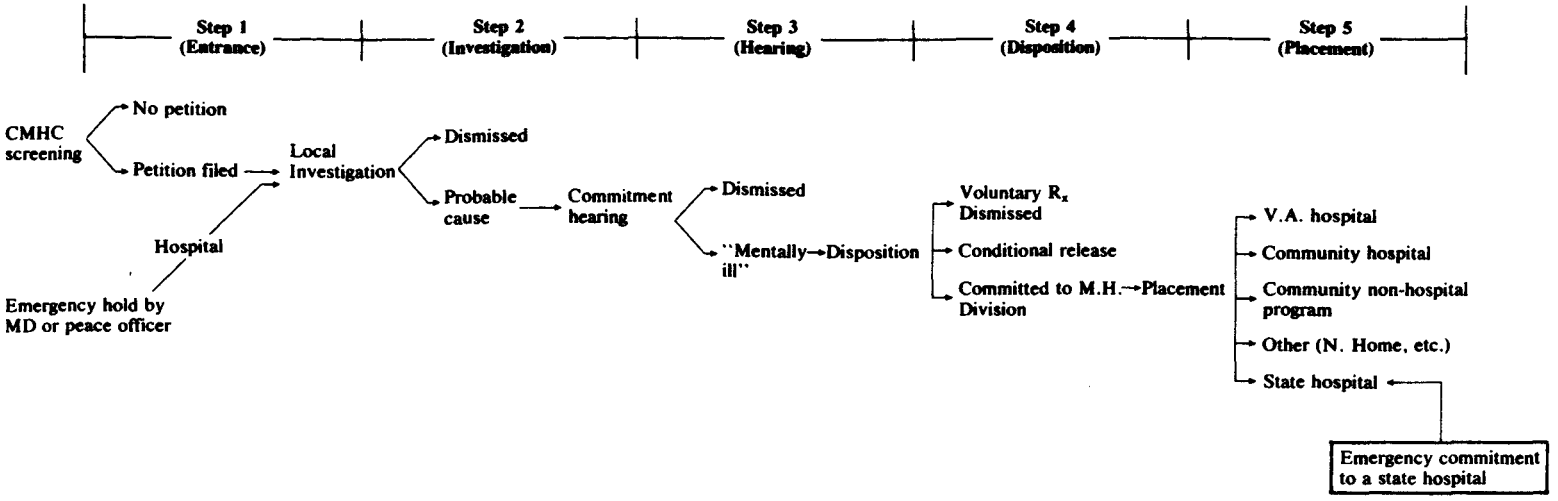
In addition to the procedures outlined above, it is possible to obtain an "emergency commitment" directly to the state hospital (Figure 1). This provision was included to accommodate rural areas of the state where a judge is not always available. Here a person can be committed at the request of two persons with the support of two physicians or the county health officer and the agreement of the state hospital that an emergency exists. The limit on this type of commitment is 15 days, after which the person may go through the usual commitment process.

Key Decisions and Decision Makers

The Figure also lists the key decisions that must be made during each step of the commitment process and who we believe to be the most important decision makers.

In Step 1 (Entrance) the question is whether a person should enter the civil commitment process. This decision is made by three groups of individuals. Physicians may decide to hospitalize someone against his/her will or to prevent a hospitalized patient from leaving. Peace officers decide whether a person in custody will be taken to jail or to a hospital or clinic for an evaluation of his/her mental status. CMHC staff screen all requests by citizens to have someone committed and greatly influence whether a petition will be filed or the person will be diverted from the commitment

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



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

Decision makers:
(1) CMHC staff
(2) MD's
(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"?

Decision maker:
Local investigator

Determining Factors:
Local investigator knowledge, skill, and attitude

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

Decision maker:
Judge

Determining Factors:
Judicial knowledge, skill, and attitude

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

Decision maker:
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?

Decision maker:
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?

Decision makers:
(1) CMHC director
(2) Local psychiatrists

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

process. They also occasionally screen potential peace officer holds and may influence those procedures as well.

The decision to be made in Step 2 (Investigation) is the presence or absence of probable cause of mental illness as defined in the statute.[16] Though technically decided by the circuit court judge, in practice judges almost always follow the recommendations of the local investigator.

Step 3 (Hearing) entails deciding whether clear and convincing evidence of mental illness exists. Two examiners are appointed by the judge, and at least one must be a physician. Oregon's procedures are somewhat peculiar since the role of the court examiners has evolved into an in-court interview during the actual commitment hearing. Based solely on the results of this brief interview, examiners submit their written opinions concerning the person's mental condition, recommendations for treatment, and whether they believe the person will cooperate with voluntary treatment. While the opinions of the court examiners are important, the decision on whether this burden of proof has been met rests with the judge.

How the mentally ill person should be treated is decided in Step 4 (Disposition). As in Step 2, the judge technically decides this question. The views of the patient, family, and friends are important, but judges usually give them less weight than the opinion expressed by the court examiners, who are the key decision makers at this step.

Step 5 (Placement) concerns where the committed person should be treated. The statute states that the mentally ill person is committed to the Mental Health Division,[17] which then decides where the person can best be treated or delegates this responsibility to the local CMHC director.[18] Such delegation is what usually occurs, and the CMHC director then makes this decision.

We have described how it is possible to bypass these steps in the commitment procedure with an emergency commitment (Figure 1). Here the decision becomes whether a person should be committed directly to the state hospital. Emergency commitment involves physicians, county health officers, state hospital staff, and citizens seeking to have a person committed. In practice, the final decision is almost always made in consultation with the CMHC director who indicates whether alternative commitment procedures are not feasible or desirable. To a certain extent, the development of community alternatives to emergency commitment depends on the cooperation of local psychiatrists, and their attitudes are an important determining factor.

Method of Study and Results

Since 1977, each of Oregon's county mental health programs has been required to compile certain civil commitment statistics and to submit quarterly reports to the State Mental Health Division. The forms used for reporting are uniform from county to county and include detailed definitions

of all 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 six counties with populations greater than 100,000. The information obtained reflects how key decisions in the commitment process are made in the counties studied. The data in the tables represent the averages in the various categories for fiscal years 1977-78 to 1980-81 and is presented per 10,000 population.

Table 1 provides information pertinent to Step 1 (Entrance) in the civil commitment process (Figure 1). A significant difference exists between counties in the numbers of screenings, investigations, petitions, peace officer holds, physician holds, and in how a person arrives at the point of an investigation. Statewide and in counties A, C, D, and E it is most frequently by a peace officer hold, but in county B it is by petition, and in county F by a physician hold. The percentage of screenings resulting in investigations also is significantly different among the counties and varies from 27 percent in county B to 86 percent in county F. This means the percentage of screenings diverted from the commitment process ranges from 14 percent in county F to 73 percent in county B.

Table 1 also shows the correlation between number of screenings and number of investigations in the counties is not significant. Therefore, other

Table 1. Screenings, Routes to Investigation, and Investigations (Inv.)* (Averages for FY 77-78 to 80-81 per 10,000 Population).

Counties	Screenings	Routes to Investigation						Investigations	
		Petitions		P. O. Holds		MD Holds			
		Av.	% Inv.	Av.	% Inv.	Av.	% Inv.	Av.	% Screenings
A	58.5	2.2	10	11.9	52	8.7	38	22.8	39
B	16.4	3.1	70	0.5	11	0.9	20	4.4	27
C	27.9	4.8	42	6.1	54	0.6	5	11.3	41
D	17.3	2.7	33	3.8	46	1.7	21	8.2	47
E	42.6†	3.4	18	13.2	70	2.3	12	18.8	40‡
F	27.9	3.9	16	8.7	36	11.3	47	23.9	86
State totals	27.5	3.5	25	7.2	51	3.5	25	14.2	52

*Averages and percentages do not total correctly because of rounding.
†Data available only for FY 79-80 and 80-81.
‡Percent calculated using only data from FY 79-80 and 80-81.

Pearson Product Moment Correlations:	r	p <
Screenings/Invest.	.74	Not sig.
F Tests	p <	Critical Difference for p < .05
Screenings	.001	17.0
Investigations	.005	10.4
Petitions	.001	0.8
P. O. Holds	.001	2.2
MD Holds	.001	1.7
X^2	p <	
Routes to investigation	.001	
% Screenings leading to investigations	.001	

factors beside just the number of screenings that occur are important in determining the number of investigations conducted.

Table 2 presents data on the outcome of Step 2 (Investigation) and Step 3 (Hearing). In addition it contains information on emergency commitments directly to a state hospital and total commitments (commitments plus emergency commitments). There are significant differences between the counties in numbers of hearings, commitments, emergency commitments, and total commitments as well as in percentage of investigations leading to hearings, percentage of hearings leading to commitments, and source of total commitments.

Table 2 indicates that a significant correlation exists between number of county investigations (Table 1) and number of cases reaching the stage of a commitment hearing. As might be expected, the more investigations conducted, the more hearings result. However, the percentage of investigations resulting in hearings varies differently. County B with the smallest number of investigations has the highest percentage of hearings, while the opposite is true for county F. There also is an expected significant correlation between the number of commitment hearings and the number of commitments. Counties B and D with the fewest hearings have the fewest commitments. Once again, however, this is not true for the percentage of hearings

Table 2. Hearings, Commitments, Emergency Commitments, and "Total" Commitments * (Averages for FY 77-78 to 80-81 per 10,000 Population)

Counties	Hearings		Commitments			Emergency Commitments		"Total" Commitments†
	Av.	% Inv.	Av.	% Hearings	% T.C.	Av.	% T.C.	
A	10.9	48	5.1	47	96	0.1	2	5.3
B	4.0	91	1.9	48	35	3.7	67	5.5
C	8.3	73	6.3	76	91	0.6	9	6.9
D	3.5	43	2.3	66	100	0.0	0	2.3
E	8.3	44	6.2	75	94	0.4	6	6.6
F	9.5	40	7.8	82	100	0.0	0	7.8
State totals	7.3	51	4.5	62	85	0.8	15	5.3

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

Pearson Product Moment Correlations:	r	p <
Investigations/hearings	.90	.01
Hearings/commitments	.83	.05
F Tests	p <	Critical Difference for p <.05
Hearings:	.001	1.9
Commitments	.001	1.3
Emergency commitments	.001	0.5
"Total" commitments	.001	1.5

X^2	p <ψ+
% Inv. leading to hearings	.001
% Hearings leading to commitments	.001
Source of "total" commitments	.001

that result in commitments as county A, with the largest number of hearings, has the lowest percentage of commitments.

To present a true picture of civil commitment in the counties, emergency commitments directly to the state hospital must be considered. Table 2 illustrates dramatic differences in use of this type procedure. In most populous counties it is rarely used, but in county B it accounts for about two-thirds of the total commitments. The addition of this data elevates the number of total commitments for county B into a range similar to the other counties and highlights the lower number for county D.

Table 3 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. The data in Table 3 also includes 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 illustrates significant differences between the counties in the numbers of hearings attended by CMHC staff, patients found not mentally ill, and patients committed to the Mental Health Division. In addition, there are significant differences between the counties in the overall outcome of those hearings attended and in the disposition of patients found to be mentally ill. The absence of mental illness at a hearing attended varies from a low of 3 percent in county D to a high of 35 percent in county A. Once a person is found to be mentally ill, commitments to the Mental Health

Table 3. Results of Hearings Attended (H.A.)*
(Averages for FY 77-78 to 80-81 per 10,000 Population)

Counties	Hearings Attended (H.A.)	Not "Mentally Ill"		Voluntary or Conditional release			Committed		
		Av.	%H.A.	Av.	%H.A.	%M.I.	Av.	%H.A.	%M.I.
A	9.7	3.4	35	1.1	11	18	5.1	53	82
B	1.7	0.5	29	0.1	6	8	1.1	65	92
C	9.7	2.8	29	0.4	4	6	6.4	66	94
D	3.6	0.1	3	0.9	25	25	2.7	75	75
E†	8.0	1.2	15	1.3	16	19	5.6	70	81
F	9.4	0.5	5	1.1	12	11	7.8	83	89
State totals	6.5	1.5	23	0.8	12	16	4.2	65	84

*Averages and percentages do not total correctly because of rounding.
†Data available only for fiscal years 78-79 to 80-81.

F Tests	$p <$	Critical Difference for $p < .05$
Hearings attended	.001	1.4
Not "mentally ill"	.001	1.2
Voluntary/C.R.	Not Sig.	—
Committed	.001	2.0

X^2	$p <$
Outcome of hearings attended	.001
Disposition of "mentally ill"	.001

Division range from 75 percent in county D to 94 percent in county C.

Table 4 presents data from Step 5 (Placement). It demonstrates significant differences between the counties for each of the placements as well as for the overall pattern of patient placement. State hospital treatment occurs for about 80 percent or more of committed patients except in county F where it is 59 percent. Community hospitals are used for 17 percent of the patients in counties A and D, and community non-hospital programs for 23 percent in county F.

Table 4. Placement of Committed Patients*
(Averages for FY 77-78 to 80-81 per 10,000 Population)

Counties	State Hospital		VA Hospital		Community Hospital		Community non-Hospital		Other	
	Av.	%T.C.†	Av.	%T.C.	Av.	%T.C.	Av.	%T.C.	Av.	%T.C.
A	4.2	79	0.2	4	0.9	17	0.0	0	0.0	0
B	5.5	100	0.0	0	0.0	0	0.0	0	0.0	0
C	6.6	96	0.0	0	0.2	3	0.0	0	0.0	0
D	1.9	83	0.0	0	0.4	17	0.0	0	0.0	0
E	6.5	98	0.1	2	0.0	0	0.0	0	0.1	2
F	4.6	59	0.6	8	0.9	2	1.8	23	0.2	3
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.
†%T.C. = % of "Total" Commitments.

F Tests	p <	Critical Difference for p <.05
State Hospital	.001	1.20
VA Hospital	.005	0.30
Community Hospital	.005	0.40
Community Non/Hospital	.001	0.30
Other	.025	0.04

X^2	p<
Placement o Committed Patients	.001

Discussion

It is apparent from our data that the key decisions in the steps in Oregon's civil commitment process are made differently from one county to another, even though all use the same statute. One factor that could complicate the data would be wide variations in the numbers of seriously mentally ill persons from one county to another. In an attempt to control for this, we have described only the most populous counties with urban centers located along the state's major freeway system. Counties A and E contain state hospitals and might be expected to have larger concentrations of patients. If this were an overriding factor, we would expect these counties to have significantly more investigations, hearings, and commitments than the others. Tables 1 and 2 reveal this is not true. Other factors must be important as well for determining county outcomes of the key decisions (Figure 3).

Differences in screenings, route to investigation, and investigations (Table 1) point to variations in the involvement of county CMHCs, physi-

cians, peace officers, and the general public in the commitment process. Community tolerance of mental illness, CMHC resources and program philosophy, and the attitudes of peace officers and physicians are all-important factors for determining who will become involved in the commitment procedures (Step 1), who will be diverted to an alternate system of care or confinement, and who will be left alone.

Our data (Table 2) indicates the outcomes of investigations (Step 2) and commitment hearings (Step 3) vary, suggesting that the determinations of the existence of probable cause and clear and convincing evidence of mental illness are different from county to county. Since these decisions involve local investigators and judges, their knowledge, skills, and attitudes are important factors in these determinations.

Examination of the data on emergency commitments (Table 2) suggests that it might be used in county B to avoid the standard commitment procedures and to arrange for direct admission to the state hospital. In such an environment, we might expect to find evidence of a lack of involvement in the commitment process and few community alternatives for local treatment of committed patients. In fact, county B reports the lowest numbers of screenings and investigations, the second lowest number of hearings, the lowest number of hearings attended, and the highest percentage of committed patients being treated in a state hospital. The emergency commitment provision was included in the statutes to help those rural counties where judges were not always present at a time of crisis. We believe the most important factors accounting for the significant use of this procedure in this urban county are the attitudes of the local psychiatrists and CMHC director toward mutual involvement and cooperation in the civil commitment process.

Most commitment hearings (Step 3) result in a finding of clear and convincing evidence of mental illness (Table 3), and most mentally ill are committed to the Mental Health Division for treatment (Step 4). Significant numbers of those in counties A, D, and E do obtain voluntary treatment or conditional release, however. To be found mentally ill in Oregon, a person has to be either dangerous or unable to care for himself or herself, and such impairment is a definite factor influencing court examiners to recommend commitment. Other important factors are the general attitudes of the examiners toward alternative treatments and their knowledge of the existence of community resources.

CMHC directors (Table 4) chose to have the large majority of committed patients treated in a state hospital (Step 5). Again, the seriousness of the mental condition of these patients is undoubtedly a major factor here, but the existence of alternative resources, the attitude of CMHC directors toward community treatment, and the distance to a state hospital are also important. County F is unusual with 23 percent of its committed patients treated in non-hospital programs in the community and only 59 percent referred to a state hospital.

Differences are revealed more fully if we closely examine the data from the entire process in two counties. For example, counties C and F both report the same numbers of screenings (Table 1) and rarely use emergency commitments (Table 2). Yet in county C the routes to investigations are usually peace officer holds or petitions, whereas in county F they are physician holds and peace officer holds (Table 1). There are more than twice as many investigations performed in county F, and since the number of screenings are equal, the percentage of diversions from the commitment process in county F is about one fourth that in county C. The statistics equalize somewhat, however, as the percentage of investigations leading to a commitment hearing is much greater in county C (Table 2). The percentage of hearings that culminate in commitment is somewhat greater in county F (Tables 2 and 3), and there are large differences in the placement of committed patients (Table 4). Ninety-six percent of those from county C are treated in a state hospital compared to 59 percent from county F where community non-hospital programs are used to treat 23 percent.

We believe there are important implications for this type of an analysis of civil commitment processes. First, the data can be used by local CMHC administrators to identify differences between their county and another, to consider what factors might be responsible for these differences, and to decide whether any interventions are desirable or feasible. In the example above, although county F has more than twice as many investigations as county C, a high percentage of them do not result in a finding of probable cause of mental illness, and thus no hearing occurs. The attitudes of the decision makers in Step 1 (Figure 1) in county F may be too liberal concerning when to enter a person into the civil commitment process or there may be too few CMHC resources directed toward diversion techniques. The first problem might be corrected with community consultation or education efforts and the second with administrative shifts in the emphasis of local programs. A similar analysis of major differences can be made for each step in the commitment process. Knowing the important decision makers and the determining factors suggests possible solutions for identified problems.

Second, state administrators are provided with information that might be used in a cautious fashion to evaluate the efforts of local programs. With the identification of key decision makers, it is possible to consider who is primarily responsible for different aspects of the commitment process. It then becomes feasible to examine data that reflect the performance of CMHCs such as screenings, placements, and emergency commitments. It is important to remember that no one really knows the ideal value of the data for any step in this process. With several years' experience, however, it would be possible to develop estimates of acceptable ranges. An alternate possibility would be to compare the performance of a program with itself over time and to identify significant changes. This type analysis could be used as the basis for reimbursement of programs whose efforts save the state a considerable amount of money. An example might be county F

where a significant number of committed patients are treated in community non-hospital programs rather than the state hospital.

Third, this analysis readily identifies areas for further research at each step in the commitment process. We need more information concerning the factors that influence decision makers and whether it is possible to intervene effectively to correct perceived problems.

Finally, we believe the principles we have applied to the analysis of Oregon's civil commitment process can and should be used in other states—even with totally different statutes and mental health systems. To adequately understand civil commitment in any area requires more than a global examination of data. Procedures must be separated, decisions and decision makers identified, and determining factors analyzed. We believe that efforts of this type will enable us to more fully understand the procedures, identify problems and their solutions, and make the process more therapeutic for our patients.

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