

# **The Effect of Mental Health System Changes on Civil Commitment**

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In recent reports we have described unexpected and significant local variations in the effects of new civil commitment statutes<sup>1</sup> and how key decisions in the commitment process are made in both urban<sup>2</sup> and rural<sup>3</sup> areas. We have recommended that commitment procedures be divided into specific steps in order to identify the decisions to be made at each point, who makes the important decisions, and the factors that determine the outcome of the process. We believe a number of important factors in addition to the commitment laws combine to determine ultimately the observed effects in any area. These include the characteristics of the mental health system and the attitude and cooperation of judges, law enforcement personnel, and selected mental health professionals. We have also suggested that detailed analyses of commitment processes might be valuable for both local and state administrators charged with developing effective and efficient mental health programs.

In this article we continue our study of civil commitment with an analysis of the changes that occurred in one Oregon county mental health program (CMHP) over a six-year period and the effect of these changes on the commitment process. We begin with a brief review of Oregon's commitment procedures and present data which demonstrate the significant changes in the study county during the fiscal years (FY) 77-78 to FY 82-83. We compare the data with a timetable of changes that took place in the local mental health system and then examine the characteristics of patients before and during the period of change as well as other mental health system factors that might have affected the data. We conclude with a discussion of our results and their programmatic and research implications.

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## Civil Commitment in Oregon—Steps in the Process, Key Decisions, Decision Makers, and Determining Factors

Figure 1 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 has already been described in detail in a previous article,<sup>2</sup> and we will provide only a brief overview here.

Step 1 (Entrance) indicates that people enter the 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 (PO) or physician (MD). The decision here is whether or not entrance should occur, and the decision makers are the MDs and POs who place people on holds and the CMHP staff who screen local resident requests to file a commitment petition and provide consultation to MDs and POs concerning the appropriateness of their holds. Among major determining factors are community tolerance, CMHP resources and program philosophy, and the attitudes of individual POs and MDs.

In Step 2 (Investigation) an investigation is conducted by a mental health professional from the local CMHP who makes recommendations to the 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 or not mental illness exists, using a standard of "clear and convincing" evidence. Two court-appointed examiners (at least one must be a physician) conduct an interview during the actual commitment hearing and render written opinions concerning the person's mental condition and whether or not he/she meets the statutory definition of a mental illness.<sup>4</sup> They also make recommendations for treatment and indicate whether or not they believe the person will cooperate with voluntary treatment. The judge then decides whether or not the standard of proof has been met. The determining factors are his/her knowledge, skill, and attitude regarding mental illness and involuntary treatment.<sup>5</sup>

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 (SMHD) for up to 180 days. Although suggested treatment plans are frequently presented to judges by defense attorneys, judges usually rely on the opinions expressed by the

\* 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."<sup>4</sup>

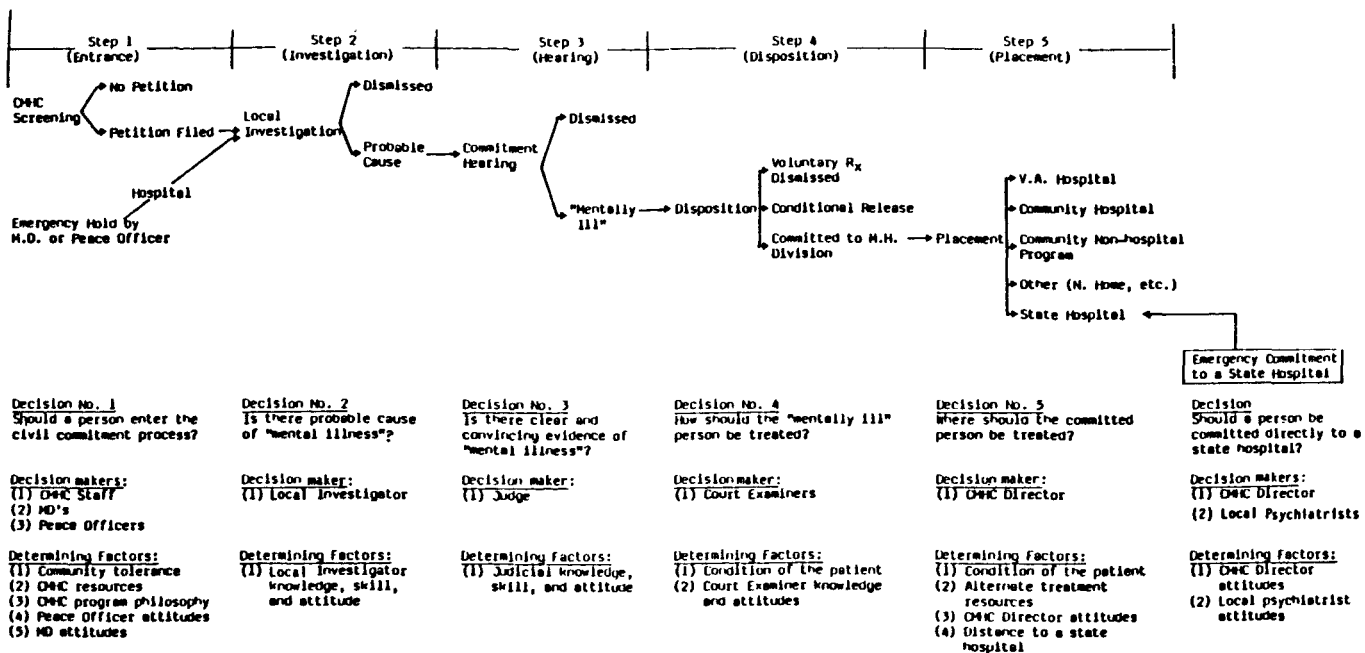


Figure 1. Steps in the civil commitment process, key decisions, decision makers, and determining factors.

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 SMHD but it almost always accepts the recommendation of the local CMHP 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 CMHP 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 commitment" 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 CMHP 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 regard to caring for involuntary patients in local community hospitals. Therefore, the attitudes of CMHP directors and local psychiatrists are the important determining factors in this step.

## Method

Since 1977, each of Oregon's CMHPs has been required to compile civil commitment statistics and submit quarterly reports to the SMHD. The reporting forms have been consistent from year to year and include detailed definitions of all of the information requested. The data reported in Tables 1 to 4 and plotted in Figure 2 were obtained from these forms for FY (July 1 to June 30) 77-78 to FY 82-83 for one Oregon county whose population varied from 50,900 in FY 77-78 to 59,000 in FY 82-83. The data are presented per 10,000 population and reflect how key decisions in the commitment process were made in this county during the study period.

We also conducted on-site discussions with CMHP personnel involved in commitment procedures who provided information concerning the nature of the local mental health and judicial systems from FY 77-78 to FY 83-84. This enabled us to identify the specific times when important changes occurred as shown in Figure 2. While this information was collected

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**Table 1. Screenings, Routes to Investigation, and Investigations for the FY 77-78 to FY 82-83 per 10,000 Population\***

FY	Screenings	Routes to Investigations							
		Petitions		PO Holds		MD Holds		Investigations	
		No.	% Inv†	No.	% Inv	No.	% Inv	No.	% Screen
77-78	14.7	4.3	31	5.5	40	3.9	29	13.8	93
78-79	16.3	2.7	20	5.6	41	5.4	39	13.6	84
79-80	15.9	4.0	28	6.6	46	3.6	26	14.2	90
80-81	15.3	4.4	31	5.1	36	4.5	33	14.0	91
81-82	23.0	7.5	34	7.2	32	7.7	34	22.4	97
82-83	16.4	3.4	22	6.3	40	5.9	38	15.6	95
						x <sup>2</sup>	df	p<	
Screenings—all years						16.23	5	0.01	
Petitions—all years						18.34	5	0.01	
PO holds—all years						3.04	5	NS	
MD holds—all years						12.36	5	0.05	
Routes to investigation—all years						11.41	10	NS	
Investigations—all years						21.91	5	0.001	
Investigations—FY 81-82 versus all other years						20.99	1	0.001	
Investigations—all years excluding FY 81-82						1.01	4	NS	
Screenings leading to investigations—all years						15.68	5	0.01	

\* Numbers and percentages do not total correctly because of rounding.

† Inv, investigations.

**Table 2. Hearings, Commitments, Emergency Commitments, and Total Commitments for the FY 77-78 to FY 82-83 per 10,000 Population\***

FY	Hearings		No.	Commitments		% TC†	Emergency Commitments		TC‡
	No.	% Inv		% Hearings	% TC†		No.	% TC	
77-78	7.9	57	4.7	60	100	0	0	0	4.7
78-79	5.8	42	5.0	87	96	0.2	4	5.2	5.2
79-80	7.3	51	5.7	78	100	0	0	5.7	5.7
80-81	7.7	55	6.4	83	97	0.2	3	6.6	6.6
81-82	12.3	55	10.6	87	100	0	0	10.6	10.6
82-83	8.0	51	6.3	79	100	0	0	6.3	6.3
						$\chi^2$	df	p<	
Hearings—all years						16.78	5	0.01	
Commitments—all years						20.79	5	0.001	
TC—all years						20.13	5	0.01	
Investigations leading to hearings—all years						4.27	5	NS	
Hearings leading to commitment—all years						13.03	5	0.05	
Hearings leading to commitment—FY 81-82 versus all other years						2.67	1	NS	

\* Numbers and percentages do not total correctly because of rounding.

† TC, total commitments.

‡ TC = commitments plus emergency commitments.

retrospectively, it consisted of items such as dates of staffing and procedure changes that could be verified.

An examination of the commitment data reveals that significant changes occurred in the FY 81-82. To study possible changes in patient characteristics during the year, we compared data obtained from record reviews on

**Table 3. Results of Hearings Attended for the FY 77-78 to FY 82-83 per 10,000 Population\***

FY	Hearings†		Not Mentally Ill		Voluntary/Conditional Release			Committed		
	No.	% Hearings	No.	% HA†	No.	% HA	% MI	No.	% HA	% MI
77-78	7.9	100	1.8	23	1.4	18	23	4.7	60	77
78-79	5.8	100	0.4	7	0.4	7	7	5.0	87	93
79-80	7.3	100	1.1	15	0.5	8	9	5.7	78	91
80-81	7.7	100	1.2	18	0.2	3	3	6.4	83	97
81-82	12.3	100	0.5	4	1.1	9	10	10.6	87	90
82-83	8.0	100	0.8	10	0.8	10	12	6.3	80	88
					$\chi^2$			df		p<
Outcome of HA (MI versus not MI)—all years					10.72			5		NS
Disposition of MI (committed versus voluntary/conditional release)—all years					8.20			5		NS

\* Numbers and percentages do not total correctly because of rounding.

† HA, hearings attended; MI, mentally ill.

**Table 4. Placement of Committed Patients for the FY 77-78 to FY 82-83 per 10,000 Population\***

FY	State Hospital		VA Hospital		Community Hospital		Community Non-Hospital		Other	
	No.	% TC†	No.	% TC	No.	% TC	No.	% TC	No.	% TC
77-78	2.4	50	0.6	13	0	0	1.8	38	0	0
78-79	3.3	63	0.2	4	0.8	15	0.6	11	0.4	7
79-80	5.5	97	0	0	0	0	0.2	3	0	0
80-81	6.1	92	0	0	0.3	5	0	0	0.2	3
81-82	9.3	88	0.2	2	0.3	3	0.3	3	0.5	5
82-83	5.3	84	0	0	0.3	5	0.5	8	0.2	3
					$\chi^2$			df		p<
Placement of committed patients (state hospital versus all others)—all years					32.27			5		0.001
Placement of committed patients (state hospital versus all others)—FY 81-82 versus all other years					1.47			1		NS
Placement of committed patients (state hospital versus all others)—FY 79-80 to FY 82-83					3.60			3		NS

\* Numbers and percentages do not total correctly because of rounding.

† TC, total commitments. TC = commitments plus emergency commitments.

random samples of one-third of the patients who had been investigated for possible commitment hearings during the FY 79-80 and FY 81-82.

## Results

Table 1 provides information pertinent to Step 1 (Entrance) in the commitment process (Fig. 1). There were significant increases in the FY 81-82 in the number of screenings, petitions, MD holds, investigations, and percentage of screenings leading to an investigation (inverse of the percentage of screenings that resulted in a diversion out of the commitment process). There were no changes in the number of PO holds or in the overall pattern of routes to an investigation.

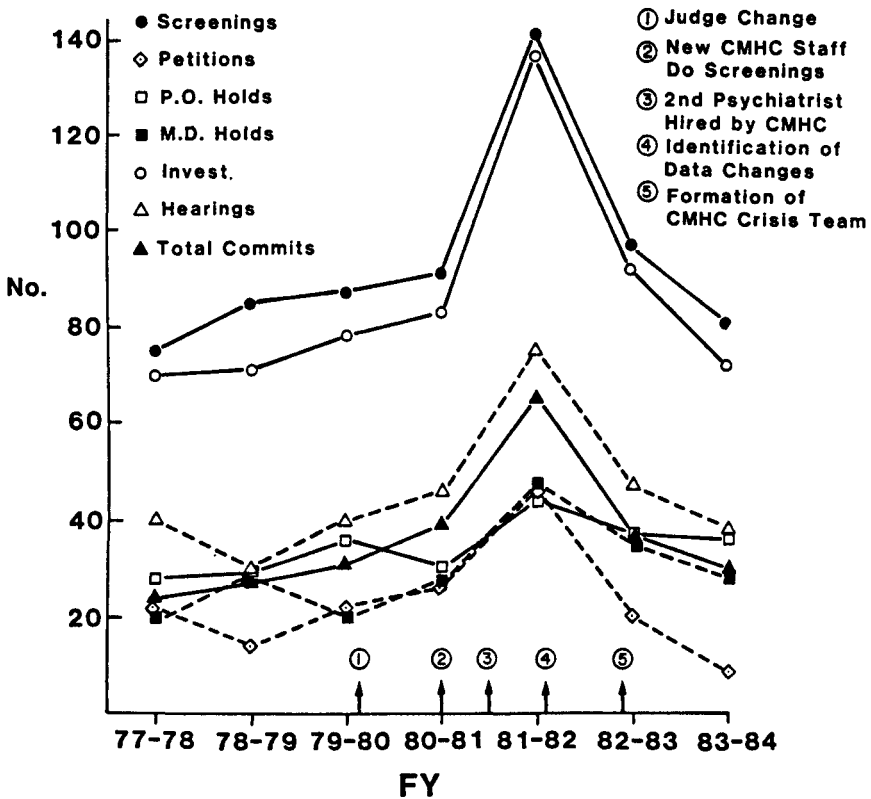


Figure 2. Change in civil commitment data—FY 77-78 to FY 83-84.

Table 2 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). Although there were significant increases in the FY 81-82 in the number of hearings, commitments, and total commitments, the percentage of investigations leading to a hearing and the percentage of hearings leading to a commitment did not change.

Table 3 contains information about Step 3 (Hearing) and Step 4 (Disposition). All hearings were attended by CMHP staff and there were no significant changes over the study period in the percentage of individuals found to be mentally ill at a commitment hearing or in the percentage of mentally ill committed to the SMHD.

Table 4 presents the data from Step 5 (Placement). There were no significant differences in the placement of committed patients (state hospital versus all others) from the FY 79-80 to FY 82-83 and placement in the FY 81-82 was similar to those of all other years.

Figure 2 plots the number of screenings, petitions, PO holds, MD holds, investigations, hearings, and total commitments from the FY 77-78 to FY

83–84, demonstrating the significant changes in the FY 81–82 for all but PO holds. Figure 2 also illustrates the timing of changes in the local mental health system during the study period. These changes were identified by CMHP personnel who had dealt with patients involved in the commitment process during the FY 77–78 to FY 83–84. Specific changes designated by numbers on Figure 2 include the following:

1. February 1980. The county judge who had presided over commitment hearings for many years resigned and was replaced by a judge who was felt to be more inclined to enforce due process safeguards during commitment proceedings.

2. January 1981. Budget cuts forced the CMHP to reduce personnel costs, which made it necessary for the staff performing commitment screenings to assume additional duties. New staff with less training and experience in commitment and diversion techniques began to do screenings and provide consultation to petitioners, MDs, POs, and the local hospital emergency room (ER). There was no clear policy concerning the process of consultation to the ER and new staff often felt uncomfortable in this role. The net result was that ER personnel frequently made unilateral decisions concerning the appropriateness of an MD hold.

3. July 1981. The CMHP hired a second psychiatrist. Other staff who had assumed additional program duties because of budget cuts began to rely on the psychiatrists to provide consultation to the ER and screen patients there for the appropriateness of MD holds. Psychiatric screenings and consultations were usually made by phone with little attempt to pursue diversion possibilities for ER patients.

4. August 1981. SMHD administrators identified increasing numbers of commitments from the study county and called local administrators to make them aware of the situation. Local administrators requested that CMHP staff resume on-site consultation to the ER and vigorous diversion efforts with petitioners, MDs, and POs.

5. November 1982. A crisis/intake team was formed within the CMHP and a small number of staff once again began to assume responsibility for screening. Face to face consultation with petitioners, MDs, POs, and ER staff was encouraged and diversion efforts were emphasized.

Several other factors must be considered that could have been responsible for changes in commitment data. There were no significant modifications in the commitment statute and no sudden county population changes during the study period. CMHP personnel do not believe that there were major changes in the attitude or behavior of local MDs, POs, prosecuting and defense attorneys, or court examiners.

CMHP staff expected that the change in judges which occurred in



February 1980 (Fig. 2) might have resulted in a decrease in the percentage of persons found to be mentally ill at a commitment hearing and therefore an increase in the rate of release initiated by the new judge. An examination of the data in Tables 2 and 3 indicates that these expectations did not occur. There appears to be little difference in decision making by the two judges.

Changes in commitment data could also be due to significant changes in the characteristics of people entering the process. To investigate this possibility, we compared random samples of one-third of the total patients who had been investigated for possible commitment hearings during the FY 79–80 ( $n = 26$ ) and FY 81–82 ( $n = 46$ ). As shown in Figure 2, these years are before and during significant changes in commitment data. The people in these two groups were similar demographically. They were typically young, white, unemployed, single or divorced, or separated men with a high school education who lived in the local county with their families or spouses (FY 79–80 group characteristics: median age of 29 years, 69 percent men, 100 percent white, 50 percent single, 27 percent divorced or separated, 65 percent unemployed, 88 percent local county residents, 50 percent living with family or spouse, median education of 12 years. FY 81–82 group characteristics: median age of 35.5 years, 70 percent men, 96 percent white, 33 percent single, 35 percent divorced or separated, 72 percent unemployed, 85 percent local county residents, 57 percent living with family or spouse, median education of 12 years). When people were separated into “major” (schizophrenia, affective disorder, organic brain syndrome) and “minor” (all other diagnoses) categories of mental illness, the FY 79–80 and FY 81–82 groups were similar (major mental illness: 46 percent in FY 79–80 and 52 percent in FY 81–82). Members of the two groups had similar treatment histories and numbers of past investigations and hospitalizations. Most had never been to the CMHP (69 percent in FY 79–80 and 63 percent in FY 81–82) and had no prior investigations (85 percent in FY 79–80 and 89 percent in FY 81–82) or hospitalizations (69 percent in FY 79–80 and 70 percent in FY 81–82). There were no significant differences between the groups in the route to investigation, reason for investigation, outcome of investigation, and outcome of hearing. PO holds accounted for almost one-half of the investigations in both groups (42 percent in FY 79–80 and 46 percent in FY 81–82) and the reason for an investigation was usually that the person was felt to be dangerous to themselves (34 percent in FY 79–80 and 38 percent in FY 81–82) or others (21 percent in FY 79–80 and 42 percent in FY 81–82). In both groups, about one-half of the investigations led to a recommendation for a commitment hearing (46 percent in FY 79–80 and 54 percent in FY 81–82) and the majority of hearings resulted in commitments (75 percent in FY 79–80 and 92 percent in FY 81–82).

## Discussion

There are a number of conclusions to be made from our study. First, the CMHP staff who did screenings in the study county played a crucial role in the commitment process. The manner in which screenings were done and the effort that was put into diversions appear to be the major factors responsible for the observed changes in commitment data. When psychiatrists and inexperienced CMHP staff began to work with petitioners and to consult with MDs and the ER staff (Fig. 2), petitions and MD holds increased and the percentage of screenings resulting in diversions out of the commitment process decreased (Table 1). Since PO holds are usually placed on people after the POs themselves have attempted a diversion, it is not surprising that they remained fairly constant during the study period. With feedback from the SMHD, CMHP administrators were able to readjust screening procedures and diversion efforts and the commitment data returned to "baseline" (Fig. 2).

The effect of the decrease in the number of diversions on the commitment data is further emphasized by the fact that the rates of referral for a commitment hearing, determination of mental illness, commitment to the SMHD, and placement in a state hospital were all relatively constant during the study period despite increased numbers of investigations and hearings during the FY 81-82 (Tables 1 to 4). With less experienced CMHP staff doing screenings and less effort being placed on diversions during the FY 81-82 (Fig. 2), it might be expected that more people would inappropriately be investigated. If this were true, it might also be expected that subsequent decision makers (Fig. 1) would correct the error and that smaller percentages of people would be referred to a commitment hearing, found mentally ill, committed to the SMHD, or placed in a state hospital. None of these occurred. One explanation is that investigators, the judge, and court examiners made automatic decisions at a certain rate irrespective of who was before them. Based on our own clinical experience and that of others,<sup>6</sup> this seems unlikely. Another possible explanation is suggested by the fact that those people investigated in the FY79-80 and FY 81-82 were similar. With the same types of individuals entering the commitment process, decision making might be expected to be uniform over time. Indeed, this is just exactly what we would hope to discover. Greater numbers of similar individuals reaching the point of an investigation in the FY 81-82 could be the result of either a sudden and time-limited epidemic of serious mental illness in the study county or less effort to manage these individuals outside of the commitment process. We have no evidence to support the former possibility and ample evidence to indicate that diversion efforts had diminished during the FY 81-82. Smaller numbers of diversions resulted in larger

numbers of people entering the commitment process. Once involved, it appears that people in this county were managed in a relatively uniform fashion over the study period.

These findings are in line with what is well known by most community psychiatrists. At any moment there are many individuals in the community who are committable.<sup>7</sup> Whether or not they are committed depends in part upon how the mental health system chooses to manage them. When vigorous efforts are expended, some can be supported in the community. If there is even a small lapse in effort, however, many will promptly find their way into courts, hospitals, and jails.<sup>8,9</sup>

Second, the data on the people investigated during the FY 79-80 and 81-82 and a review of their cases indicate that commitment procedures were used in the study county to meet a number of mental health system needs. One group of people investigated had a history of major mental illnesses (schizophrenia, affective disorder, organic brain syndrome) and were experiencing an exacerbation of symptoms. They were severely disturbed and appear to be similar to those described in a number of studies of people who have either been committed or hospitalized during the commitment process.<sup>7,10-13</sup> For them, civil commitment procedures were a means of tertiary prevention since one of the goals of the process was to bring them into contact with treatment resources in order to arrest their disorders and prevent further disability.<sup>14</sup>

A second group of investigated individuals were somewhat different. They did not have a history of major mental illness and had never been investigated, hospitalized, or seen by CMHP staff. The commitment procedures represented their first contact with the mental system. From an examination of their records, it appears that many were in a personal or family crisis and acted in a manner which frightened those around them. Peace officers were frequently called to intervene. The disordered behavior of some of the people in this group was symptomatic of the early stages of a major mental illness. For them commitment procedures were a form of secondary prevention since they resulted in early diagnosis and treatment.<sup>14</sup> The behavior of others in the group, however, was more indicative of a crisis in their family or support system than in themselves. They did not yet have a major mental illness and commitment procedures were used to terminate chaotic, confused, and potentially dangerous situations by removing them from the scene. This use of commitment procedures was a form of primary prevention since it prevented the onset of more serious medical and legal problems for the person involved or others around them.<sup>14</sup> While many were subsequently found not to have a "mental illness" and were released within a few hours or days, some were stimulated by the process to take constructive steps to solve ongoing problems in their lives.

We believe the use of commitment procedures by a mental health system in the ways that we have described are all legitimate. Some critics might suggest that involvement of the last subgroup of people in a commitment process is an inappropriate and unjustified violation of their civil rights. The discovery that similar types of patients have significant morbidity and mortality following release from a civil commitment process,<sup>7</sup> however, suggests that efforts to involve them in mental health treatment should perhaps be even more vigorous.

Third, as we have suggested in earlier reports,<sup>2,3</sup> a detailed analysis of commitment data can indeed be used by state and local mental health administrators to monitor a community mental health system and the application of a commitment law. At least for the situation that existed in our study county, it was then possible to readjust the CMHP and to bring the commitment data back to baseline. This type of practical utilization of data analysis is not just interesting from an administrative or systems standpoint; there are significant fiscal ramifications as well. Excluding the FY 81–82, the average number of total commitments for the six-year study period was 38. In the FY 81–82 it was 65, for an increase of 27 commitments. The average length of hospital stay for committed patients in Oregon is about 80 days at a cost of at least \$120 per day.<sup>15</sup> This means that the additional commitments in the FY 81–82 in the study county cost the state about \$260,000.

Fourth, our study has clearly demonstrated the dependence of commitment processes on the mental health system within which they occur. In the study county the observed data changes were the result of changes in the CMHP and not in commitment procedures themselves. We do not mean to imply that investigators and judges were unimportant to the outcome of civil commitment in this county. Their role in determining the data changes in the FY 81–82, however, was relatively minor compared with CMHP staff doing screenings and diversions. Unlike investigators and judges who conceivably base their decisions upon whether or not a person meets a legal standard for commitment, CMHP staff are influenced by the amount of time they have to do their job, their knowledge of diversion resources, and the importance CMHP administrators place on their diversion activities. In the current era of deinstitutionalization with its pressure on CMHPs to minimize their dependence on state hospitals, local administrators may find it advantageous to shift resources into concerted diversion efforts.

Finally, our study has significant research implications. Since civil commitment procedures do depend upon the characteristics of the mental health system within which they occur, any conclusions concerning the function or relative importance of decision makers in civil commitment

without a mental health system analysis are tentative at best. Similarly, studies that do not describe the characteristics of the people involved in civil commitment are also inadequate. We obviously need more investigations of the type we have described. We do not know if what we have learned in our study county can be generalized to other counties or other states. We believe our broad conclusions will hold true but that specific commitment practices will vary widely from one locale to another. Additional studies can expand our knowledge of civil commitment and our understanding of how commitment procedures fit into an overall system of care for the mentally ill.

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