Investigators' and Judges' Opinions About Civil Commitment

Bentson H. McFarland, MD, PhD; Larry R. Faulkner, MD; Joseph D. Bloom, MD; Roxy J. Hallaux, MN; and J. Donald Bray, MD

As part of our work with the Oregon Task Force on Civil Commitment, we surveyed the judges and commitment investigators involved in the state's involuntary treatment program. In Oregon the investigators recommend whether or not a commitment hearing should be held. These mental health professionals indicated that current confidentiality laws restrict their access to important information. The investigators also expressed concern about the lack of resources with which to divert clients out of the commitment system. Judges too felt that relaxing the rules of evidence would improve the quality of commitment hearings. Regarding changes in the system, investigators and judges indicated that outpatient treatment (including compliance with medications) should be required of committed patients. These professionals noted that involuntary outpatient treatment could only be enforced if the system included a mechanism for hospitalizing patients who were noncompliant. Although the investigators believed commitment criteria should be broadened so that their clients could receive treatment before becoming dangerous, judges did not generally endorse this view. We discuss the implications of these findings for new civil commitment legislation.

State civil commitment laws are once again in transition.[1-4] Craig and Paterson note that "during the last several years at least 34 states have considered revising or have revised their adult commitment laws."[5] Oregon has been no exception to this trend. Two bills, one focused on expanding criteria for commitment and the other on outpatient commitment, were proposed in the 1985 session of the biennial state legislature. Although these measures were not enacted, they did set the stage for further examination of involuntary treatment in Oregon. Three tragic events further raised public and professional interest in civil commitment. Two Oregon psychiatrists were recently killed; one was beaten to death by a patient he was attending in a general hospital, and the other was shot to death in his office by a chronically mentally ill patient. Fi-

Dr. McFarland is director, Western Mental Health Research Center, Oregon Health Sciences University (OHSU) and investigator, Kaiser Permanente Center for Health Research, Portland, OR; Dr. Faulkner is associate professor and director of education, OHSU; Dr. Bloom is professor and chairman, department of psychiatry, OHSU; Ms. Hallaux is special projects coordinator, Oregon Mental Health Division (OMHD) Salem, OR; and Dr. Bray is assistant administrator, OMHD. Address all correspondence to Dr. McFarland, Mail code L-460, Oregon Health Sciences University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97201.

nally, a chronically mentally ill patient with a long criminal history and his hostage were killed by police who were attempting to enter the hostage's home.

The Oregon Mental Health Division (OMHD) responded to these developments by appointing a Task Force charged with examining the state's involuntary treatment system and recommending improvements. As in other states[6], the Task Force's membership was broad based, representing the legislature, the judiciary, the bar, the community mental health system, the state hospitals, civil libertarians, family members of mentally ill persons, and private psychiatrists. In addition to reviewing the literature on civil commitment and taking testimony from dozens of witnesses, the Task Force commissioned surveys of judges, commitment investigators, family members of mentally ill persons, and mentally ill clients of the community mental health system. Elsewhere,[7] we describe the patient and family member surveys and compare our results with similar work done in other states.[8] Here we report on the views of Oregon's judges and commitment investigators regarding involuntary treatment. These results will be of interest to policy makers formulating new civil commitment statutes. In addition, our findings provide feedback to legislators concerned with the operation of current involuntary treatment laws. Finally, the surveys offered workers in the field an opportunity to inform administrators of difficulties encountered in using present day commitment procedures.

A brief explanation of the commitment investigator's role will be helpful. Under Oregon law, a person may enter the commitment process in three ways. Any two people may file a petition in which a third person is alleged to be "mentally ill." Emergency hospitalization can be initiated by two physicians or by a police officer who then brings an allegedly mentally ill person to a treatment facility.

After a citizen petition or an emergency hospitalization has occurred, an investigation is conducted by a local mental health professional who makes recommendations to a circuit court judge concerning whether probable cause of "mental illness" exists. Employing a two-part definition, the current Oregon statute says that 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."[9] The investigator's recommendation also includes a narrative summary of the case as well as the investigator's opinions about the client's alleged mental disorder, dangerousness, and willingness to comply with voluntary treatment. Based on the investigator's report, the judge then decides whether or not to hold a commitment hearing. If a hearing is not scheduled the allegedly mentally ill person is discharged from the civil commitment system. The investigator's role is significant since judges almost always follow the investigators' recommendations regarding whether or not to hold a hearing. Theoretical and empirical studies suggest that the investigators have substantial impact on the operation of Oregon's

involuntary treatment program.[10,11] Accordingly, the Task Force felt it important to obtain the views of the commitment investigators as well as the circuit court judges—both of which we report here.

Methods

Working in conjunction with members of the Oregon Task Force on Civil Commitment of Mentally Ill Persons, the authors devised questionnaires aimed at commitment investigators and circuit court judges. The surveys were then reviewed by the Task Force, by officers of the Commitment Investigators Association of Oregon, and by staff members of the OMHD. Modifications suggested by these reviews were then incorporated into the final questionnaires. The judge and investigator questionnaires were similar. The questionnaires requested demographic information about the investigators and judges. Next we used multiple choice questions to ask the respondents how they interpreted Oregon's current commitment statutes. Finally, using a checklist format, we asked the judges and investigators for their views on problems with present laws and for their opinions on proposed modifications. Judge questionnaires were mailed to all Oregon circuit court judges (N = 60). Investigator questionnaires were mailed to all members of the Commitment Investigators Association of Oregon and to other community mental health personnel who do investigations but are not members of the organization (N = 95). OMHD staff and Task Force members worked diligently to ensure the questionnaires' completion and return.

Results

The rates of return were very good. For the investigators, 92 of 95 (97%) questionnaires were returned. The judges returned 46 of 60 (77%). When interpreting the rate of return for the judges, it should be noted that in some counties civil commitment cases are handled by only one of the several circuit court judges. Thus there are many circuit court judges who have no experience with involuntary treatment. It is likely that the judges with little or no commitment experience did not return the questionnaires. However, we cannot verify this assumption from our data. Both the judges and the investigators appeared to have read the lengthy surveys carefully. Most investigators and many judges made comments in the margins. The majority (78%) of the investigators wrote extensive comments at the end of the questionnaire, as did 23 (50%) of the judges. Table 1 gives demographic information about the judges and investigators. Important here are the findings that the investigators are experienced mental health professionals, the judges have substantial time on the bench, and both groups deal frequently with civil commitment. It is interesting to note that 80% of the investigators have masters degrees or higher while 14% have bachelors degrees.

As we mentioned, Oregon's definition of "mental illness" requires the presence of a mental disorder. Table 2 shows the judges' and investigators' views on diagnoses which satisfy the "mental dis-

Table 1
Demographics of Investigators and Judges

	Investigators	Judges
N	92	46
Average age in years	40	52
Sex		
Male	51 (55%)	46 (100%)
Female	41 (45%)	0 (0%)
Highest degree		
JD	–	46 (100%)
PhD	9 (10%)	
Masters	64 (70%)	
Bachelors	13 (14%)	
RN	3 (3%)	
Other	1 (1%)	
None	1 (1%)	
Average years on job	7	11
Range of years on job	1–21	1–31
Average commitment cases per month	16	7

Table 2
Diagnoses Believed to be "Mental Disorders"

Diagnosis	Investigators	Judges
Schizophrenia	86 (93%)	38 (83%)
Bipolar affective disorder	85 (92%)	24 (52%)
Major depressive disorder	82 (89%)	36 (78%)
Organic mental disorders	81 (89%)	38 (83%)
Alcohol dependence	44 (48%)	19 (41%)
Drug dependence	41 (45%)	19 (41%)
Adjustment disorder	34 (37%)	12 (26%)
Antisocial personality disorder	21 (23%)	14 (30%)
Other personality disorders	36 (39%)	10 (22%)
Mental retardation	21 (23%)	12 (26%)
"I don't think about diagnosis"	4 (4%)	1 (2%)

order" requirements of the law. A clear pattern emerges regarding diagnosis. Most judges and investigators feel that schizophrenia, bipolar affective disorder, major depressive disorder, and organic mental disorders satisfy the diagnostic requirement, whereas only a minority of either group believed personality disorders, adjustment disorders, or mental retardation to be "mental disorders" in this context. Proportionately fewer judges than investigators felt bipolar affective disorder to be a "mental disorder." An important result was the lack of consensus among either judges or investigators concerning alcohol and drug dependence.

Turning now to the second portion of Oregon's definition of "mental illness," Table 3 lists the judges' and investigators' ratings of behavioral and situational factors pertinent to their decision making about commitment. The rating scale ranges from one ("no influence")

Table 3
Importance of Behavioral and Situational Factors*

Factor	Investigators	Judges
Dangerous to others	4.76	4.66
Dangerous to self	4.69	4.75
Unable to provide for basic needs	4.53	4.33
Evidence of noncompliance with treatment	3.52	3.51
Past psychiatric history	3.40	3.56
Diagnosis	3.38	3.80
Therapist's desire for commitment	2.40	2.68
Evidence of poverty	1.65	1.21
Family's desire for commitment	1.92	1.72
Client's inability to pay for treatment	1.16	1.18

* Importance was measured on a five point scale where 1 = "No importance" and 5 = "Very important."

to five ("very great influence"). The judges and investigators clearly say they are greatly influenced by the notions of dangerousness and inability to care for basic needs listed in the statute. On the other hand, the person's resources and the wishes of the person's family are not felt to be important. The person's diagnosis and history are of intermediate influence.

Lack of information about the allegedly mentally ill person was mentioned as a problem by 47 investigators (51%) and by 15 judges (33%). Current Oregon law restricts the investigator's contacts with informants. The doctor-patient privilege and the psychotherapist-patient privilege, as well as the hearsay rules, limit the information that may be presented in court. When they were asked to recommend changes in the commitment process, several investigators (43 or 47%) felt that the rules of evidence should be relaxed at commitment hearings as did 11 judges (24%). No judge and only one investigator felt that the rules of evidence should be stricter.

When questioned regarding problems in the current system, investigators (70%) identified lack of resources with which to divert persons out of the civil commitment system as their chief concern. Along these lines, 33 judges (72%) noted that education about community alternatives to state hospitalization would be helpful in making commitment decisions.

When asked to recommend changes in Oregon's involuntary treatment program, the investigators (63%) endorsed a statement that committed people should be required to participate in outpatient treatment and take their medications. Forty-eight percent of the judges also endorsed this suggestion.

Outpatient commitment *per se* (with no intervening hospitalization) of persons found to be committable under the current standards was favored in theory by large majorities of both judges (74%) and investigators (72%). However, both judges (43%) and investigators (75%) pointed out that under current law there is no way to enforce the conditions of outpatient commitment.

We next asked the judges and investigators for their opinions about broadening the criteria for civil commitment. We were interested in two types of criteria—namely, criteria for commitment *per se* (either inpatient or outpatient) and criteria for commitment to outpatient treatment only. Regarding the latter, we wondered whether or not respondents favored less strict standards for outpatient as opposed to inpatient commitment. The results are given in Table 4. The 88 investigators who answered both questions tended to respond similarly to the two items. In fact 40 investigators answered "yes" to both questions, 18 replied "no" to both, and three had no opinion on either item (chi-squared = 31.5, degrees of freedom = 4, $p = .0001$). On the other hand, the 42 judges who responded to the two items did not necessarily answer them both the same way. There were nine judges who responded "yes" to both questions, eight who answered "no" to both, and six who gave "no opinion" for each answer (chi-squared = 8.8, degrees of freedom = 4, p = not significant).

As indicated in Table 4, the majority of investigators and a plurality of judges favored standards for commitment to outpatient treatment which would be less strict than those for inpatient commitment. Additional new criteria for outpatient commitment endorsed by judges and investigators included severe deterioration in routine functioning, being in danger of serious physical harm resulting from a failure to provide for essential needs, and inability to seek voluntary treatment.

On the other hand, Table 4 also shows that investigators and judges seemed to disagree about broadening criteria for commitment to inpatient or outpatient treatment. Whereas a clear majority of the investigators endorsed a wider standard for inpatient or outpatient commitment, there was no clear opinion among the judges. Again, a majority of investigators favored criteria such as being in danger of serious physical harm resulting from a failure to provide for basic needs (54%) or severe deterioration in routine functioning (52%). Only a minority of judges endorsed these suggested, additional criteria.

We also examined the data in a search

Table 4
Criteria for Commitment

Criteria	Investigators	Judges
"Do you favor outpatient commitment criteria less strict than those for inpatient commitment?"		
Yes	47 (51%)	17 (37%)
No	34 (37%)	14 (30%)
No opinion	9 (10%)	13 (28%)
"Should inpatient or outpatient commitment criteria be broadened?"		
Yes	56 (61%)	15 (33%)
No	26 (28%)	14 (30%)
No opinion	6 (7%)	14 (30%)

for possible relationships between demographic factors (given in Table 1) on the one hand and the respondents' opinions on the other. We examined the following demographic data: age, sex (for investigators only—all judges were male), years on the job, and number of commitment cases per month. We looked for relationships between the demographic factors and the following questionnaire items: alcohol or drug dependence as a "mental disorder" (as in Table 2); importance of noncompliance with treatment, past psychiatric history, and diagnosis (as in Table 3); and strictness of outpatient commitment criteria versus inpatient, or broadening commitment criteria generally (as in Table 4). Since we were making numerous statistical comparisons we chose $p = .01$ as our level of significance. All our comparisons were nonsignificant with this exception: Investigators who favored less strict criteria for outpatient as opposed to inpatient commitment on the average had fewer years on the job than those who answered "no" or "no opinion" to that question ($F = 5.41$; $df = 2, 81$; $p = .006$).

Finally, Table 5 summarizes the judges' and investigators' views on special populations served by the involuntary treatment program. In general, there is agreement between judges and investigators on the number of their clients who are involved with the criminal justice system, i.e., in jail, on probation, or on parole at the time of the hearing or investigation (about 20%); are juveniles (about 5%); or are over age 65 (about 20%). There is also good agreement between these mental health and legal professionals about the utility of civil commitment in dealing with these individuals.

Discussion

The surveys of commitment investigators and circuit court judges revealed significant concerns about our involuntary treatment program. In addition, we discovered that these professionals had several suggestions for improving the system. Here we summarize the professionals' opinions and compare their views with those of other persons concerned about civil commitment. As we shall see, these data are important for policymakers considering legislative changes in this area.

A clear finding from our survey was the judges' and investigators' need for more information about the allegedly mentally ill person. Although a strictly legalistic approach to commitment does have its strong points,[12,13] our study indicates that rigid rules of confidentiality and evidence are preventing decision makers from obtaining necessary information. Further, a parallel survey of family members of mentally ill persons suggested that it is quite difficult for the average citizen to navigate unassisted through a legal process which is as complicated as our current civil commitment system.[7] These findings were incorporated in the Task Force's report,[14] which recommended extensive changes in the evidentiary requirements associated with civil commitment.

Confirming Zusman's[15] contention that "mental health laws do not provide

Table 5
Special Populations

Population	Investigators	Judges
Percentage of clients currently involved with criminal justice system	18%	22%
Percentage of clients under age 18	5%	8%
Percentage of clients over age 65	16%	24%
"Is civil commitment appropriate for juveniles?"		
Often	1 (1%)	1 (2%)
Sometimes	52 (57%)	31 (67%)
Rarely	30 (33%)	10 (22%)
Never	5 (5%)	1 (2%)
"Is civil commitment appropriate for clients over age 65?"		
Often	18 (20%)	6 (13%)
Sometimes	60 (65%)	37 (80%)
Rarely	11 (12%)	0 (0%)
Never	0 (0%)	0 (0%)

funding or create the service units necessary," we found that the investigators' chief concern about civil commitment was lack of resources with which to divert clients out of the involuntary treatment system. These frontline professionals know that civil commitment in Oregon almost always means admission to a state hospital. The investigators clearly spoke of the need for more local services which could be used as alternatives to state hospitalizations. Again, the Task Force incorporated in its report detailed fiscal recommendations for improved outpatient resources.

Outpatient treatment was a topic of great interest to the judges and investigators. Our survey indicated that these professionals favored a system in which committed patients would be required to comply with outpatient treatment, including medications. These results are similar to those obtained from our parallel survey of mentally ill persons' family members.[7] However, the professionals and the family members were skeptical about the utility of commitment to outpatient treatment *per se* with no period of intervening hospitalization. Both groups of professionals saw the need for a revocation mechanism in outpatient commitment. These recommendations, too, were included in the Task Force's report.

Finally, the judges and investigators gave a good deal of thought to the question of broadening the criteria for civil commitment. Lamb and Mills[16] have outlined the clinical rationale for expanded commitment criteria. Stone[17] and Wexler[18] discuss the pros and cons of a model law designed to achieve those clinical aims. Although the investigators in our survey did support broadening the commitment criteria, in their written comments and in their testimony to the Task Force there was much concern about "flooding the system." The Task Force itself discussed in detail Washington State's experience with expanded criteria which reportedly both severely taxed the mental health system and tended to force the voluntary patient out of the system in favor of an expanded

involuntary group.[2,3] The Washington experience cautioned against expanding criteria without increasing resources. The judges in our survey were not clearly in favor of broader criteria for civil commitment.

The Task Force considered expansion of commitment criteria *per se* and widening the standards just for outpatient commitment. After reviewing the literature on outpatient commitment,[19-22] the Task Force did not favor a separate standard for involuntary, outpatient treatment. Interestingly, a majority of the investigators in our survey did favor such a system, whereas the judges did not. However, the Task Force did recommend a "deterioration" standard for chronically mentally ill persons similar to that described by Dunham.[23] Under this recommendation, persons with a history of chronic mental illness who have had prior recent state hospitalizations need only be shown to be in an episode of deterioration likely to result in dangerousness or grave disability in order to be committed.

Not surprisingly, the surveys and the Task Force left several issues unaddressed. There was no consensus among the judges and investigators regarding civil commitment for alcohol and drug dependent persons. There is a good deal of controversy in this area. As pointed out in Table 2, less than 50% of judges and investigators consider an alcohol or drug diagnosis as sufficient to meet Oregon statutory definition of a "mental disorder." Statutory law does not define mental disorder, and there even is one recent Oregon Court of Appeals case[24] which recognized chronic alcoholism as a mental disorder for purposes of civil commitment. We suspect that most investigators and judges don't appreciate this situation owing to practical fears of overwhelming an already overburdened system. The Task Force, for its part, noted that this area was of great importance but was unable to deal with the subject due to lack of time and for financial reasons. Similarly, the Task Force failed to deal with the very difficult problems of the juveniles and the elderly in the civil commitment system.

Finally, it is our impression that the investigator and judge questionnaires added to the deliberations of the Task Force by providing a more comprehensive data base than that presented in testimony. For the most part, these professionals mirror general concerns about the current civil commitment process and join with many others in calling for a serious reexamination of present day commitment law.

Conclusions

Surveys of civil commitment investigators and circuit court judges showed that these professionals would like to relax the rules of evidence which presently restrict their access to important information about allegedly mentally ill persons. Lack of resources for diverting clients away from involuntary treatment was a great concern for the investigators. Both groups of professionals felt that compulsory outpatient treatment (including compliance with medications) should be a part of civil commitment. The judges and investigators generally favored a system in which involuntary hospitalization would be followed by en-

forced outpatient care. A mechanism for rehospitalization in the event of noncompliance was also felt to be important. The investigators tended to favor broadening the commitment criteria so as to prevent deterioration, but judges did not generally endorse this suggestion. These findings were used by a Task Force on Civil Commitment of Mentally Ill Persons to recommend legislative changes in Oregon's civil commitment system.

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