

Civil Commitment Is Disappearing in Oregon

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Over the past 20 years, in Oregon, the number of individuals entered into the civil commitment process has risen, but the number of those actually committed has gone down dramatically. This commentary compares commitment data during a time when the state's population has increased substantially, while commitment rates have dropped by 50 percent. There are many possible factors that have contributed to this decline in commitment rates, including a stricter functional definition of "danger to self or others," but perhaps the most significant reason is the shortage of the acute psychiatric beds that are essential in the commitment process. It is hard not to conclude that civil commitment in this state is headed toward functional extinction.

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I hold an enduring belief that from a public policy point of view civil commitment is the most important forensic mental health statute. I explored this position in an earlier commentary¹ in which I focused on a history of civil commitment in Oregon along with a discussion of the many apparent conflicts that exist in these statutes in a national context. In this commentary, I will attempt to describe the Oregon statute in an empirical context spanning the past 20 years. I will present data from 1983, 1993, and 2003. These data illustrate that civil commitment is becoming less relevant in the care of the seriously mentally ill in Oregon. It is becoming less relevant, because as the population of the state increases, the number of people civilly committed has gone down dramatically, illustrating a significant policy shift in the treatment of mentally ill citizens.

I believe that these findings have relevance in the national context. Ten years ago, I was in a western state and observed, in a major public city hospital, seriously mentally ill patients who had been entered into that state's civil commitment system handcuffed to gurneys because there were no beds available in the state system. In May 2006, I was in a southern state where a local psychiatrist told me that he had to care for a large number of seriously ill patients in the emergency room. They were confined to lounge

chairs in an auxiliary room while waiting for beds in the hospital. These patients were being detained under the civil commitment statute of his state and there simply was no place for them to stay. These experiences and many anecdotal accounts lead me to believe that what is presented in this commentary is not unique to Oregon.

I came to Oregon from Alaska in 1977 to join the university faculty in the Department of Psychiatry at the Oregon Health & Science University. I was recruited to head a component of the residency training program focused on community psychiatry.² I had taken a fellowship with Dr. Gerald Caplan at the Laboratory of Community Psychiatry in Boston and was very interested in population-based psychiatry.³ I had developed an interest in forensic psychiatry while I was practicing in Alaska, and, during that time, I first became acquainted with the movement against civil commitment led in those days in Alaska by the American Civil Liberties Union. As a young psychiatrist in practice, I found the ACLU's position shocking. They argued that people should be committed only when they were seriously ill and had acted dangerously. Further, if a person's actions could be considered to be a crime, then the person should be prosecuted for that crime rather than be committed. These early days (the late 1960s and early 1970s) brought the first changes in the commitment laws across the country, and there is little doubt that many of the changes were very necessary. In Alaska, however, the state had a new state hospital

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Table 1 Civil Commitment Comparisons

Year	Inv.	Hear.	% Hear./Inv.	Total CC	% Inv. Resulting in CC	% Hear. Resulting in CC	Inv./100K	Hear./100K	CC/100K
1983	3996	1633	41%	1165	29%	71%	154	63	45
1993	5864	1495	26%	959	16%	64%	189	48	31
2003	8315	988	12%	785	9%	80%	238	28	22

1983 population approximately 2.6 million; 1993 population approximately 3.1 million; 2003 population 3.5 million. Inv., investigations; Hear., hearings; CC, civil commitments.

and the general problem was trying to get someone into the hospital rather than, as in other states, trying to get long-stay patients out of the hospital. Yet the rhetoric was national.

When I started working in Oregon in 1977, the civil commitment law, which had been modernized in 1973,⁴ was relatively well accepted. As part of our university community psychiatry program we began to study the various mental health laws. We focused on developing empirical models for measuring the effects of these laws on the patients involved in the public mental health system, including a focus on insanity acquittees, civil commitment, and treatment refusal.

Led by Dr. Larry Faulkner, we studied Oregon's civil commitment statute⁵ and eventually developed a three-step model for examining the statute. Each step in the model had a key decision-maker, and a key decision that had to be made.⁶ Step 1 was screening or entry into the civil commitment process. Step 2 was an investigation of the initial petition by a mental health investigator, and Step 3 was the civil commitment hearing conducted by a judge.

The key decision-maker in Step 2 is the precommitment investigator, a person employed by the various Oregon counties whose role it is to determine whether there is probable cause that the person being investigated meets the definition of mental illness as written in the statute. The definition of mental disorder in Oregon is broad. The key section of the definition is as follows:

[A] mentally ill person means a person who, because of a mental disorder, is one or more of the following: (A) dangerous to self or others (B) unable to provide for basic personal needs and is not receiving such care as is necessary for health or safety.⁷

The key decision-maker in Step 3 is the judge, and the decision is whether there is clear and convincing evidence that the person in question is mentally ill by the same definition. We were able to obtain data from the Oregon Mental Health and Disabilities Determination Office, including information on those individuals who continued in the commitment pro-

cess and were eventually committed, and those released by investigators at Step 2, and by the judges at Step 3.

In 1983 there were 3996 investigations, 1633 hearings, and 1165 commitments in the state of Oregon. Stated another way, 41 percent of the investigations resulted in hearings and 71 percent of the hearings resulted in commitments, so that only 29 percent of investigations resulted in commitments. In 1983, Oregon committed approximately 45 persons per 100,000 in the population.⁶

Contrast these findings with data from 1993 and 2003 (Table 1). Between 1983 and 2003, the population of the state increased from 2.6 million to 3.5 million and the number of investigations from 3996 to 8315. However, as the number of investigations went up, the number of actual civil commitment hearings went down from 1633 to 988. The percentage of those who went on to hearings (decided by the investigators) decreased from 41 percent of those investigated in 1983 to 12 percent in 2003. Of those persons who had a hearing, the judges continued to commit a high percentage: 71 percent in 1983 and 80 percent in 2003. The overall commitment rate per 100,000 in Oregon dropped from 45/100,000 in 1983 to 22/100,000 in 2003.

What About Beds?

We have dramatically fewer state hospital beds in Oregon. The mid-1950s were the years with the largest number of inpatient state hospital beds in the country. Oregon had over 5000 civil beds. Today the state system has a total of 741 beds, of which 307 (41%) are civil beds and 434 (59%) are designated for the forensic system.

General hospital psychiatric units are also limited in the number of available beds. According to the Oregon Association of Hospitals and Health Systems, in 2004 there were 358 general hospital psychiatric beds in the state of Oregon, with 152 (42%) located in Portland. An additional 52 beds were lo-

cated in the VA system. Taken together, there were approximately 720 civil beds in the state, with approximately 43 percent in the state system. In an earlier study, we examined changes in hospitalization patterns in the state, comparing the early 1980s with the early 1990s⁸ and found important changes. The earlier time period was characterized by the use of the state hospital for voluntary patients, while the latter time period was characterized by individuals involved in the civil commitment process who were hospitalized in both state and community facilities. Thus, there was a dramatic shift in the predominant status of patients in the hospital and in the number of hospitals that, in the latter time period, were used predominantly for involuntary patients. The use of the psychiatric hospital for the voluntary patient in Oregon had fallen by the wayside.

Discussion

The commitment of only 988 people in a population of 3.5 million demonstrates that civil commitment in Oregon in 2003 was headed toward functional extinction and, if the numbers are accurate, the impact of civil commitment on the mentally ill population becomes more and more negligible.

How did this situation develop in Oregon? An obvious explanation is that there just are not enough psychiatric beds in the state to meet the need. Over the past decade, the state of Oregon has seen a net decrease in psychiatric beds in both the public and private sectors. The system has shifted from one supporting both voluntary and involuntary hospitalization to one supporting only involuntary treatment systems, civil commitment or patients sent to the hospital by the criminal justice system, those who are incompetent to stand trial, and the large number of insanity acquittees under the jurisdiction of the Oregon Psychiatric Security Review Board.⁹

In addition to growth in the forensic population, over 10 years ago Oregon closed one of the state hospitals following the report of a governor's commission that found it to be badly in need of repair. Two hundred twenty-five civil hospital beds were lost to the system. A new hospital was promised, and although there is political movement now for the state to build new facilities, to date no facilities have been built.

The private sector has also lost beds over the past decade. Reimbursement for psychiatric services has not kept pace with that for other medical services,

and several general hospitals have eliminated psychiatric beds to make way for the more profitable medical-surgical beds.

Intangible factors also could have led to changes in how the psychiatric beds are used. According to the data presented in this commentary, 75 to 80 percent of those who enter the civil commitment system were subsequently released from emergency hold on recommendation of the precommitment investigator. (I do not actually know how many of these patients converted from an emergency hold to voluntary status. From past experience and in talking to hospital-based psychiatrists, it is my impression that most patients who are released from emergency holds are discharged from the hospital.) With fewer available psychiatric beds it may very well be that, as the bed shortage increased, mental health investigators adjusted their interpretation of the meaning of probable cause and, as a result, more individuals who need hospital-level treatment have been washed out of the system.

Another intangible factor is the possible influence of case law on the civil commitment process. Although there has not been a landmark appellate decision in the civil commitment area since the statute was modernized in 1973, there have been decisions that have focused on various aspects of the commitment process, including some focus on the definition of mental disorder cited earlier. Focus on the definition may have led to judges' asking investigators to use a more stringent definition in practice than the definition written in the statute. This notion is a speculation based on anecdotal evidence. The model described herein could be used to examine this question from an empirical viewpoint by focusing on the law in practice in a county-by-county comparison or in a single county or using a cross-time comparison,¹⁰ before and after appellate court decisions. Further, empirical models such as those described in this commentary can be adjusted for most every state. Such models are critical for understanding the status of civil commitment in the country today.

Also of importance is how the existing psychiatric beds in the system are utilized. In Oregon, a person entered into the civil commitment process has an investigation conducted either in the hospital (where the person has been admitted on an emergency hold for up to five judicial days) or, if the person has not been hospitalized, in the community. In 2004, approximately 98 percent of investigations took place

while the patients were hospitalized on emergency holds. In an earlier study, it certainly appeared that treatment was compromised during the precommitment hospitalization.¹¹ Whether this was due to hospitals' and physicians' granting a qualified right to refuse treatment to the precommitment patient or was due to other factors, it is clear that these five judicial days of hospitalization are not optimal from a legal or a medical point of view. One way to achieve a better balance for those who enter the civil commitment process is to have the legal aspects of the process progress quickly and then have a longer initial treatment period. This type of modification of the Oregon civil commitment statute could result in much greater efficiency in the use of the psychiatric beds in the system and could protect the civil rights of patients in a manner that is certainly equal to or better than that in Oregon today.

In conclusion, after attempting to track through some of the twists and turns of the history of this story, I have concluded that civil commitment in Oregon is in danger of becoming more of a historical novelty than an important tool in the management of a small portion of seriously mentally ill individuals. I believe that the same situation may be occurring nationally, where psychiatric hospitalization for seriously mentally ill individuals has decreased and been replaced increasingly by the use of the criminal justice system in the management of these individuals. Stated another way, the use of civil commitment as a method of diverting individuals from the criminal justice system to the mental health system has been replaced by diversion from one part of the criminal justice system to another,¹² from jails to mental health courts.^{13,14} Reversing this trend toward criminal justice sanctions will take a concerted effort to restore civil commitment to a meaningful place in the mental health system.

What I found shocking in 1973 appears to be accepted in 2006: a definition of mental illness that focuses more on imminent dangerousness than on need for treatment and on the increasing use of the criminal justice system for the management of mentally ill individuals.

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