

Competency to Stand Trial, Civil Commitment, and Oregon State Hospital

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This article examines the explosive growth of individuals referred for competency to stand trial evaluation and restoration services in the state of Oregon and at Oregon State Hospital between the years 2000 and 2020. This paper also examines the links between competency to stand trial and civil commitment statutes. As yearly civil commitments rates have decreased in Oregon, competency to stand trial commitments to Oregon State Hospital have increased, suggesting an inverse relationship between these two important statutes. There is an overlap in the jurisdiction of these statutes, with both needing to function harmoniously for the civil and the criminal justice processes to each work for the benefit of the individuals involved in the criminal justice and mental health systems.

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Across the United States, there has been a dramatic increase in jail detainees referred to psychiatric hospitals for competency to stand trial (CST) evaluation or restoration services.^{1–3} It is not altogether clear why this is happening at this time. On one level, this surge involves state hospital beds, with too many jail detainees waiting for CST services and too few hospital beds. According to a Treatment Advocacy Center report, the nation had a total of 49,907 state hospital beds in 2005. In 2010 this number was reduced to 43,318 beds, representing 14.1 beds per 100,000 individuals in the U.S. population.⁴ In 2016, the 43,318 beds were further reduced to 37,679 beds, or 11.7 beds per 100,000 in the population.⁵ The Treatment Advocacy Center also developed an estimate of the number of beds necessary to meet the full service needs of a state population and determined that the 11.7 beds per 100,000 in 2016 would meet only 23.4 percent of the beds needed nationwide. From this perspective, the CST crisis could

fundamentally be a bed problem; the population of the country increased while the number of state hospital beds decreased to the point that were just too few beds in these hospitals to meet the service needs of the population, including the growing needs of the CST system. While having an insufficient number of beds certainly continues to be a part of the story, it does not fully explain why the CST population has increased so dramatically in recent years.

In exploring the cause of the CST crisis beyond the bed shortage, we need to broaden the focus to recognize that every state has three main statutory provisions that may be applied to a person with serious mental illness manifesting behavioral problems. These are civil commitment, CST, and the insanity defense. This article explores the significant overlap between the applications of these statutes. As an illustration, it is well known that police officers can and often do make choices that direct persons of interest either to a jail cell or to a medical-psychiatric facility where the person can be entered into the state's civil commitment process. If an individual with serious mental illness is brought to jail, the CST process may soon be activated, requiring evaluation, judicial hearings, and potential restoration services.

The CST process itself is complicated and has many moving parts and actors including prosecutors,

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defense attorneys, judges, psychiatric and psychological evaluators, local jails, state psychiatric hospitals, community mental health programs, state administrators and state legislatures. All have different roles, and each approaches CST from a distinct viewpoint determined by the interplay of their varying responsibilities. The process takes time and resources, and there are many possible results. Diversion out of the criminal justice system can begin early and lead to civil commitment or, if charges are later dropped, to an assortment of community alternatives. If competency is restored, the criminal justice process continues, which can result in conviction or an insanity verdict. If competency cannot be restored, the person may be found incompetent to stand trial and not restorable, a designation that represents either a semi-permanent or permanent dismissal of criminal charges possibly with a civil commitment. The point is that civil commitment and CST services and even the insanity defense have overlapping purposes, and these statutes are intertwined at different points within the civil and the criminal justice systems as officials grapple with persons with severe mental illness who engage in troublesome or illegal behavior. Thus, how these statutes work in each jurisdiction may influence the numbers of individuals referred for CST services.

This article focuses mainly on the CST process in one state, Oregon, and on its only state-run psychiatric hospital, the Oregon State Hospital (OSH). OSH operates with two campuses, one located in Salem, the state capital, while the second is further south in Junction City. The hospital has a total of approximately 600 beds, 99 percent of which are focused on three involuntary patient groups: those civilly committed⁶; those sent to the hospital for CST evaluation⁷ or restoration⁸; and those found guilty except for insanity, the Oregon insanity verdict, who have also been placed under the jurisdiction of the Psychiatric Security Review Board.⁹ Treatment Advocacy Center reports indicate that OSH beds have been relatively stable over the past 20 years, with 691 beds reported in 2005, 700 beds in 2010, and 653 in 2016, achieving 32.4 percent of the full-service needs designated by the Treatment Advocacy Center as the per-capita target. At the end of 2018, the average daily population at OSH had fallen about 10 percent to 607 patients divided between these three involuntary patient groups: CST (42%), insanity acquittees (34%), and civil commitment patients (24%).¹⁰

It is also instructive to focus on OSH because, beginning in 2003, OSH was required by the Ninth Circuit Court of Appeals' decision in *Oregon Advocacy Ctr. v. Mink*¹¹ to admit all jail CST detainees requiring court-ordered CST evaluation or restoration services within seven days following the signing of a judicial order requiring hospitalization. In recent years, the state was unable to keep up with the seven-day mandate because of the escalating CST population of jail detainees requiring hospital services. On April 30, 2019, Disabilities Rights Oregon filed an *amicus curiae* brief in the Circuit Court for the state of Oregon claiming that the state of Oregon was in contempt of the original *Mink* decision.¹² This led to a lawsuit filed by Disability Rights Oregon in the federal district court. After several hearings, the case was settled eventually for the state after the Chief Judge of the District Court encouraged the state to return to compliance with the *Mink* decision, and after the Oregon legislature in 2019 passed SB24 (see discussion).¹³

This article has several goals. First, we explore a possible inverse relationship between civil commitment and the use of CST to stimulate interest in data collection and hypothesis development in this area. Second, we review data from OSH Quality Management reports to better understand the dramatic increase in the CST population at OSH and to illustrate the types of information that offer suggestions for reduction in the use of CST services in other state hospitals. Finally, we discuss the potentially negative state-wide effects of the increase in hospital usage by CST patients, which decreases the number of beds available for civil commitment patients at OSH.

Methods

Data for this report were made available by the Public Records and Internal Litigation Coordinator of the Fiscal and Operations Division of the Oregon Health Authority (OHA) following a request for release of public information. These data include both CST admissions and CST average daily population (ADP) numbers for the years 2000 to 2020. In addition, the OHA Public Records coordinator provided data from the OSH Quality Management section, which focused on specific questions regarding Oregon counties' contributions to the CST hospital population during the years 2012 to 2019. Analyses performed on these data are summarized in the text.

All of the material provided to the authors has been retained and is available upon request to the authors.

Results

Competency to Stand Trial

In Oregon, examinations for CST can take place while criminally charged individuals are in jail, at OSH via judicial order, or in the community on bond or released on their own recognizance. Outpatient evaluation and restoration have always been possible in the state, but outpatient restoration has been rare. There are separate statutes for a judge to order either competency evaluation⁷ or restoration⁸ at OSH. In 2011, anticipating increases in the CST population at OSH, the legislature passed a statute which stated that an individual could only be hospitalized at OSH for CST services if there is a judicial finding that the individual in question is dangerous and that there are no available community resources to carry out the CST functions.¹⁴ Wherever the examination takes place, it must be carried out by state-certified psychiatrists or psychologists¹⁵ in community practice, via local county contracts, or by certified OSH examiners who often perform examinations in outpatient settings or via a short-stay hospitalization at OSH. Once found IST by a judge, and if a restoration program is necessary, the judge will decide whether the restoration program should be at OSH or in the community. Jail restoration services now developing in some states are not permitted in Oregon.^{16,17} Following the *Mink* decision, the transfer from jail to OSH must take place within seven days.

Table 1 includes the number of admissions each year and the ADP of individuals committed to OSH for CST services from 2000 to 2020. The yearly number of admissions and the ADP gradually increased from the year 2000 until 2011. Admissions and ADP increased sharply from 2013 until 2019 when 700 patients were admitted (4.5 times more than in 2000, for an increase of 349%) and with the ADP for 2020 being 284.5 patients. Admissions dropped slightly to 627 in 2020, influenced by the COVID-19 pandemic.

Table 2 is derived from OSH Quality Management reports, which focused on five of the state’s six most populous counties for the years 2012 to 2019. During that eight-year period, most CST admissions involved felonies (i.e., 58 to 64 percent for four counties and 83 percent for the other, Jackson County, which is smaller

Table 1 Competency to Stand Trial Admissions and Average Daily Population at Oregon State Hospital

Year	Admissions	Average Daily Population
2000	156	73.5
2001	159	77.9
2002	192	84.5
2003	246	84.6
2004	292	90.1
2005	289	90.3
2006	311	90.2
2007	312	101.2
2008	301	98.7
2009	288	99.4
2010	283	97.8
2011	363	105.2
2012	365	109.4
2013	428	130.3
2014	461	149.6
2015	543	170.4
2016	623	218.7
2017	610	194
2018	720	228.2
2019	700	263
2020*	627	284.5

* 2020 data affected by COVID-19 reductions.

in population and had fewer total CST admissions). Misdemeanor admissions ranged from 27 percent to 42 percent. Data available from each county indicated that the proportion of admissions involving felonies seems to be increasing; the OSH-CST census on October 31, 2019, shows a higher proportion involving felonies for each county in 2019 than that seen for felony admissions in 2012.

The OSH Quality Management reports on these five counties also documented that the proportion of admissions for competency evaluation only was 5.7 percent (146 of 2,573 CST admissions). Further, 80 patients were referred for restoration from municipal courts, with most (68) coming from one county in the relatively short period from 2016 to 2019.

The OHS Quality Management reports also provided some information on 32 of Oregon’s 36 counties, with the overall number of CST admissions (expressed as admissions per month) between 2012 and 2019 almost doubling from 30.5 admissions per month in 2012 to 58.3 in 2019. There were four counties with more than two admissions per month in 2012, but there were nine such counties in 2019. Four of the five counties with the most CST admissions had the largest numeric increases in admissions per month, but some counties with very low rates had high relative increases (a county with 0.2 admissions per month increased to 1.7, an almost 9-fold increase).

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Table 2 CST Data from Five Oregon Counties, 2012–2019

County	2012–2019 CST Admissions	2012–2019 Misdemeanor Admissions	2012–2019 Felony Admissions	October 31, 2019 Misdemeanor Census	October 31, 2019 Felony Census
Multnomah	960	355 (37)	605 (63)	10 (20)	38 (78)
Washington	389	165 (42)	224 (58)	8 (25)	22 (69)
Lane	543	226 (42)	317 (58)	9 (30)	19 (63)
Marion	507	200 (39)	307 (61)	4 (14)	24 (83)
Jackson	174	30 (17)	144 (83)	3 (10)	27 (87)
Total	2,573	976 (38)	1597 (62)	34 (20)	130 (76)

Data are presented as *n* (%). Percentage values may not total 100 due to unknown status for some cases. CST = competency to stand trial

Civil Commitment

Civil commitment in Oregon is used only for those who meet the typical criteria of danger to self or others or those unable to provide for their basic personal needs and not receiving help in this area. There is one exception within the general commitment statute that was promulgated in 2013 for the category of individuals judged to be incompetent to stand trial and not restorable and who are determined to continue to be “extremely dangerous persons”¹⁸ and are committed to the jurisdiction of the Oregon Psychiatric Security Review Board. There were 17 such individuals committed between 2013 and 2019. We believe that they probably are not represented in the general commitment statistics, but the number is so small that it would have no significant influence on the population rates.

The commitment rates include all civil commitments made by judges in each year in the Oregon counties and then reported to the OHA, which totals the statewide data. All civil commitments in Oregon, except for those designated as extremely dangerous persons, are made to the OHA, which can place the committed person at OSH, retain them in a community hospital until a bed is available at OSH, or place the committed person in an outpatient setting.

Table 3 presents the total number of individuals civilly committed per 100,000 for select years from 1972 to 2019. These figures represent data from

Table 3 Civil Commitments in Oregon, 1972–2019

Year	Civil Commitments (per 100,000)
1972	53
1983	45
1993	31
2003	22
2013	15
2019	12

earlier reports^{19,20} and from current information provided by the OHA. From the inception of the current version of the state’s civil commitment statute in 1973 to 2019, there was a steady decline in the numbers of Oregonians civilly committed by Oregon courts (Table 3). In 1973, the courts committed an average of 53 persons per 100,000 Oregonians, while in 2019 the same state courts committed 12 persons per 100,000.

Discussion

We have presented data showing the steady rise of CST admissions and ADP of CST patients hospitalized at OSH from 2000 through the first nine months of 2020. In addition, data presented on patients civilly committed to the jurisdiction of the OHA demonstrates a steady decline in commitments over a period of almost 50 years. The CST data will be discussed first, followed by a discussion of an apparent link between CST and civil commitment.

The steep rise of CST patients at OSH in the last decade precipitated a crisis at the hospital, at the OHA, and at the state legislature. As illustrated in Table 1 and Table 2, the number of new CST patients admitted per year increased from 156 in 2000 to 700 in 2019, while ADP rose from 73.5 in 2000 to 130.3 in 2010, and to an all-time high of 284.5 in 2020. This dramatic increase in the demand for CST beds at OSH was associated with a rise in jail detainees waiting beyond seven days for transfer to OSH,^{11–13} in violation of the 1993 *Mink* decision.¹¹

All admissions to OSH for CST services originate from Oregon’s 36 counties. In five of six of the most populous counties in Oregon, which also have the highest number of CST admissions, relatively few were for evaluation only, indicating that competency

evaluations in these counties are being handled within the local communities. Data were not available for this report that would establish whether the more rural counties (with smaller populations) used OSH for evaluation-only admissions during 2012 to 2019, but we might anticipate this possibility given that these locations often lack the resources needed to conduct competency examinations. For these more rural counties, consultation with the OSH forensic program might help identify options for local evaluation services if needed.

From 2012 to 2019, in four of the five counties with the most CST admissions, 40 percent were for individuals charged with misdemeanors. The misdemeanor population often exhibits factors associated with minor criminal activity, such as homelessness, noncompliance with prior treatment, and a history of denial of illness.^{21,22} Such individuals represent a target population for possible complete diversion out of the criminal justice system and into mental health treatment, either through civil commitment or assisted outpatient treatment, along with sheltered housing and other requisite hospital or community programs.²³ Each misdemeanor case could be reviewed for possible diversion with a decision made early in a CST hospital stay as to whether the case should continue in the criminal courts or be transferred to the civil courts and the mental health system. Obviously, representatives from each side, civil and criminal justice, would need to be involved and capable of making such judgements.

With the CST population increasing each year and with *Mink* in place, the U.S. Federal District of Oregon played a prominent role in what happened at OSH. The federal district court encouraged both the hospital and the state legislature to focus their attention on the CST problem. On March 12, 2019, the Director of the Oregon Health Authority and the Superintendent of OSH presented a plan to the state legislature focused on the CST population and steps the hospital took or would take to lessen the pressure on the facility,¹⁰ including making the CST population the priority population for admission to the hospital. That same 2019 legislative session went on to pass SB24,²⁴ which focused on policy changes in the hope of reducing the numbers of individuals sent to OSH for CST services. The new law requires more exploration of community alternatives to state hospitalization especially by attempting to limit misdemeanor-charged individuals sent to the hospital to

those who are perceived to be dangerous. These actions were similar to suggestions made in a recently published report from the Council of State Governments and the American Psychiatric Association Foundation,²⁵ which explored the CST crisis and suggested ten strategies for rethinking the current approach taken by states.

Additional efforts will likely be needed to reduce the rise in CST admissions, possibly involving civil commitment. The Council of State Governments' report (Ref. 25, p 7), referring to data from Oregon, suggested that there could be a causal relationship between civil commitment decline and the rise in CST cases. There is an old adage in clinical forensic psychiatry that says, "when civil commitment goes down, criminal confinement goes up." We cannot find an attribution to this saying, but it can be illustrated relatively easily. In 1972, Abramson²⁶ demonstrated that passage of California's landmark civil commitment statute, the Lanterman, Petris, Short (LPS) Act, led to an increase in criminal confinement under the state's then CST statutes. Oregon's 1973 civil commitment reform statute resembles the LPS Act. These statutes and others that were new at the time were summarized by Stone²⁷ and Appelbaum.²⁸ In addition, over time, decisions by the Oregon Court of Appeals²⁰ on commitment criteria led to the evolution away from the original intent of the 1973 legislature to stricter definitions of criteria for civil commitment.

Serious mental illness is criminalized when a person experiencing serious mental illness might have been brought to a community hospital and entered into the civil commitment process, but instead is brought to jail, or when that same person goes through the civil commitment process and is not committed because the Court of Appeals has changed the original legislative intent of the commitment statute.²⁰ Every practicing forensic psychiatrist has seen these scenarios repeatedly. Soon after arrest, that person is placed in the CST process within the criminal justice system. This type of criminalization occurs frequently and represents a latter wave of criminalization only indirectly related to the first wave, which had developed following the severe sequelae of too rapid and too deep early deinstitutionalization.^{29,30} This is a new type of criminalization of the re-institutionalization type. We view this current wave of criminalization in Oregon as at least partially related to the significant drop in civil

commitment in this state. We hope to stimulate research from other states exploring the possible relationship between these two important statutory provisions. Hypotheses can be developed from the initial approaches suggested by the data in this article to produce detailed research studies that examine the demographic, mental health, and criminal justice system involvement of CST restoration individuals in much the same manner as earlier research looked at the individual and system characteristics of insanity acquittees.³¹

Further, we should not consider the CST crisis as occurring in a vacuum, so we return now to the interplay of civil commitment, CST, and the insanity defense. These statutes are the bedrock of the law's approach to dealing most effectively with individuals with serious mental illness and accompanied behavioral problems. The legal system in any state should be designed for these three statutes to work well in their prescribed manner, each according to its goals. Civil commitment is meant for those with serious mental illness, with or without behavioral problems, who reject voluntary treatment and who meet criteria related to dangerousness and grave disability. The insanity defense is designed to preserve the integrity of the criminal law by not punishing those few individuals who are not held blameworthy for their actions because of their serious mental illness. While intended to preserve the fairness of criminal trials, CST in practice often appears to function as a backstop when one or both of these statutes fails in a particular jurisdiction. Steadman and colleagues demonstrated this in their exploration of the effects of the *Hinckley* verdict.³² In an associated study of one of the early *mens rea* states, Montana, the group found a drop in insanity acquittals following the adoption of a *mens rea* insanity defense while at the same time reporting an increase in the use of the state's CST statutes.³³ This early observation regarding CST and the insanity defense seems now to hold in all four *mens rea* states,³⁴ which are related to the recent Supreme Court case of *Kahler v. Kansas*.³⁵ It appears that if the use of civil commitment or the insanity defense declines, then the use of CST rises.

As discussed in the Council of State Governments report,²⁵ CST is an indispensable legal statute that, at the same time, is a poor mental health treatment statute, particularly as it lacks provisions for meaningful continuity of care. As illustrated by OSH data, the

increased numbers of CST patients are causing system-wide problems in Oregon, as the state made CST patients the priority patients for admission to OSH. The result at OSH has been that CST patients are taking up many beds that are needed for the proper functioning of the civil commitment statutes because of the Ninth Circuit of Appeals 2003 *Mink* decision.¹¹ *Mink* has had the very positive effect of limiting the time that individuals found IST can be retained in jails before being transferred to OSH. This decision has reverberated in other states with the goal of limiting prolonged and often destructive stays in jail³⁶ for individuals waiting for a CST bed in a psychiatric hospital.³⁷ In Oregon, however, its preferred status is causing a backlog of individuals waiting for a civil commitment bed.³⁸ This situation could get worse, as it is very possible that further decreases in civil commitment will cause CST to continue to grow, pushing the whole system to work against itself and against more appropriate treatment of persons with serious mental illness. What is needed now is an emphasis on the positive treatment aspects of civil commitment or similar statutes like assisted outpatient treatment,²³ provision of sufficient beds in hospitals to meet population needs, and generally moving back from criminal court confinement to civil commitment and to voluntary mental hospital services. This is the direction that we should follow.

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