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For the Oregon Health Authority
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Standardization of Civil Commitment Processes Across the State of Oregon

UVA | FRANK BATTEN SCHOOL of LEADERSHIP and PUBLIC POLICY

Standardization of Civil Commitment Processes Across the State of Oregon

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Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

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Honor Pledge

On my honor, I pledge that I have neither given nor received help on this assignment.

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Acronyms and Key Terms

Acronym	Meaning
CMHP(s)	Community Mental Health Program(s): State-funded, local-level organizations that provide services to local residents related to behavioral health, mental health, and substance use (*Oregon Health Authority : Community Mental Health Programs : Behavioral Health Services : State of Oregon*, n.d.).
OHA	Oregon Health Authority
OPA 4	Operations and Policy Analyst 4: Policy advisor to senior management or does large-scale organizational improvement work at the policy level of a state agency (*Job Profile : Classification and Compensation : Human Resource Services Division : State of Oregon*, n.d.).
OPA 3	Operations and Policy Analyst 3: Gives consultative advice on the administrative, policy, programmatic and management aspects of agency operations (*Job Profile : Classification and Compensation : Human Resource Services Division : State of Oregon*, n.d.).
OSH	Oregon State Hospital: Oregon State Hospital (OSH) provides patient-centered, psychiatric treatment for adults from throughout the state who need hospital-level care (*Oregon Health Authority : About Us : Oregon State Hospital : State of Oregon*, n.d.).
ORS	Oregon Revised Statutes: Codified laws of the state of Oregon.
OAR(s)	Oregon Administrative Rule(s): Any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency (*Oregon Secretary of State Administrative Rules*, n.d.).

Executive Summary

Civil commitment is the process by which an individual who is deemed to have a mental illness is mandated to receive treatment in either an inpatient or outpatient setting. Within the civil commitment process, the CMHPs are the primary agent and decision-makers as they evaluate requests for civil commitment, conduct investigations on individuals undergoing the civil commitment process and are delegated the responsibility of care of an individual who is mandated to undergo civil commitment. However, research suggests that critical decisions by CMHP staff have been influenced by various factors including knowledge of the process, interpretations of civil commitment terminology and civil bed availability, creating disorder in civil processes across the state.

As a result, in the state of Oregon, there are currently inconsistent civil commitment processes taking place throughout the Community Mental Health Programs (CMHPs), which are overseen by the Oregon Health Authority. This absence of uniformity has resulted in a lack of equity in process, treatment and outcomes for individuals undergoing civil commitment.

If the process were to remain as it is today, civil commitment patients would continue to receive inadequate treatment which can lead to an increased risk of houselessness, substance use and or criminal activity. While others' freedoms could be stripped without reason. By getting individuals treatment they need, not only would the persons undergoing civil commitment benefit, but the greater public would also benefit because of a decreased risk of harm.

Extensive academic and qualitative research led to three policy alternatives to address this issue which include: additional civil commitment process training for CMHP staff, the clarification of civil commitment terminology within the Oregon Administrative Rules, and increased funding for civil commitment beds. Each of these alternatives has been evaluated using the criteria of cost, effectiveness, feasibility and equity.

Considering the criteria, it is recommended that the Oregon Health Authority should implement subsequent training for CMHP staff regarding the civil commitment process. The training would include instructions on how to apply rules and statute to investigations, a standardized checklist of criteria for investigators when evaluating an individual undergoing the civil commitment process, and regional discussions to address the stigma of mental health as it relates to the Northern, Southern and Frontier counties. In conjunction, it is also recommended that the Oregon Administrative Rules are reviewed for ambiguity in foundational civil commitment terminology such as "dangerousness" "imminent" and "basic need," and undergo a rules process to make these terms more explicit.

By implementing these policy recommendations, the Oregon Health Authority can ensure that all CMHP staff conducting civil commitment processes have equivalent knowledge and awareness of bias, as well as a clear understanding of civil terminology and evaluative criteria for investigations.

Introduction

This document is being prepared for the Oregon Health Authority, a government agency of the state of Oregon, whose mission is "ensuring all people and communities can achieve optimum physical, mental and social wellbeing through partnerships, prevention and access to quality, affordable health care" (Oregon Health Authority : About OHA : State of Oregon, n.d.). It will address the problem of inconsistent civil commitment processes across the state of Oregon and describe three different policy alternatives to address the issue. These alternatives will be analyzed based off criteria and a final recommendation will be provided as a pathway forward.

Problem Statement

The inconsistent civil commitment processes across the CMHPs in the state of Oregon have led to inadequate treatment of individuals going through the civil commitment process. Inadequate treatment has the capability to result in houselessness, substance use, and or an increase in criminal activity following commitment (Hansen et al., 2022). There is currently an opportunity to improve the civil commitment system in the state of Oregon by creating consistent processes across the 36 counties that generates greater equity in process, treatment and outcomes for individuals.

Client Overview

Civil commitment is the process by which a judge decides whether an individual alleged to be mentally ill should be required to accept mental health treatment. Civil commitment can involve admitting an individual to a medical or mental health institution against their will (Oregon Health Authority : Civil Commitment : Behavioral Health Services : State of Oregon, n.d.). The process of civil commitment in the state of Oregon falls under the purview of the Oregon Health Authority Behavioral Health Intensive Services Team.

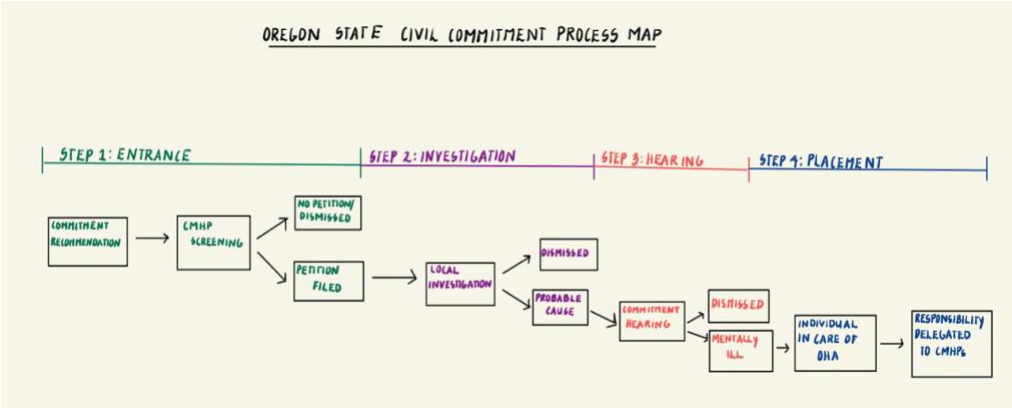
The Behavioral Health Unit's mission is to assist Oregonians in achieving physical, mental and social wellbeing by working with individuals, counties and providers to deliver "access to health, mental health and addiction services and supports" (Oregon Health Authority : Civil Commitment : Behavioral Health Services : State of Oregon, n.d.). The Oregon Health Authority's Intensive Services Team oversees the civil commitment process including the CMHPs which are the primary agents and decision-makers in the practice of civil commitment.

Background

History of Civil Commitment

The history of civil commitment in Oregon dates back to 1862, where law was created that a county judge could order hospitalization of an individual by reason of "insanity or idiocy" (Bloom & Williams, 1994). In 1973, the term "mentally ill person" was defined as "a person who, because of a mental disorder is either dangerous to himself or others or is unstable to provide for his basic personal needs and is not receiving care that is necessary for his health and safety" (Bloom & Williams, 1994). Additional regulations continued to be introduced overtime including: precommitment investigations, limitations on the duration of commitments, legal representation, and commitment hearings (Bloom, 2004; Bloom & Williams, 1994). In the 1960s and 1970s, Oregon courts began to see hospitalization as the stripping of one's fundamental liberties and shifted away from hospitalization, favoring community treatment as an alternative (Bloom & Williams, 1994). Today, about 600 Oregonians per year are ordered to receive treatment through the process of civil commitment (Bloom et al., 2022).

The Civil Commitment Process



In a simplified structure, the first step in the civil commitment process is entrance and screening. In this phase, the decision is made of whether a person should formally enter the civil commitment process at the local level (Faulkner et al., 1986). CMHP staff screen requests and decide whether petitions are dismissed or filed based on community tolerance, CMHP resources, and the attitudes of CMHP staff (Bloom et al., 1985). Any two people have the ability to file a petition with a CMHP, or a medical hold must be placed on an individual to begin the civil commitment process (Faulkner et al., 1986).

The second stage is the "investigation stage" in which an investigation is conducted by CMHP staff who make a recommendation to a judge concerning whether probable cause of mental illness exists (Bloom et al., 1985; Faulkner et al., 1986). In this stage, the decision pertains to the certainty with which it can be shown that the person who has entered the civil commitment process is "mentally ill" as defined by state law (Faulkner et al., 1986). This investigation by CMHP staff can include the facts of the case, legal documents filed, or an examination of the person (Faulkner et al., 1986). An individual can be discharged during this phase if CMHP staff find involuntary treatment unnecessary (Faulkner et al., 1986). The CMHP investigator's knowledge, skill and attitude are important determining factors during the investigation (Bloom et al., 1985).

Next, is the civil commitment hearing. In the hearing, the decision is officially made whether the individual is mentally ill. A judge from a circuit court determines whether or not the individual fits the statutory definition of mental illness (Bloom et al., 1985). The burden of proof is strict in this phase as there is a standard of "beyond a reasonable doubt" (Faulkner et al., 1986). If the judge determines that the individual is not mentally ill, the case is dismissed. Although technically this is decided by the judge, in practice, judges often follow the recommendations of the CMHP investigator and court-appointed examiners, who may come from a CMHP (Faulkner et al., 1986).

Finally, the last stage in the process is "placement." Placement determines where the individual should be treated if they are civilly committed by the judge (Bloom et al., 1985). The individual is placed in the care of the Oregon Health Authority, who then delegates the responsibility of care to the CMHP (Bloom et al., 1985). The CMHP staff decides where the individual is treated (Bloom et al., 1985).[1]

[1] Treatment may be conducted at the Oregon State Hospital, an acute care hospital, outpatient care, or another residential facility.

CMHPs in the Civil Commitment Process

As displayed, CMHPs are involved in almost every step of the civil commitment process (Faulkner et al., 1986; Larry R. Faulkner et al., 1983).[2] However, it has been found that mental health professionals at the community level base their decision-making process pertaining to civil commitment on several factors including the evaluation setting, the professional's tendency to detain patients, budgetary restrictions, distance to the nearest hospital, the availability of beds, and the attitude of the CMHP staff (Bloom et al., 1985; Engleman et al., 1998). Evidence has found that, when all other factors are controlled, some mental health professionals have a greater tendency to detain patients than others, and patients have significantly greater chances of being admitted to civil commitment if beds are available (Engleman et al., 1998). Given that CMHP staff are influenced by time constraints to complete their job, their own knowledge of the process, and treatment resources, there has been a consequence of differing processes for those recommended to civil commitment.

Contributing Factors to the Problem

Lack of Beds

Over the past twenty years in Oregon, the number of individuals entering into the civil commitment process continues to increase, however, the number of those actually committed is decreasing (Bloom, 2006). In 1973, about 53 individuals per 100,000 were civilly committed by the Oregon court system, however, in 2019, Oregon's courts committed only 12 persons per 100,000 (Bloom et al., 2022). A factor that has been found to contribute to this is the shortages of psychiatric beds in acute care hospitals which provide short-term patient care (Bloom, 2006). Today, only 307 beds are used for civil commitment across the state, and almost half of these beds are located in Portland (Bloom, 2006). Currently, there are not enough psychiatric beds in the state to meet the need. It has also been found that mental health investigators in CMHPs have recommended to commit patients based on bed availability and not if the individual fits the statute for civil commitment, resulting in persons who need hospital level treatment being washed out of the system (Bloom, 2006). Because counties have differing availability of beds in their nearby facilities, inconsistent outcomes in terms of bed placement occur.

Unclear Civil Commitment Rules and Statutes

An additional factor that contributes to inconsistent civil processes is vaguely defined terminology within civil commitment rule and statute that complicate the decision-making of CMHP staff. A particular example of this is the dangerousness statute which details that a person can be civilly committed in Oregon if they are mentally ill meaning, "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" (Bloom, 2006). Research suggests that both the public and civil commitment professionals have trouble distinguishing the definition of "mental disorder" compared to being "mentally ill." Further, it has

[2] CMHP staff screen the requests by citizens to have an individual committed and influence whether a petition will be filed or the individual will be dismissed from the commitment process (Bloom et al., 1985; Faulkner et al., 1986; Larry R. Faulkner et al., 1983). After a petition has been filed, a local mental health professional then conducts an investigation and makes a recommendation to a circuit judge of whether there is probable cause that mental illness exists within the individual requested to be committed (Bloom et al., 1985; Faulkner et al., 1986). If that individual is formally committed by a judge, the CMHP is then delegated responsibility for that individual (Bloom et al., 1985).

been found that the term of dangerousness is interpreted differently across CMHP staff (Morris, 2020).

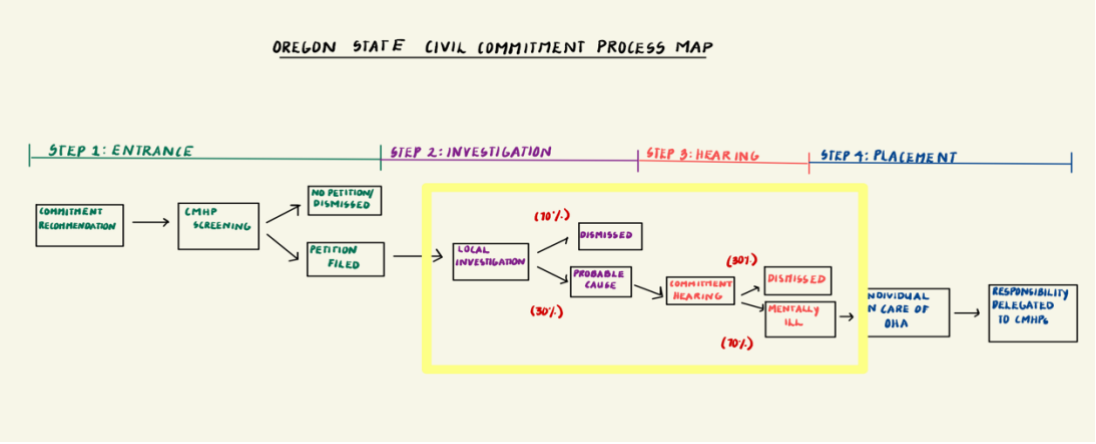
Consequences of the Problem

The process of civil commitment acts as a preventative measure for those who are mentally ill and provides a buffer between voluntary mental health and the criminal justice system (Bloom, 2004). However, inconsistent civil commitment processes across counties can lead to a lack of care, or not being able to provide patients the level of treatment that they need. Inadequate treatment can lead to houselessness, substance use an or an increase in criminal activity as the not adequately treated persons may not know how to cope with their mental illness after being discharged from a facility or dismissed from the civil commitment process (Hansen et al., 2022). These actions can push an individual to have encounters with the criminal justice system, which is the pathway civil commitment aims to prevent in the first place (Hansen et al., 2022). On the other hand, if an individual is committed without cause, not only would they be deprived of their freedoms, but they would be taking away limited resources from those who truly need treatment.

According to my client, as well as an Operations and Policy Analyst 4 (OPA 4) at OHA, those who do not receive proper treatment within the civil commitment system digress mentally and continue to pose a danger to themselves and society. The OPA 4 made a particularly resounding point that if the status quo remains, it becomes a matter of life or death because currently, each year one or more individuals that should have been committed die in the streets during the winter months. As a result, providing effective treatment during the civil commitment process is a proactive approach in leading individuals away from the criminal justice system, or from personal harm, in the future. This is critical, as it allows the process of civil commitment to not only protect and treat the individual, but also protect the public by decreasing the risk of public harm.

A Measure of Civil Commitment Process Consistency

The measure of accuracy for evaluating each alternative will be based on the finding that in Oregon State, 70 percent of civil commitment releases occur during the precommitment investigation which is conducted by CMHP staff, while an additional 30 percent of dismissals occur by a judge at the civil commitment hearing (Bloom, 2004). For illustration, if 100 people were to have a civil commitment filed against them and go onto the local investigation stage, 70 of these individuals would be dismissed by a CMHP and 30 would be recommended for a hearing. At a civil commitment hearing 30% of the 30 individuals would be dismissed, which is 9 people, meaning that 21 individuals end up being civilly committed.



During the investigation stage, outlined by the chart above, the CMHP can choose to either dismiss an individual during the civil commitment process or recommend them for a civil commitment hearing. They base their recommendation off criterion outlined by civil commitment statute and rule as well as their own perspective which allows room for bias and inconsistency.

It is assumed that because biases may play a role in the investigation stage, within the 70% dismissal rate, there may be individuals who were recommended for a hearing but should not have been, and individuals who were not recommended for a hearing but should have been. The CMHP early dismissal rate will be used as the primary measure of accuracy for assessing the efficacy of each of proposed policy alternative.

Alternatives

Policy Alternative 1: Civil Commitment Process Training for CMHP Staff

To create a more uniform and equitable process across CMHPs in Oregon, one recommendation is to offer additional civil commitment training to the mental health professionals employed at CMHPs across Oregon State. Existing research suggests that mental health training for providers and mental health professionals has been widely researched and results in positive impacts.

In 2016, a study was presented on civil commitment evaluation knowledge and training in a Southeastern state. Currently, the American Psychiatric Association asserts that adult psychiatric evaluations should include 11 domains of assessment including: the history of present illness, past psychiatric history, substance use/abuse history, medical history, development and social history, occupation and military history, legal history, family history, review of the system, physical exam and mental status exam (Perrigo & Williams, 2016).

Individual training sessions were arranged with providers that engaged with the state's civil commitment process. The sessions covered an introduction to civil commitment, its history, the laws involved in civil commitment, as well as assessment documentation and practices including the 11 domains of adult psychiatric assessment (Perrigo & Williams, 2016). The training was then accompanied by a standardized form for evaluation (Perrigo & Williams, 2016). Before the training and standardized form, an average of 25.5% of the APA's 11 domains were included in civil commitment assessment documentation and an average of 74% of cases were recommended for commitment (Perrigo & Williams, 2016). Post training and standardized form, 65.63% of APA domains were included in assessment documentation and 76% of cases were recommended for commitment (Perrigo & Williams, 2016). This suggests that both the training and standardized forms improves the quality of provided documentation, and likely the quality of the evaluation which will be used by the judge during the individual's civil commitment hearing (Perrigo & Williams, 2016).

Additionally, under the California Mental Health Service Authority, there is a Provider Education Program (PEP), which is a mental health educational-training program for mental health service providers (Wong et al., 2016). PEP aims to change negative attitudes, beliefs and behaviors toward mental illness and treatment for those in the mental health field (Wong et al., 2016). The results of the PEP training indicate reductions in perceptions of dangerousness of individuals with mental health challenges, decreases in intentions to delay treatment, greater awareness of the stigma of mental illness and more positive recovery beliefs and treatment intentions (Wong et al., 2016).

The finding that PEP training indicated reductions in perceptions of dangerousness of individuals with mental health challenges is particularly important to the civil commitment process, as one of the criteria for being admitted into civil commitment is being an individual with mental illness that poses a danger to themselves or others (Faulkner et al., 1986). Further, as established by the 2016 study, without necessary training and standardized documentation, a mentally unstable individual could be released from the commitment process and potentially impose harm on themselves or the community, or an individual's autonomy could be compromised unnecessarily (Perrigo & Williams, 2016).

Furthermore, if beliefs regarding mental illness and the process of civil commitment can be shaped because of additional training, it may lead CMHP staff to recognize and remove their biases surrounding mental illness, and in turn, have more beneficial intentions of treatment for patients. This could lead to more equitable outcomes for those undergoing the civil commitment process. In essence, introducing a uniform training to CMHPs could put CMHP staff across counties on equivalent terms for how they assess individuals undergoing the civil commitment process.

A Licensing and Certification Specialist at OHA spoke about the current training process for mental health investigators at CMHPs regarding civil commitment. The Specialist remarked that every investigator is certified through OHA and must go through 8 hours of training on the pre-commitment process. To renew their certification, investigators must take these training sessions every 3 years. Currently, the training takes place virtually and reviews statutes, rules and case laws. The Specialist remarked that the training should be 40 hours instead of 8 to cover adjunct topics, however, with low staffing, it would be especially difficult to have CMHP staff away from their responsibilities for that amount of time. The Specialist noted that the most valuable skill for investigators to cover during training would be to practice application of these statutes and rules to reporting cases, but there is not enough time in the training sessions.

It was also commented by an OPA 4 that the training currently conducted for investigators provides a framework for the process, however, it does not describe how to interview people or operate on a multidisciplinary team. A Compliance Specialist 3 on the civil commitment team commented that if investigators are not given practical training, then they would have different approaches to the process. To address stigma, the OPA 4 recommended holding regional meetings with OHA and CMHPs as various geographic locations in Oregon hold different values regarding mental health. They explained that Frontier counties are independent from government, whereas Southern counties are more conservative leaning, while Northern counties hold largely liberal values. As a result, Frontier counties would want less government, Southern counties would want more restrictive options, and Northern counties would push for deinstitutionalization.

Policy Alternative 2: Clarifying the Dangerousness Definition in the Oregon Administrative Rules

Today, in the state of Oregon, civil commitment statutes and rules have not been updated in over 30 years. This has led to outdated or unclear rules, specifically regarding the dangerousness standard, which is key in the process of admitting an individual into civil commitment (Simpson Jr., 1984).[3] The dangerousness standard was established through the case O'Connor v. Donaldson,

[3] Currently, Oregon's dangerousness standard states*: [A]"Person with mental illness" 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 that are necessary to avoid serious physical harm in the near future and is not receiving such care as is*

which ruled that the states must show that "the person is dangerous to themselves or others and that they are not capable of living safely under the supervision of family or friends" in order to be civilly committed, however states have not applied this standard uniformly (Moon, 2014).

An OPA 4 on the civil commitment team remarked that there is variation in the interpretation of standards, including what it means to be dangerous or meet basic needs. They stated that there is not a universally accepted definition resulting in inconsistency in processes and how inpatient and outpatient options are used. A CMHP Crisis Manager concurred with this assessment stating that that statutory language is ambiguous which accounts process disparities in CMHPs.

Because the term "dangerousness" is left up to personal interpretation, and requires the capacity to foresee the possibility of a harmful event, it has resulted in different outcomes in terms of dismissal throughout the civil commitment process (Dallaire et al., 2000). One study has found that some psychiatrists interpret the standard to require that the individual going through the civil process pose an immediate danger, while others thought the statute required the individual's condition as a possible or potential danger which leads to dissimilar outcomes for the patients (Gordont, 2016). Out of the dangerousness criteria has come two flaws: under inclusiveness and over inclusiveness (Simpson Jr., 1984). Under inclusiveness is defined as the system failing to detect and commit individuals who are a danger to themselves or others and over inclusiveness occurs when an individual is involuntarily committed to a mental health facility when they pose no danger to themselves or others (Simpson Jr., 1984).

Data demonstrates that in Oregon, 70 percent of releases occurred during the precommitment investigation by a CMHP staffer, while 30 percent occurred at the commitment hearing (Bloom, 2004). This is meaningful data because the investigator is supposed to pass the individual onto a hearing if there is probable cause to believe the person fits the definition of mentally ill (Bloom, 2004). The fact that so few individuals are passed onto a hearing displays a conflict between the physicians in Oregon that see a patient as severely ill and in need of treatment, and the CMHP employees who make the determination based off of their personal assessment of dangerousness (Anfang & Appelbaum, 2006; Bloom, 2004).

This data leads to the question, "What is sufficient evidence of dangerousness and what standard of proof of dangerousness should be required?" (Simpson Jr., 1984). To remedy this, some states require evidence that the mentally ill individual has committed a recent act that has posed a risk of substantial harm to themselves or others or that harmful conduct will likely be repeated by the individual (Simpson Jr., 1984). There are several states that directly outline and define the definition of dangerousness in statute including: Colorado, New Jersey, North Carolina, and

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necessary to avoid such harm. (C) A person: (i) With a chronic mental illness[;] (ii) Who, within the previous three years, has twice been placed in a hospital or approved inpatient facility by the [Oregon Health Authority] or the Department of Human Services[;] (iii) Who is exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations or inpatient placements referred to in sub subparagraph (ii) of this subparagraph; and (iv) Who, unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate so that the person will become a person described under either or both subparagraph (A) or (B) of this paragraph or both" (Treatment Advocacy Center, 2020).

Wisconsin (Treatment Advocacy Center, 2020).[4] By more concretely defining "dangerousness" the aspect of personal interpretation would be removed from the process, thereby, creating greater standardization and equitable application of the criteria across CMHPs.[5] As a result, a proposed alternative is further defining the term "dangerousness" within the Oregon Administrative Rules and outlining criteria as to what would constitute dangerousness to allow for an objective evaluation by CMHP investigators.

Policy Alternative 3: Additional Funding for Increased Beds

Over time, the United States has been following the trend of deinstitutionalization or decreasing the number of individuals in mental institutions. An OPA 4 on the civil commitment team provided context around why the number of psychiatric facilities has decreased overtime. They stated that in the 1970s, there was a deinstitutionalization wave, and prior to that, people were put in psychiatric hospitals and homes. In the 1990s, there was a push for community-based services, but it did not provide the same structure as a treatment facility. Currently, Oregon State is down to about 1.25 Oregon State Hospital (OSH) campuses, which most civil commitment patients are housed, because of these political waves. It was also remarked by this Analyst that, today, there are long waitlists for the highest levels of care like OSH because OHA does not have the infrastructure in place for lower levels of care such as home and community-based care. Since there is not an infrastructure in place at the lower levels, individuals wait for months to get into a higher level of care.

A Crisis Manager at a central Oregon CMHP remarked that they currently have an acute care crisis taking place where they are woefully under resourced at the acute care level including at the State Hospital and at Secure Residential Treatment Facilities (SRTFs). This has led to facilities refusing to accept civil commitment patients, and local hospitals who do not have the infrastructure are bearing the burden. Currently, their civil commitment patients are housed locally because OSH does not have enough beds, however, these local facilities do not have therapies or outdoor space. The civilly committed patients at these local facilities end up being discharged to homelessness because there is no place for them. In four years, the crisis manager's county has sent one civil commitment to OSH but have about 6-7 civil commitments that should be placed in an OSH per year.

It has been estimated that there should be at least 50 psychiatric beds per 100,000 population (La et al., 2016). However, on average, in the United States, there are about 11.7 psychiatric beds per 100,000 people with about 5.5 of these beds occupied by forensic patients instead of civil patients (Fuller et al., 2016). In Oregon, there are 16.2 beds per 100,000 population which is 32.4% of the recommended amount of beds per 100,000 individuals (Fuller et al., 2016). As more beds are diverted to forensic patients, or patients who have been convicted of crimes, fewer beds are left for individuals who have not committed crimes (Fuller et al., 2016). In 15 states, including Oregon,

[4] Please refer to Appendix A for a comparison dangerousness definitions adopted by various states (Treatment Advocacy Center, 2020).

[5] Note that this alternative specifies that the definition would be in Oregon Administrative Rule not Oregon Revised Statute. This is because an OPA 4 at OHA who has extensive experience with statute and rulemaking noted that it is "close to impossible" for OHA to bring a statute change forward and get it passed as elected officials would likely not bring this bill forward due to its controversial nature. As a result, it is more practical to define in within Oregon Administrative Rule.

more than 50% of the state hospital beds were filled by forensic patients (Fuller et al., 2016), and out of Oregon's 16.2 beds per 100,000 people, only 5.3 of these beds are for civil commitment patients (Fuller et al., 2016). Research suggests that with fewer psychiatric beds available, mental health investigators have interpreted laws more stringently to reduce the number of individuals who qualify for a hospital bed, effectively washing people out of the system during the civil commitment process who need treatment (Bloom, 2006; Stettin, 2014), and because counties have differing availability of beds in their nearby facilities, inconsistent outcomes in terms of bed placement occur (Bloom, 2006). By increasing the number of beds at psychiatric facilities with typically lower bed availability, CMHP staff could increase equity by reducing the weight they place on bed availability in their evaluations. Further, increasing beds could improve overall civil commitment outcomes by increasing the share of patients who receive the intensity of care that they need.

Supplemental Recommendation: Mandate Quarterly Data Reporting from CMHPs and Produce an Annual Civil Commitment Report

This supplemental recommendation is overarching and does not pertain directly to the issue at hand but would be beneficial for the overall civil commitment process. Currently, there is variation in data amongst community mental health programs, hospitals, clinics, and courts as they each retain separate data for civilly committed individuals and do not often communicate with one another (Morris, 2020). An OPA 4 on the civil commitment team remarked that civil commitment data is kept in four spots and none of the data is the same. These spots include the courts, the Oregon State Hospital, MOTS (Measures and Outcomes Tracking System) and hospitals. When patients receive involuntary care it frequently includes treatment in several different facilities, and transportation across counties which makes gathering data on individuals going through the process even more challenging (Morris, 2020). Not having data on the decisions made regarding individuals in the civil commitment process has been detrimental to the state government's ability to assess CMHP actions. A data reporting system for CMHPs could facilitate oversight by the state, and reform the civil commitment process to produce more equitable outcomes (Morris, 2020).

A data reporting system could also be used by CMHP administrators to identify variations between their county and other counties, allowing them to understand what factors may be impacting their differing outcomes, and how they could resolve irregularities (Larry R. Faulkner et al., 1983). The data could additionally be used by state administrators to evaluate the efforts of local mental health programs (Morris, 2020). It was also mentioned by an OPA 4 that OHA needs stronger technical assistance regarding data as no one is enforcing that individuals enter in data the same way. Data reporting is not an infeasible practice as several states presently track civil commitment data including Virginia, Massachusetts, and California (Morris, 2020). All three of these states also produce reports of their data on an annual basis (Morris, 2020).

Criteria

Cost

The criterion of cost is defined as the direct and indirect costs to the Oregon Health Authority in implementing the alternative. The cost is evaluated in numeric form by assessing how much funding each alternative would need to be implemented. The indirect and direct costs of each alternative may differ, but will likely include administrative costs, cost of psychiatric resources, educational material costs and system costs. All salaries included in costs have been adjusted to include typical benefits.

Effectiveness
The criterion of effectiveness will be evaluated based on the percentage point change each alternative has on the dismissal rate of civil commitment cases at the investigation stage within CMHPs. This will be based on the finding that in Oregon State, 70 percent of civil commitment releases occur during the precommitment investigation which is conducted by CMHP staff, while an additional 30 percent of dismissals occur by a judge at the civil commitment hearing (Bloom, 2004). The effectiveness will be determined by how much the 70 percent dismissal rate increases or decreases.

Feasibility
The criterion of feasibility will be evaluated on if OHA would be able to implement the alternative itself, if the alternative could be enforced by OHA, and if OHA has or can easily obtain the resources to implement the alternative for several years. Community support will also need to be considered including the buy-in of OHA staff and CMHP staff.

Equity
The criterion of equity will be evaluated on if the alternative is able to be implemented in all geographic areas of Oregon experiencing civil commitment processes and allocated in the same manner across all thirty-six counties of Oregon, thereby, allowing for greater equity in outcomes for individuals experiencing the process.

Assessment of Alternatives by Criterion

Alternative 1: Civil Commitment Process Training for CMHP Staff

Cost

For Civil Commitment Process Training to be implemented for CMHP staff in all 36 counties of Oregon, there are two direct costs. One would be the salary of a Licensing and Certification Specialist for Oregon Health Authority Health Systems Division. A current employee at OHA who trains and certifies investigators and examiners from CMHPs for civil commitment is designated as an Operations and Policy Analyst 3. The Operations and Policy Analyst 3 has an average annual salary inclusive of benefits of about $105,928.35 (Operations & Policy Analyst 3 Salary, n.d.).[6] It would likely take a full year, and therefore 100% of the specialist's salary to conduct, create and implement additional civil commitment process trainings. This training could take place once every three years to train new staff members and recertify returning staff members of the CMHPs. Furthermore, it would also take about 20% of an Operations and Policy Analyst 4's time to assist the Licensing and Certification Specialist in creating the training as well as conduct regional meetings with CMHP staff regarding stigma and any ongoing civil commitment process issues. With an OPA 4's salary, inclusive of benefits, of $124,718.49, this would come out to a total cost of $130,872.05 annually.

To note, both OHA and CMHPs will likely provide in-kind costs for these trainings including applications such as Microsoft Office, printed materials and a space to conduct the trainings.

Please refer to Appendix B for further details on cost calculations.

[6] All calculated salaries have been adjusted for major benefits. The 2022 State of Oregon Salary and Benefit Report by the Department of Administrative Services reports that "On average, base pay accounts for 71% of the State's total compensation package, while major benefits account for 29%" (Oregon Department of Administrative Services, 2023).

Effectiveness

A 2016 study displayed that investigators with background in family training showed a significant increase in rate of commitment from 60% to 79% after a training session and standardized documentation was provided (Perrigo & Williams, 2016). Participants with psychiatric training showed a decrease in commitments rates from 83.75% to 77.66% (Perrigo & Williams, 2016). OHA reports that most current investigators have a background in family and social work and weighted their amount at 70% of staff members in CMHPs, while weighting those with psychiatric backgrounds at about 30%. To calculate the effectiveness of training for mental health professionals, the weighted average of the relative percent increase from family and psychiatric training were calculated, which came out to a 20% relative change in commitment rates.

Given the 70% dismissal rate in the investigation stage of the civil commitment process and the additional 30% dismissal rate by a judge, the 20% relative change would be applied to the hypothetical 21 persons out of the 100 original persons who would continue forward in the commitment process. Holding the judge dismissal rate at 30% constant, the CMHP dismissal rate would equal about 35.7%. This results in a dismissal rate of between 64%-65% instead of 70%. This means that the intervention of training could decrease the dismissal rate of investigators by approximately 5-6 percentage points.

For greater detail on the effectiveness calculations for this alternative, please refer to Appendix C.

Feasibility

Sustainability

Currently in the Oregon Administrative Rules, it is outlined that mental health investigators are mandated by rule to complete a training for their position with Licensing and Certification from OHA (*Oregon Secretary of State Administrative Rules*, n.d.). In addition, for mental health investigators to be recertified they must complete eight hours of training or education in the assessment of mental disorder or the assessment of dangerousness which is approved by the Health Systems Division (*Oregon Secretary of State Administrative Rules*, n.d.). Because this training structure is similarly implemented, with positions for Licensing and Certification already in place, it is likely that additional civil commitment trainings could be carried out on a three-year basis in perpetuity and the training schedule would be feasible for the Oregon Health Authority to sustain financially.

Community Support

Given that training is already mandated for CMHP Mental Health Investigators in the Oregon Administrative Rules, it is likely that further training would be supported. However, there may be pushback because of the additional time the training requires of CMHP staff who are already understaffed and under resourced.

Enforcement

Enforcement levels are also high for training as it is written in Oregon Administrative Rule that CMHP investigators and additional staff need to participate in required training to be certified. Further trainings on civil commitment processes could act as another educational requirement for the certification and recertification of CMHP staff. To further enforce this measure, specifics of the training and its requirements could be included in OAR 309-033-0920, Certification of Mental

Health Investigators (*Oregon Secretary of State Administrative Rules*, n.d.). This process would be done entirely through OHA and would not need the passage of the State Legislature. The drafted OAR would need to follow the OHA rules process.

Overall, implementing additional trainings for CMHP investigators would have high feasibility.

Equity

The trainings would be implemented in all geographic areas of Oregon experiencing civil commitment processes and allocated in the same manner, as the same Licensing and Certification Specialist would administer the same training to all 36 county CMHPs. By administering the training across the CMHPs, CMHP staff regardless of geographic area would have the same education on the civil commitment process and put all investigators at the same baseline when evaluating civil commitment clients. Further, given that rural counties tend to hold greater stigma surrounding mental illness, discussions surrounding bias could promote greater equity across urban and rural CMHPs as well (Mack et al., 2022).

Overall, implementing additional trainings would be ranked high in terms of equity.

Alternative 2: Clarifying the Dangerousness Definition in the Oregon Administrative Rules

Cost

A rules revision would involve an OPA 4, an OHA Rules Coordinator and Compliance Specialist 3 at OHA to construct a draft definition of dangerousness. An OPA 4 has an annual salary of about $124,718.49 including benefits (*Oregon Government Salaries*, n.d.). A consulted OPA 4 at OHA voiced that they spent approximately 40% of their time conducting rule overhauls over the past year, meaning that the weighted cost of an OPA 4 would be about $49,887.40. A rules revision team is usually comprised of two individuals, which would likely lead to the addition of a Compliance Specialist 3. This would take up about 20% of their time, leading to a weighted salary inclusive of benefits of $22,848.26. Lastly, to lead the revision and file the new definition with the Secretary State as well as facilitate the public hearings and the Rules Advisory Committee, an OHA Rules Coordinator would need to be involved. Given their caseload, this rule revision would likely take up about 30% of their time which leads to a weighted salary, inclusive of benefits, of $31,358.99. The total cost of these three individuals for one year would be about $104,094.65.

For further detail on cost calculations refer to Appendix B.

Effectiveness

The effectiveness of this alternative has been assessed using a bounding exercise to estimate the impact of revising the dangerousness definition on CMHP early dismissal rates. The central benchmark used in assessing effectiveness is that research has shown in North Carolina, 27.5% of individuals going through the civil commitment process are deemed dangerous because of a physical attack (Hiday & Smith, 1987). This means that about 27.5% of individuals would likely fit what is considered to be dangerous, as physically attacking an individual is widely understood as a dangerous act, and therefore, would be unlikely to be dismissed by investigators or judges.[7] Based

[7] Using the original dismissal rate of 70% by investigators and 30% by judges in Oregon, 21 persons would move forward in the commitment process. Given the North Carolina physical attack rate, there would be about 5-6 physical attacks which would be grounds for fitting dangerousness. If there were 100 persons going through the commitment

on the North Carolina data, I assume that roughly 27.5 percent of the civilly committed patients in Oregon are committed because of committing a physical attack against others. This would be approximately 5-6 percent of all individuals entering the civil commitment process.

This means that at most, with a stricter dangerousness standard, about 95% would be dismissed by investigators. It can be assumed that because a stricter definition of dangerousness would result in greater dismissal rate as the definition would narrow who qualifies as dangerous. This means that at minimum, the dismissal rate would stay at the current rate of 70%, as the same amount or more individuals would be dismissed, not less. This would lead to an increase of between 0 and 25 percentage points. Where the dismissal rate falls in the range of 70%-95% will depend on the narrowness of the definition.

For greater detail on the effectiveness calculations for this alternative, please refer to Appendix C.

Feasibility

Sustainability, Enforcement and Community Support

Given that the definitions would be codified in rule, they could be easily sustained and enforced. The current civil commitment rule set has not been revised in about 3 decades, and if an explicit definition of dangerousness and additional terminology were to be put into rule, it would likely be sustainable for decades to come. Further, because this would be a "one-time" project, it would be financially feasible for the Oregon Health Authority to take on.

However, there would be much difficulty in gaining support for a change in the definition of dangerousness within the community. The dangerousness standard has been controversial since its mandate in 1975 (Moon, 2014), and it is likely that stakeholders including the Department of Justice (DOJ), providers, the Oregon Association of Hospitals and Health Systems, OSH, peers, and CMHP staff would all have differing perspectives on how the definition should be formulated, which could make it difficult for the revised OAR to be put in place.

Additionally, an OPA 4 mentioned that explicitly defining vague terms in the OARs could have two major consequences including that defining one term leads to defining everything within that term and then it is a cycle of having to define every tiny detail, and that terms are used differently throughout the Oregon Administrative Rules, and as a result, there would be contradicting definitions of the same term which could be confusing for staff.

Because of the high sustainability and enforcement, but low community support, explicitly defining "dangerousness" and additional civil commitment terminology would have "Medium" feasibility.

Equity

OARs are implemented in all geographic areas of the state and would apply to CMHPs in the same manner. However, a narrower definition would set a higher standard for dangerousness which could result in under inclusiveness as the system could fail to detect individuals who are a

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process, the original investigator dismissal rate of 70% would bring this down to 30 people, holding the judge's dismissal rate at 30%, 9 more would be exited from the process meaning that 21 persons would move forward. Given that there are 5-6 physical attacks, about 5-6 individuals would be put through the process from the original 100 persons meaning the upper bound of dismissal would be about 94%-95%.

danger to themselves or others because they are bounded by the language of the definition (Simpson Jr., 1984). It is important to note that this could also impact Northern, Southern and Frontier counties differently as Northern counties are pro-deinstitutionalization, while Southern counties tend to be conservative leaning and Frontier counties do not want government involvement.

As a result of its possibility of impacting various geographic regions differently, equitability for this alternative is ranked as "Medium."

Alternative 3: Additional Funding for Increased Beds

Cost

According to an OPA 4, a bed at the Oregon State Hospital costs approximately $1,500 per day. According to estimates below in the effectiveness section, Oregon State needs approximately 10 more civil commitment beds per year. Given that the budget is on a biennium schedule, if this program were to be implemented for two years, the total cost of the ten beds would be approximately $11.2 million.[8]

Funding for the beds would have to come from the CFAA (County Financial Assistance Agreements) in which the Oregon Health Authority provides funding to the CMHPs (Oregon Health Authority 2021-23 Legislatively Adopted Budget, n.d.). For more beds to be allocated, there would have to be a pool of funds in the state's passed budget for behavioral health infrastructure, in which a Compliance Specialist at the Oregon Health Authority would disperse via contracts to the CMHPs. A Compliance Specialist 3's annual salary inclusive of benefits is about $114,241.32 (Oregon Government Salaries, n.d.). A Compliance Specialist 3 at OHA noted that meeting with the parties, and making sure they are fulfilling their obligations takes up between 15%–20% of their worktime. The average of this range is 17.5%. 17.5% of a Compliance Specialist 3's annual salary, inclusive of benefits, is about $19,992.23. Given that the other alternatives are measured in terms of one year, a one-year cost of this alternative is approximately $5,604,492.23.

For greater detail on cost calculations refer to Appendix B.

Effectiveness

It has been estimated that there should be at least 50 psychiatric beds per 100,000 in the population (Fuller et al., 2016). In the state of Oregon, there are currently 16.2 beds per 100,000 in the population which is 32.4% of the recommended number of beds per 100,000 individuals (Fuller et al., 2016). Out of Oregon's 16.2 beds per 100,000 people, only 5.3 of these beds are for civilly committed patients (Fuller et al., 2016). Therefore, about 1/3 of Oregon's beds are for those under civil commitment, while 2/3 are for forensic patients. Assuming the share of forensic beds would not change, the overall number of civil beds should be triple the amount that is currently standing to reach the recommended capacity, which would be 15 beds. After the current 70% and 30% dismissal rates by both the investigators and judge, of the 21 people out of 100 to continue forward in the commitment process only 5 beds are available for them. Therefore, only 1/4 of

[8] This number comes about because $1,500 multiplied by 365 days in a year is equal to $547,500. This would then have to be multiplied by 10 for the number of needed beds which is about $5.5 million. Adjusting for inflation in the second year (5.5M × 1.04), given a two-year cycle, since the Oregon State Legislature passes a budget for OHA biannually, this would come out to approximately $11 million.

those civilly committed are receiving a bed and 16 individuals are being undertreated. The new rate of 15 civil beds instead of 5.3 leads to a bounding exercise:

(1) On one end, the beds could triple, yet the commitment rate would stay constant because the number of individuals who would have previously been committed under the 70% dismissal rate are receiving beds. Explicitly, increasing beds would mean that more already-committed patients are receiving the level of care they need, and CMHPs may be hesitant to commit more patients for whom there still would not be capacity to provide sufficient care. This would result in no new commitments, but more of the 21 people committed would receive a bed (instead of 5 persons receiving a bed, 15 persons out of the 21 would receive a bed). This would be the upper bound for dismissal rates at 70% because there is no change in dismissal rate, only a change in the number of individuals allocated a bed.

(2) Concerning the lower bound to this exercise, it is established that under current conditions, 16 people are being undertreated while 5 are receiving a bed. With the new condition of the beds, there would be up to 31 individuals that are not dismissed throughout the civil commitment process. To get 31 people through the process, the dismissal rate would have to be at 56%. In more simple terms, CMHPs may still commit more patients than there are beds for, and if the number of commitments in excess of bed availability stays the same, that would result in 31 committed patients.

As a result, the intervention of an additional 10 beds for civil commitment could yield a between 56%–70% dismissal rate by investigators, which is between a 0-14 percentage point decrease in dismissal rate.

For greater detail on the effectiveness calculations for this alternative, please refer to Appendix C.

Feasibility

Sustainability

In the 21-23 biennium, OHA was allocated $1.35 billion by the State Legislature for Behavioral Health and contracted millions of dollars through CMHPs for supported housing and beds for forensic clients, which could be applied similarly to civil commitment (Oregon Health Authority, 2022). However, funding for CMHPs is based off the Governor's Budget passed by the State Legislature every two years. Given that the nature of the funding is contingent on the Governor and their priorities for the state, it is not likely that funding ten additional civil commitment beds would be sustainable in the long-term.

Community Support

There would likely be high support from CMHP staff for increasing civil beds as they would be able to place a greater number of civilly committed individuals into facilities for treatment instead of having to set up more complex outpatient treatment plans. However, facility staff may be opposed to increasing beds as there is currently a staffing shortage crisis at psychiatric hospitals in Oregon State (Oregonian/OregonLive, 2022). Adding more beds to facilities would only increase workload on facility staff, and therefore, may cause pushback from OSH, Acute Care Facilities, and the Oregon Association of Hospitals and Health Systems.

Both the OPA 4 and the Compliance Specialist 3 on the civil commitment team felt that the State Legislature would support and provide funds for additional beds. However, they would not assist in resolving the workforce shortage. It was remarked by the Compliance Specialist 3 that additional beds do not necessarily equate to better treatment. As a result of the limited staffing, more beds could just warehouse people without effective treatment. The OPA 4 felt that there should not be a greater investment in OSH beds because Aid and Assist patients have taken them over and there is no room for civil patients. Instead, they suggested that hospital units should be expanded to align beds with staffing ratios and closed facilities should be reopened.

Enforcement

As described, a Compliance 3 Specialist would work with the CMHPs to provide oversight to ensure CMHPs are fulfilling their obligations of putting the funding towards civil commitment beds at nearby facilities.

Although community support and enforcement are highly feasible, financially, this endeavor would not be sustainable, and as a result, would be ranked as having "Medium" feasibility.

Equity

This alternative can increase equitable outcomes by removing capacity bias in investigations and allowing more civilly committed individuals' inpatient treatment. Additionally, the allocation of beds would be distributed based on need. Given this, the equitability of additional funding for increased beds would be high.

For an assessment of the Supplemental Alternative of Mandating Quarterly Data Reporting from CMHPs, please refer to Appendix D.

Outcomes Matrix[9]

	Cost (At One Year)	Effectiveness	Feasibility	Equity
Alternative 1: Civil Commitment Training	$130,872.05	5 to 6 Percentage Point Decrease	High	High
Alternative 2: Revising Definitions	$104,094.65	0 to 25 Percentage Point Increase	Medium	Medium
Alternative 3: Increasing Beds	$5,604,492.23	0 to 14 Percentage Point Decrease	Medium	High

Recommendations

Considering cost, effectiveness, feasibility and equity, it is suggested that the Oregon Health Authority implement subsequent training on the civil commitment process including how to apply rules and statute to investigations, providing a standardized checklist of what investigators should be considering when evaluating an individual undergoing the civil commitment process, and conducting regional meetings between CMHP and OHA to address stigma surrounding mental health as it relates to the Northern, Southern and Frontier counties.

In parallel with the training, it is also recommended that the OARs are reviewed for ambiguity in foundational civil commitment terminology such as "dangerousness" and "basic need" and to undergo a rules process to make these terms more explicit. However, while conducting this rule review, it is crucial that OHA staff pay careful attention to how these definitions may impact early dismissal rates. As noted by the range of effectiveness of a stricter dangerousness standard, more explicit definitions could result in increased dismissal rates.

Implementation

Implementing Trainings

The first step in the process to implementing trainings would be to hire one additional Licensing and Certification Specialist who will be able to conduct the trainings across the state. Leadership for the Behavioral Health Team will have to send out an application, conduct interviews and hire an individual who meets the qualifications to train CMHPs on civil commitment processes. After the hiring has taken place, the Licensing and Certification Specialist will need to collaborate with an Operations and Policy Analyst or Compliance Specialist on the civil commitment team to draft a rule regarding the mandating of further training for CMHP investigators on the civil commitment process in addition to their current training standards in Oregon Administrative Rule 309.033.0920, Certification of Mental Health Investigators. For the rule to be effective the following rules process will have to take place which is overseen by an OHA Rules Coordinator:

[9] Note that when cost is assessed, each alternative is evaluated on the scale of a one-year timeline. However, it is expected that the rule revisions will take place one time, whereas increasing beds would incur costs of those beds every year, and there would likely be diminishing training costs overtime as less CMHP staff would need to be trained.

1. Engagement sessions with CMHP Directors, staff, and additional stakeholders from all counties will be held to gauge feedback and thoughts on the rule revision and mandating of additional training.
2. A financial and equity impact statement of the rule revision will have to be drafted by the Licensing and Certification Specialist as well as those on the civil commitment team.
3. Rules Advisory Committee invitations will be sent out to a select list of individuals to give additional feedback on the rule revision.
4. The proposed rule changes will be sent to a general contact list of individuals subscribed to Oregon Health Authority's listserve to receive updates on civil commitment rules.
5. A Rules Advisory Committee meeting will be held with the select individuals and notes will be taken on their feedback on the rule revision, as well as the financial and equity impact statements.
6. A written comment period following the RAC will be held for members of the RAC to submit additional feedback to the OHA members drafting the rule revision.
7. A Public Comment Period on the rule revision for the Secretary of State will open.
8. A Public Hearing on the rule revision will be conducted by OHA members drafting the rule revision.
9. The Public Comment Period on the rule revision for the Secretary of State will close.
10. The Oregon Health Authority Staff and Rules Coordinator will file the rule revision with the Secretary of State.
11. The new rule will become effective.

After the rule has becomes effective, the Licensing and Certification Specialist along with the Operations and Policy Analyst or Compliance Specialist from the civil commitment team will need to create materials for the trainings including PowerPoints, practical exercises and cases, and a standardized checklist of criteria for investigators to refer to when investigating an individual undergoing the civil commitment process.

The Licensing and Certification Specialist will then have to reach out to CMHP Directors to schedule training sessions throughout the year with all 36 county-level programs. After scheduling these training sessions with the CMHPs, the Specialist will have to travel to the CMHPs on those scheduled dates to conduct the trainings.

The rule process will only take place one time. However, the additional training for CMHP investigators will take place at least once every three years to recertify mental health investigators at the CMHPs as well as train new CMHP investigators.

Further, the civil commitment team including the Operations and Policy Analyst and Compliance Specialist will set up regional meetings with counties to discuss any challenges they have run into when conducting the civil process and stigmas surrounding civil commitment in their region. To do this, the members of the civil commitment team will have to send communications about these meetings to all CMHPs and their staff, create an agenda for the regional meetings, and hold the meeting to discuss addressing challenges and stigmas within regional communities.

Possible Challenges and Limitations in Implementing Trainings

There may be challenges in finding a candidate for the Licensing and Certification Specialist position. This could be mitigated by casting a wide net for the position and advertising it to

CMHPs and hospitals who may have staff that qualify for the role. Another challenge that could be faced is that CMHP Directors and staff oppose the idea of additional trainings because it takes away valued time of the CMHP staff, which is highly under resourced. This could be mitigated by splitting the training sessions up, such as having training for one hour every other Friday for three months, so it is not eating up a day's worth of work all at once.

Regarding regional meetings, CMHP members and staff may not want to attend and are not required to attend. Without their participation, stigma and other obstacles they are facing in their work may not be addressed. This can be mitigated by incentivizing attendance at the meetings. One incentive could be implementing stipends for the CMHP staff in exchange for attendance and participation. However, this stipend would have to be factored into the cost of the alternative if it is pursued.

Implementing More Explicit Definitions

In addition to implementing practical training while conducting the rules revision process, OHA staff should work to define vague terms concerning the civil commitment criterion including "dangerousness," "basic needs" and "imminent." To implement this, OHA staff would follow the same rules process as listed in the "Implementing Training" section. However, before the engagement sessions take place, the civil commitment team should create a small workgroup including stakeholders from CMHPs, hospitals, the DA's Office, and OSH to discuss and craft definitions to present in the engagement sessions with additional stakeholders. To do this, the civil commitment staff would have to invite select persons to the workgroup and set up meetings to decide what terms need to be more explicitly defined and how they would define them incorporating feedback from all the primary stakeholders. After the rules process takes place and the definitions are put into effect, the civil commitment team would have to inform CMHPs of these new definitions. This could be done in one of two ways:

(1) The definitions could be implemented into the newly established civil commitment trainings which would be presented to all CMHPs by a Licensing and Certification Specialist.
(2) The OHA civil commitment team could set up separate meeting sessions to explain the effective definitions to CMHPs and answer any questions on how to apply the definitions to the civil process.

Possible Challenges and Limitations in Implementing More Explicit Definitions

The two largest challenges in implementing more explicit definitions for civil commitment processes and criteria into the Oregon Administrative Rules include:

(1) The workgroup is not able to come up with an agreed upon definition of the terms.
(2) A large group of the stakeholders are against the agreed upon definitions, and as a result, there is no stakeholder buy-in.

The first challenge could be mitigated by comparing Oregon's current definitions to definitions of these terms in other states that are similar to Oregon politically, demographically, and geographically. After finding state definitions that resonate with the group, the new definitions can be crafted around the comparable state's standard. To address the second challenge, OHA would

have to consult all stakeholders individually to receive their input and continue to edit and revise the definitions until the majority of stakeholders are on board.

Conclusion

Overall, standardizing the civil commitment process across Oregon State is complex and does not have a perfect solution. However, by implementing additional process trainings and regional meetings to address stigma and challenges, as well as concretely defining civil commitment terminology within the Oregon Administrative Rules, it is possible to remove biases in the process, leading to more equitable outcomes for individuals and greater uniformity in Oregon's 36 counties.

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APPENDIX

Appendix A: State Comparison of Dangerousness Statute and Definitions

STATE	DANGEROUSNESS AND DEFINITION OF DANGEROUSNESS STATUTE
Oregon	"Dangerous to self or others."
Wisconsin	The individual is dangerous because he or she does any of the following: a. Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm. b. Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do serious physical harm. c. Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury is not substantial ... if reasonable provision for the subject individual's protection is available in the community and there is a reasonable probability that the individual will avail himself or herself of these services[.] ... Food, shelter or other care provided to an individual who is substantially incapable of obtaining the care for himself or herself, by a person other than a treatment facility, does not constitute e reasonable provision for the subject individual's protection available in the community[.]
North Carolina	"Dangerous to himself or others" means: a. "Dangerous to himself" means that within the relevant past: 1. The individual has acted in such a way as to show: I. That he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self- protection and safety; and II. That there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself; or 2. The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given pursuant to this Chapter; or

	3. The individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter. Previous episodes of dangerousness to self, when applicable, may be considered when determining reasonable probability of physical debilitation, suicide, or self-mutilation. b. "Dangerous to others" means that within the relevant past, the individual has inflicted or attempted to inflict or threatened to inflict serious bodily harm on another or has acted in such a way as to create a substantial risk of serious bodily harm to another or has engaged in extreme destruction of property; and that there is a reasonable probability that this conduct will be repeated. Previous episodes of dangerousness to others, when applicable, may be considered when determining reasonable probability of future dangerous conduct. Clear, cogent, and convincing evidence that an individual has committed a homicide in the relevant past is prima facie evidence of dangerousness to others.
New Jersey	"Dangerous to self" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical harm or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available. This determination shall take into account a person's history, recent behavior and any recent act, threat or serious psychiatric deterioration. "Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act, threat, or serious psychiatric deterioration.
Colorado	"Danger to self or others" means: (a) With respect to an individual, that the individual poses a substantial risk of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm to himself or herself; or (b) With respect to other persons, that the individual poses a substantial risk of physical harm to another person or persons, as manifested by evidence of recent homicidal or other violent behavior by the person in question, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt, or threat to do serious physical harm by the person in question.

Source: Treatment Advocacy Center. (2020). *STATE STANDARDS FOR CIVIL COMMITMENT*.

Appendix B: Cost Calculations

Civil Commmitment Process Training	Weighted Cost at One Year *Major benefits accounted for as 29% of the position's salary
Licensing and Certification Specialist Salary (100% of their time)	$82,115.00 x 0.29= $23,813.35 $82,115.00 + $23,813.35= $105,928.35 $105,928.35 x 1.00= $105,928.35
Operations and Policy Analyst 4 Salary (20% of their time)	$96,681.00 x 0.29= $28,037.49 $96,681.00 + 28,037.49= $124,718.49 $124,718.49 x 0.20= $24,943.70
Total Cost At One Year	$130,872.05

Revised Definitions	Weighted Cost at One Year *Major benefits accounted for as 29% of the position's salary
Operations and Policy Analyst 4 Salary (35% of their time)	$96,681.00 x 0.29= $28,037.49 $96,681.00 + $28,037.49= $124,718.49 $124,718.49 x 0.40= $49,887.40
OHA Rules Coordinator (30% of their time)	$81,030.98 x 0.29= $23,498.98 $81,030.98 + $23,498.98= $104,529.96 $104,529.96 x 0.30= $31,358.99
Compliance Specialist 3 (20% of their time)	$88,559.16 x 0.29= $25,682.16 $88,559.16 + $25,682.16= $114,241.32 $114,241.32 x 0.20= $22,848.26
Total Cost At One Year	$104,094.65

Increasing Beds	Weighted Cost at One Year *Major benefits accounted for as 29% of the position's salary
Compliance Specialist 3 (20% of their time)	$88,559.16 x 0.29= $25,682.16 $88,559.16 + $25,682.16= $114,241.32 $114,241.32 x 0.175= $19,992.23
Beds ($1,500 per day)	$1,500 x 365= $547,500 $547,500 x 10= $5,475,000 (Year 1) $5,475,000 x 1.04= $5,694,000 (Adjusting for Inflation in Year 2) [($5,475,000 + $5,694,000)/2]= $5,584,500
Total Cost At One Year	$5,604,492.23

Data Reporting	Weighted Cost at One Year *Major benefits accounted for as 29% of the position's salary
Operations and Policy Analyst 4 Salary (100% of their time)	$96,681.00 x 0.29= $28,037.49 $96,681.00 + 28,037.49= $124,718.49 $124,718.49 x 1.00= $124,718.49
Information Systems Specialist 5 (20% of their time)	$80,000 x 0.29= $23,200 $80,000 + $23,200= $103,200 $103,200 x 0.20= $20,640
MOTS Data Tracking System	Unavailable
Total Cost At One Year	$145,358.49 in addition to the unaccounted costs of the MOTS data tracking system

Appendix C: Effectiveness Calculations[10]

Alternative 1: Civil Commitment Process Training for CMHP Staff

Difference in family training rate of commitment: 79%-60%= 19%
Difference in psychiatric training rate of commitment: 77.66%-83.75%= –6.09

Averages of rates of commitment:
Family training average rate of commitment: 19/60= 32%
Psychiatric training average rate of commitment: –6.09/83.75= –7.2%

Weighted averages of rates of commitment
Family training weighted rate of commitment: 32% × 0.7= 22.4%
Psychiatric training weighted rate of commitment: –7.2% × 0.3= –2.16

Weighted averages of rates of commitment added:
22.4% + –2.16%= 20.24% or about 20%

Weighted average in numerical context of the civil commitment process:
If 100 individuals enter in the civil commitment process, 70% are dismissed during the NMI stage which is 100 × 0.7= 70. Decreasing the 70 dismissed cases from the original 100 persons leaves 30 people going through the civil commitment process. An additional 30% of the 70 are then dismissed by a judge during the individual's hearing for civil commitment, which would be 70 × 0.3= 21, meaning that 21 persons would undergo civil commitment out of the 100 persons that were originally filed for commitment.

Applying the added weighted average rates of commitment:
21 persons × 0.20 or 20%= about 4 persons
21+4= 25 persons put through civil commitment process instead of 21
25 persons/70% investigator dismissal rate= 35.7%
100%-35.7%= 64.3%

Dismissal rate is 64%–65% instead of the original 70%
70%–64%= 6%
70%–65%= 5%

Intervention of training could decrease investigator dismissal rates by approximately 5–6 percentage points.

[10] It is critical to acknowledge the limitations in the assessment of effectiveness of all three alternatives. The data is loosely based off tangential studies, which is a result of the lack of quantifiable data regarding these alternatives and absence of data surrounding civil commitment in general.

Alternative 2: Clarifying the Dangerousness Definition in Civil Commitment Rules

If 100 individuals enter in the civil commitment process, 70% are dismissed during the NMI stage which is 100 × 0.7= 70. Decreasing the 70 dismissed cases from the original 100 persons leaves 30 people going through the civil commitment process. An additional 30% of the 70 are then dismissed by a judge during the individual's hearing for civil commitment, which would be 70 × 0.3= 21, meaning that 21 persons would undergo civil commitment out of the 100 persons that were originally filed for commitment. In North Carolina, about 27.5% of individuals going through the civil commitment process are deemed dangerous because of physical attack. Meaning that about 27.5% of individuals without doubt fit what is considered to be dangerous and therefore, would not be dismissed by investigators or judges. This 27.5% of individuals deemed definitively dangerous will be applied to understand the effectiveness a revision of the dangerousness standard could have in Oregon State.

21 persons × 0.275= 5.7 persons would commit a physical attack out of the 21 people not dismissed in Oregon's civil commitment process.

As a result, 5-6 more people would be put through the civil commitment process from the original 100 people.

Upper Bound:
100 people– 5 people= 95%
100 people– 6 people= 94%

The dismissal rate by investigators could be between approximately 70%–95%.

Dangerousness standard dismissal rate compared to original dismissal rate:
Lower Bound: 70%-70%= 0%
Upper bound: 95%–70%= 25%

Intervention of a tightly defined dangerousness standard could increase dismissal rates by between 0 and 25 percentage points.

Alternative 3: Additional Funding for Increased Beds

Context of Recommended Capacity:
It has been estimated that there should be at least 50 psychiatric beds per 100,000 in the population (Fuller et al., 2016). In the state of Oregon, there are currently 16.2 beds per 100,000 in the population which is 32.4% of the recommended number of beds per 100,000 individuals (Fuller et al., 2016). Out of Oregon's 16.2 beds per 100,000 people, only 5.3 of these beds are for civilly committed patients (Fuller et al., 2016). Therefore, about 1/3 of Oregon's beds are for those under civil commitment, while 2/3 are for forensic patients. Assuming the share of forensic beds would not change, the overall number of civil beds should be triple the amount that is currently standing to reach the recommended capacity.

Additionally, we are still under the assumption that if 100 individuals enter in the civil commitment process, 70% are dismissed during the NMI stage which is $100 \times 0.7 = 70$. Decreasing the 70 dismissed cases from the original 100 persons leaves 30 people going through the civil commitment process. An additional 30% of the 70 are then dismissed by a judge during the individual's hearing for civil commitment, which would be $70 \times 0.3 = 21$, meaning that 21 persons would undergo civil commitment out of the 100 persons that were originally filed for commitment.

Recommended Capacity Calculation:
Given that 21 persons are not dismissed throughout the civil commitment process, and only 5 of those 21 persons are receiving a civil bed, it is led to believe that 16 are being undertreated because they are not receiving a bed (21-5= 16). Using the new rate of tripling the number of civil beds, there should be about 15 civil beds instead of 5.3. In this instance 15/21 individuals would receive a bed. Out of this comes two scenarios which leads to a bounding exercise:

(1) On one end, the beds could triple, yet the commitment rate would stay constant because the number of individuals who would have previously been committed under the 70% dismissal rate are receiving beds. There are no new commitments, but more of the 21 persons committed, would receive a bed (Instead of 5 persons receiving a bed, 15 persons out of the 21 would receive a bed). This would become our upper bound for dismissal rates at 70% because there is no change in dismissal rate, only a change in how many individuals are allocated a bed.

(2) Concerning the lower bound to this exercise, it is established that under current conditions, 16 people are being undertreated because they did not receive a bed given 21 are committed, but only 5 are receiving a bed. Currently, there are 16 individuals without beds and 5 with beds (16+5= 21), with the new condition of the beds, there would be up to 31 individuals that are not dismissed throughout the civil commitment process as 16+15= 31.

To yield 31 people, the new dismissal rate would be:
31/ (0.7) = about 44% (Number of individuals not dismissed divided by the original dismissal rate); new amount of individuals not dismissed

100%-44%= 56% (Lower Bound Dismissal rate with 15 beds)

The intervention of an additional 10 beds for civil commitment could yield a between 56%–70% dismissal rate by investigators, which is between a 14–0 percentage point decrease in dismissal rate.

Appendix D: Application of Criteria to Supplemental Alternative of Data Reporting

Overarching Alternative: Mandate Quarterly Data Reporting from CMHPs and Produce an Annual Civil Commitment Report

Cost

The cost of gathering and presenting this data would likely be the salary of two separate employees. This includes an OPA 4 and an Information Systems Specialist 2. The Operations and Policy Analyst 4 would collect, organize, and construct reports of the data which would be their full salary. They would also meet and work with the CMHPs to gather this data. The salary of an OPA 4 is $124,718.49 inclusive of benefits (*Oregon Government Salaries*, n.d.). Furthermore, an Information Systems Specialist would work on a dashboard for the OPA 4 to store all the data. This would take about 20% of their salary. An Information Systems Specialist 5 has an annual salary of $103,200 inclusive of benefits (*Oregon Government Salaries*, n.d.) leading to a cost of $20,640 for one year.

An additional cost to this alternative would be the usage of MOTS (Measures and Outcomes Tracking System) which OHA uses to store and manage a majority of their data (*Oregon Health Authority : Measures and Outcomes Tracking System (MOTS) : Community Outcome Management and Performance Accountability Support System (COMPASS) : State of Oregon*, n.d.). However, the cost of this data management system, especially for an organization as large as OHA, is unclear. It is suggested that OHA reach out internally to inquire about the cost of this system, although it is known that MOTS is already purchased and used by OHA for other behavioral health clients including PSRB and Aid and Assist.

For one year, collecting, organizing and distributing civil commitment data would amount to about $145,358.49 in addition to the unaccounted cost of the MOTS data tracking system.

For greater detail on cost calculations, please refer to Appendix B.

Effectiveness, Feasibility and Equity

Data reporting would likely not have a direct influence on the civil commitment investigator dismissal rate; however, it would make patterns of commitment between counties more transparent. In terms of feasibility, established in Oregon Administrative Rule (OAR) 309-033-0290, a Community Mental Health Program must supply information about a person under civil commitment including "any other data as requested by the Division" (*Oregon Secretary of State Administrative Rules*, n.d.). As a result, it would be simple to request needed data from the CMHPs regarding their procedures surrounding the commitment of an individual. It is also sustainable financially as the Oregon Health Authority has Operations and Policy Analysts in place to collect, analyze and present data alike to this in other Health Systems Division Units such as for Aid and Assist clients. Much like the training, specifics on data reporting for CMHPs could be added to OAR 309-033-0290 with a rules process. As stated previously, the rules process is conducted entirely through OHA and would not need the passage of the State Legislature. The drafted OAR regarding data would follow the OHA rules process which involves filing the rule with the Secretary of State and the assistance of an OHA Rules Coordinator to hold public comment sessions and Rules Advisory Committees (RACs).

What could be more difficult to achieve is community support and enforcement of data reporting. According to an OHA Policy Analyst, recently, the Oregon Health Authority issued that CMHPs provide a form detailing any transfers or placements of civil commitment clients to facilities. There was a large amount of pushback from CMHPs noting that they are understaffed, time-constrained, and the form was an added burden to their workload. There would likely be even greater pushback if additional data reporting was required of them. The only leverage OHA could utilize to force the CMHPs to supply this data is withholding CFAA funding. However, withholding funding would only disadvantage the Oregon Health Authority as they need Community Mental Health Programs to continue to supply behavioral health services in their respective counties.

Although data reporting does not influence equity directly, a data reporting system could be used by the Oregon Health Authority and CMHP administrators to identify variations between counties and allow them to resolve irregularities (Larry R. Faulkner et al., 1983), which could lead to more equitable practices and therefore, outcomes, for those undergoing the civil commitments process.