

SENATE BILLS 510, 255 HOUSE BILL 2100

SENATE COMMITTEE ON JUDICIARY

April 4, 1973

1:00 p.m.

407 State Capitol

Members Present: Senator John Burns  
Senator George Eivers  
Senator C. R. Hoyt  
Senator Keith Burns, Vice Chairman  
Senator Elizabeth W. Browne, Chairman

Excused: Senator Vernon Cook  
Senator Robert Smith

WITNESSES: Dr. J. D. Bray, Administrator, Mental Health  
Division  
Dr. Kole, Assistant Administrator for Mental  
Health Services  
Dr. Brooks, Chairman of the Task Force for  
Senate Bill 510  
Judge Henry Kaye, Circuit Court Judge, Sixth  
Judicial District  
Judge Douglas Spencer, Circuit Judge, Second  
Judicial District  
David Koffee, Portland, Oregon  
Dr. John H. Waterman, Psychiatrist and Former  
Director of Mental Health Section of the  
Oregon State Board of Health  
Dr. Jeffry L. Hicks, 2475 Jefferson, Eugene, Ore.,  
Board of Social Issues, Oregon Psychological  
Association  
Judge William S. McLennan, Circuit Court Judge,  
Multnomah County, Dept. Number 7  
Dr. Don Weston, President of the Oregon  
Association of Mental Health Clinic Directors  
Judge Gordon Sloan, Workmen's Compensation Board  
Mr. E. F. Malagon, Attorney from Eugene repre-  
senting the American Trial Lawyers Association  
and the Oregon Workmen's Compensation  
Attorneys  
Mr. Karl R. Frederick, Associated Oregon Industries  
Harvey Ward, representing the Motor Vehicles Dept.

SENATE BILL 510

DR. J. D. BRAY, Administrator, Mental Health Division, DR. KOLE, Assistant Administrator for Mental Health Services, DR. BROOKS, Chairman of the Task Force that developed the basic ideas for Senate Bill 510. SEE EXHIBIT A. Dr. BRAY explained that because of the patchwork way in which the laws had developed, the Mental Health Division, during the winter of 1972, appointed a Task Force to study the commitment laws that exist now and to review the

commitment laws of the other states. Their goal was to examine the laws and come up with a position that would be suitable to the number of organizations and people. Ten organizations participated in the Task Force and were officially requested by the Division to participate along with private psychiatrists, hospital superintendents, etc.

Attachment I (EXHIBIT B) carries the membership of the task force.

DR. BRAY continued his testimony. (SEE EXHIBIT A).

In reply to a question by SENATOR JOHN BURNS, DR. BRAY referred him to Attachment II (EXHIBIT C). These are court commitments only. They do not include voluntary commitments.

SENATOR JOHN BURNS asked why there has been a decrease and DR. BRAY replied that this was because of the developments of alternatives and that some counties are beginning to screen prior to commitment.

SENATOR JOHN BURNS then asked what the increment in the mental health staffing has been in Multnomah and Washington Counties. He wanted to know, since the discussion had talked about investigation and development of alternatives, what staff is available to the Division to perform these kinds of services.

DR. BRAY replied that during the past biennium, all community health clinics of which the Multnomah Community Health clinic is one, have been held to a five percent per year growth in actual increases in bodies. Since the beginning of this biennium there has been very little increase.

SENATOR JOHN BURNS wanted to know why there had been the dramatic reduction as per EXHIBIT C if there has not been an increase in staff.

DR. BRAY explained that part of this can be explained by the use of the new technique. However, he feels that the staff is being stretched very thinly in order to accomplish what has been accomplished.

SENATOR JOHN BURNS asked whether it was not true that a great many people were using the Crisis Unit when formerly they had been taken to court. DR. BRAY agreed that this was a factor and would fall under their classification of alternatives to hospital care.

SENATOR BURNS asked whether their budget had been heard in the Ways and Means Committee. Was the Crisis Unit Budget included with the Medical School budget rather than with mental health? SENATOR BURNS asked that DR. BRAY keep him personally apprised of the happenings with regard to these budgets.

SENATOR HOYT asked what was special about Deschutes, Jackson, Polk and Umatilla Counties and Linn that there seems to be no apparent improvement.

DR. BRAY replied to SENATOR HOYT'S question by saying that the statistics in EXHIBIT C referred to just court committed patients. To be more complete, voluntary patients that are admitted should be shown on this Exhibit. The second consideration would be the existence of alternatives in the counties to state level hospital care.

It was also pointed out by DR. KOLE that Umatilla County houses Eastern Oregon Hospital and patients go to that hospital voluntarily from Eastern Oregon and end up being committed within the County of Umatilla. This would show up in the statistics for Umatilla County.

SENATOR HOYT then asked about the other counties west of the mountains that had shown little improvement.

DR. KOLE stated that different counties had implemented the early intervention techniques differently. DR. KOLE cannot state on a county by county basis which have and which have not.

DR. BRAY continued with his testimony. SEE EXHIBIT A.

SENATOR BROWNE asked DR. BRAY to please summarize his testimony due to the other witnesses who must be heard. He gladly complied. SEE EXHIBIT A.

ALSO see EXHIBITS D, E, F.

SENATOR JOHN BURNS asked whether the budget referred to in DR. BRAY'S testimony was the budget just approved by Ways and Means and DR. BRAY replied that it was.

SENATOR JOHN BURNS asked whether any consideration had been given to readjustment of the ratio of contribution between the local and the state for mental health funding in view of the fact that there is going to be a saving to the localities for its law enforcement.

DR. BRAY replied that this information was not available at the time of the Ways and Means decision.

DR. BROOKS called attention to EXHIBIT F.

DR. BRAY stated that they did have one proposed amendment. If the moneys are not forthcoming--actually, even if they are,--it is going to be difficult to make these significant changes by July 1 of this year. They would like to postpone the enactment of this bill until July 1, 1974. DR. BRAY said that he feels Senate Bill 510 represents the most significant change in Oregon commitment laws probably ever.

SENATOR JOHN BURNS commended the task force who worked on this project. He feels they all did a tremendous job.

JUDGE HENRY KAYE, Circuit Court Judge, Sixth Judicial District (Umatilla and Moro Counties). Judge Kaye was a member of the task force under the leadership of DR. BROOKS.

JUDGE KAYE responded to the question which had been asked earlier as to why Umatilla County shows a high commitment record. The only answer that he could give was because Eastern Oregon Hospital and Training Center is located in Pendleton and it serves the greater portion of eastern Oregon. Many people come to this hospital under a voluntary commitment procedure and then at the time they seek release, the hospital staff, in many cases, does not feel they are ready for release. This is where Judge Kaye is called upon to do a court commitment. This, Judge Kaye feels, accounts for the figures in EXHIBIT B.

JUDGE KAYE stated that, generally speaking, he is in favor of Senate Bill 510. He pointed out that those on the task force from the legal profession often took a different viewpoint from those representing the medical profession about some of the items incorporated in Senate Bill 510.

There were two or three things that Judge Kaye called the committee's attention to.

He called attention to section 3, page 3, lines 7 and 8. He then drew attention to line 18, page 3. Judge Kaye submits that the two persons who sign the notice of mental illness (lines 7 and 8) should also be exempt from criminal or civil liability provided they have acted in good faith on probable cause and without malice.

SENATOR HOYT asked the Judge if the person being committed does not have the benefit of a private, individual attorney--how are you going to keep these people honest was the point made by SENATOR HOYT.

JUDGE KAYE stated the bill specifically provides that an attorney shall be appointed for any person who is the subject of a commitment.

JUDGE KAYE then called attention to page 8, line 30. "If the court finds....." Also, line 32. JUDGE KAYE submitted that there are many cases where the person who has been found mentally ill will say that if he is not sent to the hospital he will be glad to go on an outpatient basis treatment; if it is a situation of alcoholism, the subject will be glad to go to AA, etc. They will agree to do most anything rather than be sent to the hospital.

The proposed law provides that if he is permitted to do the things he says he will do rather than go to the hospital, then the petition is dismissed. If, after he has made this representation to you that he will do all of these things and he doesn't, then the

whole procedure must be repeated that is set forth in detail in this bill. JUDGE KAYE submitted that provision should be made for a conditional release. Then the person may be put on a voluntary basis and the petition is not dismissed unless you want to provide that it shall be dismissed after 45 days.

SENATOR JOHN BURNS asked whether the Judge's objection could be met by substituting the word "shall" for "may" on line 34.

JUDGE KAYE thought that would be acceptable.

JUDGE DOUGLAS SPENCER, Circuit Judge, Second Judicial District which is Lane County. SEE EXHIBIT G.

JUDGE SPENCER pointed out that there is a gap in the statute as it presently exists and as it is continued and that is that unless counsel is waived, they may now, and must under this new statute appoint an attorney. JUDGE SPENCER pointed out that unless it is waived this would require that an attorney be appointed whether the individual was able to afford one or not. If he is able to afford an attorney and does not choose to do so, under the statute, one would still have to be appointed because he hadn't waived one. This would not make a difference in Lane County because in Lane County they do not believe a person can waive an attorney if he is committed. A waiver of attorney is all right if he is not committed, but if he is committed, it is not. So, an attorney is appointed in every case where the individual does not have one.

In reply to question as to who paid for the attorney, JUDGE SPENCER stated that the county pays the attorney--poorly.

SENATOR JOHN BURNS asked with funds from where were these attorneys paid. JUDGE SPENCER replied that they were paid from a budget received from Lane County Commissioners.

SENATOR BURNS then stated that there was no statutory procedure for it now. It does not come under 135 on criminal appointments. He then asked whether it was just by agreement of the court and the county commissioners.

JUDGE SPENCER replied that he gathered that was true. It has been done since before he went on the bench and he never questioned it. He continued that if the committee does believe there is such a thing as a "waiver" then he would point out the wording in section 6 subsection (2) on page 6 of the bill. They know of no basis for appointing counsel except at public expense.

JUDGE SPENCER then returned to his written testimony. SEE EXHIBIT G. He now addressed his remarks to section 12 (3) 15, 16, 17, 18 and 19.

SENATOR JOHN BURNS asked whether there were any private psychiatric security facilities in Lane County.

JUDGE SPENCER replied that there was. The Robert O. Johnson unit at the Sacred Heart Hospital does have some security facilities. It is used and it works out all right in 98% of the cases.

JUDGE SPENCER is concerned about the counties that just do not have hospitals.

JUDGE KAYE stated that he did not mean to be in disagreement with his colleague, but he would submit to the committee that subsection (5) of section 3 would cover the situation that JUDGE SPENCER is concerned about. That subsection covers the situation that JUDGE SPENCER is concerned about, of time delay of investigation. The subsection provides that if the court finds there is probable cause to believe that failing to take the alleged mentally ill person into custody--pending the investigation before the hearing, then, the court may issue and the patient may be taken into custody under an emergency situation. JUDGE KAYE feels that probable cause can be given by the person who is making the complaint of the mental illness of the individual.

JUDGE SPENCER replied that he is thinking of the unhappiness and anxiety caused by the delay, not so much the danger to the patient or the community.

DAVID KOFFEE (did not give his address). He explained that his paper was not exhaustive. (DID NOT LEAVE HIS TESTIMONY.) MR. KOFFEE explained that he is an ex-mental patient. His problem is epilepsy. He said he has a very rare form of this disease. The symptoms parallel those that are classified under mental illness. He was called a schizophrenic for a long time. MR. KOFFEE explained that he was reading into the record a temporary draft and an improved draft would be mailed later. See written testimony of April 16, 1973.

MR. KOFFEE was not asked any questions.

MR. KOFFEE urged that in Senate Bill 510 the amended portion, at least, of ORS 426.290 section 27 appearing in lines 12-20 on page 16 of the printed bill be stricken.

DR. JOHN H. WATERMAN, psychiatrist and was Director of the Mental Health Section of the Oregon State Board of Health and the Community Health Section of the Oregon State Board of Health for 18 years. DR. WATERMAN appeared not in behalf of the group. He had acted as a consultant. He stated that under the old law he had served on as many commitment hearings as any psychiatrist that he knows of and he has never seen anyone actually railroaded into the hospital.

DR. WATERMAN stated that he thinks the proposed law is an excellent one.

He does agree with some of the objections raised by both JUDGE SPENCER and JUDGE KAYE that need to be evaluated and thought about. He feels that investigations are necessary for physicians to render good diagnoses in relation to patients. He is very much in favor of the whole trend of the bill which is to provide community services for mentally ill persons. This has been accomplished in Douglas County. They have a holding facility much the same as the one at Sacred Heart Hospital in Lane County.

DR. WATERMAN stated that he was in favor of the bill and it should be financed properly as DR. BRAY pointed out.

JEFFRY L. HICKS, 2475 Jefferson, Eugene, Ore., Board of Social Issues, Oregon Psychological Association. "We of the Board are strongly in favor of the passage of Senate Bill 510." EXHIBIT J.

There are a couple of areas of the bill over which they do have some concern. Dr. Hicks referred the committee to page 4, lines 21 and 22. He stated he should probably start before that with the words "If the court finds ...." The Board's concern came from the feeling that this might place the community mental health directors in the position of jailers. The issue of creditability is of primary importance.

SENATOR JOHN BURNS asked DR. HICKS what he would substitute for it. DR. HICKS stated that the consensus of his committee was that the detention proceedings should be relegated to existing law enforcement agencies for actual detention. They do not want the community mental health director put in a position of taking the person into custody.

SENATOR HOYT wanted to know how discretion could be used in taking people into custody when an untrained person would be doing it.

MR. HICKS replied that he was not sure he had a solution to that problem. He does not think it is necessary to have uniformed people breaking down the doors. He cannot see why it would not be feasible to have uniformed law enforcement personnel.

SENATOR JOHN BURNS asked JUDGE McLENNAN who executed the warrants in Multnomah County now.

JUDGE McLENNAN replied it was the Multnomah County Department of Public Health. Also, in reply to SENATOR JOHN BURNS, the Judge did say that on some rare occasions they requested help from the uniformed police officers. They have three men and one woman--all of whom have training--in police work.

MR. HICKS called attention to the second area of concern of the Board he represented. He referred the committee to page 16, lines 12 - 20. Their concern is that when a person who is not mentally ill is hospitalized and there is a procedure suggested such

as any form of surgery it is usually procedure to consult that person's relatives. DR. HICKS sees nothing of this sort in the proposed bill. He sees nothing that would include next of kin. He would suggest that that be included.

DR. HICKS stated that the Board of Social Issues feels that this bill is a very powerful piece of legislation and is strongly in support of its passage.

JUDGE WILLIAM S. McLENNAN, Circuit Court Judge, Multnomah County-- Department Number 7, hears all of the mental commitments that are conducted in Multnomah County. In any one year there are approximately 3,000 referrals made to the court in Multnomah County--as many as 800 result in commitment hearings. He has a staff of three devoted to this area of the law. The Judge spends about half of his time conducting these hearings. In Multnomah County over the last three months they have had public health nurses who have been employing precommitment screening process on an experimental basis. As far as he can determine, this appears to be quite satisfactory. It has reduced substantially the number of hearings that have come before the court.

SENATE BILL 510 contains a number of provisions which relate to due process. JUDGE McLENNAN and JUDGE DICKSON before him have been employing essentially all of the due process rights that are contained in this bill. They are very fortunate in Multnomah County to have the facilities of the Crises Unit at Multnomah Hospital. In those cases where the alleged mentally ill person has not had ample notice, quite often he does order that the person be returned to the Crises Unit for a period of time before the hearing in order that that person might prepare for the hearing and in order that that person might get some evaluation from the Crisis Unit as to how the person behaves in the hospital.

With respect to the right of counsel, the practice in Multnomah County is that the alleged mentally ill person has counsel in every case. They are often an opportunity and time in which to employ their own counsel; they are offered an opportunity if they do not have funds to select their own attorney--at this point I will appoint that attorney for them and the fee will be paid by the county; or finally, if they do not have a particular attorney in mind, or if they do not select their attorney, the Judge will appoint the public defender. A proportion of the cases are handled by the Public Defender. He has an attorney in Judge McLENNAN'S court five mornings a week. He has become extremely expert in handling the case. JUDGE McLENNAN has found that this has been a very satisfactory arrangement.

The prospective patient is offered an opportunity for a public trial; or, if they prefer, that the matter be heard in Chambers. A transcript of the hearing is made in every case. The Public Defender also provides, in Multnomah County, a social worker who can make provisions for alternative to commitment and is also very valuable

in terms of followup in cases where people have been committed. She can take care of details if the person has been committed. She can make provision for closing of an apartment, feeding of pets, etc.

JUDGE McCLENNAN discussed the right of the patient when in the mental hospital to be free from lobotomy and electro shock therapy. He has had a number of cases where persons have previously been in state mental hospitals and have been subjected to electro shock therapy and they request that anything be done to avoid further therapy of this sort. They do not want to go back as a court-committed patient because if they do they feel they will be subjected to electro shock therapy. JUDGE McLENNAN is informed that very, very rarely do they use this type of therapy; and pscho-surgery is completely obsolete. Since it is not done anyway, it would be much easier on the system if the Judge could look at the people and say honestly that they are not going to have to submit to the electro shock therapy or lobotomy without your expressed informed consent.

SENATOR HOYT asked whether the Judge saw any contradiction between the matter of the reports and the reports not being used in the hearing. Is that a matter that would bother JUDGE McLENNAN.

JUDGE McLENNAN replied that he did not find it bothersome. They do have reports from their precommitment screening team that come in now. Unless there is objection from counsel, he does make them available to the panel of physicians. So far, JUDGE McLENNAN knows of no case where the attorney has objected.

DR. DON WESTON, President of the Oregon Association of Mental Health Clinic Directors. This is the group of men who conduct the mental health programs in the community clinics. He is also Director of the Tualatin Valley Guidance Clinic. (SEE EXHIBIT H). They support the passage of Senate Bill 510.

SEE EXHIBIT I.

#### SENATE BILL 255

JUDGE GORDON SLOAN, Workmen's Compensation Board. JUDGE SLOAN stated that the Board vigorously supports the bill. It does not affect many people, but when it does affect people it can have very serious effects. The purpose of the bill is to correct inequities. This bill has been cleared by the Labor Committee and has now been referred to the Judiciary Committee.

MR. E. F. MALAGON, Attorney from Eugene, representing the American Trial Lawyers Association and the Oregon Workmen's Compensation Attorneys. The only thing that MR. MALAGON would add to what JUDGE SLOAN has said is that he would read briefly from the Supreme Court-- Oreg. 254.136--page 142 and MR. MALAGON read JUSTICE O'CONNELL dissent.

EARL R. FREDERICK, Associated Oregon Industries. MR. FREDERICK SPOKE in opposition to the bill, Senate Bill 255.

SENATE COMMITTEE ON JUDICIARY  
Room 407-A State Capitol  
April 16, 1973

1:00

SENATE BILLS 510, 583, 354, 563, 570, 352

MEMBERS PRESENT:           SENATOR JOHN BURNS  
                              SENATOR KEITH BURNS  
                              SENATOR EIVERS  
                              SENATOR HOYT  
                              SENATOR SMITH  
                              SENATOR BROWNE

Members excused:           Senator Cook

Witnesses:

Charles Williamson, Attorney, Legal Aid Service, Portland  
Stevie Remington, Executive Director of the American Civil  
                              Liberties Union  
Ruth Shepherd, private citizen, staff member of legislative  
                              Committee on Aging  
Representative Peck  
Jeffrey Mutnick, Public Defender, Multnomah County, Portland  
Sargeant John Murley, Tigard Police Department  
Gill Bellamy, Oregon Traffic Safety Commission

The meeting was called to order at 1:00 P.M. by Chairman Browne.

SENATE BILL 510

CHARLES WILLIAMSON: Attorney Legal Aid Service, Portland.  
Mr. Williamson referred to several newspaper clippings that  
came out in the last few months relating to mental health  
in Oregon. (SEE EXHIBIT A--archives file only) The Legal  
Aid Service handles many commitments of low income persons  
and became concerned about this area. Some of the problems  
that arise are: (1) persons are taken from their home early  
in the morning and given prefunctory hearings, (2) elderly  
and harmless persons, in some respects out of touch with  
reality, were committed, although, there was not much that  
could be done for them and they were functioning outside of  
an institution, (3) persons are taken to a mental hospital  
for a 'trial visit' and this is indefinite, sometimes they  
are committed 2-3 years later. SB 510 reflects some of the  
changes that the Constitution has required that the law make.  
Legal Aid endorses this bill. See written proposed amendments,  
EXHIBIT B.

STEVIE REMINGTON: Executive Director of the American Civil  
Liberties Union. She submitted testimony prepared by Myron  
Katz, Chairperson of the ACLU Task Force on Involuntary  
Mental Commitment. SEE EXHIBIT C.

RUTH SHEPHERD: Testifying on behalf of herself, with the per-  
mission of the Committee on Aging of which she is a staff member.

She generally supports this bill with a few reservations. Ms. Shepherd cited her past experience in this field from which she has drawn her testimony. It is possible that none of the referrals of elderly persons to mental hospitals over the last few years were necessary. They must be seen in the light of the great need for alternative services. Alternative services at the community level all too often neglect the senior persons of that community. Very few persons are involved with these programs. Welfare designated \$30,000 in the last biennium to home care services which might have precluded institutional care had we been able to increase that amount. Only 99 persons over 65, in the last biennium, were recorded as having been involved with the division and treatment program at any point in the state.

SENATOR JOHN BURNS: Please translate that figure, I don't understand it.

SHEPHERD: Only 99 persons appeared in community mental health centers for treatments that the state provides in the division services that were 65 or over.

SENATOR JOHN BURNS: Voluntarily?

SHEPHERD: Right. That would be an additional figure to those that were committed to the hospital. Although older persons constitute 10% of the population nationally, they account for 25% of the mental hospital admissions.

SENATOR KEITH BURNS: When you were talking to the number of persons in the institution, were you referring to the number only over 65?

SHEPHERD: Yes. That has diminished by a good deal. The above statistic does not demonstrate the elderly's incident of mental illness but the inadequacy of the out patient care. There are reasons why commitments are made unnecessarily. One of the major ones is the lack of awareness of alternatives that are available. There often are nursing home beds or foster care beds available in the community. These are not seen by the judge or the physician, or both, as a viable alternative.

SENATOR KEITH BURNS: Most of those do not really fulfill the need of the person who ends up in a mental institution who otherwise could remain at home. Those are not a good in-between. The home care works and the alternative, often, is a mental institution and not the nursing home, rest home.

SHEPHERD: Insofar as nursing home care is a good alternative, and discharge is now from the state hospital to a nursing home, I would say that nursing home is a very good sensible alternative for many of them. For some of those, 16% of the nursing home patients would not belong there if there were alternatives. There

is an unevenness of alternative care in the state. The Portland area is virtually the only place where you have some choices for senior citizens. We want to support this bill but give a heavy shot for the fact that state government has still not addressed itself specifically to alternatives for seniors.

The most common problem among seniors is depression. The symptoms are loss of interest, poor appetite, an attitude of hopelessness and often, personal neglect. Commitments are frequently based on opinions of a welfare worker, a physician or judge, or collectively, who seem to rely on these instances as a life style rather than a need for mental hospitalization. The suicide rate among men climbs steadily with age until it reaches 59 per 1,000 at the age of 85 compared to an average for men of all ages of 16% per 1,000. Persistent severe depression isn't natural, even in older people who are physically ill. The treatment is usually effective, especially if caught early.

SENATOR SMITH: Do you have examples of eccentric life styles?

SHEPHERD: Yes. One hearing, a woman on welfare, 75-80, in pretty good physical health had lived in her house for a good number of years and had been visited once in a while by a welfare worker.

SENATOR SMITH: Was she committed?

SHEPHERD: Yes.

SENATOR SMITH: Why was she committed?

SHEPHERD: There was pressure to obtain the use of her home on the part of her son. In addition to that, she lived with all the blinds down and only got off to the grocery store once every ten days. Her house was a hovel. The welfare worker could not see any organization and felt the woman couldn't shape up and get herself tidy.

SENATOR SMITH: Was the court aware of the pressure for the use of the house?

SHEPHERD: Yes, they were. The woman came into court in a completely bewildered condition not really knowing why she was there. She couldn't tell the judge how old she was or where she was born and a few other selected questions of that nature. In effect, these questions make up definitions of mental illness. The question of care was brought up by another case worker who said that she wondered if it wouldn't have been nice if a few years ago they had gone in with a housekeeper and cleaned her up once a week and gotten something going by letting her know that someone cared. We realize that we are talking about

a small percentage of senior citizens but we also have the concept that about 14% of senior citizens are in a framework referred to as a "risk". They have growing tendencies; such as the need for a little custodial care, a little supervision, a few protective services and minor home services.

SENATOR KEITH BURNS: Most of the cases I have seen fit the description of the person you mentioned. Senility, paranoia, lack of memory and recall. They aren't any harm to themselves, they aren't any harm to anyone else. What can we do?

SHEPHERD: It wouldn't be an either/or kind of a thing. Alternative care is on a continuum in which there are responses to the functional disorder no matter where you are on it. One of the most outstanding, challenging things is the possibility that you can cluster a group of people in a foster care setting with day care as the center point--nutrition, socializing, etc. We haven't learned on how to put out hand, yet, administratively, on how to do that.

SENATOR KEITH BURNS: You are talking about alternatives to institutions and alternatives to nursing homes?

SHEPHERD: Mainly alternatives to state institutions at this point. As far as this bill is concerned. In that regard, nursing homes are an alternative. I would like to conclude with support of this bill but emphasize the possibility that the alternatives spoken of do not exist in enough numbers to make the plan a reality.

SENATOR SMITH: The example you described would have been committed under this bill as it is under existing law.

SHEPHERD: No. I would say that the example, given the intent of this bill, the person would not have been committed but would have been directed toward some kind of alternative care.

SENATOR SMITH: It seems to me this is an alternative method of commitment.

WILLIAMSON: Before anything got to the commitment process, you would have a person going out to make an evaluation to see what other sort of resources would be available to the person prior to going through any sort of hearing or institutionization. This has been successful in Multnomah County where it has already been implemented.

SENATOR SMITH: As I read the bill, this primarily provides that the community health program director makes a determination as to probable cause for the question of a court commitment. It is another person's individual decision.

WILLIAMSON: That is correct, but they also talk to the person to determine what sorts of things they might do. Page 8-9, lines 27-34, some of that is already in existing law, but that would require that you could only commit a person when it is the last workable alternative--resources are not available for their care as needed.

REPRESENTATIVE PECK: I am not going into the details of the bill or give you a lot of facts or figures, I'll just tell you why I was glad to be one of the proponents of this bill. The reason I came to the legislature in 1949 was to try to change the commitment law that they had at that time. I tried to get some others who were going to be candidates to do something about it and I couldn't be sure they would so I filed at the last minute. I did this because I had visited the State Hospital and had seen some of the people there that I didn't think should be there and I had a neighbor I was very fond of who was confined and I didn't think she should be there. At that time there were a group of people who were advocating jury trials for the mentally ill. I thought this was wrong to subject these people to this kind of treatment. My dad had a very serious nervous breakdown at one time and I knew that if he ever had to go through that, he would have never gotten home. He was that upset at the time.

I was able the first session, with the help of Representative Gettis from Roseburg to change so that two people had to sign the application and in Multnomah County, the district attorney's office was to sit in, they felt that it was that important. I followed this through quite a bit. I spent several days at a time on several occasions in the Eastern Oregon State Hospital before and since they have the retarded over there, too. I went over there to check into some complaints and I wandered around to see if some of the things I have heard were true. I haven't stayed over night at the State Hospital or Dammasch or the other institutions but I have visited them frequently. This session I have been attending Mass nearly every Sunday at the State Hospital and then I visit around and talk to people.

I supported this bill because, although there have been changes in the commitment laws since 1949, I feel there are still a lot of changes due. I think this bill was an attempt to do this. To make things better for these people. In 1949 and for many years after 1961 or so, we didn't have a way of taking mentally ill people from the state hospital and putting them in nursing homes and homes for the aged. We appropriated money one of those sessions to do this. I think we started out with \$437,000. This was to give people in the state hospital and state homes a chance to go back to their own homes, apartments, or to live with some of their people and also to send those that needed the care to nursing homes and homes for the aged

) so that they didn't have to die in a state hospital if they didn't need to be there. They had gotten help there, some of them, to the extent that they could do these things although they were not well enough to go out absolutely on their own. They didn't have the money. We had to provide their welfare system for them. We went to the Department of Health to do this and they didn't have the money. Welfare said they didn't have it in their budget so we finally got this money and put it in the welfare department to see if they would handle it. At the beginning, their administrator did not like it at all, he wasn't too happy with it even a second session. The fact that their talking about phasing the state hospital out in from 2 to 4 years is indicative that there are fewer people out there. We are doing something for them and they are getting out into the community. It is necessary at times to bring people in there and some people never will be able to go into these facilities. You may have to build additions to Dammasch to take care of the few hundred people that might require private care. It isn't that they do crimes, there are people out there, of course, who are there because they were considered criminally insane. In the old days they were put over there, and even now some rely on that--"Put me in a mental hospital-- I did wrong but I did it because I wasn't well". These people are not only a threat to themselves in things that they do, they are a threat in some instances to other people but when you see people out there that have to have mittens on to protect them from harming themselves, and other sorts of things like this-- these people are sick and need some care and the state is responsible for this. Certainly, I don't want to see one person die in the state institution who shouldn't be there. Not only for themselves, but also for their families. Much of the time I was fighting for change in the beginning may be a poor comparison.

) I have seen a couple of examinations. One of the questions is, "Have you or any member of your family ever been in a mental institution?" This is a mark against them if they had to say so. I think it is a shame that some of these poor old grandparents of these young people were there. They hadn't really done anything wrong, just somewhere along the road they had gotten off the balance. They are mentally sick, they need a little help. There is no reason to have them stay there until they die. If they could go out to these other institutions, it makes quite a bit of difference.

) I have sat in on perhaps as many hearings in Multnomah County court on committing people as any legislator has here. I started doing this after 49 and I kept it on. Judge Dixon was there. He invited me up. In those days we had a little room downstairs where we could keep them temporarily while they were awaiting hearing. Then they went out to the Morning-side hospital. Now we have a crisis ward up in the Medical school.

They have 11 beds where people go and wait for their hearings. Some of those people go home without having to have a hearing. They give them some kind of care and whatever is wrong with them is improved and they come out all right. They go on home and they don't have to stay and have a hearing. The last time I appeared before Judge Dixon I went up on one particular case, a young girl that said she knew me. They called me and thought I might be interested. I went up there and I didn't know the girl. Finally they asked her if she was a friend of Grace Peck and she said, "I sure am! She knows I'm not insane". They asked if she saw me in the room. She looked around and looked right at me. She said, "If anyone here says she is Grace Peck, she is an imposter". Of course she was sick and came down here. The thing I am getting at is the compassion that Judge Dixon had when he talked to these people. I can't imagine anyone being sent down here who didn't need to be in recent years, for sure. The compassion, the way he talked, the way he told them to take it easy. Like he was talking to someone at home he loved. The other attorney representing the defendant, a public defender is out of this world. He is a young Judge Dixon and any other judge who really had compassion. In one instance, I went back the next day to hear the hearing of a young black woman whose husband was in the service. She had some children at home and there were not any vacant beds at the crisis ward so they had to find a place for her that night. They did, until her husband came in from camp. He made arrangements and she went into a mental facility of some sort. The way he talked to her, I kind of got the fever and I kept going back because I liked the way he worked and I knew it would be the last week I would be able to see Judge Dixon in action. At any rate, the way he would turn to this young defendant and ask whether they should answer this question--they didn't know what to do. He would nod and say a little something to them. There was so much real feeling about these people that I couldn't help but think what a long way we've come since 1949. I bring this up because I think we have to see that good things have come into being for these people. Certainly we have to do a lot more. Of course everyone you meet out at the state hospital that can talk at all will tell you they shouldn't be there. They've got some reason. I think that this bill is a real big step toward correcting anything that may be wrong. I have not seen amendments that have been proposed but in your wisdom, I know you will decide whether or not they are good amendments. I think the heart of this bill is real good and I'm proud to have my name on it.

JEFFREY MUTNICK: Public Defender in Multnomah County. We signed a contract with Multnomah County to provide representation for all indigent persons in all involuntary commitment proceedings who had no lawyers of their own. This was a result of the State v. Collman Legal Aid decision in April, requiring counsel in all involuntary commitment procedures. We signed a contract

with the county that enabled the county to have us represent all persons who were without an attorney. The normal criminal question of whether or not the person had property was dispensed with and it was changed to a question of whether or not they had a lawyer. The packet that we handed out is a copy of all the statistics that we accumulated during a six month period. (SEE THE ARCHIVES FILE FOR STATISTICS) It is a six month cumulative report. There are six monthly reports containing copies of the alternatives work that we did. In effect, the county got two people for the price of one. I acted as the attorney and we also employed an alternatives worker, Janet Casemeyer. Her function was to come into the hearings in the morning with me and interview the individual and seek an alternative that we could present to the court. It was all done on a relatively hasty basis but we found it to be extremely productive. We were able to place people in private hospitals, nursing homes. Our job is really one of a liason. We acted as an intermediary. We would call the hospital and find out whether they had a place, whether they would take a welfare patient, and perhaps we would seek a parole for the individual to a responsible member of their family or in many cases to myself and Ms. Casemeyer. All this had to be done in about 15 or 20 minutes. This is why the 24 hour notice requirement would be beneficial. As Director of the Civil Commitment Committee for the Public Defender during the period of October 1972 to March 1973 I represented 227 indigent persons.

Although there were certain procedural questions remaining to be resolved by this committee in regard to SB 510 we would energetically support the following substantive provisions. The concept of pre-commitment screening as embodied in sections 1, 2, and 3 of the proposed bill will have the effect of limiting the number of commitment hearings and will aid those persons seeking help for their loved ones to come into contact with the resources of the Community Mental Health Clinic. There is a statistic on the six month cumulative survey that states that 63 cases were screened in an experimental project in Multnomah County and only 15 actually required commitment. One of the problems we found was that people had heard that there was this thing called a commitment hearing and you'll note from the socio-economic statistics that most of these people didn't really have the where-with-all to seek out the mental health clinics and by consequence came directly to the court. By referring them, first, to the mental health clinic, a lot of people found that their problems weren't as serious as they thought they were and they were able to get them squared away before they had to come to court. A lot of the hearings were dispensed with. It is also important that individuals be given a right to periodic review to enable the committed person to participate in his own therapy and work toward his own designated date of possible release. This should add little or no additional burden to the hospitals in that we have found

that the average length of stay for these 112 persons committed whom we represented to be 41 days. It is also our position that the Fourteenth Amendment of due process requires periodic review of persons involuntarily committed.

This same rationale applies as far as our support of section 14, the privilege of becoming a voluntary patient. We would vigorously support section 9, relating to confidentiality of information and would urge that this committee strengthen this section to require consent of the patient to allow any information. It is my understanding that this information could be used by the doctors and by the court to determine whether or not the individual is mentally ill. It is my feeling that we should require the consent of the individual before using any of that information. I don't think that it would provide any additional burden for the court or additional problem in eventually committing an individual if that was the necessary result. I would offer that the standard to be applied in determining whether or not an individual should be committed should be whether or not he is dangerous to himself or other people beyond a reasonable doubt as evidenced by recent overt acts. There was a recent Wisconsin decision, Legzard v. Schmidt. The court stated in their decision, in requiring this standard, "the fact is that if a sociologist predicted that a person is 80% likely to commit a felonious act no law would permit his confinement". The Supreme Court in Humphrey v. Cady, 405 US 504, p.509, stated that implicit in this definition of requiring a person to be dangerous to himself or other people is that the person has the potential of doing harm to himself or others that is great enough to justify massive curtailment of liberties. The only standard great enough to justify this massive curtailment of liberties is dangerous to himself or other persons beyond a reasonable doubt as evidenced by a recent overt act.

SENATOR SMITH: On page 12, lines 25-27--you would restore the language?

MUTNICK: I was referring primarily to page 2 of the definition, where it defines mentally ill person as a person who because of a mental disorder is either dangerous to himself or others beyond a reasonable doubt as evidenced by a recent overt act as the basic standard for commitment. The "unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety", in my personal opinion, conflicts with the previous standard. I think that in the cases that I have handled, I have seen cases where the physician is touched by the situation emotionally and although the person may not have been dangerous to himself, it could be arguable that he is dangerous if he wasn't eating, wasn't sleeping, and that eventually his physical condition would deteriorate.

SENATOR JOHN BURNS: They send him to the state hospital?

MUTNICK: Correct.

SENATOR KEITH BURNS: What we are saying is we don't now have the resources to take care of people who fall in that category. In lieu of those resources, we are putting them in mental institutions.

MUTNICK: It is my feeling that the resources are available. We manage to place quite a few people in a structured living situation and since the middle of November, whenever we would get a case that was, in effect, a geriatric, we made an attempt to postpone a hearing up to 72 hours to seek any possible alternatives to commitment. It has been our feeling that stabilization of individuals who are on medication over the age of 65 is not all that difficult. In an intensive situation, it can be done rather quickly. One of the problems, is that the nursing homes don't have the facilities to stabilize the individuals because they have a doctor that comes out only about once a month.

SENATOR KEITH BURNS: Isn't that part of the reason they send them to the mental institution, to stabilize them and then place them in a nursing home?

MUTNICK: That is the argument.

SENATOR KEITH BURNS: In fact, that happens a lot of times?

MUTNICK: It does happen, but in fact, it is an extra step in the process, in my opinion.

SENATOR KEITH BURNS: That is the reason why they have to do that because they don't have the facilities otherwise.

MUTNICK: Because the situation wasn't caught early enough, sometimes. Pre-commitment screening might alleviate that.

SENATOR JOHN BURNS: When you are talking about that, though, you are talking about something other than sub paragraph b. Your talking about a person expressing senility, paranoia, and various other things. Your not just talking about whats in b. Otherwise, you wouldn't be talking about medications to stabilize and so forth.

MUTNICK: That's not really the case. The situation referred to in b, my understanding of that, a person who is more like those who come out at night and ravage through the garbage can, who hasn't gone to the grocery store or goes to the store and buys 50 cans of tomatoes without a can opener. In effect, that person is unable to provide for his basic personal needs. If you stretch this definition.

SENATOR JOHN BURNS: Are you handling the Washington and Clackamas commitments as well as Multnomah?

MUTNICK: We will start handling Washington in July.

SENATOR JOHN BURNS: In the old days they used to commit them for being drunk, or alcoholics. That practice has absolutely stopped, hasn't it?

MUTNICK: Unless there is some organic functional disorder.

SENATOR JOHN BURNS: One of the problems in the old days was the fact that there was a feeling on the part of some that the geriatric cases might get better treatment at Dammasch than some of the nursing homes. I was interested to hear you say that you thought that the resources were there. I think they are too. Particularly, what I'm concerned in, is your assessment of the capacity of the crisis unit. Do you think that it is overtaxed, do we need more beds up there? Have you been running into situations where the court has been taking people up to the crisis unit for a period and there aren't any beds?

MUTNICK: That has been a problem.

SENATOR JOHN BURNS: Is it a continual problem?

MUTNICK: Yes.

SENATOR JOHN BURNS: What is your assessment of the additional capacity that we need up there? I think they do a terrific job. Could it easily be doubled?

MUTNICK: Yes.

SENATOR JOHN BURNS: Would you come to Ways and Means when testimony is going to be heard on that budget and testify? Typically we hear from people in the mental health division and others who might have the same perspective or the same objectivity. I think it would help the committee.

MUTNICK: We are currently involved in a lawsuit in this area and I think that this committee could save us all a lot of trouble if they included this in the bill. I urge the committee to consider an amendment granting an indigent individual involuntarily committed an appeal which is free -- without filing fees, entitled to a free attorney, entitled to a free transcript, and waiver of bond. The court in State v. Collman stated that there is a right to an appeal but since this is a civil proceeding rather than a criminal proceeding it is impossible for an indigent to pursue this appeal. I don't think that many of them want to, if they do, they can't. They can't come up with the \$25.00 filing fee, they can't get an attorney, they can't afford to have the transcript typed up. A criminal would have all those rights.

SENATOR BROWNE: Do you appeal any of them?

MUTNICK: I'm not permitted by our contract to appeal. I am going to appeal one for purposes of securing the right of appeal. There are a few that I might have appealed had I had the resources to do so.

SENATOR KEITH BURNS: Can they hold a person in the crisis unit for 24 hours?

MUTNICK: They can hold them up to 96 hours.

SENATOR KEITH BURNS: Is that sufficient time to stabilize a person so they can go into a nursing home?

MUTNICK: I think it is. I'm not a physician.

SENATOR KEITH BURNS: The think I'm trying to get to--nursing homes are fine once a person is stabilized and they get the medication there. Nursing homes in many of these cases are reluctant to take patients that arrive in that condition. That is why I say that we don't have the resources to take care of them the way it is now. Many of those people could also be taken care of in homes if there was enough day care for them.

SENATOR EIVERS: One of the reasons is not because they don't want to--they just don't stay stabilized all the time. It's the problem of getting them back when you have to go through so much red tape to try to get them back to the facility where they were released from. If the policy would change where the operator could say this patient is now changed enough that he needs to go back for more intensive treatment, and get them back in there without a lot of red tape.

SENATOR KEITH BURNS: You can do that. The person that they are released to can sign a warrant. A policeman could pick them up and return them. That is in present law. The lack of facilities is another item.

SENATOR SMITH: On page 9, line 33,34, it states that an attorney will be provided at no cost if he is unable to provide an attorney. Shouldn't we be identifying an indigent in that situation rather than the language or is that sufficient?

MUTNICK: I think it is supposed to be similar language to indigents. There are statistics in the packet that we handed out about the number of employed individuals that we represented. We represented about 90% of the people that went through commitment hearings in Multnomah County. Out of 227, 51 had worked recently. Most of the time people are either unable to state that they wish an attorney, unable to state who their attorney would be or unable to afford one or unable to answer the questions

about their financial liens. If you did stipulate that it were an indigent, it would be difficult if you held strictly to the guidelines as we do in the criminal court it would be difficult for a lot of these people to have lawyers.

SENATOR BROWNE: Do you put drunks in the crisis unit?

MUTNICK: I have.

SENATOR BROWNE: Are you familiar with the facility in Lane County, the Johnson facility?

MUTNICK: I've never been there. I've heard good things about it. The only time I've ever sent a drunk to the crisis unit is when he was picked up at 10 PM and I'm supposed to represent him at 8:00 the next morning and he is still hung over.

SENATOR SMITH: Page 12, lines 25-27, why was the language stricken?

MUTNICK: You mean, "he is convinced that the patient was . . .

SENATOR BROWNE: Mr. Williamson, do you want to answer the question?

WILLIAMSON: The standard for release is pretty vague. All the superintendent has to say is that it is in his best interest. The standard that is inserted is the same standard for commitment. If he is not mentally ill anymore, he shouldn't have to be in there. Theoretically, under the existing statute, under the language you could have people in there that couldn't be committed before they had a hearing.

SENATOR BROWNE: You were on the task force, weren't you?

WILLIAMSON: Yes.

SENATOR SMITH: Page 15, line 33, subsection (h) are the words, "substantial rights may be affected". Are substantial rights identified? Are they defined anywhere? Is this a constitutional right?

WILLIAMSON: They are not defined.

SENATOR BROWNE: What it means is incarceration, isn't it?

WILLIAMSON: I think it refers to a transfer from a pre-ward or a ward where you get a relatively large amount of freedoms to a ward that is restricted. In some situations, if it is a punitive sort of transfer, you would have a right to a hearing.

SENATOR SMITH: Page 18, you have provided that no person shall be subject to electro-shock therapy. Is that a medical decision?

Not being familiar with the procedures except by rumor, I understand that it is being used with a great amount of success in some cases. I wonder why the language is included.

WILLIAMSON: A patient can be given electro-shock therapy or other serious or possibly dangerous treatment if it is approved by an independent physician. It is not outlawed completely. Some of the persons we have represented have a real dread of this sort of treatment in a hospital. Some of the drug treatments are even more drastic than electro-shock treatments. The purpose of this section was simply to make sure that it is a well founded decision.

MUTNICK: I think it is primarily a philosophical decision.

HOYT: If the witnesses here today could get together the suggested amendments so that we could submit them to the Mental Health Department, it would help.

Written testimony was submitted by David Coffee, EXHIBIT E.

SENATE BILL 583

SGT. JOHN MURLEY: Tigard Police Department. Sgt. Murley gave a report of several accident cases involving DUI's. Sgt. Murley understands ORS 482.430, conviction of a crime, is grounds for mandatory revocation or suspension. Under subsection 1, the word "shall" is a mandatory and not permissive. He suggests the bill be amended to provide for a mandatory sentence for each and every case of negligent homicide.

SENATOR HOYT: I would like to have a clarification from the Motor Vehicle Division as to how they are handling disposition of criminally negligent homicides now.

John DeWenter was requested to check this out.

GIL BELLAMY: Oregon Traffic Safety Commission. Authorized to represent the Governor. Mr. Bellamy cited examples of drunkenness problems. He also stated that the Governor supports this bill.

SENATOR JOHN BURNS: I would suggest to Mr. Bellamy that he contact the Public Utilities Commissioner to see if they have the power to revoke the certificate of any truck driver with a poor record. If they are unable to do this, we will provide a committee bill to do it.

John DeWenter was instructed to get the names of the specific persons Mr. Bellamy referred to and check it out.

SENATOR KEITH BURNS: As I understand this bill, a person has to kill twice, right?

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SENATOR JOHN BURNS MOVED to pass Senate Bill 712 out with a Do Pass recommendation. SENATOR EIVERS wanted to know what the word "member" was referring to in line 26. There was a question whether the word was "lender" rather than "member". It was "lender". SENATOR VERN COOK MOVED the amendment and it was accepted by consensus.

Roll Call

Senator John Burns	aye
Senator Keith Burns	aye
Senator Cook	aye
Senator Eivers	aye
Senator Hoyt	aye
Senator Browne	aye

Motion passed.

Senate Bill 792

SENATOR JOHN BURNS said that a bill had been passed on expungement of pre-1971 drug offenders. The present statute provides if it is a Class C felony or misdemeanor and three years expire, application for expungement is possible. Senator John Burns asked if the purpose was to provide expungement for Class A felonies. SENATOR KEITH BURNS said he would like to see it left up to the courts. He said he did not think that it should apply to multiple offenders. Senator Browne asked Senator John Burns if he wanted the bill to be amended so that it would only apply to first time offenders. Senator John Burns said that if expunction would apply to anything above a Class C felony that the time period should be extended and that multiple felons should be excluded. Seven years was agreed upon. Mr. DeWenter was directed to draw up the amendments.

Senate Bill 510

CHAIRMAN BROWNE asked the committee to consider Senate Bill 510. She said that there were three separate sets of amendments for the committee to consider. Mr. DeWenter stated that Dr. Bray's amendments encompassed the ACLU's amendments as well as Mr. Williamson's amendments with one exception. The exception as suggested by the ACLU would delete an exception to the requirement that a person give his consent for such treatments as electric shock.

SENATOR COOK wanted an explanation of Dr. Bray's amendments. Mr. DeWenter explained that the amendments would extend the effective date of the bill. Another amendment would provide that a person must be proved beyond a reasonable doubt to be mentally ill. Another would require that the investigative report would not be given to the two physicians that the court appoints.

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SENATOR JOHN BURNS said that he wished to propose an amendment which would delete sections 15, 16, 17 and 18. He said his amendment spoke to the mandatory 45-day detainer period. He felt the procedure in the bill was cumbersome. He also wanted to change the mandatory maximum to six months or a year.

SENATOR JOHN BURNS MOVED to delete sections 15, 16, 17 and 18 of the bill and to change the mandatory maximum to 180 days.

CHAIRMAN BROWNE, at the request of Senator Hoyt, asked Dr. Bray and Mr. Williamson to comment on Senator Burns' motion. Mr. Williamson said that section 26 on page 14 would preserve the trial visit. Chairman Browne said that since it was a maximum, the person could be sent home on a trial visit at any time. Senator John Burns said he wanted the six months because if an individual were in the hospital for six months, the hospital could petition the court and have the court commit him again rather than go through the procedures in the bill. Chairman Browne commented that the bill would have to be gone through to make it consistent with Senator Burns' amendment. Dr. Bray commented that if a person were ill over the six-month period, he would have to go back to court every six months. Senator John Burns said that was true. Dr. Bray said he would prefer not to see that because it would cause an unnecessary burden on administrators. Chairman Browne asked Senator John Burns to form an ad hoc committee with Dr. Bray and Charles Williamson and to come up with a proposal that everyone could agree on.

CHAIRMAN BROWNE remarked that she had a bill that Senator Mahoney wanted the committee to submit as a committee bill. The bill would abolish the use of an affidavit in a no-fault divorce case. Senator Hoyt questioned the committee submitting the bill rather than the Rules Committee. He wanted the substantive matter explored before going to the expense of printing the bill. Chairman Browne said she would talk to Senator Mahoney and asked John DeWenter to call Francis Harrington to get his opinion on the bill.

#### Senate Bill 835

CHAIRMAN BROWNE asked the committee to consider Senate Bill 835. She said the circuit court judges had submitted the bill. She said that presently an individual may have spent some time in a county jail prior to sentencing and that time should be applied to his sentence. The judges wanted the sheriff to compute the time and report it to them rather than holding an extra hearing.

SENATOR GEORGE EIVERS MOVED the bill out with a Do Pass recommendation.

ROLL CALL

SENATOR JOHN BURNS -- Aye  
 SENATOR KEITH BURNS -- Aye  
 SENATOR EIVERS -- No  
 SENATOR HOYT -- Aye  
 SENATOR SMITH -- No  
 SENATOR BROWNE -- Aye

MOTION PASSED.

SENATE BILL 255

Chairman Browne commented that Judge Sloan supported the bill. Carl Fredricks from AOI had opposed the bill. The bill preserves a workman compensation claim after the death of a workman. There were no amendments. Senator John Burns wanted time to look the bill over.

SENATE BILL 510

Chairman Browne asked John Burns to present the ad hoc committee amendments. The amendments would extend the period of committment to a maximum of 180 days.

Senator John Burns moved the adoption of the amendments. There was no objection to the adoption of the amendments.

Senator Smith asked how the patient could determine whether he ought to have electric shock or not. Chairman Browne said a patient in an institution doesn't have the ability to decide or he or she would not be there. But on the other hand, the patient does not have access to other doctor's opinions.

Chairman Browne asked the committee what they thought of one doctor within the institution and one doctor outside of the institution.. Charlie Williamson said the bill provided for that already. Mr. DeWenter said there were other amendments. Dr. Bray's amendments incorporated Charlie Williamson's amendments as well as the ACLU's amendments. There was further discussion of the amendments.

Senator John Burns moved Dr. Bray's amendments.

ROLL CALL

SENATOR KEITH BURNS -- Aye  
 SENATOR JOHN BURNS -- Aye  
 SENATOR EIVERS -- Aye  
 SENATOR HOYT -- Aye  
 SENATOR SMITH -- Aye  
 SENATOR BROWNE -- Aye

MOTION PASSED.

Senator John Burns moved the bill out with a do pass recommendation as amended.

ROLL CALL

SENATOR KEITH BURNS -- Aye  
SENATOR JOHN BURNS -- Aye  
SENATOR EIVERS -- Aye  
SENATOR HOYT -- Aye  
SENATOR SMITH -- Aye  
SENATOR BROWNE -- Aye

MOTION PASSED.

Chairman Browne asked Senator Keith Burns if he was ready to take up Senate Bill 668. Senator Keith Burns said he needed a mock up bill before hand because the bill had been amended.

SENATE BILL 791

Senator Keith Burns moved Senate Bill 791 to the floor with a do pass recommendation. Senator Eivers wanted to know about the effect on a default case. Senator Keith Burns said he didn't think it would arise in a default case. There was considerable discussion of the procedures involved and current practice.

ROLL CALL

SENATOR JOHN BURNS -- Aye  
SENATOR KEITH BURNS -- Aye  
SENATOR EIVERS -- No  
SENATOR HOYT -- Aye  
SENATOR SMITH -- No  
SENATOR BROWNE -- Aye

MOTION PASSED.

HOUSE BILL 2102

Mr. DeWenter verified that there had been no testimony on the bill. Basically, the bill increases the penalties available to a court for a party which refuses another party to discover evidence prior to trial. Those provisions were taken from the Federal Rules of Procedure.

Senator John Burns said that since the Bar had not appeared on the bill he would not be inclined to take up the bill. Chairman Browne asked Mr. DeWenter to notify the Bar that there would be no further action until they showed up.

HOUSE BILL 2101

Chairman Browne said Austin Crowe and David Landis appeared.

Senator John Burns moved it out do pass to the floor.

ROLL CALL

SENATOR JOHN BURNS -- Aye  
SENATOR KEITH BURNS -- No  
SENATOR EIVERS -- No  
SENATOR SMITH -- Aye  
SENATOR BROWNE -- Aye



EXHIBIT A

## MENTAL HEALTH DIVISION

OREGON STATE ARCHIVES

SB 510  
1 of 51

S. JUDICIARY COM.

### DEPARTMENT OF HUMAN RESOURCES

2570 CENTER STREET N.E. • • SALEM, OREGON • • 97310

TOM McCALL  
GOVERNOR

April 4, 1973

J. D. BRAY, M.D.  
Division Administrator

#### DIVISIONS

Children's Services  
Corrections  
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Vocational Rehabilitation  
Welfare

#### SPECIAL PROGRAMS

Aging  
Camps  
Economic Opportunity  
Multi-Service Centers

TO: The Honorable Elizabeth W. Browne  
Chairman  
Senate Committee on Judiciary

FROM: J. D. Bray, M.D.  
Administrator

SUBJECT: Senate Bill 510—Relating to involuntary commitments  
of mentally ill persons

In almost every legislative assembly in the last 20 years, changes have been made in the Oregon commitment laws. Commitment procedures have become more efficient and humane. Alternative methods for treatment have been developing in the communities. However, the entire commitment system has not been evaluated at one time. This, combined with recent court decisions related to right to treatment and civil rights, has made necessary a comprehensive study of Oregon's commitment laws this biennium. In 1972, a Mental Health Division task force comprised of representatives of Mental Health Division hospitals, the State Mental Health Advisory Board, and ten involved organizations made an exhaustive study over six months of the commitment laws of all 50 states and made recommendations for extensive revisions in the Oregon commitment statutes. The membership of this task force is shown in Attachment I. This task force report is the basis for Senate Bill 510.

#### Definition of Mental Illness

This entire bill is designed to encourage voluntary treatment within the community in preference to state hospitalization

The Honorable Elizabeth W. Browne  
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after commitment. Commitment is considered to be appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety. Inclusion of the latter concept allows commitment of some persons, primarily the elderly and those with chronic psychoses or organic brain disease, who are disoriented, out of contact with reality, or unable to make decisions about their basic needs because of their mental condition. It does not include the mentally retarded or persons who are unable to care for their basic needs but are being properly cared for by others.

Mental illness is not defined in existing statutes. Therefore, the proposed definition is restrictive and relates to involuntary commitments only. This definition should not be confused with a standard for voluntary admission to state mental hospitals or to community treatment facilities. Persons may legitimately seek and need voluntary admission but not be a "mentally ill person" under this definition.

#### Commitment to the Mental Health Division

If a person were committed under this bill, he would be committed to the Mental Health Division rather than to a specified state mental hospital as under current statutes. This allows the Division to arrange for his treatment either at a state mental hospital or within the community in a general hospital, day treatment program, nursing home, or other facility considered to be best suited to provide the treatment and supervision needed by the individual.

Procedures are defined to insure adequate communication between the courts, community mental health programs, treating facilities, health departments, law enforcement agencies, and the Division. These will be elaborated upon through administrative rules which will allow a phase-in of alternatives to state hospitalization. Until such alternatives are developed, some counties will continue to send all committed patients to a designated state mental hospital. As alternatives are developed, the county community mental health program director, or his designee,

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based upon information in the preliminary investigation report and the report of the two examining persons, will determine the appropriate treating facility for the committed person, will arrange admission to that treating facility, and will follow up to assure continuity of care. Although more complex, the responsibilities are clearly defined and treating facilities would be used in a more flexible way to meet individual patient needs than is possible in the present system.

#### Preliminary Investigation and Crisis Treatment

As under existing statutes, commitment proceedings would be initiated on a petition by two persons, the county health officer, or any magistrate. Under existing practices, the next step varies from county to county. In some counties, a uniformed police officer visits the home and issues a citation to appear in court at a specified time and place, or may immediately take the person into custody and take him to a general or state hospital where the person is examined by a physician and admitted to the hospital if appropriate. The person may be detained in a jail until the hearing if the hospital refuses admission.

In six to ten counties, trained community mental health staff or public health nurses have been visiting the person, wherever he is, instead of a peace officer. They work with the allegedly mentally ill person, family and petitioners (who are usually family members, neighbors, friends, or landlord) to assess and clarify the total situation and to resolve the crisis on the spot if possible. Failing that, they try to work out a plan for voluntary treatment within the community. If they conclude that the person is probably mentally ill and in need of commitment, a report is returned to the court for further action.

The investigating person also collects information which may be helpful in aftercare planning, after the person leaves the hospital. Peace officers may accompany the mental health staff or go instead of mental health staff if the person is sufficiently dangerous or uncontrollable as to require their assistance. As a result of these actions within the past year, commitments have

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been reduced by approximately 30 percent in these counties, even with limited alternatives for treatment available. State-wide, there were 1,168 court commitments in FY 1971-72, compared to 1,559 the prior year, and 1,651 during FY 1969-70. A summary by county is shown in Attachment II.

Under the proposed revisions, a preliminary investigation of this sort would be mandatory. Peace officers would still be utilized where necessary, but the responsibility to initiate the investigations, at the request of the court, would be with the community mental health program director or his designee. Although fact finding is one intent of this activity, this is not seen as primarily detective work but as an opportunity for crisis treatment by a trained mental health professional. It provides a method of controlling hospital utilization and costs which is extremely difficult when the person has already arrived at the hospital door. Pre-admission evaluations of non-emergency referrals to general hospitals have been initiated in some areas of the country as a means of controlling hospital utilization and costs. It reduces court workload, and allows flexible use of community alternatives which are best suited to the needs of the person and society.

#### Detention Pending Commitment Hearings

Under existing statutes, a peace officer responding to a petition for commitment or who otherwise identifies a person believed to be mentally ill and of immediate danger to himself or others may take that person into custody and transport him to a hospital where he is to be examined by a physician. If the person must be transported some distance to a hospital in another county, a certificate from a licensed physician is required to insure that the person is medically capable of handling the trip. The person may be detained in a general hospital approved by the Division for up to five days pending a hearing on a peace officer hold, or for up to 72 hours when a commitment petition has been filed.

At present, there is some ambiguity regarding the roles of the court, hospital, and treating physician. The result is confusion as to what treatment is allowable and desirable during

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this detention period. Many individuals detained under these conditions are frightened, belligerent, confused, and showing obvious symptoms of mental illness, many of which will respond to routine medical treatment, often to sufficient degree that no commitment or even further hospitalization is necessary.

The peace officer hold statutes are retained in this bill, providing for immediate examination and hospitalization of a presumed mentally ill person when necessary. In addition, detention can be initiated by the person doing the initial investigation under the proposed changes, and, since this person would be a peace officer when the need for detention is anticipated, this could also be immediate. The responsibilities of the treating physician for emergency care, custody and treatment during detention is clearly defined, including procedures for the use of mechanical restraints. A report of treatment and its results becomes a part of the record provided to the judge at the commitment hearing.

#### Protection of Personal Rights During Commitment Process

Ambiguity is frightening. Every attempt is made in the new statutes to insure that the allegedly mentally ill person knows who is saying what and the purpose and possible consequences of each step in the proceedings. He is also informed verbally and in writing at each significant stage in the process of his rights.

At all steps in the process, the person's civil rights are carefully protected. Representation by legal counsel becomes mandatory, except in unusual circumstances, to be paid for by the county if the person cannot pay. Seventy-five percent of committed persons now are represented by counsel at their hearings.

#### Psychiatric Examinations

Under current statutes, the judge appoints two licensed physicians, not necessarily psychiatrists, to examine the person as to his mental condition. This information becomes the primary basis for commitment. Other than the commitment

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petitions, the examining physicians often have no additional information about the person's total life situation and they may have no specific training in psychiatry, beyond what they obtained in becoming general physicians.

There are selected clinical psychologists, psychiatric social workers and psychiatric nurses who have become very competent in evaluating the mentally ill. These individuals are assisting the courts in some counties with mental commitments, although they cannot officially examine the person and report their findings to the judge. One physician is necessary to determine possible organic causes for the person's mental illness, to analyze the effect of medication and other concurrent illness on the person's mental state, and to assess their mental condition. The Mental Health Division believes that carefully selected non-physicians can evaluate the person's mental condition, and, because of their knowledge of community mental health programs, make a valuable contribution in assessing the person's total situation and of community alternatives available for treatment. It makes more efficient use of existing mental health manpower.

#### Limitation on Duration of Commitments

At present, commitments are for an indefinite period of time. Under the proposed statutes, initial commitments would be for 45 days, with recommitments for up to 90 days until a person has been in a treatment facility for at least a year. Thereafter, commitments would be for up to 180 days. This procedure encourages active treatment, aftercare planning, and early movement of patients to voluntary status. It protects the individual against indefinite detention, while providing procedures so that individuals can be detained and treated as long as necessary, if they continue to meet the initial criteria for commitment.

This is not to imply that patients are being kept unnecessarily long in the state hospitals. For March 1, 1971 to February 29, 1972, 54 percent of patients in the three state hospitals have been hospitalized less than 45 days. Each patient has an individualized treatment plan developed by the team assigned

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assigned to his care, and this plan is periodically reviewed and revised. In addition, each hospital has a Utilization Review Committee which examines randomly selected charts to monitor quality of care and appropriateness of hospital utilization. Very few new admissions, approximately 2 percent, become chronic patients, i.e., stay more than one year. However, from the experience of other states, there is reason to believe that hospital stays can be substantially shortened with revised commitment procedures, particularly with the development of community alternatives for treatment, and that a larger proportion of patients can be treated on a voluntary basis.

In California, which has a 17-day initial commitment period, only 1 percent of admissions to state hospitals required readmission hearings. There is some concern that California discharges patients too soon, before they have recovered sufficiently to be cared for in community mental health services and facilities. The result is that some are being handled through criminal procedures. The proposed duration of commitment in this bill reflects current thinking on civil rights and is a compromise position on ideal duration of commitment. The longer recommitment periods recognize that the longer a patient is hospitalized, the more likely it is that he will need continued hospitalization.

#### Detention in Jails

Current statutes (ORS 426.140) allow detention in jail of mentally ill persons who have committed no crimes pending commitment hearings. Some hospitals have been reluctant to provide custody and treatment for acutely disturbed, mentally ill persons. This is primarily related to community attitudes about mental illness and staff insecurity in dealing with bizarre and potentially destructive behavior. Occasionally, a person may need the maximum security provided by a jail, but most patients can be detained and treated in a general hospital if a secure room is available and if staff have had necessary training. This is the most desirable method of handling disturbed, frightened mentally ill persons.

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#### Trial Visit Status

Under current statutes, a committed patient may be returned to the community for an indefinite period of time on a conditional discharge status known as trial visit. The person may be returned to the hospital upon a written petition by one individual, without an additional court hearing. During 10 months of 1972-73, 463 patients from the three state hospitals had their trial visit revoked after they had been in the community more than 90 days. One-hundred and forty-two requested hearings before the Hospital Disposition Board, and 23 were represented at these hearings by legal counsel.

Under the proposed revisions, a person could leave the treating facility on trial visit status during his period of commitment; but trial visit would terminate when the commitment terminated, or 90 days maximum.

#### Bill of Rights for Committed Patients

Consistent with recent court decisions, an expanded list of personal and civil rights is defined in this bill, and this statement of rights would be posted in a prominent place in all facilities housing committed patients. The right to communicate freely, wear one's own clothes, have privacy and religious freedom and be paid for work performed are designed to enhance personal dignity and sense of individuality and to develop skills necessary for return to the community. A treatment plan, kept current with the patient's progress, is standard practice, but is mentioned to be consistent with court decisions on right to treatment and with Medicaid and Medicare standards. Persons would not lose their civil rights simply because of commitment to a mental hospital unless adjudicated incompetent as a separate court action.

Persons would be expected to sign an informed consent before any potentially unusual or hazardous treatment. However, the director of the facility or his designee, after consultation with an independent examining physician, could require such treatment, particularly electroshock therapy, if it were medically indicated. Electroshock therapy is an accepted

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medical treatment for severe depression, and its use may prevent suicide when other available treatment methods would fail. It is essential that there be a mechanism to require such treatment, even if the person is unable or unwilling at the time to provide his consent. A copy of a recent Massachusetts Journal of Mental Health report on electro-convulsive therapy is made available to the Committee for background information on this issue.

A section-by-section commentary on this bill, prepared by the task force chairman, is included as Attachment III.

#### Fiscal Impact

The task force report on which Senate Bill 510 is based was not completed in time to analyze its fiscal impact and to request funds for implementation as part of the 1973-75 biennial budget request of the Mental Health Division. This analysis, conducted by another task force, was completed in February 1973. Membership of this task force is shown in Attachment IV.

The task force concluded that costs to the counties for other than community mental health programs would not be substantially changed by this bill. Reductions in some areas would balance the increase in others. Based on reports from scattered counties for fiscal year 1970-71, it is estimated that sheriffs offices spend at least \$24,300 per year on the commitment process, and most of this would be saved with the proposed revisions. Health departments spend at least \$56,000 per year and much of this would be saved, although public health nurses would continue to play a significant role in pre-commitment investigations and disposition planning. Circuit courts spend at least \$139,000 per year on court commitments.

Although recommitment hearings would be required on a small minority of patients, the total number of hearings should be substantially reduced by the preliminary investigations and the new definition of mental illness. The use of one qualified non-physician in lieu of one physician for examinations would reduce the cost of hearings, but hearings will be somewhat longer (one to two hours compared to 30 to 60 minutes) under the new procedures, and attorneys will be required in almost

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all cases, compared to the 75 percent of cases where allegedly mentally ill persons are now represented by legal counsel.

Experience in those counties which have been utilizing preliminary investigations with court commitment petitions demonstrates that one-third can be resolved without a hearing, one-third enter voluntary treatment (usually proposed by the preliminary investigator) following the commitment hearing, and one-third require court commitment. The following time is required by a mental health staff person to handle court commitments:

<u>Activity</u>	<u>Time</u>
Pre-petition evaluation	1 hour/person
Pre-commitment investigation plus court report	4 hours/person
Commitment hearing	2 hours/person
Post-commitment disposition	2 hours/person
Monitoring if placed in community	1 hour/person/month

Substantially more time is required for the evaluation and disposition of some persons.

In order to perform the preliminary investigations, participate in the commitment hearings, and arrange disposition and follow up of voluntary and committed patients, the community mental health clinics will experience a substantially increased workload, particularly in those counties having a high volume of commitments. Based on the time projections described previously, assuming statewide implementation, and assuming that most clinics would need additional resources to provide these additional services, \$564,538 would be needed for the 1973-75 biennium, or \$289,027 for fiscal year 1974-75, if this Act became effective July 1, 1974, as shown in Attachment V.

Mental health clinics are now spending at least \$75,000 per year on activities directly related to court commitments. Most

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community mental health clinics would have great difficulty absorbing this increased workload without additional resources. With the exception of 13 Eastern Oregon counties, the clinics experience no growth beyond cost of living increases during the 1971-73 biennium and are anticipated to experience no growth in the funding of outpatient services during the 1973-75 biennium. This bill could be phased in county-by-county after July 1, 1974, with an appropriation request to the 1974 Legislative Assembly based on next year's experience in planning and in implementation of the alternatives to state hospitalization.

Fiscal impact on state mental hospitals is difficult to estimate. Attachment II shows the number of court commitments by county to the state mental hospitals for the past three years. This number is declining, although total first admissions and re-admissions are staying basically unchanged. One result of this bill may be to reduce the proportion of committed patients admitted to the state mental hospitals, but not the total numbers. The extent to which total admissions can be reduced depends on the rate of development of alternatives in the community to state hospitalization and the availability of crisis services at the time petitions for commitment are filed, or crises are brought to the attention of community mental health programs through other means. It is probable that there will be relatively little decrease in average daily population in the state hospitals, beyond that already projected, until at least the second year of the biennium.

With full implementation of alternatives to hospitalization in high admission counties, and with preliminary investigations under this bill, involuntary admissions from these counties are predicted to decrease by as much as 50 percent. Voluntary admissions should also drop, but by a lesser amount. Since the average length of stay for new admissions is six to eight weeks, at least six admissions must be prevented to reduce the average daily population by one. Thus, if total commitments were reduced by 240 during fiscal year 1974-75, the reduction in average daily population of the three mental hospitals would be approximately 40 below that projected. Thus, no substantial savings in clinical or administrative costs within the state mental hospitals are anticipated during the 1973-75 biennium,

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but the results of these programs will be considered in reducing clinical, support, and administrative costs in the state hospitals during the 1975-77 biennium.

Proposed Amendment

To allow orderly implementation of this bill and the development of community alternatives for treatment of committed patients, additional time should be allowed for program planning and development. Therefore, it is recommended that this bill become effective July 1, 1974.

Summary

Senate Bill 510 represents a major departure from existing commitment procedures in Oregon. However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow up. Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities. The Mental Health Division urges approval of Senate Bill 510.

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Attachments

## MENTAL HEALTH DIVISION

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## TASK FORCE ON OREGON COMMITMENT LAWS

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<u>Name</u>	<u>Representing</u>	<u>City</u>
D. K. Brooks, M.D. Chairman	State Hospitals	Salem
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
Eugene L. Bui	Oregon Law Enforcement Council	Portland
John T. Herron, M.D.	Oregon Conference of Local Health Officers	Salem
Myron B. Katz	American Civil Liberties Union of Oregon	Portland
Judge Henry Kaye	Mental Health Advisory Board	Pendleton
David C. Kent	Mental Health Advisory Board	Portland
Richard P. Noble	Oregon State Bar	Portland
Michael J. Park	Mental Health Association of Oregon	Beaverton
Wayne M. Pidgeon, M.D.	Oregon District Branch, American Psychiatric Association	Portland
Judge Douglas R. Spencer	Oregon Circuit Judges' Association	Eugene
Daniel V. Voiss, M.D.	Oregon Medical Association	Portland
Charles R. Williamson	Legal Aid Service	Portland

4-4-73

## COURT COMMITMENTS TO STATE MENTAL HOSPITALS BY COUNTY

FISCAL YEAR 1969-70 TO FISCAL YEAR 1971-72

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<u>County</u>	<u>FY 1969-70</u>	<u>FY 1970-71</u>	<u>FY 1971-72</u>	<u>Average</u>
Unknown	0	2	1	1.0
Baker	25	12	17	18.0
Benton	16	19	12	15.7
Clackamas	118	80	73	90.3
Clatsop	22	18	18	19.3
Columbia	11	13	13	12.3
Coos	26	32	22	26.7
Crook	4	11	5	6.7
Curry	3	9	2	4.7
Deschutes	14	16	12	14.0
Douglas	37	45	44	42.0
Gilliam	0	1	0	.3
Grant	7	9	9	8.3
Harney	4	17	15	12.0
Hood River	17	14	9	13.3
Jackson	33	56	48	45.7
Jefferson	5	1	2	1.7
Josephine	40	41	45	42.0
Klamath	42	35	38	38.3
Lake	1	2	4	2.3
Lane	83	77	60	73.3
Lincoln	14	11	11	12.0
Linn	24	23	22	23.0
Malheur	13	18	16	15.7
Marion	104	107	68	93.0
Morrow	3	2	3	2.7
Multnomah	781	677	430	629.3
Polk	16	24	22	20.7
Sherman	1	0	0	.3
Tillamook	7	14	7	9.3
Umatilla	50	68	71	63.0
Union	15	19	9	14.3
Wallowa	1	3	3	2.3
Wasco	37	35	15	29.0
Washington	61	40	31	44.0
Yamhill	16	8	11	11.7
TOTAL	1,651	1,559	1,168	1,458.0

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COMMENTARY ON SENATE BILL 510

Prepared by D. K. Brooks, M.D., Chairman  
Mental Health Division Task Force on Oregon Commitment Laws

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SECTION 1

Subsection (1) represents no change from the present wording in ORS 426.005.

Subsection (2) defines a "mentally ill person" and is based on a study of definitions of "mental illness" and standards for commitment throughout the United States. The Task Force reached the criteria for a "mentally ill person" to be used in both the original commitment and the periodic review procedure.

This definition (2) is twofold:

(a) The test of "dangerous" is adopted. It is in use in nearly one-third of the states with nearly half of the 50 states having the similar standard of "likely to injure himself or others."

(b) This alternative standard for commitment is basically taken from 1972 changes in the commitment laws in Pennsylvania. Situations covered under this definition are where a person may not be "dangerous" at all, but is in such a mental condition that he either cannot or will not provide for "basic personal needs" necessary for his own health and safety.

The requirement in (b) that the person not be receiving such care is to eliminate from the definition those persons who may be unable themselves to supply their basic needs, but who are in fact being properly cared for by others, whether relatives, a nursing home, etc.

It is pointed out that this criterion (b) deals with involuntary commitments and is not to be confused with standards for voluntary admissions. A person seeking voluntary admission may be but need not be a "mentally ill person" as defined in this section.

Subsection (3) adds the definition of "facility" in order to handle the new commitment procedures in which persons will receive the best available treatment without being restricted to specific state hospitals. (See Section 2 of this 1973 Act.)

Subsection (4) defines the term, "director of the facility." In light of the new procedures for commitment to the division, periodic review, and release, such "directors" will necessarily be delegated certain duties and responsibilities.

SECTION 2

In subsection (1), the present system of a court committing persons to a specific institution within the Mental Health Division is changed to provide for commitments directly to the Mental Health Division. The Division thus has the authority to assign mentally ill persons to the treatment facility, public or private, local or state, which it deems most suited to the person's treatment needs.

Under the present system, the division may direct a judge to commit the person to a specific state-run institution, ORS 426.060 (2). The section as amended by this Act will be of value to both the patient and the institutions by providing for smoother administration of involuntary commitments within the mental health system, public and private, through the Mental Health Division.

Subsection (2) was amended to give the division flexibility in situations in which it would be to the patient's best interest to be treated in a facility outside the public, state-run institutes.

### SECTION 3

Section 3 amends ORS 426.070 to include an investigation in the allegedly mentally ill person's community as a part of the commitment procedure. The investigation will assure that adequate information is available to the committing court before a commitment decision is made.

The procedure for investigations is outlined in subsection (2). The investigation is to be used in determining whether there is sufficient probable cause, under subsection (3) of this section, upon which to hold a formal hearing on the matter.

Section 3 of this Act considers both emergency situations and situations where time is not of such essence. In the latter case, an investigation must be conducted, according to the provisions in subsection (2) of this section, and prior to any detention of the allegedly mentally ill person. An emergency is handled under subsection (3), which sets down a criterion of "an imminent and serious danger to the person or to others" upon which the judge may detain the allegedly mentally ill person prior to the investigation. This situation in no way affects the emergency provisions in ORS 426.215, allowing a peace officer to detain prior to any investigation (section 32 of this Act).

Subsections (3) and (4) add to ORS 426.070 the procedure to be followed after the investigation and prior to a formal hearing. The standard for triggering further commitment procedure is to be "probable cause" to believe the person is a "mentally ill person" as defined in section 1 of this Act. Probable cause is to be based on the investigative report which, under section 9 of this Act, may not itself be used at the actual hearing without the allegedly mentally ill person's express consent.

The second sentence of subsection (3) will allow flexibility in situations where a courtroom setting may be unnecessary or even harmful to the person (e.g., an elderly person confined to a nursing home).

The next sentence in subsection (3) is to allow voluntary appearance by the allegedly mentally ill person where there is no reason to believe that he would not appear at the hearing. This is a change from the current procedure of having the allegedly mentally ill person brought before the court whether he would have done so voluntarily or not. Persons detained under emergency provisions are excluded from appearing voluntarily and are to be brought to the hearing within 72 hours of the original emergency detention.

The final sentence in subsection (3) grants the court discretion in providing for the allegedly mentally ill person's welfare pending the formal hearing.

Subsection (4) requires that the person have access to the investigative report. This will meet certain due process requirements by giving the person investigated a fair opportunity to refute the information presented and to prepare for the formal hearing.

Subsection (5) provides the procedures to be followed in emergency situations in which there is probable cause to believe that immediate custody is necessary for the safety of the person or others.

Subsection (6) is added to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanation concerning use of any mechanical restraint on such persons.

#### SECTION 4

ORS 426.080 is amended to allow service of the citation by persons other than law enforcement personnel.

#### SECTION 5

ORS 426.090 is amended to require the committing judge to file "specific reasons" why the person is being cited. This is to give the person adequate notice of the reasons for the proceedings.

The change in contents of the citation will give further assurances that the allegedly mentally ill person will be aware of his right to be represented by counsel throughout the proceedings.

With the new requirement advocating voluntary appearances whenever possible, section 5, as per section 4 of this Act, removes the requirement that the person serving the citation be the officer who takes the allegedly mentally ill person into custody.

Finally, this section provides for guarantees that the allegedly mentally ill person will be served the citation within 24 hours prior to the hearing. This was felt necessary with regard to the person's rights to due process and preparation for the hearing.

#### SECTION 6

The statute on appointment of counsel, ORS 426.100, is both expanded and made more positive by the amendments in this section. On the strength of recent court decisions concerning the right to counsel (i.e., State v. Collman in Oregon), the Task Force felt that it was appropriate and necessary to spell out the allegedly mentally ill person's rights in this area.

The major change is found in subsections (2) and (3). These require that counsel be provided to all persons, including indigents, unless refused in accordance with subsection (2). The criteria of an express, knowing, and intelligent refusal by the allegedly mentally ill person was based on the Collman decision which held that the right to counsel was to be "accorded unless intelligently and understandingly waived."

Subsection (4) adds certain safeguards where a continuance of a commitment hearing is requested. Most importantly, the court must grant a postponement upon such a request from the allegedly mentally ill person, his attorney or guardian. The maximum period of delay is still 72 hours, but a new provision for a longer continuance upon specific request has been added for special circumstances. The final sentence is unchanged from the old statute and is to be used where detention pending the hearing is deemed a necessity.

#### SECTION 8

This section is included as a result of the events leading up to the Collman case which is representative of similar cases. Because the allegedly mentally ill person's ability to defend himself may be affected by certain drugs and treatment administered prior to the hearing, the court should be fully advised of the facts and should take such facts into account in reaching a conclusion as to the mental condition of the person in question.

#### SECTION 9

This section begins with a promulgation of the rights of confrontation and cross-examination which the Task Force felt were essential to a fair hearing. The second sentence categorizes the investigative report, not as evidence which may be used against the allegedly mentally ill person, but rather as information upon which probable cause to hold a hearing may be based. This is considered necessary for the following reasons:

(a) To insure that certain parts of the report, possibly based solely on hearsay interviews, will not be introduced as evidence against the allegedly mentally ill person during the hearing.

(b) To provide for a valid, open interview of the allegedly mentally ill person without fear of its later use against him.

(c) The investigative interview might otherwise require the protection of legal counsel for every person being subjected to a preliminary investigation.

Since the alleged mentally ill person is provided with a copy of the investigative report prior to the hearing as per Section 4 of this Act, the report may be introduced as evidence only with his express consent.

#### SECTION 10

Section 10 amends ORS 426.110 to allow appointment of "qualified persons" to help examine the allegedly mentally ill person. A "qualified person" is determined

on recommendation of the division and will thus allow the use of persons trained in mental health but who are not licensed physicians. This section as amended will still require at least one licensed physician, but will provide authority to substitute such a designated "qualified person" for one of the physicians.

#### SECTION 11

Section 11 amends ORS 426.120 to provide for separate reports by each examining physician, eliminating the use of joint findings. Each report is to include the type of treatment recommended if that be the opinion. This should aid both the court and the division in their functions of providing the appropriate delivery of services to the mentally ill person.

The final sentence of this section will be of value to the court in determining whether or not to allow voluntary treatment as per subsection (1) of ORS 426.130 as amended in Section 12 of this Act.

#### SECTION 12

Section 12 amends ORS 426.130 by replacing the present "parole before commitment" statute with alternatives available to the court upon completion of the formal hearing. The alternatives open to the court following a commitment hearing are as follows:

(a) If not found to be a mentally ill person, the person must be discharged from the custody of the court.

(b) If found to be a mentally ill person:

(1) In anticipation of participation in treatment on a voluntary basis the person may be released. This alternative will be based on recommendations of the examining physicians, as well as the evidence at the hearing, in determining whether the person would participate in such a voluntary program.

(2) There may be ordered a conditional release to a qualified legal guardian, relative, or friend. This is essentially the same as the present parole before commitment statute (ORS 426.130), with the best interest of the mentally ill person the primary determining factor.

(3) The court may order commitment to the Mental Health Division for an initial period of up to 45 days. This subsection should be interpreted to encourage the alternatives in (1) and (2), and only if these other choices are "not in the best interest of the mentally ill person" should an involuntary commitment be ordered.

#### SECTION 14

In support of prevailing professional opinion that involuntarily committed patients will benefit by changing to voluntary status as simply and quickly as is practicable, the Task Force felt it necessary to include a provision to that effect. Upon such an alteration of status, the patient is to be considered a voluntary patient in every respect including the right to release within 72 hours of request.

SECTIONS 15 THROUGH 17

These new sections (sections 15 through 17) are the heart of the new periodic review procedure of involuntarily committed patients. While the voluntary patient is protected from indeterminable confinement by the right to be released within 72 hours of such a request, the involuntarily committed patient presently has no guarantee that his status would be reviewed from without the facility to which he is committed. In an effort to afford such a protection, this new review system includes opportunities for review procedures to be instigated following the initial 45-day commitment period, after each additional 90-day commitment period within the first year of hospitalization, and semi-annually thereafter.

It was felt that the initial burden of action should be on the division in seeking further hospitalization of an involuntary patient. Thus, at the end of each commitment period the division must, (1) release the patient, or (2) certify to the court "that the patient is still mentally ill and in need of further treatment."

If a further period of commitment is sought, the division is responsible for notifying the patient as per section 15 of this Act. This notification consists of delivering the certification to the patient by either a doctor or registered nurse from the facility. This method of service was favored over service by an officer of the court.

Once the certification has been properly served on the patient, the burden of affirmative action shifts to the patient. He must make known his intention to protest further commitment within 14 days of service of the certificate. Failure to protest will subject the patient to further hospitalization without a hearing. Section 15 promulgates the content of the certificate which is to be self-explaining and in "clear and simple language." The certificate itself is a key step in the periodic review system. It notifies the patient of the situation and explains the rights he has and procedures which he must follow in order to protest a further period of commitment.

Section 16 provides for notification by the division to the court and also provides for the safeguard of additional notice to the patient. The second notice is given by the court upon protest by the patient, and it re-emphasizes and explains the review procedures and rights. This section, along with similar notice requirements in section 15 of this Act, is aimed at insuring that the patient will be fully advised of the review procedure and its ramifications.

The hearing procedures are contained in section 17. Two important features of this section concern appointment of legal counsel and retaining an examining physician. Legal counsel is made mandatory at all certification hearings unless, as in ORS 426.100 (2) as amended by section 6 of this Act, it is "expressly, knowingly, and intelligently" refused. Section 17 also requires the appointment of both legal counsel and an independent examining physician for indigent patients without cost to such patients. These provisions were included in light of recent judicial decisions concerning such matters as the right to legal counsel.

After a full hearing, the court is charged with determining (a) whether the individual is still a "mentally ill person", and (b) whether the individual is in need of further treatment. The court, through (a), will be using the same criteria

for continued commitment as was used in the original court commitment and as defined in section 1 of this Act. This will therefore give true periodic reviews and rehearings to patients who request such. The second standard, (b), was included for situations in which the person may not have fully recovered and is thus within the definition of a mentally ill person but for whom further hospitalization will be of no value. Upon an affirmative finding of both (a) and (b), the court may then order a commitment for up to an additional 90 days, at which time the review system is repeated as per sections 15 through 17 of this Act.

#### SECTION 18

Recognizing the fact that some mentally ill persons remain hospitalized for years, the Task Force felt it was necessary to provide for less frequent certification for further commitment of such long-term patients. Instead of the 90-day commitment periods, section 15 provides for up to 180-day periods for persons who have been involuntary patients for greater than a year.

It should be emphasized that this section does not eliminate these persons from the periodic review system; rather they are included in the same procedures (sections 15 through 17) but may be committed for a longer period of time.

Persons on trial visit status are specifically limited to a maximum commitment period of 90 days notwithstanding the length of the patient's prior custody. This is necessary in light of a recent consent decree in which it was stipulated that no person on trial visit for greater than 90 days shall be denied a hearing prior to being returned to the treatment facility. Therefore, this limitation on length of trial visit will meet the requirements of the decree and provide for periodic review under sections 15 through 17 of this 1973 Act.

#### SECTION 19

So as not to penalize unfairly the counties in which the various treatment facilities are located, the present policy, ORS 426.310, of charging the costs to the county of the person's residence is continued with regard to the new periodic review system of this Act.

#### SECTION 20

Section 20 was added so as not to affect ORS 426.300, which allows the discharge of patients at times prior to the end of the commitment period.

#### SECTION 21

Section 21 amends ORS 426.160 to provide for a full account of the new review procedures of this Act in the court records.

SECTION 22

Since the courts, under this Act, commit a person to the Mental Health Division rather than to an individual hospital, the "division" is substituted for the "superintendent" in the discharging of patients from the jurisdiction of the committing court. This section also changes the criteria for such discharges in coordination with other provisions of this Act.

SECTION 23

Section 23 deletes a phrase in subsection (1) which allows for detention of alleged or adjudicated mentally ill persons in jails. The change follows the argument that jails should not be used to quarter any person being detained under the mental health statutes, even on a temporary basis. Unless also incarcerated on a criminal charge, a mentally ill person or one allegedly mentally ill is neither guilty of nor charged with any crime. Therefore, it is argued that jails are simply improper for detention of such a person.

Subsection (2) of ORS 426.140 is amended by substituting the word "community." This change will thereby not limit such confinements to "county" facilities. For more clarity, this subsection also narrows the designation of "health officer" by the addition of the word "county."

SECTION 24

Section 24 amends ORS 426.150 by conforming this statute to other changes in this Act. Specifically, the changes relate to section 2 concerning commitments to the "division," and Section 10, concerning the use of "qualified persons" as recommended by the division.

SECTION 25

Section 25 contains changes to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 26

Section 26 provides for coordination of the general conditions of a trial visit with the patient's treatment plan during his period of hospitalization. The length of a trial visit is limited to a maximum period of 90 days pursuant to section 18 of this 1973 Act.

The section also adds the doctor who takes administrative responsibility for a patient's release on trial visit to those persons who are exempt from liability for the patient's expenses or conduct while on trial visit. Also, there is the substitution of "division" for "superintendent," as well as the substitution of the word "facility" for "hospital" to conform with section 2 of this 1973 Act.

SECTION 27

Section 27 amends ORS 426.290 so as to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 28Patients' Rights

The Task Force has concluded that the status of a "mentally ill person" should not strip the person of certain rights. Section 28 of this Act is the promulgation of a patients' "Bill of Rights" and is to be posted in all the facilities housing such patients, as well as given to each patient upon admission and made available to other interested persons (section 31 of this Act).

Although most of the rights listed in this section are currently being adhered to throughout the state, the Task Force felt that a statutory guarantee would be in the best interest of patients, both present and future.

Section 28 is a codification of rights basic to every patient under treatment by the Mental Health Division. The rights found herein are the result of consideration of patients' rights provisions in mental health laws throughout the United States, proposed changes in other states, articles on patients' civil rights, as well as recent judicial decisions.

Under subsection (1):

(a) The right of communication is expanded from its present form. ORS 426.375 (1) (a) and (b) are the equivalent of the first two provisions in (a) of this subsection and are unchanged in handling of visitors and mail. Added to this right of communication is "reasonable access to telephones." This subsection was taken from the California patients' rights statute under section 5325, and was felt to be a necessary part of the communications right.

(b) The general policy throughout the mental hospitalization system is to encourage a certain degree of patient individuality. With this in mind, the Task Force has included the right to wear one's own clothing. This in no way changes the responsibility of the division to provide patients with proper personal clothing. Rather, it protects the personal choice of the patients as to the clothing he might wish to wear.

It should be understood that the reasonableness of the attire should be based not only on the patient's wishes, but also on the affect that the particular attire might have on other patients. "Reasonableness" should be within the discretion of the hospital authorities and the right subject to limitation for good cause, and any denial should be entered into the patient's treatment record.

(c) This section is similar to (b) in an effort to encourage individualization of patients during the hospitalization period. The right to keep personal possessions is considered necessary to encourage both the responsibility in the

) patient and to aid in his self-respect. However, this section is not to be used in any manner which may be detrimental to the progress and treatment of any patient. The inclusion of "toilet articles" was taken from the California law and intended to be a guideline for the type of possessions to which this right applies.

(d) The right to religious freedom is basic throughout the country. It was felt to be of such nature that it should not be denied by reason of a person's mental condition.

(e) Providing for a private storage area goes hand in hand with subsection (c) in seeking patient responsibility and individuality, as well as security for personal possessions. The provided area should be of reasonable size to accommodate the patient's reasonable needs, but not so large as a "warehouse" for the patient's possessions.

(f) The right to a reasonable supply of writing materials and stamps is felt to be essential to carry out the guarantees of free communication by mail. Certainly without these items, right to use the mails would be meaningless to an indigent patient. The current policy of the state system is to issue one stamp per week for those who have none. Thus, there would be little change in the basic policy of making the mails available to all patients.

(g) This section should be considered an important step toward guaranteeing adequate treatment for all patients. A written treatment plan has been viewed as an essential safeguard by advocates of "right to treatment" theories. (Following this thinking, anyone hospitalized has the right to "adequate treatment," and if not so treated he should be released.) This provision furnishes a built-in protection against a person being cared for without any treatment guidelines or progress reports.

(h) The right to be represented by legal counsel is essential to every citizen, whether he is hospitalized, imprisoned, or a member of the general public. This section insures compliance with recent judicial decrees concerning patients' rights.

(i) The right to petition for a writ of habeas corpus, although provided for in other sections of the law, was felt to be necessary to make more complete this patients' rights section. Thus, this would merely re-emphasize and not change the present law on the subject.

(j) This section guarantees the continuation of the current hospital policies of not forcing any patient to work on routine labor tasks, unless such work is regarded by the hospital staff as an important part of the patient's treatment.

) Following comments from staff personnel, the Task Force concluded that it is necessary to provide for the use of certain tasks in situations where the patient's treatment plan calls for some required work projects. The requirement of a written treatment plan in subsection (g), including such items as work treatment, affords protection against abuse of this exception.

(k) This provision was adopted by the Task Force recognizing the recent federal court decision in Alabama which held that patients be paid the federal minimum hourly wage for services performed beyond personal housekeeping duties. The feeling of the Task Force was that the patients should be paid a "reasonable compensation" on an efficiency scale in proportion to their output.

While this section is not meant to provide for patient employment during hospitalization, it is intended to allow the patient to realize some financial gain, regardless of the amount, as compensation for his labor efforts other than his personal housekeeping. In addition, staff personnel have advocated some form of compensation system to add to the patient's feeling of accomplishment and sense of personal worth in a type of "employer-employee" setting.

(1) This section allows the Mental Health Division to add, by regulation, certain rights to the statutory list. It provides for flexibility in addition to the patients' rights as posted, and still does not restrict or deny the statutory rights provided for in this act.

(m) This is no change from the present statutes under ORS 426.375 (1) (c). It is a general statement on the legal capacity of the mental patient.

(2) The right of a patient to have a voice in the type of treatment he will receive was the topic of much discussion, both within and without the Task Force sessions. Subsection (2) relating to this matter was felt to be of such nature that it should be set apart from the other patients' rights provisions. The proposed draft begins with a basic sentence from the Alabama "Right to Treatment" case, Wyatt v. Stickney, in protecting the patient from certain treatment procedures without his "express and informed consent."

In order to protect the interest of a patient who may be unable, by reason of his illness, to give such consent, but who may be in need of such treatment, the section adds the second and third sentences. These are similar to the procedure in the new California law, section 5326, in denying the right for "good cause only" and that any denial will be entered into the patient's treatment record, but goes even further as a safeguard, in that it requires "consultation with and approval of an independent examining physician." This will provide assurance that such treatments will not be performed without deliberation and consultation with a physician from without the staff of the facility.

Note: There was considerable discussion pro and con on the singling out of lobotomy and electro-shock therapy as treatments falling under this section. No lobotomies have been performed in state hospitals for more than 15 years. There was professional disagreement within the Task Force with regard to whether or not electro-shock therapy is "potentially unusual or hazardous." However, it was recognized that the general patient population has placed lobotomy and electro-shock therapy in the hazardous category, notwithstanding any professional opinions. Therefore, it is stressed that these treatments were not included because they are deemed "bad" treatments, but rather to allay specific fears which may have been associated with these treatments.

Subsection (3) contains changes to conform with wording changes of this 1973 Act.

SECTION 29

ORS 426.375, the present patient rights section, is repealed and a more complete promulgation will be substituted in the form of ORS 426.385 as amended by Section 28 of this Act.

SECTION 31

Section 31 provides for the posting of the guaranteed rights which is felt to be essential in the protection of the rights of patients. The amendments proposed in Section 28 of this Act are for the benefit of the patient and would be little more than statutory rhetoric if the information is not made readily available to those persons affected.

The same rationale is used in requiring that a copy be given to each patient upon admission to a facility. Other persons may also be furnished with such a copy of the patients' rights in an attempt to further insure that these rights are not improperly denied.

SECTION 32

The peace officer provision, ORS 426.215, is amended by Section 32 to coordinate with the amendments of this Act and to add safeguards for persons to whom this section applies.

Subsection (1) (b) of ORS 426.215 is amended to include consideration of the effect removing the person to another county will have on the person's physical health. Also added to this subsection of ORS 426.215 is the requirement that the examination be conducted within the previous 24 hours so as to assure a current evaluation based on the person's current situation.

Subsections (2) and (4) add an "administrator" as the one who may be responsible for causing the person to be examined.

Subsection (3) is amended to provide for commencement of the investigatory procedures under ORS 426.070 as amended by Section 3 of this 1973 Act.

Subsection (5) is added so as to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (Section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanations concerning the use of any mechanical restraints on such persons.

## MENTAL HEALTH DIVISION

## TASK FORCE ON IMPLEMENTATION AND FISCAL IMPACT OF SENATE BILL 510

S. JUDICIARY COM.

<u>Name</u>	<u>Representing</u>	<u>City</u>
Warren B. Barnes	Oregon Sheriff's Association	Hillsboro
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
E. W. Bloomquist	Association of Oregon Hospital Administrators	Astoria
D. K. Brooks, M.D.	State Hospitals	Salem
Vyvian Downer, P.H.N.	County Health Departments	Coquille
Therese Engelmann	Public	Eugene
R. L. Guiss, M.D.	State Hospitals	Wilsonville
John T. Herron, M.D.	Health Officers Association	Salem
William Kortge	Association of Oregon Counties	The Dalles
Fred E. Letz, MSW, Chairman	Mental Health Division	Salem
Josephine McWhirter	Mental Health Clinics	Portland
Helen Mead	Multnomah County Circuit Court	Portland
Alan Marek, MSW, ACSW	Association of Oregon Mental Health Clinic Directors	McMinnville
Judge Gregory Milnes	Oregon Circuit Judges' Association	Hillsboro
Thomas F. Nugent, M.S.	Association of Oregon Mental Health Clinic Directors	Eugene

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S. JUDICIARY COM.

Name

Representing

City

Marylyn Ruckwardt, R.N., M.N.

Mental Health Division

Salem

William L. Stacy, MSW

Association of Oregon  
Mental Health Clinic  
Directors

Baker

John Truett

Oregon Sheriff's  
Association

Roseburg

4-4-73

MENTAL HEALTH DIVISION COMMITMENT LAWS  
FISCAL IMPACT OF SENATE BILL 510 ON  
COMMUNITY MENTAL HEALTH PROGRAMS  
1973-75 BIENNIUM

Multnomah - 500 Commitments

	<u>1973-74</u>	<u>1974-75</u>	<u>1973-75</u>
Personnel	\$ 49,585	\$ 64,121	\$113,706
Services and Supplies	\$ 5,300	\$ 5,300	\$ 10,600
Capital Outlay	\$ 1,797		\$ 1,797
TOTAL	\$ 56,652	\$ 69,421	\$126,103

Lane and Marion - 100 Commitments Each

	<u>1973-74</u>	<u>1974-75</u>	<u>1973-75</u>
Personnel	\$ 40,480	\$ 42,505	\$ 82,985
Services and Supplies	\$ 4,700	\$ 4,700	\$ 9,400
Capital Outlay	\$ 1,617		\$ 1,617
TOTAL	\$ 46,797	\$ 47,205	\$ 94,002
TOTAL x 2	\$ 93,594	\$ 94,410	\$188,004

Clackamas - 75 Commitments

	<u>1973-74</u>	<u>1974-75</u>	<u>1973-75</u>
Personnel	\$ 24,911	\$ 26,156	\$ 51,067
Services and Supplies	\$ 900	\$ 900	\$ 1,800
Capital Outlay	\$ 954		\$ 954
TOTAL	\$ 26,765	\$ 27,056	\$ 53,821

Douglas, Jackson, Josephine,  
Klamath, Washington - 25 to 40 Commitments

	<u>1973-74</u>	<u>1974-75</u>	<u>1973-75</u>
Personnel	\$ 9,396	\$ 9,778	\$ 19,174
Services and Supplies	\$ 850	\$ 850	\$ 1,700
Capital Outlay	\$ 296		\$ 296

TOTAL	\$ 10,542	\$ 10,628	\$ 21,170
TOTAL x 5	\$ 52,710	\$ 53,140	\$105,850

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S. JUDICIARY COM.

Benton, Clatsop, Columbia, Deschutes-Crook, Lincoln,  
Tillamook, Yamhill, Coos, Linn, Polk - 10 to 24 Commitments

	<u>1973-74</u>	<u>1974-75</u>	<u>1973-75</u>
Personnel	\$ 4,100	\$ 4,100	\$ 8,200
Services and Supplies	\$ 400	\$ 400	\$ 800
Capital Outlay	\$ 76		\$ 76
TOTAL	\$ 4,576	\$ 4,500	\$ 9,076
TOTAL x 10	\$ 45,760	\$ 45,000	\$ 90,760
TOTAL ALL COUNTIES	\$275,511	\$289,027	\$564,538

DMK:alb  
April 4, 1973

COMMENTS ON PROPOSED AMENDMENTS TO  
INVOLUNTARY COMMITMENT LEGISLATION

Douglas R. Spencer  
Circuit Judge, Lane County  
1 March 1973

I. "Probable cause" investigation.

"Probable cause", as that term is understood by judges in connection with the issuance of arrest warrants and search warrants, is a determination the judge is to make on the basis of sworn statements. If the sworn statements include not only matters within the personal knowledge of the affiant, but also hearsay statements of third persons, the affidavit must state why the affiant places reliance upon the hearsay statements of the third parties. By analogy, if the proposed legislation really contemplates that the judge shall make a determination of probable cause based even in part on the investigation report, it would appear that due process requires that the report be sworn to by the investigator, and that the investigator state specifically and in detail what each third person told him, and state specifically whether or not he, the investigator, places credence in what each third person told him, and why he does or does not place credence in it.

When the report has been completed, it "shall be promptly submitted to the court." The court is then to determine whether or not there is probable cause to believe that the person investigated is a mentally ill person. Obviously the judge is to read the report. Subsection 3(3). But the investigative report is not to be introduced in evidence at the hearing without the express consent of the alleged mentally ill person. Section 9. Does this mean that the judge who read the report for the purpose of finding probable cause is disqualified to conduct the hearing, because he possesses this forbidden information? If so, the problems this procedure would create in single-judge districts is obvious.

And, note that the doctors have seen the investigator's report, to assist them in their evaluation of the subject. Subsection 3(4). These doctors make their reports in writing to the court. Section 11. These findings presumably would be based in part on the investigative report which they have read. The judge, who has not seen the investigative report, must then evaluate the doctors' reports which are based in part upon the investigative report!

The alleged mentally ill person has the right to cross-examine the doctors. Section 9. He can hardly do a complete job of cross-examining the doctors without inquiring into the weight they gave to various aspects of the investigative report, and therefore may be forced to consent to its being received into evidence.

But my objections to this "probable cause" investigation go beyond the problems involved in its administration. I consider it poor policy, for the following reasons:

First, I believe the investigation to be unnecessary. In the meetings of the task force which drafted this proposed legislation it was never suggested that there is in fact a problem to which this investigatory procedure is the solution. I was a member of that task force. I know of no data that would indicate that mental hearings are being held without probable cause. The sworn statements of the two citizens, or of the county health officer, or magistrate, together with some sophisticated questioning of the petitioners by court personnel, seem to be insuring that probable cause exists before a warrant is issued, to the best of my belief on the basis of personal experience, and on the basis of what I could learn in serving on the task force.

Second, the procedure is time consuming. It is not unreasonable to suggest that several days could elapse before the investigation would be completed, and the report written and considered by the judge. There are many times when a decent regard for the welfare of people requires moving faster than that. The subject may need prompt medication or hospitalization. There is a real risk that during the delay uncertainty and fear will cause anxiety in the subject. By the time the investigator could get well started under the present procedure we could have brought the subject in, held a hearing, and had the subject either back home or in the hospital.

Third, the investigation is an outrageous invasion of privacy. By the time we have interviewed relatives and neighbors it really won't make any difference whether there is probable cause or not-- everyone will know that the person is being checked out to see if he is mentally ill. On the other hand, under present procedures we can pick a person up in the morning and have him home by noon if he is not to be committed; and unless he or the petitioners talk about it, there's no reason for anyone to know.

## II. Appointment of Counsel

Subsection 6(2) provides that the court shall appoint an attorney unless an attorney is "expressly, knowingly and intelligently refused." Note that this is without regard to indigency--i.e., the court is required to appoint an attorney for J. Paul Getty unless he "knowingly and intelligently refuses" one.

Subsection 3 says that the court shall order the county to pay for the attorney if the person is unable to afford counsel. Actually, the county will have to pay court-appointed counsel whether or not the person is able to pay. It seems doubtful whether court-appointed attorney can successfully assert a claim for a fee from a client who didn't order his services.

## III. Limitation on period of initial commitment: Procedure for periodic extensions.

The limitation to commitment for 45 days contained in subsection 12(3), and the provisions of sections 15, 16, 17, 18 and 19 address themselves to no problem that I know of. I have heard no one suggest that patients in our state hospitals are being kept longer than necessary. These provisions proceed on the assumption that the administrations of our mental hospitals cannot be relied upon to discharge their patients when they no longer need hospitalization, unless judges require them to do so. I have no reason to believe this is so. If it ever should be, I believe the writ of habeas corpus provides an adequate remedy.

These sections will obviously cost the state and counties considerable in terms of the time of judges, physicians, lawyers and court and hospital personnel. I would prefer to see the valuable time of such persons employed to solve real problems. The "cost of hearings" is to be charged back to the county of residence. How do you compute the "costs of hearings"? Do such costs include the time of the court reporter, court clerk and bailiff? Do they include a sum which amortizes the cost to the county of maintaining the judge's courtroom, chambers and library?

## IV. Criteria for discharge

I strongly support section 22 which establishes the criteria for discharge to be the converse of the criteria for commitment, and permits the Mental Health Division to sign an application for welfare for an eligible patient.

V. Prohibition against confinement in jail

There are instances, fortunately rare, when a jail is the only facility secure enough to hold a violent mentally ill person in the community. I have had the experience of being told by hospital personnel that a patient awaiting a mental hearing was tearing up their psychiatric ward, and I would have to find someplace else for him. I doubt that the drafters of this provision would suggest that such a patient should be released.

OREGON ASSOCIATION OF MENTAL HEALTH CLINIC DIRECTORS

14600 N.W. Cornell Road  
Portland, Oregon 97229  
Phone: 645-3581

Testimony: Senate Bill 510  
Commitment Procedures

OREGON STATE ARCHIVES

S. JUDICIARY COM.

INTRODUCTION

I am Dr. Don Weston, President of the Oregon Association of Mental Health Clinic Directors. This group is composed of the Directors of the Community Mental Health Programs of the State of Oregon. Our programs are varied because of the varied geography and the variety of emotional needs of the people of Oregon.

I am the Director of the Tualatin Valley Guidance Clinic, the mental health facility for Washington County. My background includes eighteen years experience in diagnosis and treatment of emotional problems of children, adolescents, adults, and families.

Senate Bill 510

Commitment to the Mental Health Division The concept of commitment to the Mental Health Division rather than commitment to a particular hospital is an excellent aspect of Senate Bill 510. This permits much greater flexibility in planning for appropriate treatment approaches. At the present time the courts have only the State Hospitals as the treatment facility. this bill would insure that people receive the necessary care. The most effective manner of providing this care would be determined by a person designated by the Mental Health Division. This would usually reside in the Community Clinic program where there is the greatest knowledge of resources would allow for the most appropriate treatment program for individuals.

Exhibit  
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Pre-Commitment Evaluation The concept of pre-commitment evaluation is excellent. This would provide opportunity to determine whether or not hospitalization is required. This would be an opportunity to seek local alternatives to State Hospitalization. This approach has been demonstrated as effective by the Social Service Staff of Dammasch State Hospital in Multnomah County a number of years ago, and is being demonstrated effective in a current program.

The Clinic Directors Association has testified before the Ways and Means Committee and the Human Resources Committee of the House that this commitment bill and the "Alternatives to Hospitalization" programs of the Mental Health Division must be considered as related programs.

If our goal is to reduce the population of the State Hospitals, this can be achieved through supporting the development of "Alternatives to Hospitalization" within the community. To achieve this, the Community Clinic must have the responsibility for admission and discharge from State Hospital units. Where local alternatives are developed, a person might spend three to five days in a local general hospital rather than thirty to forty-five days in the State Hospital. As Day-Treatment and Night-Treatment programs are developed in the community, a number of State Hospital

admissions could be avoided. The cost of these local programs is less than hospitalization, and the gain to the individual in remaining in touch with his family and community is immeasurable.

Thus, the Clinic Directors support the concept of Pre-Commitment Evaluation when this is seen as an opportunity for finding alternatives to hospitalization. This requires the development of Alternative programs in most communities in the State.

Mental Health Professionals and Commitment The Clinic Directors support the concept of using one physician and one Mental Health Professional for commitment. For smaller Counties and smaller communities, it is difficult to obtain two physicians to certify persons for commitment. Often, the physicians' experience with mental health problems is limited or was much earlier in the physician's experience.

The use of one Physician and one Mental Health Professional, when desired by the Judge, would assist in this problem.

Senate Bill 510 and Staffing The Clinic Directors Association supports the passage of Senate Bill 510 because it represents a forward step in providing appropriate mental health care which is responsive to the needs of the people of Oregon. We can support this Bill only if there are funds available to provide the Staff to

perform the Pre-Commitment Evaluation which would be required by this bill. As written, the Judges could order the Community Clinics to do Pre-Commitment evaluations. In some Counties, the number of commitments is so small that this could be absorbed into the Clinic program without additional staff. In other Counties, this would seriously impair Community Mental Health programs and would require reduction of other services to meet the demands of Pre-Commitment Screening. Therefore, we can support this Bill only if funds are available to provide adequate staffing to conduct the program effectively.

The Mental Health Division has studied the staff needs and costs involved in the implementation of this program.

The Mental Health Clinic Directors would point out that there are costs to the Counties in some of the procedures of this Bill. We would hope that the Legislature will see the importance of this approach to Commitment and Alternatives to Hospitalization to provide the necessary funding. We would hope that the Counties will be ready to provide support in our combined effort to provide more responsive mental health services for the people of Oregon.

AMERICAN CIVIL LIBERTIES UNION  
310 Senator Building  
Portland, Oregon 97204

STATEMENT OF THE AMERICAN CIVIL LIBERTIES UNION OF OREGON  
REGARDING SENATE BILL 510  
Before the Senate Judiciary Committee  
April 4, 1973  
\*\*\*\*

My name is Myron Katz. I represent the American Civil Liberties Union of Oregon.

For several years now the American Civil Liberties Union, nationally and here in Oregon, has been debating the substantive and procedural questions concerning involuntary commitment for mental illness. On the substantive side, much of the discussion has centered on the issue of whether involuntary confinement for mental illness is ever justifiable and, if justified, under what circumstances and upon what criteria.

There is growing concern among civil libertarians as to the propriety of denying liberty to any person on the prospective and speculative grounds that it is possible he may do injury to himself or to others. Many civil libertarians believe that just as no person should be arrested and jailed on the grounds that it is conceivable he might in the future commit a crime, so, too, a person should not be preventively detained on the speculative grounds that he is mentally ill and might become a danger to himself or to others. Our concern is further intensified by the admittedly poor track record of behavioral scientists and others in trying to accurately forecast human conduct.

There have been many instances, well documented, where erratic, eccentric and quaint deportment has resulted in a person being committed against his will, probably because he is more a nuisance than a threat. But even if a person is a threat, it is difficult to see why he should have his liberty taken away when he has not committed a crime and when similar preventive detention against potential criminals, even the most dangerous, is abhorred as a clear-cut infringement on civil liberties. It is denying liberty to people, against their wishes, ostensibly for their own good, that causes much concern among civil libertarians.

Unfortunately, these substantive issues are not yet fully resolved and the discussion in civil liberties circles continues.

That is not so with respect to procedural questions. The procedures that must be afforded a person in connection with a state's

initial effort to involuntarily commit that person to a mental institution and the subsequent decision to retain that person there are no longer a matter of serious dispute, as state and federal courts are making abundantly clear almost every day.

SB 510, the product of a Task Force established by the Oregon Mental Health Division on which the ACLU participated, deals almost exclusively with these procedural rights. Whether or not a person who has not committed a crime should ever be involuntarily committed to an institution for the mentally ill, the fact is that all states including Oregon continue to do so on the ground that such persons are mentally ill, or pose a danger to themselves or others, or are in need of treatment, care or custody, or on some other criteria. That being the case, it is of utmost importance that whenever an involuntary commitment procedure is undertaken, there is proper respect for an allegedly mentally ill person's rights including that person's rights once confined and following treatment. On this virtually all civil libertarians and, we are pleased to note, most courts of law agree.

Although the ACLU of Oregon does not endorse the proposition implicit in SB 510 that involuntary commitment of mentally ill persons is necessarily proper, we do endorse the proposition that due process should be observed under all circumstances. In this respect, we believe that SB 510, while it may not go as far as we would like it to go, is a good bill and should pass.

\* \* \* \* \*

To perfect the bill further, the ACLU of Oregon offers three amendments, the first of which, having been unintentionally omitted from the printed bill, is also recommended by the Oregon Mental Health Division Task Force:

On page 8 of the printed bill, line 31, after "ill" insert "beyond a reasonable doubt".

On page 11, line 16, after "person" insert "beyond a reasonable doubt".

On page 16, line 15, after the period delete the remainder of the line; and on the same page delete all of lines 16 through 20.

###

Thank you for this opportunity to testify.

## SENATE BILL 510

41

S. JUDICIARY COM.

Key Features of Proposed Involuntary Mental Commitment Law

- 1) Defines mentally ill person as (a) danger to self or others or (b) unable to provide basic needs for health or safety. (Present law has no definition.).
- 2) Sworn statement by two persons triggers procedure - investigation by county mental health clinic or county health officer to determine if there is probable cause to believe a person is mentally ill. (Present law does not provide for any investigation as to probable cause; judge must begin commitment proceedings by sworn statement of two persons.).
- 3) If there is probable cause, a formal hearing is begun. Allegedly mentally ill person is given access to investigative report; opportunity must be given for voluntary appearance at hearing; emergency detainee must have hearing within 72 hours. Citation must cite specific reasons why person is believed to be mentally ill. (None of these provisions is in the present law.).
- 4) Allegedly mentally ill person must be advised of rights in court and told the reasons for proceedings, the nature of the proceedings, and the possible consequences. He will have the right to subpoena witnesses and right to counsel, without cost if he cannot afford counsel. Others can request an attorney on his behalf. Court shall appoint counsel unless expressly, knowingly and intelligently refused. Postponement of proceedings must be granted upon request. (Except for being advised of right to counsel, none of these provisions is in the present law.).
- 5) Court must be advised of drugs administered which might affect allegedly mentally ill person at hearing. He has right to cross examine all witnesses including examining physicians. The earlier investigative report cannot be used as evidence without his express consent. The examining physicians must submit separate written reports. (None of these provisions is in the present law.).
- 6) If the court finds that the allegedly mentally ill person is not mentally ill, he is discharged. If he is found mentally ill beyond a reasonable doubt the court may do one of three things: (1) dismiss the case if he is willing to receive voluntary treatment; (2) conditionally release him to the custody of a guardian, relative or friend able to care for him; or (3) commit him involuntarily for a period not to exceed 45 days. (Item 1 and 45-day maximum are new.).

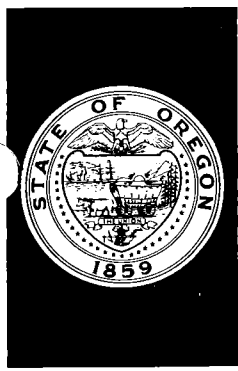
- 7) Any time after involuntary commitment, the patient may change his status to voluntary commitment if approved by Division of Mental Health in which case he is eligible for release within 72 hours if requested. (Entirely new.).
- 8) Patient must be discharged within 45 days unless Division of Mental Health certifies to the court in the county where the treatment facility is located that he still needs treatment. Copy of certificate must be given patient. If the patient does not protest, he may be recommitted up to 90 days. (All new.).
- 9) If patient protests, a new court hearing must be held with an independent physician's examination. Again, patient can subpoena witnesses, offer evidence; and legal counsel must again be appointed unless expressly, knowingly and intelligently refused. If the court finds the person is still mentally ill and in need of further treatment, he can be recommitted up to a maximum of 90 additional days. The cycle repeats each 90 days; after 1 year, the maximum commitment time is changed to 180 days.
- 10) Patient must be discharged if no longer mentally ill or, if transferred to voluntary status, upon request. (Unlike present law, the standard for involuntary commitment is the same as the standard for discharge.).
- 11) Under no circumstance can jails be used for detention. (Present law permits use of jails if other suitable place is unavailable.).
- 12) List of rights of involuntarily committed persons is explicitly stated: communication, own clothing, personal possessions, religious freedom, private storage with access, writing materials and stamps, written treatment plan, legal counsel whenever substantial rights may be affected, habeas corpus, no routine labor compelled unless essential for treatment, reasonable compensation for work, all civil rights, and freedom from potentially hazardous treatment including lobotomy and shock unless express and informed patient consent is given (but can be denied for cause after consultation with independent examining physician with record made). Rights must be given to patient and conspicuously posted. (Present law permits hospital superintendent to suspend all specified rights; and there is no requirement for posting or informing patients of rights.).

EXHIBIT J

OREGON STATE ARCHIVES

43

S. JUDICIARY COM.



**FAIRVIEW HOSPITAL AND TRAINING CENTER  
MENTAL HEALTH DIVISION**

**DEPARTMENT OF HUMAN RESOURCES**

2250 STRONG ROAD S.E. • SALEM, OREGON • 97310 • Phone 378-5100

TOM McCALL  
GOVERNOR

LARRY W. TALKINGTON, Ph.D.  
Superintendent

Make Checks payable to  
Fairview Hospital

April 4, 1973

Harriett Civin, Clerk  
Senate Judiciary Committee  
Room 407  
Capitol Building  
Salem, Oregon 97310

Dear Ms. Civin:

On Wednesday, April 4, 1973 I testified before the Senate Judiciary Committee in support of Senate Bill 510. I would like to make an amendment to that testimony. When Senator John Burns asked if I was a psychologist I responded "Yes," I would like my testimony to be amended as follows: "Yes, I am a psychologist with Fairview Hospital and Training Center, Salem, Oregon."

Sincerely yours,

*Jeffrey L. Hicks*  
Jeffrey L. Hicks, Ph.D.

JLH/pf

CHARLES R. WILLIAMSON  
Legal Aid Service  
732 S. W. Third Avenue  
Portland, Oregon 97204  
April 4, 1973

PROPOSED AMENDMENTS TO S B 510

On page 3 of the printed bill, line 27, after the period insert "If the allegedly mentally ill person consents,".

Explanation: It was felt by the committee that having investigators in your neighborhood investigating your sanity with your friends and neighbors could constitute a substantial invasion of privacy by the state. The individual should have the right to stop such an investigation from taking place should he so desire.

On page 4, line 5, after the period insert: "The person shall be given the opportunity to appear voluntarily at the hearing unless he fails to appear or unless he is detained pursuant to subsection (5) of this section."

Explanation: Language to this effect was deleted from the committee's original proposal. At present, people can be summarily arrested (sometimes in their nightclothes) and taken to the courthouse immediately for a "hearing." For people who are probably a little disoriented anyway, this can be a traumatic experience. If possible, people should be given a chance to appear on their own volition. If they present a danger, they can be taken into custody under section 4(5).

45

S. JUDICIARY COM.

On page 8, line 31, after "ill" insert "beyond a reasonable doubt".

Explanation: The committee agreed that "beyond a reasonable doubt" should be the standard of proof for involuntary commitment. In proceedings where a person's liberty is at stake, this standard arguably must be applied whether the proceedings are labelled "civil" or "criminal." See In re Gault, 387 U.S. 1 (1967). The U. S. Supreme Court applied this principle to juvenile court proceedings in In re Winship, 397 U.S. 358, 90 S. Ct. 1068 (1970). There is no evidence that the mentally ill persons are more dangerous than the population at large. There is, therefore, no reason they should not be given every procedural safeguard prior to involuntary incarceration.

AMERICAN CIVIL LIBERTIES UNION  
310 Senator Building  
Portland, Oregon 97204

46

S. JUDICIARY COM.

STATEMENT OF THE AMERICAN CIVIL LIBERTIES UNION OF OREGON  
REGARDING SENATE BILL 510  
Before the Senate Judiciary Committee  
April 4, 1973  
\*\*\*\*

My name is Myron Katz. I represent the American Civil Liberties Union of Oregon.

For several years now the American Civil Liberties Union, nationally and here in Oregon, has been debating the substantive and procedural questions concerning involuntary commitment for mental illness. On the substantive side, much of the discussion has centered on the issue of whether involuntary confinement for mental illness is ever justifiable and, if justified, under what circumstances and upon what criteria.

There is growing concern among civil libertarians as to the propriety of denying liberty to any person on the prospective and speculative grounds that it is possible he may do injury to himself or to others. Many civil libertarians believe that just as no person should be arrested and jailed on the grounds that it is conceivable he might in the future commit a crime, so, too, a person should not be preventively detained on the speculative grounds that he is mentally ill and might become a danger to himself or to others. Our concern is further intensified by the admittedly poor track record of behavioral scientists and others in trying to accurately forecast human conduct.

There have been many instances, well documented, where erratic, eccentric and quaint deportment has resulted in a person being committed against his will, probably because he is more a nuisance than a threat. But even if a person is a threat, it is difficult to see why he should have his liberty taken away when he has not committed a crime and when similar preventive detention against potential criminals, even the most dangerous, is abhorred as a clear-cut infringement on civil liberties. It is denying liberty to people, against their wishes, ostensibly for their own good, that causes much concern among civil libertarians.

Unfortunately, these substantive issues are not yet fully resolved and the discussion in civil liberties circles continues.

That is not so with respect to procedural questions. The procedures that must be afforded a person in connection with a state's

initial effort to involuntarily commit that person to a mental institution and the subsequent decision to retain that person there are no longer a matter of serious dispute, as state and federal courts are making abundantly clear almost every day.

SB 510, the product of a Task Force established by the Oregon Mental Health Division on which the ACLU participated, deals almost exclusively with these procedural rights. Whether or not a person who has not committed a crime should ever be involuntarily committed to an institution for the mentally ill, the fact is that all states including Oregon continue to do so on the ground that such persons are mentally ill, or pose a danger to themselves or others, or are in need of treatment, care or custody, or on some other criteria. That being the case, it is of utmost importance that whenever an involuntary commitment procedure is undertaken, there is proper respect for an allegedly mentally ill person's rights including that person's rights once confined and following treatment. On this virtually all civil libertarians and, we are pleased to note, most courts of law agree.

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###

Thank you for this opportunity to testify.

## SENATE BILL 510

48

Key Features of Proposed Involuntary Mental Commitment Law

S. JUDICIARY COM.

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5541 NE 72  
Portland, Ore 97218  
April 16, 1973

STATEMENT OF DAVID R. COFFEE REGARDING SENATE BILL 510  
Before the Senate Judiciary Committee

April 16, 1973

I am an ex-mental patient. I represent only myself.

Senate Bill 510 is progressive. It needs but few revisions, so long as mental illness (an ambiguous term) is not defined in present statutes, but continues to be used as a basis for commitment.

For reasons both simple and complex our society is tolerant toward powers granted physicians in respect to the mentally ill. If a Physician strikes at the brain or other part of the body, by physical means (restraints are not necessarily included), of a mental patient and against his ~~autonomy~~, then a charge of battery is indicated.

*consent*  
Physicians are in general a reputable lot. So are bank presidents. But who would formulate laws (other than perhaps bank presidents) that would permit bank presidents to tamper with one's bank account, even to add to it? If bank presidents did this very seldom (parallel- "psychosurgery" and forced medication) it would not be sufficient. If bank presidents had to first consult among themselves, and obtain support from one or more of their colleagues, this still would not suffice for formulation of these laws.

If one is suspected of shoplifting, suspicion alone is not sufficient grounds for arrest. Arrest on grounds of suspicion might be grounds for a charge of false arrest. A person is in reality arrested when he is detained against his will. Thus a person who is forceably brought before a mental hearing and found to be relatively free of mental defect ( the burden of proof should not be his) (Memninger says all persons are more or less mentally ill) should be able to bring charges of false arrest, or even of kidnapping.

The use and threat of use fo force can be insidious, sophisticated, and tramatic use and threat of use of force can be covertly employed.

I think these elements should be considered in revision of SB 510.

Crininals who are dangerous walk the streets every day. If a person is dangerous because of incompetency, he should be placed where he is no longer dangerous. If a person is not incompetent and has broken a law then he should be treated in the criminal arena.

5541 NE 72

Portland, Ore 97218

April 15, 1973

(abstract composed by student for class assignment)

COFFEE, DAVID R. (Psychology 407 Seminar: Psychology of Conflict Instructor: Ekerou PSU Oregon Division of Continuing Education Spring Term 1973)

ANOMIE: A PERSONAL PERSPECTIVE

Discusses socio-medical institution and correlates. Argues intrinsic factionalism. Argues factionalism elimination by subsumed category elimination. Offers professional opinion in support of argument. Offers personal opinion and experiences in support of argument. Offers self as determinant in argument. David R. Coffee

## HOUSE HUMAN RESOURCES COMMITTEE

May 31, 1973

321 State Capitol

## Members Present:

Rep. Grace Peck. Chairman  
 Rep. Vera Katz, Vice-Chairman  
 Rep. Howard Cherry  
 Rep. Al Densmore  
 Rep. Peg Dereli  
 Rep. Robert Elliott  
 Rep. Ralph Groener  
 Rep. S. Johnson  
 Rep. Stephen Kafoury  
 Rep. Brad Morris  
 Rep. Gordon Macpherson

## Witnesses:

Dr. D. Bray, Mental Health Division  
 Dr. Delbert Kole, Oregon State Hospital  
 Dr. Dean K. Brooks, Oregon State Hospital  
 Myron Katz, ACLU  
 Mr. Charles Williamson, Legal Aid Service

Chairman Peck announced that the hearings on SB 275 would be postponed until next week, when, she hoped it would be possible to show the tape of a TV show, "The Ultimate Experimental Animal: Man" so that the committee could view it before making a decision on this bill.

SB 510

Dr. J.D. Bray, Administrator of Mental Health Division, made his presentation in support of this bill. (Exhibit 1, in files) He said, in part, that changes in Oregon commitment laws have been made in almost every legislative session in the last 20 years. Commitment procedures have become more efficient and humane. Alternative methods for treatment have been developing in the communities. However, the entire commitment system has not been evaluated at one time. This, combined with recent court decisions related to right to treatment and civil rights, has made necessary a comprehensive study of Oregon Commitment laws.

Engrossed Senate Bill 510 represents a major departure from existing commitment procedures in Oregon. However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow-up.

Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities. The Mental Health Division urges approval of Engrossed Senate Bill 510.

Dr. Bray introduced Dr. Delbert Kole and Dr. Dean K. Brooks, of the Oregon State Hospital to help him answer questions from the committee concerning this bill.

Rep. Katz asked if the patient had a right to deny the choice of examining physician for the commitment procedure.

Dr. Kole said that not usually, but that the wording of the bill does not exclude or include this specifically.

Rep. Katz asked what type of work is assigned to patients in the institutions.

Dr. Bray said that there is a form of patient government in the wards and the patients are responsible for each ward as they would be for their own homes. They must keep it clean, decide when it needs paint and redecoration and so forth. It should be meaningful work, but this varies with the patient. Meaningful work to a depressant patient could be the assignment of a specific work task, a routine task, and this would be part of the treatment process.

Rep. Groener asked if any of the patients are advanced enough to help in the care of other patients.

Dr. Kole said that for some years they have had patients assisting in the nursing programs. The patients requesting this type of training learn the basic nursing skills, how to bathe patients, how to help take care of patient's daily needs, and so forth. They are put through a regular training course at the end of which time, they are allowed to work within the institution. Many of the patients have been able to move out of the institutions into nursing homes and into care homes.

Dr. Bray covered the fiscal impact of the bill as his closing remarks. He said it does call for basic changes in the way things are being done now, in the counties and in the courts.

Dr. Brooks said that most persons have an attorney when they go for commitment hearings, many times it is a public defender.

Myron Katz, American Civil Liberties Union, presented printed testimony in support of the bill. (Exhibit 2, in files) He said, in part, For several years now the American Civil Liberties Union, nationally and here in Oregon, has been debating the substantive and procedural questions concerning involuntary commitment for mental illness. On the substantive side, much of the discussion has centered on the issue of whether involuntary confinement for mental illness is ever justifiable and, if justified, under what circumstances and upon what criteria.

SB 510, the product of a Task Force established by the Oregon Mental Health Division on which the ACLU participated, deals almost exclusively with these procedural rights. Whether or not a person who has not committed a crime should ever be involuntarily committed to an institution for the mentally ill, the fact is that all states including Oregon continue to do so on the ground that such persons are mentally ill, or pose a danger to themselves or to others, or are in need of treatment, care or custody, or on some other criteria

That being the case, it is of utmost importance that whenever an involuntary commitment procedure is undertaken, there is proper respect for an allegedly mentally ill person's rights including that person's rights once confined and following treatment. On this virtually all civil libertarians and, we are pleased to note, most courts of law agree.

Although the ACLU of Oregon does not endorse the proposition implicit in SB 510 that involuntary commitment of mentally ill persons is necessarily proper, we do endorse the proposition that due process should be observed under all circumstances. In this respect, we believe that SB 510, while it may not go as far as we would like it to go, is a good bill and should pass.

To perfect the bill further, the ACLU of Oregon offers one amendment:

On page 16 of the printed engrossed bill, line 15, after the period delete the rest of the line.

Delete lines 16 through 20.

He mentioned HB 2330 that, he said, amends the same statute, coming from the Oregon Bar Association. He said that he did not recommend its adoption, but section 13 of the bill says 'no patient of the state hospitals for the mentally ill should be subject to shock therapy or cerebral lobotomy unless the nature of the procedure and the attendant risks have been explained to him and he has given his informed consent to the procedure.' The only reservation he has, he said, is that if this bill goes back to the Senate the bill may not have time to be acted on during this session of the Legislature.

Chairman Peck asked if the person is too ill to make the decision would it be left to a relative or guardian to do so.

Mr. Katz said that unless the patient could give his informed consent the procedure could not be carried out. He said that today two people can trigger a procedure that leads directly to commitment and under this bill, two people will only be able to trigger a procedure which leads to an investigation to determine whether or not it gives them probable cause for initiating a hearing.

Mr. Charles Williamson, Legal Aid Service, presented printed testimony to the committee for them to read and ask questions about, (Exhibit 3, in files) He said that he had served on the committee that helped to draft this bill and there were many conflicting views and a lot of people would think that the bill could be made stronger in different ways. He said that it represents a compromise, but is a gigantic step forward from existing Oregon law as far as the treatment of mentally ill people goes and the involuntary commitment of them.

Rep. Groener moved that the committee send this bill to the Ways and Means committee, with a 'do pass' recommendation.

Rep. Katz said that she would like it to go into the record that Mr. Myron Katz's amendment was discussed by the committee.

Motion carried with Rep. Morris voting 'nay'.

Chairman Peck spoke about a legal technicality concerning the Senate's passing of HB 2367.

Meeting adjourned.

---

Tape recording log:

*Tape # 33 Side 2*

Dr. D. Bray, (29-309)  
Dr. Delbert Kole (135-154)  
Dr. Brooks (309-363)  
Mr. Williamson (363-380)

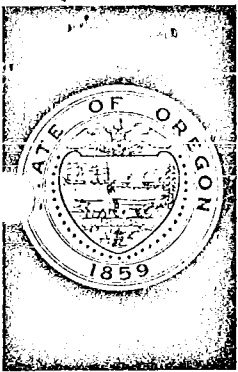


Exhibit 1, 10F34  
OREGON STATE ARCHIVES  
5-31-73  
SB 510  
H. HUM RES.

# MENTAL HEALTH DIVISION

## DEPARTMENT OF HUMAN RESOURCES

2570 CENTER STREET N.E. • • SALEM, OREGON • • 97310

TOM McCALL  
GOVERNOR

May 31, 1973

J. D. BRAY, M.D.  
Division Administrator

### DIVISIONS

Children's Services  
Corrections  
Employment  
Health  
Mental Health  
Vocational Rehabilitation  
Welfare

### SPECIAL PROGRAMS

Aging  
Camps  
Economic Opportunity  
Multi-Service Centers

TO: The Honorable Grace Olivier Peck  
Chairman  
House Committee on Human Resources

FROM: J. D. Bray, M.D.  
Administrator

SUBJECT: Engrossed Senate Bill 510--Relating to involuntary  
commitments of mentally  
ill persons

Changes in Oregon commitment laws have been made in almost every legislative session in the last 20 years. Commitment procedures have become more efficient and humane. Alternative methods for treatment have been developing in the communities. However, the entire commitment system has not been evaluated at one time. This, combined with recent court decisions related to right to treatment and civil rights, has made necessary a comprehensive study of Oregon commitment laws.

In 1972, a Mental Health Division task force comprised of representatives of Mental Health Division hospitals, the State Mental Health Advisory Board, and ten involved organizations made an exhaustive study over six months of the commitment laws of all 50 states and made recommendations for extensive revisions in the Oregon commitment statutes. This task force report is the basis for Senate Bill 510. The membership of this task force is shown in Attachment A.

The Honorable Grace Olivier Peck  
Page 2  
May 31, 1973

#### Definition of Mental Illness

This entire bill is designed to encourage voluntary treatment within the community in preference to state hospitalization after commitment. Commitment is considered to be appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety. Inclusion of the latter concept allows commitment of some persons, primarily the elderly and those with chronic psychoses or organic brain disease, who are disoriented, out of contact with reality, or unable to make decisions about their basic needs because of their mental condition. It does not include the mentally retarded or persons who are unable to care for their basic needs but are being properly cared for by others.

Mental illness is not defined in existing statutes. Therefore, the proposed definition is restrictive and relates to involuntary commitments only. This definition should not be confused with a standard for voluntary admission to state mental hospitals or to community treatment facilities. Persons may legitimately seek and need voluntary admission but not be a "mentally ill person" under this definition.

#### Commitment to the Mental Health Division

If a person were committed under this bill, he would be committed to the Mental Health Division rather than to a specified state mental hospital as under current statutes. This allows the Division to arrange for his treatment either at a state mental hospital or within the community in a general hospital, day treatment program, nursing home, or other facility considered to be best suited to provide the treatment and supervision needed by the individual.

Procedures are defined to insure adequate communication between the courts, community mental health programs, treating facilities, health departments, law enforcement agencies, and the Division. These will be elaborated upon through administrative rules which will allow a phase-in of alternatives to state

The Honorable Grace Olivier Peck  
Page 3  
May 31, 1973

hospitalization. Until such alternatives are developed, some counties will continue to send all committed patients to a designated state mental hospital. As alternatives are developed, the county community mental health program director, or his designee, based upon information in the preliminary investigation report and the report of the two examining persons, will determine the appropriate treating facility for the committed person, will arrange admission to that treating facility, and will follow up to assure continuity of care. Although more complex, the responsibilities are clearly defined and treating facilities would be used in a more flexible way to meet individual patient needs than is possible in the present system.

#### Preliminary Investigation and Crisis Treatment

As under existing statutes, commitment proceedings would be initiated on a petition by two persons, the county health officer, or any magistrate. Under existing practices, the next step varies from county to county. In some counties, a uniformed police officer visits the home and issues a citation to appear in court at a specified time and place, or may immediately take the person into custody and take him to a general or state hospital where the person is examined by a physician and admitted to the hospital if appropriate. The person may be detained in a jail until the hearing if the hospital refuses admission.

In six to ten counties, trained community mental health staff or public health nurses have been visiting the person, wherever he is, instead of a peace officer. They work with the allegedly mentally ill person, family and petitioners (who are usually family members, neighbors, friends, or landlord) to assess and clarify the total situation and to resolve the crisis on the spot if possible. Failing that, they try to work out a plan for voluntary treatment within the community. If they conclude that the person is probably mentally ill and in need of commitment, a report is returned to the court for further action.

The investigating person also collects information which may be helpful in aftercare planning, after the person leaves the

The Honorable Grace Olivier Peck  
Page 4  
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hospital. Peace officers may accompany the mental health staff or go instead of mental health staff if the person is sufficiently dangerous or uncontrollable as to require their assistance. As a result of these actions within the past year, commitments have been reduced by approximately 30 percent in these counties, even with limited alternatives for treatment available. Statewide, there were 1,168 court commitments in fiscal year 1971-72, compared to 1,559 the prior year, and 1,651 during fiscal year 1969-70. A summary by county is shown in Attachment B.

Under the proposed revisions; a preliminary investigation of this sort would be mandatory. Peace officers would still be utilized where necessary, but the responsibility to initiate the investigations, at the request of the court, would be with the community mental health program director or his designee. Although fact finding is one intent of this activity, this is not seen as primarily detective work but as an opportunity for crisis treatment by a trained mental health professional. It provides a method of controlling hospital utilization and costs which is extremely difficult when the person has already arrived at the hospital door. Pre-admission evaluations of non-emergency referrals to general hospitals have been initiated in some areas of the country as a means of controlling hospital utilization and costs. It reduces court workload, and allows flexible use of community alternatives which are best suited to the needs of the person and society.

#### Detention Pending Commitment Hearings

Under existing statutes, a peace officer responding to a petition for commitment or who otherwise identifies a person believed to be mentally ill and of immediate danger to himself or others may take that person into custody and transport him to a hospital where he is to be examined by a physician. If the person must be transported some distance to a hospital in another county, a certificate from a licensed physician is required to insure that the person is medically capable of handling the trip. The person may be detained in a general hospital approved by the Division for up to five days pending a hearing on a peace officer hold, or for up to 72 hours when a commitment petition has been filed.

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At present, there is some ambiguity regarding the roles of the court, hospital, and treating physician. The result is confusion as to what treatment is allowable and desirable during this detention period. Many individuals detained under these conditions are frightened, belligerent, confused, and showing obvious symptoms of mental illness, many of which will respond to routine medical treatment, often to sufficient degree that no commitment or even further hospitalization is necessary.

The peace officer hold statutes are retained in this bill, providing for immediate examination and hospitalization of a presumed mentally ill person when necessary. In addition, detention can be initiated by the person doing the initial investigation under the proposed changes, and, since this person would be a peace officer when the need for detention is anticipated, this could also be immediate. The responsibilities of the treating physician for emergency care, custody and treatment during detention is clearly defined, including procedures for the use of mechanical restraints. A report of treatment and its results becomes a part of the record provided to the judge at the commitment hearing.

#### Protection of Personal Rights During Commitment Process

Ambiguity is frightening. Every attempt is made in the new statutes to insure that the allegedly mentally ill person knows who is saying what and the purpose and possible consequences of each step in the proceedings. He is also informed verbally and in writing at each significant stage in the process of his rights.

At all steps in the process, the person's civil rights are carefully protected. Representation by legal counsel becomes mandatory, except in unusual circumstances, to be paid for by the county if the person cannot pay. Seventy-five percent of committed persons now are represented by counsel at their hearings.

#### Psychiatric Examinations

Under current statutes, the judge appoints two licensed physicians, not necessarily psychiatrists, to examine the

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person as to his mental condition. This information becomes the primary basis for commitment. Other than the commitment petitions, the examining physicians often have no additional information about the person's total life situation and they may have no specific training in psychiatry, beyond what they obtained in becoming general physicians.

There are selected clinical psychologists, psychiatric social workers and psychiatric nurses who have become very competent in evaluating the mentally ill. These individuals are assisting the courts in some counties with mental commitments, although they cannot officially examine the person and report their findings to the judge. One physician is necessary to determine possible organic causes for the person's mental illness, to analyze the effect of medication and other concurrent illness on the person's mental state, and to assess their mental condition. The Mental Health Division believes that carefully selected non-physicians can evaluate the person's mental condition, and, because of their knowledge of community mental health programs, make a valuable contribution in assessing the person's total situation and of community alternatives available for treatment. It makes more efficient use of existing mental health manpower.

#### Limitation on Duration of Commitments

At present, commitments are for an indefinite period of time. Under Engrossed Senate Bill 510, commitments would be for 180 days. Recommitments would also be for up to 180 days. This procedure encourages active treatment, aftercare planning, and early movement of patients to voluntary status. It protects the individual against indefinite detention, while providing procedures so that individuals can be detained and treated as long as necessary, if they continue to meet the initial criteria for commitment.

This is not to imply that patients are being kept unnecessarily long in the state hospitals. For March 1, 1971 to February 29, 1972, 54 percent of patients in the three state hospitals have been hospitalized less than 45 days. Each patient has an individualized treatment plan developed by the team assigned

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to his care, and this plan is periodically reviewed and revised. In addition, each hospital has a Utilization Review Committee which examines randomly selected charts to monitor quality of care and appropriateness of hospital utilization. Very few new admissions, approximately 2 percent, become chronic patients, i.e., stay more than one year. However, from the experience of other states, there is reason to believe that hospital stays can be substantially shortened with revised commitment procedures, particularly with the development of community alternatives for treatment, and that a larger proportion of patients can be treated on a voluntary basis.

#### Detention in Jails

Existing statutes (ORS 426.140) allow detention in jail of mentally ill persons who have committed no crimes pending commitment hearings. Some hospitals have been reluctant to provide custody and treatment for acutely disturbed, mentally ill persons. This is primarily related to community attitudes about mental illness and staff insecurity in dealing with bizarre and potentially destructive behavior. Occasionally, a person may need the maximum security provided by a jail, but most patients can be detained and treated in a general hospital if a secure room is available and if staff have had necessary training. This is the most desirable method of handling disturbed, frightened mentally ill persons.

#### Trial Visit Status

Under current statutes, a committed patient may be returned to the community for an indefinite period of time on a conditional discharge status known as trial visit. The person may be returned to the hospital upon a written petition by one individual, without an additional court hearing. During 10 months of 1972-73, 463 patients from the three state hospitals had their trial visit revoked after they had been in the community more than 90 days. One-hundred and forty-two requested hearings before the Hospital Disposition Board, and 23 were represented at these hearings by legal counsel.

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Under the proposed revisions, a person could leave the treating facility on trial visit status during his period of commitment; but trial visit would terminate when the commitment terminated, or 180 days maximum.

#### Bill of Rights for Committed Patients

Consistent with recent court decisions, an expanded list of personal and civil rights is defined in this bill, and this statement of rights would be posted in a prominent place in all facilities housing committed patients. The right to communicate freely, wear one's own clothes, have privacy and religious freedom and be paid for work performed are designed to enhance personal dignity and sense of individuality and to develop skills necessary for return to the community. A treatment plan, kept current with the patient's progress, is standard practice, but is mentioned to be consistent with court decisions on right to treatment and with Medicaid and Medicare standards. Persons would not lose their civil rights simply because of commitment to a mental hospital unless adjudicated incompetent as a separate court action.

Persons would be expected to sign an informed consent before any potentially unusual or hazardous treatment. However, the director of the facility or his designee, after consultation with an independent examining physician, could require such treatment, particularly electroshock therapy, if it were medically indicated. Electroshock therapy is an accepted medical treatment for severe depression, and its use may prevent suicide when other available treatment methods would fail. It is essential that there be a mechanism to require such treatment, even if the person is unable or unwilling at the time to provide his consent. A copy of a recent "Massachusetts Journal of Mental Health" report on electro-convulsive therapy is made available to the Committee for background information on this issue.

A section-by-section commentary on this bill, prepared by the task force chairman, is included as Attachment C.

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### Fiscal Impact

The task force report on which Senate Bill 510 is based was not completed in time to analyze its fiscal impact and to request funds for implementation as part of the 1973-75 biennial budget request of the Mental Health Division. This analysis, conducted by another task force, was completed in February 1973. Membership of this task force is shown in Attachment D.

The task force concluded that costs to the counties for other than community mental health programs would not be substantially changed by this bill. Reductions in some areas would balance the increase in others. Based on reports from scattered counties for fiscal year 1970-71, it is estimated that sheriffs offices spend at least \$24,300 per year on the commitment process, and most of this would be saved with the proposed revisions. Health departments spend at least \$56,000 per year and much of this would be saved, although public health nurses would continue to play a significant role in pre-commitment investigations and disposition planning. Circuit courts spend at least \$139,000 per year on court commitments. It is not apparent that more than an insignificant portion of this amount can be saved through enactment of Senate Bill 510.

Although recommitment hearings would be required on a small minority of patients, the total number of hearings should be substantially reduced by the preliminary investigations and the new definition of mental illness. The use of one qualified non-physician in lieu of one physician for examinations would reduce the cost of hearings, but hearings will be somewhat longer (one to two hours compared to 30 to 60 minutes) under the new procedures, and attorneys will be required in almost all cases, compared to the 75 percent of cases where allegedly mentally ill persons are now represented by legal counsel.

Experience in those counties which have been utilizing preliminary investigations with court commitment petitions demonstrates that one-third can be resolved without a hearing, one-third enter voluntary treatment (usually proposed by the preliminary investigator) following the commitment hearing,

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and one-third require court commitment. The following time is required by a mental health staff person to handle court commitments:

<u>Activity</u>	<u>Time</u>
Pre-petition evaluation	1 hour/person
Pre-commitment investigation plus court report	4 hours/person
Commitment hearing	2 hours/person
Post-commitment disposition	2 hours/person
Monitoring if placed in community	1 hour/person/month

Substantially more time is required for the evaluation and disposition of some persons.

In order to perform the preliminary investigations, participate in the commitment hearings, and arrange disposition and follow up of voluntary and committed patients, the community mental health clinics will experience a substantially increased workload, particularly in those counties having a high volume of commitments. Based on the time projections described previously, assuming statewide implementation, assuming that most clinics would need additional resources to provide these additional services, and assuming that some of the current expenditures on court commitments can be saved and made available to the clinics, \$179,112 would be needed for fiscal year 1974-75, if this Act became effective July 1, 1974.

Mental health clinics are now spending at least \$75,000 per year on activities directly related to court commitments. Most community mental health clinics would have great difficulty absorbing this increased workload without additional resources. With the exception of 13 Eastern Oregon counties, the clinics experience no growth beyond cost of living increases during the 1971-73 biennium and are anticipated to experience no growth in the funding of outpatient services during the 1973-75 biennium. This bill could be phased in county-by-county

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after July 1, 1974, with an appropriation request to the 1974 Legislative Assembly based on next year's experience in planning and in implementation of the alternatives to state hospitalization.

Fiscal impact on state mental hospitals is difficult to estimate. Attachment B shows the number of court commitments by county to the state mental hospitals for the past three years. This number is declining, although total first admissions and readmissions are staying basically unchanged. One result of this bill may be to reduce the proportion of committed patients admitted to the state mental hospitals, but not the total numbers. The extent to which total admissions can be reduced depends on the rate of development of alternatives in the community to state hospitalization and the availability of crisis services at the time petitions for commitment are filed, or crises are brought to the attention of community mental health programs through other means. It is probable that there will be relatively little decrease in average daily population in the state hospitals, beyond that already projected, until at least the second year of the biennium.

With full implementation of alternatives to hospitalization in high admission counties, and with preliminary investigations under this bill, involuntary admissions from these counties are predicted to decrease by as much as 50 percent. Voluntary admissions should also drop, but by a lesser amount. Since the average length of stay for new admissions is six to eight weeks, at least six admissions must be prevented to reduce the average daily population by one. Thus, if total commitments were reduced by 240 during fiscal year 1974-75, the reduction in average daily population of the three mental hospitals would be approximately 40 below that projected. Thus, no substantial savings in clinical or administrative costs within the state mental hospitals are anticipated during the 1973-75 biennium, but the results of these programs will be considered in reducing clinical, support, and administrative costs in the state hospitals during the 1975-77 biennium.

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Summary

Engrossed Senate Bill 510 represents a major departure from existing commitment procedures in Oregon. However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow up.

Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities. The Mental Health Division urges approval of Engrossed Senate Bill 510.

JDB-DMK:alb  
Attachments

MENTAL HEALTH DIVISION  
TASK FORCE ON OREGON COMMITMENT LAWS

<u>Name</u>	<u>Representing</u>	<u>City</u>
D. K. Brooks, M.D. Chairman	State Hospitals	Salem
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
Eugene L. Bui	Oregon Law Enforcement Council	Portland
John T. Herron, M.D.	Oregon Conference of Local Health Officers	Salem
Myron B. Katz	American Civil Liberties Union of Oregon	Portland
Judge Henry Kaye	Mental Health Advisory Board	Pendleton
David C. Kent	Mental Health Advisory Board	Portland
Richard P. Noble	Oregon State Bar	Portland
Michael J. Park	Mental Health Association of Oregon	Beaverton
Wayne M. Pidgeon, M.D.	Oregon District Branch, American Psychiatric Association	Portland
Judge Douglas R. Spencer	Oregon Circuit Judges' Association	Eugene
Daniel V. Voiss, M.D.	Oregon Medical Association	Portland
Charles R. Williamson	Legal Aid Service	Portland

4-4-73

## COURT COMMITMENTS TO STATE MENTAL HOSPITALS BY COUNTY

FISCAL YEAR 1969-70 TO FISCAL YEAR 1971-72

<u>County</u>	<u>FY 1969-70</u>	<u>FY 1970-71</u>	<u>FY 1971-72</u>	<u>Average</u>
Unknown	0	2	1	1.0
Baker	25	12	17	18.0
Benton	16	19	12	15.7
Clackamas	118	80	73	90.3
Clatsop	22	18	18	19.3
Columbia	11	13	13	12.3
Coos	26	32	22	26.7
Crook	4	11	5	6.7
Curry	3	9	2	4.7
Deschutes	14	16	12	14.0
Douglas	37	45	44	42.0
Gilliam	0	1	0	.3
Grant	7	9	9	8.3
Harney	4	17	15	12.0
Hood River	17	14	9	13.3
Jackson	33	56	48	45.7
Jefferson	5	1	2	1.7
Josephine	40	41	45	42.0
Klamath	42	35	38	38.3
Lake	1	2	4	2.3
Lane	83	77	60	73.3
Lincoln	14	11	11	12.0
Linn	24	23	22	23.0
Malheur	13	18	16	15.7
Marion	104	107	68	93.0
Morrow	3	2	3	2.7
Multnomah	781	677	430	629.3
Polk	16	24	22	20.7
Sherman	1	0	0	.3
Tillamook	7	14	7	9.3
Umatilla	50	68	71	63.0
Union	15	19	9	14.3
Wallowa	1	3	3	2.3
Wasco	37	35	15	29.0
Washington	61	40	31	44.0
Yamhill	16	8	11	11.7
TOTAL	1,651	1,559	1,168	1,458.0

DMK:alb  
April 4, 1973

## COMMENTARY ON SENATE BILL 510

Prepared by D. K. Brooks, M.D., Chairman  
Mental Health Division Task Force on Oregon Commitment Laws

SECTION 1

Subsection (1) represents no change from the present wording in ORS 426.005.

Subsection (2) defines a "mentally ill person" and is based on a study of definitions of "mental illness" and standards for commitment throughout the United States. The Task Force reached the criteria for a "mentally ill person" to be used in both the original commitment and the periodic review procedure.

This definition (2) is twofold:

(a) The test of "dangerous" is adopted. It is in use in nearly one-third of the states with nearly half of the 50 states having the similar standard of "likely to injure himself or others."

(b) This alternative standard for commitment is basically taken from 1972 changes in the commitment laws in Pennsylvania. Situations covered under this definition are where a person may not be "dangerous" at all, but is in such a mental condition that he either cannot or will not provide for "basic personal needs" necessary for his own health and safety.

The requirement in (b) that the person not be receiving such care is to eliminate from the definition those persons who may be unable themselves to supply their basic needs, but who are in fact being properly cared for by others, whether relatives, a nursing home, etc.

It is pointed out that this criterion (b) deals with involuntary commitments and is not to be confused with standards for voluntary admissions. A person seeking voluntary admission may be but need not be a "mentally ill person" as defined in this section.

Subsection (3) adds the definition of "facility" in order to handle the new commitment procedures in which persons will receive the best available treatment without being restricted to specific state hospitals. (See Section 2 of this 1973 Act.)

Subsection (4) defines the term, "director of the facility." In light of the new procedures for commitment to the division, periodic review, and release, such "directors" will necessarily be delegated certain duties and responsibilities.

SECTION 2

In subsection (1), the present system of a court committing persons to a specific institution within the Mental Health Division is changed to provide for commitments directly to the Mental Health Division. The Division thus has the authority to assign mentally ill persons to the treatment facility, public or private, local or state, which it deems most suited to the person's treatment needs.

Under the present system, the division may direct a judge to commit the person to a specific state-run institution, ORS 426.060 (2). The section as amended by this Act will be of value to both the patient and the institutions by providing for smoother administration of involuntary commitments within the mental health system, public and private, through the Mental Health Division.

Subsection (2) was amended to give the division flexibility in situations in which it would be to the patient's best interest to be treated in a facility outside the public, state-run institutes.

SECTION 3

Section 3 amends ORS 426.070 to include an investigation in the allegedly mentally ill person's community as a part of the commitment procedure. The investigation will assure that adequate information is available to the committing court before a commitment decision is made.

The procedure for investigations is outlined in subsection (2). The investigation is to be used in determining whether there is sufficient probable cause, under subsection (3) of this section, upon which to hold a formal hearing on the matter.

Section 3 of this Act considers both emergency situations and situations where time is not of such essence. In the latter case, an investigation must be conducted, according to the provisions in subsection (2) of this section, and prior to any detention of the allegedly mentally ill person. An emergency is handled under subsection (3), which sets down a criterion of "an imminent and serious danger to the person or to others" upon which the judge may detain the allegedly mentally ill person prior to the investigation. This situation in no way affects the emergency provisions in ORS 426.215, allowing a peace officer to detain prior to any investigation (section 32 of this Act).

Subsections (3) and (4) add to ORS 426.070 the procedure to be followed after the investigation and prior to a formal hearing. The standard for triggering further commitment procedure is to be "probable cause" to believe the person is a "mentally ill person" as defined in section 1 of this Act. Probable cause is to be based on the investigative report which, under section 9 of this Act, may not itself be used at the actual hearing without the allegedly mentally ill person's express consent.

The second sentence of subsection (3) will allow flexibility in situations where a courtroom setting may be unnecessary or even harmful to the person (e.g., an elderly person confined to a nursing home).

The next sentence in subsection (3) is to allow voluntary appearance by the allegedly mentally ill person where there is no reason to believe that he would not appear at the hearing. This is a change from the current procedure of having the allegedly mentally ill person brought before the court whether he would have done so voluntarily or not. Persons detained under emergency provisions are excluded from appearing voluntarily and are to be brought to the hearing within 72 hours of the original emergency detention.

The final sentence in subsection (3) grants the court discretion in providing for the allegedly mentally ill person's welfare pending the formal hearing.

Subsection (4) requires that the person have access to the investigative report. This will meet certain due process requirements by giving the person investigated a fair opportunity to refute the information presented and to prepare for the formal hearing.

Subsection (5) provides the procedures to be followed in emergency situations in which there is probable cause to believe that immediate custody is necessary for the safety of the person or others.

Subsection (6) is added to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanation concerning use of any mechanical restraint on such persons.

#### SECTION 4

ORS 426.080 is amended to allow service of the citation by persons other than law enforcement personnel.

#### SECTION 5

ORS 426.090 is amended to require the committing judge to file "specific reasons" why the person is being cited. This is to give the person adequate notice of the reasons for the proceedings.

The change in contents of the citation will give further assurances that the allegedly mentally ill person will be aware of his right to be represented by counsel throughout the proceedings.

With the new requirement advocating voluntary appearances whenever possible, section 5, as per section 4 of this Act, removes the requirement that the person serving the citation be the officer who takes the allegedly mentally ill person into custody.

Finally, this section provides for guarantees that the allegedly mentally ill person will be served the citation within 24 hours prior to the hearing. This was felt necessary with regard to the person's rights to due process and preparation for the hearing.

#### SECTION 6

The statute on appointment of counsel, ORS 426.100, is both expanded and made more positive by the amendments in this section. On the strength of recent court decisions concerning the right to counsel (i.e., State v. Collman in Oregon), the Task Force felt that it was appropriate and necessary to spell out the allegedly mentally ill person's rights in this area.

The major change is found in subsections (2) and (3). These require that counsel be provided to all persons, including indigents, unless refused in accordance with subsection (2). The criteria of an express, knowing, and intelligent refusal by the allegedly mentally ill person was based on the Collman decision which held that the right to counsel was to be "accorded unless intelligently and understandingly waived."

Subsection (4) adds certain safeguards where a continuance of a commitment hearing is requested. Most importantly, the court must grant a postponement upon such a request from the allegedly mentally ill person, his attorney or guardian. The maximum period of delay is still 72 hours, but a new provision for a longer continuance upon specific request has been added for special circumstances. The final sentence is unchanged from the old statute and is to be used where detention pending the hearing is deemed a necessity.

#### SECTION 8

This section is included as a result of the events leading up to the Collman case which is representative of similar cases. Because the allegedly mentally ill person's ability to defend himself may be affected by certain drugs and treatment administered prior to the hearing, the court should be fully advised of the facts and should take such facts into account in reaching a conclusion as to the mental condition of the person in question.

#### SECTION 9

This section begins with a promulgation of the rights of confrontation and cross-examination which the Task Force felt were essential to a fair hearing. The second sentence categorizes the investigative report, not as evidence which may be used against the allegedly mentally ill person, but rather as information upon which probable cause to hold a hearing may be based. This is considered necessary for the following reasons:

(a) To insure that certain parts of the report, possibly based solely on hearsay interviews, will not be introduced as evidence against the allegedly mentally ill person during the hearing.

(b) To provide for a valid, open interview of the allegedly mentally ill person without fear of its later use against him.

(c) The investigative interview might otherwise require the protection of legal counsel for every person being subjected to a preliminary investigation.

Since the alleged mentally ill person is provided with a copy of the investigative report prior to the hearing as per Section 4 of this Act, the report may be introduced as evidence only with his express consent.

#### SECTION 10

Section 10 amends ORS 426.110 to allow appointment of "qualified persons" to help examine the allegedly mentally ill person. A "qualified person" is determined

on recommendation of the division and will thus allow the use of persons trained in mental health but who are not licensed physicians. This section as amended will still require at least one licensed physician, but will provide authority to substitute such a designated "qualified person" for one of the physicians.

SECTION 11

Section 11 amends ORS 426.120 to provide for separate reports by each examining physician, eliminating the use of joint findings. Each report is to include the type of treatment recommended if that be the opinion. This should aid both the court and the division in their functions of providing the appropriate delivery of services to the mentally ill person.

The final sentence of this section will be of value to the court in determining whether or not to allow voluntary treatment as per subsection (1) of ORS 426.130 as amended in Section 12 of this Act.

SECTION 12

Section 12 amends ORS 426.130 by replacing the present "parole before commitment" statute with alternatives available to the court upon completion of the formal hearing. The alternatives open to the court following a commitment hearing are as follows:

(a) If not found to be a mentally ill person, the person must be discharged from the custody of the court.

(b) If found to be a mentally ill person:

(1) In anticipation of participation in treatment on a voluntary basis the person may be released. This alternative will be based on recommendations of the examining physicians, as well as the evidence at the hearing, in determining whether the person would participate in such a voluntary program.

(2) There may be ordered a conditional release to a qualified legal guardian, relative, or friend. This is essentially the same as the present parole before commitment statute (ORS 426.130), with the best interest of the mentally ill person the primary determining factor.

(3) The court may order commitment to the Mental Health Division for an initial period of up to 45 days. This subsection should be interpreted to encourage the alternatives in (1) and (2), and only if these other choices are "not in the best interest of the mentally ill person" should an involuntary commitment be ordered.

SECTION 14

In support of prevailing professional opinion that involuntarily committed patients will benefit by changing to voluntary status as simply and quickly as is practicable, the Task Force felt it necessary to include a provision to that effect. Upon such an alteration of status, the patient is to be considered a voluntary patient in every respect including the right to release within 72 hours of request.

SECTIONS 15 THROUGH 17

These new sections (sections 15 through 17) are the heart of the new periodic review procedure of involuntarily committed patients. While the voluntary patient is protected from indeterminable confinement by the right to be released within 72 hours of such a request, the involuntarily committed patient presently has no guarantee that his status would be reviewed from without the facility to which he is committed. In an effort to afford such a protection, this new review system includes opportunities for review procedures to be instigated following the initial 45-day commitment period, after each additional 90-day commitment period within the first year of hospitalization, and semi-annually thereafter.

It was felt that the initial burden of action should be on the division in seeking further hospitalization of an involuntary patient. Thus, at the end of each commitment period the division must, (1) release the patient, or (2) certify to the court "that the patient is still mentally ill and in need of further treatment."

If a further period of commitment is sought, the division is responsible for notifying the patient as per section 15 of this Act. This notification consists of delivering the certification to the patient by either a doctor or registered nurse from the facility. This method of service was favored over service by an officer of the court.

Once the certification has been properly served on the patient, the burden of affirmative action shifts to the patient. He must make known his intention to protest further commitment within 14 days of service of the certificate. Failure to protest will subject the patient to further hospitalization without a hearing. Section 15 promulgates the content of the certificate which is to be self-explaining and in "clear and simple language." The certificate itself is a key step in the periodic review system. It notifies the patient of the situation and explains the rights he has and procedures which he must follow in order to protest a further period of commitment.

Section 16 provides for notification by the division to the court and also provides for the safeguard of additional notice to the patient. The second notice is given by the court upon protest by the patient, and it re-emphasizes and explains the review procedures and rights. This section, along with similar notice requirements in section 15 of this Act, is aimed at insuring that the patient will be fully advised of the review procedure and its ramifications.

The hearing procedures are contained in section 17. Two important features of this section concern appointment of legal counsel and retaining an examining physician. Legal counsel is made mandatory at all certification hearings unless, as in ORS 426.100 (2) as amended by section 6 of this Act, it is "expressly, knowingly, and intelligently" refused. Section 17 also requires the appointment of both legal counsel and an independent examining physician for indigent patients without cost to such patients. These provisions were included in light of recent judicial decisions concerning such matters as the right to legal counsel.

After a full hearing, the court is charged with determining (a) whether the individual is still a "mentally ill person", and (b) whether the individual is in need of further treatment. The court, through (a), will be using the same criteria

for continued commitment as was used in the original court commitment and as defined in section 1 of this Act. This will therefore give true periodic reviews and rehearings to patients who request such. The second standard, (b), was included for situations in which the person may not have fully recovered and is thus within the definition of a mentally ill person but for whom further hospitalization will be of no value. Upon an affirmative finding of both (a) and (b), the court may then order a commitment for up to an additional 90 days, at which time the review system is repeated as per sections 15 through 17 of this Act.

#### SECTION 18

Recognizing the fact that some mentally ill persons remain hospitalized for years, the Task Force felt it was necessary to provide for less frequent certification for further commitment of such long-term patients. Instead of the 90-day commitment periods, section 15 provides for up to 180-day periods for persons who have been involuntary patients for greater than a year.

It should be emphasized that this section does not eliminate these persons from the periodic review system; rather they are included in the same procedures (sections 15 through 17) but may be committed for a longer period of time.

Persons on trial visit status are specifically limited to a maximum commitment period of 90 days notwithstanding the length of the patient's prior custody. This is necessary in light of a recent consent decree in which it was stipulated that no person on trial visit for greater than 90 days shall be denied a hearing prior to being returned to the treatment facility. Therefore, this limitation on length of trial visit will meet the requirements of the decree and provide for periodic review under sections 15 through 17 of this 1973 Act.

#### SECTION 19

So as not to penalize unfairly the counties in which the various treatment facilities are located, the present policy, ORS 426.310, of charging the costs to the county of the person's residence is continued with regard to the new periodic review system of this Act.

#### SECTION 20

Section 20 was added so as not to affect ORS 426.300, which allows the discharge of patients at times prior to the end of the commitment period.

#### SECTION 21

Section 21 amends ORS 426.160 to provide for a full account of the new review procedures of this Act in the court records.

SECTION 22

Since the courts, under this Act, commit a person to the Mental Health Division rather than to an individual hospital, the "division" is substituted for the "superintendent" in the discharging of patients from the jurisdiction of the committing court. This section also changes the criteria for such discharges in coordination with other provisions of this Act.

SECTION 23

Section 23 deletes a phrase in subsection (1) which allows for detention of alleged or adjudicated mentally ill persons in jails. The change follows the argument that jails should not be used to quarter any person being detained under the mental health statutes, even on a temporary basis. Unless also incarcerated on a criminal charge, a mentally ill person or one allegedly mentally ill is neither guilty of nor charged with any crime. Therefore, it is argued that jails are simply improper for detention of such a person.

Subsection (2) of ORS 426.140 is amended by substituting the word "community." This change will thereby not limit such confinements to "county" facilities. For more clarity, this subsection also narrows the designation of "health officer" by the addition of the word "county."

SECTION 24

Section 24 amends ORS 426.150 by conforming this statute to other changes in this Act. Specifically, the changes relate to section 2 concerning commitments to the "division," and Section 10, concerning the use of "qualified persons" as recommended by the division.

SECTION 25

Section 25 contains changes to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 26

Section 26 provides for coordination of the general conditions of a trial visit with the patient's treatment plan during his period of hospitalization. The length of a trial visit is limited to a maximum period of 90 days pursuant to section 18 of this 1973 Act.

The section also adds the doctor who takes administrative responsibility for a patient's release on trial visit to those persons who are exempt from liability for the patient's expenses or conduct while on trial visit. Also, there is the substitution of "division" for "superintendent," as well as the substitution of the word "facility" for "hospital" to conform with section 2 of this 1973 Act.

SECTION 27

Section 27 amends ORS 426.290 so as to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 28

Patients' Rights

The Task Force has concluded that the status of a "mentally ill person" should not strip the person of certain rights. Section 28 of this Act is the promulgation of a patients' "Bill of Rights" and is to be posted in all the facilities housing such patients, as well as given to each patient upon admission and made available to other interested persons (section 31 of this Act).

Although most of the rights listed in this section are currently being adhered to throughout the state, the Task Force felt that a statutory guarantee would be in the best interest of patients, both present and future.

Section 28 is a codification of rights basic to every patient under treatment by the Mental Health Division. The rights found herein are the result of consideration of patients' rights provisions in mental health laws throughout the United States, proposed changes in other states, articles on patients' civil rights, as well as recent judicial decisions.

Under subsection (1):

(a) The right of communication is expanded from its present form. ORS 426.375 (1) (a) and (b) are the equivalent of the first two provisions in (a) of this subsection and are unchanged in handling of visitors and mail. Added to this right of communication is "reasonable access to telephones." This subsection was taken from the California patients' rights statute under section 5325, and was felt to be a necessary part of the communications right.

(b) The general policy throughout the mental hospitalization system is to encourage a certain degree of patient individuality. With this in mind, the Task Force has included the right to wear one's own clothing. This in no way changes the responsibility of the division to provide patients with proper personal clothing. Rather, it protects the personal choice of the patients as to the clothing he might wish to wear.

It should be understood that the reasonableness of the attire should be based not only on the patient's wishes, but also on the affect that the particular attire might have on other patients. "Reasonableness" should be within the discretion of the hospital authorities and the right subject to limitation for good cause, and any denial should be entered into the patient's treatment record.

(c) This section is similar to (b) in an effort to encourage individualization of patients during the hospitalization period. The right to keep personal possessions is considered necessary to encourage both the responsibility in the

patient and to aid in his self-respect. However, this section is not to be used in any manner which may be detrimental to the progress and treatment of any patient. The inclusion of "toilet articles" was taken from the California law and intended to be a guideline for the type of possessions to which this right applies.

(d) The right to religious freedom is basic throughout the country. It was felt to be of such nature that it should not be denied by reason of a person's mental condition.

(e) Providing for a private storage area goes hand in hand with subsection (c) in seeking patient responsibility and individuality, as well as security for personal possessions. The provided area should be of reasonable size to accommodate the patient's reasonable needs, but not so large as a "warehouse" for the patient's possessions.

(f) The right to a reasonable supply of writing materials and stamps is felt to be essential to carry out the guarantees of free communication by mail. Certainly without these items, right to use the mails would be meaningless to an indigent patient. The current policy of the state system is to issue one stamp per week for those who have none. Thus, there would be little change in the basic policy of making the mails available to all patients.

(g) This section should be considered an important step toward guaranteeing adequate treatment for all patients. A written treatment plan has been viewed as an essential safeguard by advocates of "right to treatment" theories. (Following this thinking, anyone hospitalized has the right to "adequate treatment," and if not so treated he should be released.) This provision furnishes a built-in protection against a person being cared for without any treatment guidelines or progress reports.

(h) The right to be represented by legal counsel is essential to every citizen, whether he is hospitalized, imprisoned, or a member of the general public. This section insures compliance with recent judicial decrees concerning patients' rights.

(i) The right to petition for a writ of habeas corpus, although provided for in other sections of the law, was felt to be necessary to make more complete this patients' rights section. Thus, this would merely re-emphasize and not change the present law on the subject.

(j) This section guarantees the continuation of the current hospital policies of not forcing any patient to work on routine labor tasks, unless such work is regarded by the hospital staff as an important part of the patient's treatment.

Following comments from staff personnel, the Task Force concluded that it is necessary to provide for the use of certain tasks in situations where the patient's treatment plan calls for some required work projects. The requirement of a written treatment plan in subsection (g), including such items as work treatment, affords protection against abuse of this exception.

(k) This provision was adopted by the Task Force recognizing the recent federal court decision in Alabama which held that patients be paid the federal minimum hourly wage for services performed beyond personal housekeeping duties. The feeling of the Task Force was that the patients should be paid a "reasonable compensation" on an efficiency scale in proportion to their output.

While this section is not meant to provide for patient employment during hospitalization, it is intended to allow the patient to realize some financial gain, regardless of the amount, as compensation for his labor efforts other than his personal housekeeping. In addition, staff personnel have advocated some form of compensation system to add to the patient's feeling of accomplishment and sense of personal worth in a type of "employer-employee" setting.

(l) This section allows the Mental Health Division to add, by regulation, certain rights to the statutory list. It provides for flexibility in addition to the patients' rights as posted, and still does not restrict or deny the statutory rights provided for in this act.

(m) This is no change from the present statutes under ORS 426.375 (1) (c). It is a general statement on the legal capacity of the mental patient.

(2) The right of a patient to have a voice in the type of treatment he will receive was the topic of much discussion, both within and without the Task Force sessions. Subsection (2) relating to this matter was felt to be of such nature that it should be set apart from the other patients' rights provisions. The proposed draft begins with a basic sentence from the Alabama "Right to Treatment" case, Wyatt v. Stickney, in protecting the patient from certain treatment procedures without his "express and informed consent."

In order to protect the interest of a patient who may be unable, by reason of his illness, to give such consent, but who may be in need of such treatment, the section adds the second and third sentences. These are similar to the procedure in the new California law, section 5326, in denying the right for "good cause only" and that any denial will be entered into the patient's treatment record, but goes even further as a safeguard, in that it requires "consultation with and approval of an independent examining physician." This will provide assurance that such treatments will not be performed without deliberation and consultation with a physician from without the staff of the facility.

Note: There was considerable discussion pro and con on the singling out of lobotomy and electro-shock therapy as treatments falling under this section. No lobotomies have been performed in state hospitals for more than 15 years. There was professional disagreement within the Task Force with regard to whether or not electro-shock therapy is "potentially unusual or hazardous." However, it was recognized that the general patient population has placed lobotomy and electro-shock therapy in the hazardous category, notwithstanding any professional opinions. Therefore, it is stressed that these treatments were not included because they are deemed "bad" treatments, but rather to allay specific fears which may have been associated with these treatments.

Subsection (3) contains changes to conform with wording changes of this 1973 Act.

SECTION 29

ORS 426.375, the present patient rights section, is repealed and a more complete promulgation will be substituted in the form of ORS 426.385 as amended by Section 28 of this Act.

SECTION 31

Section 31 provides for the posting of the guaranteed rights which is felt to be essential in the protection of the rights of patients. The amendments proposed in Section 28 of this Act are for the benefit of the patient and would be little more than statutory rhetoric if the information is not made readily available to those persons affected.

The same rationale is used in requiring that a copy be given to each patient upon admission to a facility. Other persons may also be furnished with such a copy of the patients' rights in an attempt to further insure that these rights are not improperly denied.

SECTION 32

The peace officer provision, ORS 426.215, is amended by Section 32 to coordinate with the amendments of this Act and to add safeguards for persons to whom this section applies.

Subsection (1) (b) of ORS 426.215 is amended to include consideration of the effect removing the person to another county will have on the person's physical health. Also added to this subsection of ORS 426.215 is the requirement that the examination be conducted within the previous 24 hours so as to assure a current evaluation based on the person's current situation.

Subsections (2) and (4) add an "administrator" as the one who may be responsible for causing the person to be examined.

Subsection (3) is amended to provide for commencement of the investigatory procedures under ORS 426.070 as amended by Section 3 of this 1973 Act.

Subsection (5) is added so as to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (Section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanations concerning the use of any mechanical restraints on such persons.

## ATTACHMENT D

OREGON STATE ARCHIVES

## MENTAL HEALTH DIVISION

## TASK FORCE ON IMPLEMENTATION AND FISCAL IMPACT OF SENATE BILL 510

<u>Name</u>	<u>Representing</u>	<u>City</u>
Warren B. Barnes	Oregon Sheriff's Association	Hillsboro
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
E. W. Bloomquist	Association of Oregon Hospital Administrators	Astoria
D. K. Brooks, M.D.	State Hospitals	Salem
Vyvian Downer, P.H.N.	County Health Departments	Coquille
Therese Engelmann	Public	Eugene
R. L. Guiss, M.D.	State Hospitals	Wilsonville
John T. Herron, M.D.	Health Officers Association	Salem
William Kortge	Association of Oregon Counties	The Dalles
Fred E. Letz, MSW, Chairman	Mental Health Division	Salem
Josephine McWhirter	Mental Health Clinics	Portland
Helen Mead	Multnomah County Circuit Court	Portland
Alan Marek, MSW, ACSW	Association of Oregon Mental Health Clinic Directors	McMinnville
Judge Gregory Milnes	Oregon Circuit Judges' Association	Hillsboro
Thomas F. Nugent, M.S.	Association of Oregon Mental Health Clinic Directors	Eugene

<u>Name</u>	<u>Representing</u>	<u>City</u>
Marylyn Ruckwardt, R.N., M.N.	Mental Health Division	Salem
William L. Stacy, MSW	Association of Oregon Mental Health Clinic Directors	Baker
John Truett	Oregon Sheriff's Association	Roseburg

4-4-73

AMERICAN CIVIL LIBERTIES UNION  
310 Senator Building  
Portland, Oregon 97204

STATEMENT OF THE AMERICAN CIVIL LIBERTIES UNION OF OREGON  
REGARDING ENGROSSED SENATE BILL 510  
Before the House Human Resources Committee  
May 31, 1973  
\*\*\*\*\*

My name is Myron Katz. I represent the American Civil Liberties Union of Oregon.

For several years now the American Civil Liberties Union, nationally and here in Oregon, has been debating the substantive and procedural questions concerning involuntary commitment for mental illness. On the substantive side, much of the discussion has centered on the issue of whether involuntary confinement for mental illness is ever justifiable and, if justified, under what circumstances and upon what criteria.

There is growing concern among civil libertarians as to the propriety of denying liberty to any person on the prospective and speculative grounds that it is possible he may do injury to himself or to others. Many civil libertarians believe that just as no person should be arrested and jailed on the grounds that it is conceivable he might in the future commit a crime, so, too, a person should not be preventively detained on the speculative grounds that he is mentally ill and might become a danger to himself or to others. Our concern is further intensified by the admittedly poor track record of behavioral scientists and others in trying to accurately forecast human conduct.

There have been many instances, well documented, where erratic, eccentric and quaint deportment has resulted in a person being committed against his will, probably because he is more a nuisance than a threat. But even if a person is a threat, it is difficult to see why he should have his liberty taken away when he has not committed a crime and when similar preventive detention against potential criminals, even the most dangerous, is abhorred as a clear-cut infringement on civil liberties. It is denying liberty to people, against their wishes, ostensibly for their own good, that causes much concern among civil libertarians.

Unfortunately, these substantive issues are not yet fully resolved and the discussion in civil liberties circles continues.

That is not so with respect to procedural questions. The procedures that must be afforded a person in connection with a state's initial effort to involuntarily commit that person to a mental institution and the subsequent decision to retain that person there are no longer a matter of serious dispute, as state and federal courts are making abundantly clear almost every day.

SB 510, the product of a Task Force established by the Oregon Mental Health Division on which the ACLU participated, deals almost exclusively with these procedural rights. Whether or not a person who has not committed a crime should ever be involuntarily committed to an institution for the mentally ill, the fact is that all states including Oregon continue to do so on the ground that such persons are mentally ill, or pose a danger to themselves or others, or are in need of treatment, care or custody, or on some other criteria. That being the case, it is of utmost importance that whenever an involuntary commitment procedure is undertaken, there is proper respect for an allegedly mentally ill person's rights including that person's rights once confined and following treatment. On this

virtually all civil libertarians and, we are pleased to note, most courts of law agree.

Although the ACLU of Oregon does not endorse the proposition implicit in SB 510 that involuntary commitment of mentally ill persons is necessarily proper, we do endorse the proposition that due process should be observed under all circumstances. In this respect, we believe that SB 510, while it may not go as far as we would like it to go, is a good bill and should pass.

\* \* \* \* \*

To perfect the bill further, the ACLU of Oregon offers one amendment:

On page 16 of the printed engrossed bill, line 15, after the period delete the rest of the line.

Delete lines 16 through 20.

###

Thank you for this opportunity to testify.

#### ENGROSSED SENATE BILL 510

##### Key Features of Proposed Involuntary Mental Commitment Law

- 1) Defines mentally ill person as (a) danger to self or others or (b) unable to provide basic needs for health or safety. (Present law has no definition.)
- 2) Sworn statement by two persons triggers procedure - investigation by county mental health clinic or county health officer to determine if there is probable cause to believe a person is mentally ill. (Present law does not provide for any investigation as to probable cause; judge must begin commitment proceedings by sworn statement of two persons.)
- 3) If there is probable cause, a formal hearing is begun. Allegedly mentally ill person is given access to investigative report; opportunity must be given for voluntary appearance at hearing; emergency detainee must have hearing within 72 hours. Citation must cite specific reasons why person is believed to be mentally ill. (None of these provisions is in the present law.)
- 4) Allegedly mentally ill person must be advised of rights in court and told the reasons for proceedings, the nature of the proceedings, and the possible consequences. He will have the right to subpoena witnesses and right to counsel, without cost if he cannot afford counsel. Others can request an attorney on his behalf. Court shall appoint counsel unless expressly, knowingly and intelligently refused. Postponement of proceedings must be granted upon request. (Except for being advised of right to counsel, none of these provisions is in the present law.)
- 5) Court must be advised of drugs administered which might affect allegedly mentally ill person at hearing. He has right to cross examine all witnesses including examining physicians. The earlier investigative report cannot be used as evidence without his express consent. The examining physicians must submit separate written reports. (None of these provisions is in the present law.)

- 6) If the court finds that the allegedly mentally ill person is not mentally ill, he is discharged. If he is found mentally ill beyond a reasonable doubt the court may do one of three things: (1) dismiss the case if he is willing to receive voluntary treatment; (2) conditionally release him to the custody of a guardian, relative or friend able to care for him; or (3) commit him involuntarily for a period not to exceed 180 days. (Item 1 and 180-day maximum are new.)
- 7) Any time after involuntary commitment, the patient may change his status to voluntary commitment if approved by Division of Mental Health in which case he is eligible for release within 72 hours if requested. (Entirely new.)
- 8) Patient must be discharged within 180 days unless Division of Mental Health certifies to the court in the county where the treatment facility is located that he still needs treatment. Copy of certificate must be given patient. If the patient does not protest, he may be recommitted up to 180 days. (All new)
- 9) If patient protests, a new court hearing must be held with an independent physician's examination. Again, patient can subpoena witnesses, offer evidence; and legal counsel must again be appointed unless expressly, knowingly and intelligently refused. If the court finds the person is still mentally ill and in need of further treatment, he can be recommitted up to a maximum of 180 additional days. The cycle repeats each 180 days.
- 10) Patient must be discharged if no longer mentally ill or, if transferred to voluntary status, upon request. (Unlike present law, the standard for involuntary commitment is the same as the standard for discharge.)
- 11) Unless a person is an immediate and serious danger to hospital staff or facilities, jails cannot be used for detention. (Present law permits use of jails if other suitable place is unavailable.)
- 12) List of rights of involuntarily committed persons is explicitly stated: Communication, own clothing, personal possessions, religious freedom, private storage with access, writing materials and stamps, written treatment plan, legal counsel whenever substantial rights may be affected, habeas corpus, no routine labor compelled unless essential for treatment, reasonable compensation for work, all civil rights, and freedom from potentially hazardous treatment including lobotomy and shock unless express and informed patient consent is given (but can be denied for cause after consultation with independent examining physician with record made). Rights must be given to patient and conspicuously posted. (Present law permits hospital superintendent to suspend all specified rights; and there is no requirement for posting or informing patients of rights.)

###

Exhibit 3  
5/3/13

CHARLES R. WILLIAMSON  
Legal Aid Service  
732 S. W. Third Avenue  
Portland, Oregon 97204  
April 4, 1973

TESTIMONY ON S B 510 - HUMAN RESOURCES COMMITTEE - HOUSE

Perhaps people are poor because they are mentally ill or perhaps they are mentally ill because they are poor. In any case, a large number of persons we have represented in the past have been committed to a state mental hospital against their will. Current Public Defender statistics indicate that over 40% of committed persons are on public assistance of some form, or a pension. Under 25% are employed.

We became concerned over three areas of the mental commitment process.

First, people were being taken from their houses in the early morning without notice and delivered to the courthouse for their hearing. This was done upon the sworn statement of two persons. The person was not given a chance to appear voluntarily and no "pre-hearing" investigation was done prior to picking him or her up.

Secondly, hearings were perfunctory and, on occasion, conducted while the allegedly mentally ill person was under the influence of involuntarily administered drugs. The vague standard of "mentally ill and in need of treatment, care or custody" allows a court to commit almost anyone who acts "differently." Harmless old people who sometimes wrote strange letters or talked to themselves were uprooted from their homes and committed to a state institution --

for an indefinite period of time. The commitment could last the rest of their lives.

Thirdly, release from the institution was invariably on a "trial visit" basis. Persons were hauled back to the hospital with no notice and no hearings, simply upon the sworn statement of a "citizen of Oregon."

In the past year, several changes have taken place. The Court of Appeals has ruled that attorneys must be appointed for indigent persons facing commitment. State v. Collman, 94 Or. Ad. Sh. 1780 (1972). Thus, the Public Defender in Portland has taken over defense of all indigents. Commitments have dropped by 30%.

A new probate judge has taken office in Multnomah County and has allowed pre-hearing investigations prior to picking up allegedly mentally ill people. The drop in commitments of prescreened individuals is dramatic. Further, the "dangerousness" standard of commitment has been generally applied.

Federal Judge Alfred Goodwin signed a consent decree wherein the state agreed to give administrative hearings to individuals whose trial visit was being terminated after three months. West v. Bray, (D.C. Or. 1972) 71-654.

Thus, S B 510 reflects many of the realities of current practice. In short, the bill provides for the following:

- 1) Pretrial investigation by a competent person (section 3).
- 2) A possible opportunity for allegedly mentally ill individuals to appear voluntarily at their hearings (section 5).
- 3) A discernable standard for commitment, i.e., dangerousness to one's self or others. This standard is extremely important --

) especially in the protection of the elderly. It is already in effect in 14 states. (Section 1)

4) Appointment of counsel in nearly all cases (section 6).

5) Examination of allegedly mentally ill persons by psychologists and others in addition to medical doctors. (Under existing law, only doctors, whether or not they are trained in psychology, can examine allegedly mentally ill persons.) (section 10)

6) A requirement of use of the least restrictive alternative in the commitment proceedings, i.e., sending patients to a custodial facility only if voluntary treatment or conditional release are not in the patient's best interest (section 12(3)).

7) A patient can change his status from "committed" to "voluntary" with the approval of the division. He can be discharged on 3 day notice if on voluntary status (section 14).

8) Periodic review hearings for patients detained more than six months. This will require that committed persons receive treatment or be released. They cannot be "warehoused."

9) A limit of trial visits (section 6).

10) Expanded basic rights (section 28).

We believe these provisions of the bill and the bill as a whole will tremendously benefit low income people. More treatment and better treatment can be administered to people on an outpatient basis in the community and in their homes. They will not be torn from familiar surroundings and institutionalized to the extent that they are now.

Senate Bill 510--Relating to involuntary commitments of mentally ill persons; creating new provisions; and amending ORS 426.005, 426.060, 426.070 and others; repealing ORS 426.375; and prescribing an effective date.

Senator Stevenson noted that in 1972 a Mental Health Division task force made an exhaustive study over six months of commitment laws of the 50 states and made recommendations for extensive revisions of Oregon's commitment statutes. This report is the basis for this bill which in essence says that commitment is considered appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety. If a person is committed under this bill, he would be committed to the Mental Health Division rather than a specified state hospital as under current statutes. This allows the Division wider latitude in deciding where he might best be placed, whether in the community or a hospital. At present commitments are for an indefinite period of time, whereas under this bill they would be for 180 days.

Subcommittee No. 4 was informed that the provisions of this bill can be implemented within the appropriation made to the Mental Health Division. It represents a major departure from existing commitment procedures; however, each proposed change is based on existing statutes in other states or a pilot program in Oregon and none of the changes are considered to be experimental. There might be additional costs to implement the bill for community mental health clinics for preliminary investigations, some court-ordered examinations and disposition planning and follow-up. Over a period of years, it should result in a substantial reduction in state mental hospital costs and facilitate early, voluntary treatment of mentally ill persons in their own communities.

Senator Stevenson moved that Engrossed Senate Bill 510 be reported out to the House "Do pass."

Representative Ingalls asked whether the Oregon State Bar has taken a position on this bill. Senator Stevenson said he did not know but assumed they were apprised of the existence of the task force and the bill. Senator Fadeley said that although the State Bar had not officially taken a position, several officials assisted in drafting the bill.

Senator Stevenson's motion carried, with Senator Newbry voting "no" and Senator Roberts not present for roll call vote.

The meeting recessed at 2:55 p.m., and reconvened at 4:05 p.m.

The Chairman asked for unanimous consent to move Senate Bills 878 and 371 to the end of the calendar. There were no objections to his request.

*Wm*

107 43

ANALYST: Frank/Goldsmith

DATE COMPLETED: May 8, 1973

1. Number of Measure SB 510	2. Status Original	3. Class of Bill Fiscal <input checked="" type="checkbox"/> Non-Fiscal <input type="checkbox"/> Organizational <input type="checkbox"/>
4. Subject Provisions relating to commitment of mentally ill persons		
5. Government Unit or Program Affected Mental Health Division; courts; community mental health programs		

6. Fiscal Impact

Effect on Revenue

None

Effect on Expenditures

SB 510 would modify provisions relating to involuntary commitment of mentally ill persons. Revising and expanding certain procedures, the Act would provide for commitment to the Mental Health Division rather than a specific state hospital.

The Mental Health Division estimates that the establishment of a comprehensive commitment review procedure could require total program expenditure of approximately \$600,000 biennially. With the reduction of current county responsibilities, Mental Health Division estimates that roughly \$240,000 in county expenditures could be identified as an offset to total biennial program costs. Given the county offset, increased state General Fund costs could approximate \$360,000 biennially.

By operating a much less comprehensive program and by maintaining current county program support, it might be possible for the county mental health clinics to accommodate the program within 1973-75 recommended funding.

SB 510 was not anticipated in the 1973-75 Mental Health Division budget.

LF:sc

Reviewed by Legislative Fiscal Office.

Analyst: Wilkinson  
Date: May 14, 1973

## SENATE BILL 510

Changes in Oregon commitment laws have been made in almost every legislative session in the last 20 years. Commitment procedures have become more efficient and humane. Alternative methods for treatment have been developing in the communities. However, the entire commitment system has not been evaluated at one time. This, combined with recent court decisions related to right to treatment and civil rights, has made necessary a comprehensive study of Oregon commitment laws.

In 1972, a Mental Health Division task force comprised of representatives of Mental Health Division hospitals, the State Mental Health Advisory Board, and ten involved organizations made an exhaustive study over six months of the commitment laws of all 50 states and made recommendations for extensive revisions in the Oregon commitment statutes. This task force report is the basis for Senate Bill 510.

Definition of Mental Illness

This entire bill is designed to encourage voluntary treatment within the community in preference to state hospitalization after commitment. Commitment is considered to be appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety.

Commitment to the Mental Health Division

If a person were committed under this bill, he would be committed to the Mental Health Division rather than to a specified state mental hospital as under current statutes. This allows the Division to arrange for his treatment either at a state mental hospital or within the community in a general hospital, day treatment program, nursing home, or other facility considered to be best suited to provide the treatment and supervision needed by the individual.

Preliminary Investigation and Crisis Treatment

Under the proposed revisions, a preliminary investigation would be mandatory. Trained community mental health staff or public health

nurses would visit the person, wherever he is, to assess and clarify the total situation and resolve the crisis on the spot if possible. Failing that, a plan for voluntary treatment or report to the court for further action would be developed.

#### Detention Pending Commitment Hearings

The "peace officer hold" statutes are retained in this bill, providing for immediate examination and hospitalization of a presumed mentally ill person when necessary. In addition, detention can be initiated by the person doing the initial investigation under the proposed changes, and, since this person would be a peace officer when the need for detention is anticipated, this could also be immediate. The responsibilities of the treating physician for emergency care, custody and treatment during detention is clearly defined, including procedures for the use of mechanical restraints. A report of treatment and its results becomes a part of the record provided to the judge at the commitment hearing.

#### Protection of Personal Rights During Commitment Process

At all steps in the process, the person's civil rights are carefully protected. Representation by legal counsel becomes mandatory, except in unusual circumstances, to be paid for by the county if the person cannot pay.

#### Psychiatric Examinations

Under current statutes, the judge appoints two licensed physicians, not necessarily psychiatrists, to examine the person as to his mental condition. Engrossed Senate Bill 510 provides for one of the examiners to be a carefully selected non-physician mental health professional.

#### Limitation on Duration of Commitments

At present, commitments are for an indefinite period of time. Under Engrossed Senate Bill 510, commitments would be for 180 days. Re-commitments would also be for up to 180 days.

#### Detention in Jails

Detention in jails is limited to those persons who present an immediate and serious danger to hospital staff or facilities.

### Trial Visit Status

Under the proposed revisions, a person could leave the treating facility on trial visit status during his period of commitment; but trial visit would terminate when the commitment terminated, or 180 days maximum.

### Bill of Rights for Committed Patients

Consistent with recent court decisions, an expanded list of personal and civil rights is defined in this bill, and this statement of rights would be posted in a prominent place in all facilities housing committed patients.

### Fiscal Impact

Engrossed Senate Bill 510 can be implemented within the appropriation made available to the Division. Counties can anticipate reduced costs in some departments, such as the sheriff's department and possibly the courts. The significant increased workload and costs will be in the community mental health programs, which will be responsible for screening and alternative placement. The approved budget provides that the Mental Health Division may return to the Emergency Board or the Special Session, as appropriate, for transfer of funds from state hospital budgets to community mental health programs as an offset to these costs.

### Summary

Senate Bill 510 represents a major departure from existing commitment procedures in Oregon. However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow up.

Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities.

JDB:alb

June 22, 1973

## ATTACHMENT D

## MENTAL HEALTH DIVISION

## TASK FORCE ON IMPLEMENTATION AND FISCAL IMPACT OF SENATE BILL 510

<u>Name</u>	<u>Representing</u>	<u>City</u>
Warren B. Barnes	Oregon Sheriff's Association	Hillsboro
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
E. W. Bloomquist	Association of Oregon Hospital Administrators	Astoria
D. K. Brooks, M.D.	State Hospitals	Salem
Vyvian Downer, P.H.N.	County Health Departments	Coquille
Therese Engelmann	Public	Eugene
R. L. Guiss, M.D.	State Hospitals	Wilsonville
John T. Herron, M.D.	Health Officers Association	Salem
William Kortge	Association of Oregon Counties	The Dalles
Fred E. Letz, MSW, Chairman	Mental Health Division	Salem
Josephine McWhirter	Mental Health Clinics	Portland
Helen Mead	Multnomah County Circuit Court	Portland
Alan Marek, MSW, ACSW	Association of Oregon Mental Health Clinic Directors	McMinnville
Judge Gregory Milnes	Oregon Circuit Judges' Association	Hillsboro
Thomas F. Nugent, M.S.	Association of Oregon Mental Health Clinic Directors	Eugene

<u>Name</u>	<u>Representing</u>	<u>City</u>
Marylyn Ruckwardt, R.N., M.N.	Mental Health Division	Salem
William L. Stacy, MSW	Association of Oregon Mental Health Clinic Directors	Baker
John Truett	Oregon Sheriff's Association	Roseburg

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patient and to aid in his self-respect. However, this section is not to be used in any manner which may be detrimental to the progress and treatment of any patient. The inclusion of "toilet articles" was taken from the California law and intended to be a guideline for the type of possessions to which this right applies.

(d) The right to religious freedom is basic throughout the country. It was felt to be of such nature that it should not be denied by reason of a person's mental condition.

(e) Providing for a private storage area goes hand in hand with subsection (c) in seeking patient responsibility and individuality, as well as security for personal possessions. The provided area should be of reasonable size to accommodate the patient's reasonable needs, but not so large as a "warehouse" for the patient's possessions.

(f) The right to a reasonable supply of writing materials and stamps is felt to be essential to carry out the guarantees of free communication by mail. Certainly without these items, right to use the mails would be meaningless to an indigent patient. The current policy of the state system is to issue one stamp per week for those who have none. Thus, there would be little change in the basic policy of making the mails available to all patients.

(g) This section should be considered an important step toward guaranteeing adequate treatment for all patients. A written treatment plan has been viewed as an essential safeguard by advocates of "right to treatment" theories. (Following this thinking, anyone hospitalized has the right to "adequate treatment," and if not so treated he should be released.) This provision furnishes a built-in protection against a person being cared for without any treatment guidelines or progress reports.

(h) The right to be represented by legal counsel is essential to every citizen, whether he is hospitalized, imprisoned, or a member of the general public. This section insures compliance with recent judicial decrees concerning patients' rights.

(i) The right to petition for a writ of habeas corpus, although provided for in other sections of the law, was felt to be necessary to make more complete this patients' rights section. Thus, this would merely re-emphasize and not change the present law on the subject.

(j) This section guarantees the continuation of the current hospital policies of not forcing any patient to work on routine labor tasks, unless such work is regarded by the hospital staff as an important part of the patient's treatment.

Following comments from staff personnel, the Task Force concluded that it is necessary to provide for the use of certain tasks in situations where the patient's treatment plan calls for some required work projects. The requirement of a written treatment plan in subsection (g), including such items as work treatment, affords protection against abuse of this exception.

(k) This provision was adopted by the Task Force recognizing the recent federal court decision in Alabama which held that patients be paid the federal minimum hourly wage for services performed beyond personal housekeeping duties. The feeling of the Task Force was that the patients should be paid a "reasonable compensation" on an efficiency scale in proportion to their output.

While this section is not meant to provide for patient employment during hospitalization, it is intended to allow the patient to realize some financial gain, regardless of the amount, as compensation for his labor efforts other than his personal housekeeping. In addition, staff personnel have advocated some form of compensation system to add to the patient's feeling of accomplishment and sense of personal worth in a type of "employer-employee" setting.

(l) This section allows the Mental Health Division to add, by regulation, certain rights to the statutory list. It provides for flexibility in addition to the patients' rights as posted, and still does not restrict or deny the statutory rights provided for in this act.

(m) This is no change from the present statutes under ORS 426.375 (1) (c). It is a general statement on the legal capacity of the mental patient.

(2) The right of a patient to have a voice in the type of treatment he will receive was the topic of much discussion, both within and without the Task Force sessions. Subsection (2) relating to this matter was felt to be of such nature that it should be set apart from the other patients' rights provisions. The proposed draft begins with a basic sentence from the Alabama "Right to Treatment" case, Wyatt v. Stickney, in protecting the patient from certain treatment procedures without his "express and informed consent."

In order to protect the interest of a patient who may be unable, by reason of his illness, to give such consent, but who may be in need of such treatment, the section adds the second and third sentences. These are similar to the procedure in the new California law, section 5326, in denying the right for "good cause only" and that any denial will be entered into the patient's treatment record, but goes even further as a safeguard, in that it requires "consultation with and approval of an independent examining physician." This will provide assurance that such treatments will not be performed without deliberation and consultation with a physician from without the staff of the facility.

Note: There was considerable discussion pro and con on the singling out of lobotomy and electro-shock therapy as treatments falling under this section. No lobotomies have been performed in state hospitals for more than 15 years. There was professional disagreement within the Task Force with regard to whether or not electro-shock therapy is "potentially unusual or hazardous." However, it was recognized that the general patient population has placed lobotomy and electro-shock therapy in the hazardous category, notwithstanding any professional opinions. Therefore, it is stressed that these treatments were not included because they are deemed "bad" treatments, but rather to allay specific fears which may have been associated with these treatments.

(3) Subsection (3) contains changes to conform with wording changes of this 1973 Act.

SECTION 29

ORS 426.375, the present patient rights section, is repealed and a more complete promulgation will be substituted in the form of ORS 426.385 as amended by Section 28 of this Act.

SECTION 31

Section 31 provides for the posting of the guaranteed rights which is felt to be essential in the protection of the rights of patients. The amendments proposed in Section 28 of this Act are for the benefit of the patient and would be little more than statutory rhetoric if the information is not made readily available to those persons affected.

The same rationale is used in requiring that a copy be given to each patient upon admission to a facility. Other persons may also be furnished with such a copy of the patients' rights in an attempt to further insure that these rights are not improperly denied.

SECTION 32

The peace officer provision, ORS 426.215, is amended by Section 32 to coordinate with the amendments of this Act and to add safeguards for persons to whom this section applies.

Subsection (1) (b) of ORS 426.215 is amended to include consideration of the effect removing the person to another county will have on the person's physical health. Also added to this subsection of ORS 426.215 is the requirement that the examination be conducted within the previous 24 hours so as to assure a current evaluation based on the person's current situation.

Subsections (2) and (4) add an "administrator" as the one who may be responsible for causing the person to be examined.

Subsection (3) is amended to provide for commencement of the investigatory procedures under ORS 426.070 as amended by Section 3 of this 1973 Act.

Subsection (5) is added so as to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (Section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanations concerning the use of any mechanical restraints on such persons.

# HOUSE AMENDMENTS

ENGROSSED  
TO SENATE BILL 510

JOINT  
COMMITTEE ON WAYS AND MEANS

Committee Report dated \_\_\_\_\_ Date(s) of Committee Action: \_\_\_\_\_

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See attached amendments

\_\_\_\_\_  
Committee Clerk



# MENTAL HEALTH DIVISION

## DEPARTMENT OF HUMAN RESOURCES

2570 CENTER STREET N.E. • • SALEM, OREGON • • 97310

TOM McCALL  
GOVERNOR

June 7, 1973

J. D. BRAY, M.D.  
Division Administrator

### DIVISIONS

- Children's Services
- Corrections
- Employment
- Health
- Mental Health
- Vocational Rehabilitation
- Welfare

### SPECIAL PROGRAMS

- Aging
- Camps
- Economic Opportunity
- Multi-Service Centers

TO: The Honorable Stafford Hansell  
Chairman, Subcommittee No. 4  
Joint Committee on Ways and Means

FROM: J. D. Bray, M.D.  
Administrator

SUBJECT: Engrossed Senate Bill 510--Relating to involuntary commitments of mentally ill persons

Changes in Oregon commitment laws have been made in almost every legislative session in the last 20 years. Commitment procedures have become more efficient and humane. Alternative methods for treatment have been developing in the communities. However, the entire commitment system has not been evaluated at one time. This, combined with recent court decisions related to right to treatment and civil rights, has made necessary a comprehensive study of Oregon commitment laws.

In 1972, a Mental Health Division task force comprised of representatives of Mental Health Division hospitals, the State Mental Health Advisory Board, and ten involved organizations made an exhaustive study over six months of the commitment laws of all 50 states and made recommendations for extensive revisions in the Oregon commitment statutes. This task force report is the basis for Sentate Bill 510. The membership of this task force is shown in Attachment A.

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#### Definition of Mental Illness

This entire bill is designed to encourage voluntary treatment within the community in preference to state hospitalization after commitment. Commitment is considered to be appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety. Inclusion of the latter concept allows commitment of some persons, primarily the elderly and those with chronic psychoses or organic brain disease, who are disoriented, out of contact with reality, or unable to make decisions about their basic needs because of their mental condition. It does not include the mentally retarded or persons who are unable to care for their basic needs but are being properly cared for by others.

Mental illness is not defined in existing statutes. Therefore, the proposed definition is restrictive and relates to involuntary commitments only. This definition should not be confused with a standard for voluntary admission to state mental hospitals or to community treatment facilities. Persons may legitimately seek and need voluntary admission but not be a "mentally ill person" under this definition.

#### Commitment to the Mental Health Division

If a person were committed under this bill, he would be committed to the Mental Health Division rather than to a specified state mental hospital as under current statutes. This allows the Division to arrange for his treatment either at a state mental hospital or within the community in a general hospital, day treatment program, nursing home, or other facility considered to be best suited to provide the treatment and supervision needed by the individual.

Procedures are defined to insure adequate communication between the courts, community mental health programs, treating facilities, health departments, law enforcement agencies, and the Division. These will be elaborated upon through administrative rules which will allow a phase-in of alternatives to state

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hospitalization. Until such alternatives are developed, some counties will continue to send all committed patients to a designated state mental hospital. As alternatives are developed, the county community mental health program director, or his designee, based upon information in the preliminary investigation report and the report of the two examining persons, will determine the appropriate treating facility for the committed person, will arrange admission to that treating facility, and will follow up to assure continuity of care. Although more complex, the responsibilities are clearly defined and treating facilities would be used in a more flexible way to meet individual patient needs than is possible in the present system.

#### Preliminary Investigation and Crisis Treatment

As under existing statutes, commitment proceedings would be initiated on a petition by two persons, the county health officer, or any magistrate. Under existing practices, the next step varies from county to county. In some counties, a uniformed police officer visits the home and issues a citation to appear in court at a specified time and place, or may immediately take the person into custody and take him to a general or state hospital where the person is examined by a physician and admitted to the hospital if appropriate. The person may be detained in a jail until the hearing if the hospital refuses admission.

In six to ten counties, trained community mental health staff or public health nurses have been visiting the person, wherever he is, instead of a peace officer. They work with the allegedly mentally ill person, family and petitioners (who are usually family members, neighbors, friends, or landlord) to assess and clarify the total situation and to resolve the crisis on the spot if possible. Failing that, they try to work out a plan for voluntary treatment within the community. If they conclude that the person is probably mentally ill and in need of commitment, a report is returned to the court for further action.

The investigating person also collects information which may be helpful in aftercare planning, after the person leaves the

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hospital. Peace officers may accompany the mental health staff or go instead of mental health staff if the person is sufficiently dangerous or uncontrollable as to require their assistance. As a result of these actions within the past year, commitments have been reduced by approximately 30 percent in these counties, even with limited alternatives for treatment available. Statewide, there were 1,168 court commitments in fiscal year 1971-72, compared to 1,559 the prior year, and 1,651 during fiscal year 1969-70. A summary by county is shown in Attachment B.

Under the proposed revisions; a preliminary investigation of this sort would be mandatory. Peace officers would still be utilized where necessary, but the responsibility to initiate the investigations, at the request of the court, would be with the community mental health program director or his designee. Although fact finding is one intent of this activity, this is not seen as primarily detective work but as an opportunity for crisis treatment by a trained mental health professional. It provides a method of controlling hospital utilization and costs which is extremely difficult when the person has already arrived at the hospital door. Pre-admission evaluations of non-emergency referrals to general hospitals have been initiated in some areas of the country as a means of controlling hospital utilization and costs. It reduces court workload, and allows flexible use of community alternatives which are best suited to the needs of the person and society.

#### Detention Pending Commitment Hearings

Under existing statutes, a peace officer responding to a petition for commitment or who otherwise identifies a person believed to be mentally ill and of immediate danger to himself or others may take that person into custody and transport him to a hospital where he is to be examined by a physician. If the person must be transported some distance to a hospital in another county, a certificate from a licensed physician is required to insure that the person is medically capable of handling the trip. The person may be detained in a general hospital approved by the Division for up to five days pending a hearing on a peace officer hold, or for up to 72 hours when a commitment petition has been filed.

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At present, there is some ambiguity regarding the roles of the court, hospital, and treating physician. The result is confusion as to what treatment is allowable and desirable during this detention period. Many individuals detained under these conditions are frightened, belligerent, confused, and showing obvious symptoms of mental illness, many of which will respond to routine medical treatment, often to sufficient degree that no commitment or even further hospitalization is necessary.

The peace officer hold statutes are retained in this bill, providing for immediate examination and hospitalization of a presumed mentally ill person when necessary. In addition, detention can be initiated by the person doing the initial investigation under the proposed changes, and, since this person would be a peace officer when the need for detention is anticipated, this could also be immediate. The responsibilities of the treating physician for emergency care, custody and treatment during detention is clearly defined, including procedures for the use of mechanical restraints. A report of treatment and its results becomes a part of the record provided to the judge at the commitment hearing.

#### Protection of Personal Rights During Commitment Process

Ambiguity is frightening. Every attempt is made in the new statutes to insure that the allegedly mentally ill person knows who is saying what and the purpose and possible consequences of each step in the proceedings. He is also informed verbally and in writing at each significant stage in the process of his rights.

At all steps in the process, the person's civil rights are carefully protected. Representation by legal counsel becomes mandatory, except in unusual circumstances, to be paid for by the county if the person cannot pay. Seventy-five percent of committed persons now are represented by counsel at their hearings.

#### Psychiatric Examinations

Under current statutes, the judge appoints two licensed physicians, not necessarily psychiatrists, to examine the

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person as to his mental condition. This information becomes the primary basis for commitment. Other than the commitment petitions, the examining physicians often have no additional information about the person's total life situation and they may have no specific training in psychiatry, beyond what they obtained in becoming general physicians.

There are selected clinical psychologists, psychiatric social workers and psychiatric nurses who have become very competent in evaluating the mentally ill. These individuals are assisting the courts in some counties with mental commitments, although they cannot officially examine the person and report their findings to the judge. One physician is necessary to determine possible organic causes for the person's mental illness, to analyze the effect of medication and other concurrent illness on the person's mental state, and to assess their mental condition. The Mental Health Division believes that carefully selected non-physicians can evaluate the person's mental condition, and, because of their knowledge of community mental health programs, make a valuable contribution in assessing the person's total situation and of community alternatives available for treatment. It makes more efficient use of existing mental health manpower.

#### Limitation on Duration of Commitments

At present, commitments are for an indefinite period of time. Under Engrossed Senate Bill 510, commitments would be for 180 days. Recommitments would also be for up to 180 days. This procedure encourages active treatment, aftercare planning, and early movement of patients to voluntary status. It protects the individual against indefinite detention, while providing procedures so that individuals can be detained and treated as long as necessary, if they continue to meet the initial criteria for commitment.

This is not to imply that patients are being kept unnecessarily long in the state hospitals. For March 1, 1971 to February 29, 1972, 54 percent of patients in the three state hospitals have been hospitalized less than 45 days. Each patient has an individualized treatment plan developed by the team assigned

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to his care, and this plan is periodically reviewed and revised. In addition, each hospital has a Utilization Review Committee which examines randomly selected charts to monitor quality of care and appropriateness of hospital utilization. Very few new admissions, approximately 2 percent, become chronic patients, i.e., stay more than one year. However, from the experience of other states, there is reason to believe that hospital stays can be substantially shortened with revised commitment procedures, particularly with the development of community alternatives for treatment, and that a larger proportion of patients can be treated on a voluntary basis.

#### Detention in Jails

Existing statutes (ORS 426.140) allow detention in jail of mentally ill persons who have committed no crimes pending commitment hearings. Some hospitals have been reluctant to provide custody and treatment for acutely disturbed, mentally ill persons. This is primarily related to community attitudes about mental illness and staff insecurity in dealing with bizarre and potentially destructive behavior. Occasionally, a person may need the maximum security provided by a jail, but most patients can be detained and treated in a general hospital if a secure room is available and if staff have had necessary training. This is the most desirable method of handling disturbed, frightened mentally ill persons.

#### Trial Visit Status

Under current statutes, a committed patient may be returned to the community for an indefinite period of time on a conditional discharge status known as trial visit. The person may be returned to the hospital upon a written petition by one individual, without an additional court hearing. During 10 months of 1972-73, 463 patients from the three state hospitals had their trial visit revoked after they had been in the community more than 90 days. One-hundred and forty-two requested hearings before the Hospital Disposition Board, and 23 were represented at these hearings by legal counsel.

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Under the proposed revisions, a person could leave the treating facility on trial visit status during his period of commitment; but trial visit would terminate when the commitment terminated, or 180 days maximum.

Bill of Rights for Committed Patients

Consistent with recent court decisions, an expanded list of personal and civil rights is defined in this bill, and this statement of rights would be posted in a prominent place in all facilities housing committed patients. The right to communicate freely, wear one's own clothes, have privacy and religious freedom and be paid for work performed are designed to enhance personal dignity and sense of individuality and to develop skills necessary for return to the community. A treatment plan, kept current with the patient's progress, is standard practice, but is mentioned to be consistent with court decisions on right to treatment and with Medicaid and Medicare standards. Persons would not lose their civil rights simply because of commitment to a mental hospital unless adjudicated incompetent as a separate court action.

Persons would be expected to sign an informed consent before any potentially unusual or hazardous treatment. However, the director of the facility or his designee, after consultation with an independent examining physician, could require such treatment, particularly electroshock therapy, if it were medically indicated. Electroshock therapy is an accepted medical treatment for severe depression, and its use may prevent suicide when other available treatment methods would fail. It is essential that there be a mechanism to require such treatment, even if the person is unable or unwilling at the time to provide his consent. A copy of a recent "Massachusetts Journal of Mental Health" report on electro-convulsive therapy is made available to the Committee for background information on this issue.

A section-by-section commentary on this bill, prepared by the task force chairman, is included as Attachment C.

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### Fiscal Impact

The task force report on which Senate Bill 510 is based was not completed in time to analyze its fiscal impact and to request funds for implementation as part of the 1973-75 biennial budget request of the Mental Health Division. This analysis, conducted by another task force, was completed in February 1973. Membership of this task force is shown in Attachment D.

The task force concluded that costs to the counties for other than community mental health programs would not be substantially changed by this bill. Reductions in some areas would balance the increase in others. Based on reports from scattered counties for fiscal year 1970-71, it is estimated that sheriffs offices spend at least \$24,300 per year on the commitment process, and most of this would be saved with the proposed revisions. Health departments spend at least \$56,000 per year and much of this would be saved, although public health nurses would continue to play a significant role in pre-commitment investigations and disposition planning. Circuit courts spend at least \$139,000 per year on court commitments. It is not apparent that more than an insignificant portion of this amount can be saved through enactment of Senate Bill 510.

Although recommitment hearings would be required on a small minority of patients, the total number of hearings should be substantially reduced by the preliminary investigations and the new definition of mental illness. The use of one qualified non-physician in lieu of one physician for examinations would reduce the cost of hearings, but hearings will be somewhat longer (one to two hours compared to 30 to 60 minutes) under the new procedures, and attorneys will be required in almost all cases, compared to the 75 percent of cases where allegedly mentally ill persons are now represented by legal counsel.

Experience in those counties which have been utilizing preliminary investigations with court commitment petitions demonstrates that one-third can be resolved without a hearing, one-third enter voluntary treatment (usually proposed by the preliminary investigator) following the commitment hearing,

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and one-third require court commitment. The following time is required by a mental health staff person to handle court commitments:

<u>Activity</u>	<u>Time</u>
Pre-petition evaluation	1 hour/person
Pre-commitment investigation plus court report	4 hours/person
Commitment hearing	2 hours/person
Post-commitment disposition	2 hours/person
Monitoring if placed in community	1 hour/person/month

Substantially more time is required for the evaluation and disposition of some persons.

In order to perform the preliminary investigations, participate in the commitment hearings, and arrange disposition and follow up of voluntary and committed patients, the community mental health clinics will experience a substantially increased workload, particularly in those counties having a high volume of commitments. Based on the time projections described previously, assuming statewide implementation, assuming that most clinics would need additional resources to provide these additional services, and assuming that some of the current expenditures on court commitments can be saved and made available to the clinics, \$179,112 would be needed for fiscal year 1974-75, if this Act became effective July 1, 1974.

Mental health clinics are now spending at least \$75,000 per year on activities directly related to court commitments. Most community mental health clinics would have great difficulty absorbing this increased workload without additional resources. With the exception of 13 Eastern Oregon counties, the clinics experience no growth beyond cost of living increases during the 1971-73 biennium and are anticipated to experience no growth in the funding of outpatient services during the 1973-75 biennium. This bill could be phased in county-by-county

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after July 1, 1974, with an appropriation request to the 1974 Legislative Assembly based on next year's experience in planning and in implementation of the alternatives to state hospitalization.

Fiscal impact on state mental hospitals is difficult to estimate. Attachment B shows the number of court commitments by county to the state mental hospitals for the past three years. This number is declining, although total first admissions and readmissions are staying basically unchanged. One result of this bill may be to reduce the proportion of committed patients admitted to the state mental hospitals, but not the total numbers. The extent to which total admissions can be reduced depends on the rate of development of alternatives in the community to state hospitalization and the availability of crisis services at the time petitions for commitment are filed, or crises are brought to the attention of community mental health programs through other means. It is probable that there will be relatively little decrease in average daily population in the state hospitals, beyond that already projected, until at least the second year of the biennium.

With full implementation of alternatives to hospitalization in high admission counties, and with preliminary investigations under this bill, involuntary admissions from these counties are predicted to decrease by as much as 50 percent. Voluntary admissions should also drop, but by a lesser amount. Since the average length of stay for new admissions is six to eight weeks, at least six admissions must be prevented to reduce the average daily population by one. Thus, if total commitments were reduced by 240 during fiscal year 1974-75, the reduction in average daily population of the three mental hospitals would be approximately 40 below that projected. Thus, no substantial savings in clinical or administrative costs within the state mental hospitals are anticipated during the 1973-75 biennium, but the results of these programs will be considered in reducing clinical, support, and administrative costs in the state hospitals during the 1975-77 biennium.

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However, every effort will be made to identify savings during 1973-75, particularly at Oregon State Hospital, in order to provide growth funds for the community mental health programs to ensure the capability for screening and alternative placement of both voluntary and court committed patients.

Growth funds needed by the clinics for this activity would approximate the \$183,774 annual amount deleted by the Joint Committee on Ways and Means from the Governor's Budget Recommendations.

The Mental Health Division will return to the Emergency Board or the Special Session, as appropriate, for transfer of funds from Oregon State Hospital to the community mental health programs for this purpose. The net fiscal impact of Engrossed Senate Bill 510 in the annual amount of \$179,112 of 100 percent state funds should be more than offset by the transfer of savings from Oregon State Hospital that would be subject to matching by the counties.

#### Summary

Engrossed Senate Bill 510 represents a major departure from existing commitment procedures in Oregon. However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow up.

Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities. The Mental Health Division urges approval of Engrossed Senate Bill 510.

JDB-DMK:kmb  
Attachments

MENTAL HEALTH DIVISION  
TASK FORCE ON OREGON COMMITMENT LAWS

<u>Name</u>	<u>Representing</u>	<u>City</u>
D. K. Brooks, M.D. Chairman	State Hospitals	Salem
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
Eugene L. Bui	Oregon Law Enforcement Council	Portland
John T. Herron, M.D.	Oregon Conference of Local Health Officers	Salem
Myron B. Katz	American Civil Liberties Union of Oregon	Portland
Judge Henry Kaye	Mental Health Advisory Board	Pendleton
David C. Kent	Mental Health Advisory Board	Portland
Richard P. Noble	Oregon State Bar	Portland
Michael J. Park	Mental Health Association of Oregon	Beaverton
Wayne M. Pidgeon, M.D.	Oregon District Branch, American Psychiatric Association	Portland
Judge Douglas R. Spencer	Oregon Circuit Judges' Association	Eugene
Daniel V. Voiss, M.D.	Oregon Medical Association	Portland
Charles R. Williamson	Legal Aid Service	Portland

4-4-73

## COURT COMMITMENTS TO STATE MENTAL HOSPITALS BY COUNTY

FISCAL YEAR 1969-70 TO FISCAL YEAR 1971-72

<u>County</u>	<u>FY 1969-70</u>	<u>FY 1970-71</u>	<u>FY 1971-72</u>	<u>Average</u>
Unknown	0	2	1	1.0
Baker	25	12	17	18.0
Benton	16	19	12	15.7
Clackamas	118	80	73	90.3
Clatsop	22	18	18	19.3
Columbia	11	13	13	12.3
Coos	26	32	22	26.7
Crook	4	11	5	6.7
Curry	3	9	2	4.7
Deschutes	14	16	12	14.0
Douglas	37	45	44	42.0
Gilliam	0	1	0	.3
Grant	7	9	9	8.3
Harney	4	17	15	12.0
Hood River	17	14	9	13.3
Jackson	33	56	48	45.7
Jefferson	5	1	2	1.7
Josephine	40	41	45	42.0
Klamath	42	35	38	38.3
Lake	1	2	4	2.3
Lane	83	77	60	73.3
Lincoln	14	11	11	12.0
Linn	24	23	22	23.0
Malheur	13	18	16	15.7
Marion	104	107	68	93.0
Morrow	3	2	3	2.7
Multnomah	781	677	430	629.3
Polk	16	24	22	20.7
Sherman	1	0	0	.3
Tillamook	7	14	7	9.3
Umatilla	50	68	71	63.0
Union	15	19	9	14.3
Wallowa	1	3	3	2.3
Wasco	37	35	15	29.0
Washington	61	40	31	44.0
Yamhill	16	8	11	11.7
TOTAL	1,651	1,559	1,168	1,458.0

DMK:alb  
April 4, 1973

## COMMENTARY ON SENATE BILL 510

Prepared by D. K. Brooks, M.D., Chairman  
Mental Health Division Task Force on Oregon Commitment Laws

SECTION 1

Subsection (1) represents no change from the present wording in ORS 426.005.

Subsection (2) defines a "mentally ill person" and is based on a study of definitions of "mental illness" and standards for commitment throughout the United States. The Task Force reached the criteria for a "mentally ill person" to be used in both the original commitment and the periodic review procedure.

This definition (2) is twofold:

(a) The test of "dangerous" is adopted. It is in use in nearly one-third of the states with nearly half of the 50 states having the similar standard of "likely to injure himself or others."

(b) This alternative standard for commitment is basically taken from 1972 changes in the commitment laws in Pennsylvania. Situations covered under this definition are where a person may not be "dangerous" at all, but is in such a mental condition that he either cannot or will not provide for "basic personal needs" necessary for his own health and safety.

The requirement in (b) that the person not be receiving such care is to eliminate from the definition those persons who may be unable themselves to supply their basic needs, but who are in fact being properly cared for by others, whether relatives, a nursing home, etc.

It is pointed out that this criterion (b) deals with involuntary commitments and is not to be confused with standards for voluntary admissions. A person seeking voluntary admission may be but need not be a "mentally ill person" as defined in this section.

Subsection (3) adds the definition of "facility" in order to handle the new commitment procedures in which persons will receive the best available treatment without being restricted to specific state hospitals. (See Section 2 of this 1973 Act.)

Subsection (4) defines the term, "director of the facility." In light of the new procedures for commitment to the division, periodic review, and release, such "directors" will necessarily be delegated certain duties and responsibilities.

SECTION 2

In subsection (1), the present system of a court committing persons to a specific institution within the Mental Health Division is changed to provide for commitments directly to the Mental Health Division. The Division thus has the authority to assign mentally ill persons to the treatment facility, public or private, local or state, which it deems most suited to the person's treatment needs.

Under the present system, the division may direct a judge to commit the person to a specific state-run institution, ORS 426.060 (2). The section as amended by this Act will be of value to both the patient and the institutions by providing for smoother administration of involuntary commitments within the mental health system, public and private, through the Mental Health Division.

Subsection (2) was amended to give the division flexibility in situations in which it would be to the patient's best interest to be treated in a facility outside the public, state-run institutes.

### SECTION 3

Section 3 amends ORS 426.070 to include an investigation in the allegedly mentally ill person's community as a part of the commitment procedure. The investigation will assure that adequate information is available to the committing court before a commitment decision is made.

The procedure for investigations is outlined in subsection (2). The investigation is to be used in determining whether there is sufficient probable cause, under subsection (3) of this section, upon which to hold a formal hearing on the matter.

Section 3 of this Act considers both emergency situations and situations where time is not of such essence. In the latter case, an investigation must be conducted, according to the provisions in subsection (2) of this section, and prior to any detention of the allegedly mentally ill person. An emergency is handled under subsection (3), which sets down a criterion of "an imminent and serious danger to the person or to others" upon which the judge may detain the allegedly mentally ill person prior to the investigation. This situation in no way affects the emergency provisions in ORS 426.215, allowing a peace officer to detain prior to any investigation (section 32 of this Act).

Subsections (3) and (4) add to ORS 426.070 the procedure to be followed after the investigation and prior to a formal hearing. The standard for triggering further commitment procedure is to be "probable cause" to believe the person is a "mentally ill person" as defined in section 1 of this Act. Probable cause is to be based on the investigative report which, under section 9 of this Act, may not itself be used at the actual hearing without the allegedly mentally ill person's express consent.

The second sentence of subsection (3) will allow flexibility in situations where a courtroom setting may be unnecessary or even harmful to the person (e.g., an elderly person confined to a nursing home).

The next sentence in subsection (3) is to allow voluntary appearance by the allegedly mentally ill person where there is no reason to believe that he would not appear at the hearing. This is a change from the current procedure of having the allegedly mentally ill person brought before the court whether he would have done so voluntarily or not. Persons detained under emergency provisions are excluded from appearing voluntarily and are to be brought to the hearing within 72 hours of the original emergency detention.

The final sentence in subsection (3) grants the court discretion in providing for the allegedly mentally ill person's welfare pending the formal hearing.

Subsection (4) requires that the person have access to the investigative report. This will meet certain due process requirements by giving the person investigated a fair opportunity to refute the information presented and to prepare for the formal hearing.

Subsection (5) provides the procedures to be followed in emergency situations in which there is probable cause to believe that immediate custody is necessary for the safety of the person or others.

Subsection (6) is added to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanation concerning use of any mechanical restraint on such persons.

#### SECTION 4

ORS 426.080 is amended to allow service of the citation by persons other than law enforcement personnel.

#### SECTION 5

ORS 426.090 is amended to require the committing judge to file "specific reasons" why the person is being cited. This is to give the person adequate notice of the reasons for the proceedings.

The change in contents of the citation will give further assurances that the allegedly mentally ill person will be aware of his right to be represented by counsel throughout the proceedings.

With the new requirement advocating voluntary appearances whenever possible, section 5, as per section 4 of this Act, removes the requirement that the person serving the citation be the officer who takes the allegedly mentally ill person into custody.

Finally, this section provides for guarantees that the allegedly mentally ill person will be served the citation within 24 hours prior to the hearing. This was felt necessary with regard to the person's rights to due process and preparation for the hearing.

#### SECTION 6

The statute on appointment of counsel, ORS 426.100, is both expanded and made more positive by the amendments in this section. On the strength of recent court decisions concerning the right to counsel (i.e., State v. Collman in Oregon), the Task Force felt that it was appropriate and necessary to spell out the allegedly mentally ill person's rights in this area.

The major change is found in subsections (2) and (3). These require that counsel be provided to all persons, including indigents, unless refused in accordance with subsection (2). The criteria of an express, knowing, and intelligent refusal by the allegedly mentally ill person was based on the Collman decision which held that the right to counsel was to be "accorded unless intelligently and understandingly waived."

Subsection (4) adds certain safeguards where a continuance of a commitment hearing is requested. Most importantly, the court must grant a postponement upon such a request from the allegedly mentally ill person, his attorney or guardian. The maximum period of delay is still 72 hours, but a new provision for a longer continuance upon specific request has been added for special circumstances. The final sentence is unchanged from the old statute and is to be used where detention pending the hearing is deemed a necessity.

#### SECTION 8

This section is included as a result of the events leading up to the Collman case which is representative of similar cases. Because the allegedly mentally ill person's ability to defend himself may be affected by certain drugs and treatment administered prior to the hearing, the court should be fully advised of the facts and should take such facts into account in reaching a conclusion as to the mental condition of the person in question.

#### SECTION 9

This section begins with a promulgation of the rights of confrontation and cross-examination which the Task Force felt were essential to a fair hearing. The second sentence categorizes the investigative report, not as evidence which may be used against the allegedly mentally ill person, but rather as information upon which probable cause to hold a hearing may be based. This is considered necessary for the following reasons:

- (a) To insure that certain parts of the report, possibly based solely on hearsay interviews, will not be introduced as evidence against the allegedly mentally ill person during the hearing.
- (b) To provide for a valid, open interview of the allegedly mentally ill person without fear of its later use against him.
- (c) The investigative interview might otherwise require the protection of legal counsel for every person being subjected to a preliminary investigation.

Since the alleged mentally ill person is provided with a copy of the investigative report prior to the hearing as per Section 4 of this Act, the report may be introduced as evidence only with his express consent.

#### SECTION 10

Section 10 amends ORS 426.110 to allow appointment of "qualified persons" to help examine the allegedly mentally ill person. A "qualified person" is determined

on recommendation of the division and will thus allow the use of persons trained in mental health but who are not licensed physicians. This section as amended will still require at least one licensed physician, but will provide authority to substitute such a designated "qualified person" for one of the physicians.

#### SECTION 11

Section 11 amends ORS 426.120 to provide for separate reports by each examining physician, eliminating the use of joint findings. Each report is to include the type of treatment recommended if that be the opinion. This should aid both the court and the division in their functions of providing the appropriate delivery of services to the mentally ill person.

The final sentence of this section will be of value to the court in determining whether or not to allow voluntary treatment as per subsection (1) of ORS 426.130 as amended in Section 12 of this Act.

#### SECTION 12

Section 12 amends ORS 426.130 by replacing the present "parole before commitment" statute with alternatives available to the court upon completion of the formal hearing. The alternatives open to the court following a commitment hearing are as follows:

(a) If not found to be a mentally ill person, the person must be discharged from the custody of the court.

(b) If found to be a mentally ill person:

(1) In anticipation of participation in treatment on a voluntary basis the person may be released. This alternative will be based on recommendations of the examining physicians, as well as the evidence at the hearing, in determining whether the person would participate in such a voluntary program.

(2) There may be ordered a conditional release to a qualified legal guardian, relative, or friend. This is essentially the same as the present parole before commitment statute (ORS 426.130), with the best interest of the mentally ill person the primary determining factor.

(3) The court may order commitment to the Mental Health Division for an initial period of up to 45 days. This subsection should be interpreted to encourage the alternatives in (1) and (2), and only if these other choices are "not in the best interest of the mentally ill person" should an involuntary commitment be ordered.

#### SECTION 14

In support of prevailing professional opinion that involuntarily committed patients will benefit by changing to voluntary status as simply and quickly as is practicable, the Task Force felt it necessary to include a provision to that effect. Upon such an alteration of status, the patient is to be considered a voluntary patient in every respect including the right to release within 72 hours of request.

SECTIONS 15 THROUGH 17

These new sections (sections 15 through 17) are the heart of the new periodic review procedure of involuntarily committed patients. While the voluntary patient is protected from indeterminable confinement by the right to be released within 72 hours of such a request, the involuntarily committed patient presently has no guarantee that his status would be reviewed from without the facility to which he is committed. In an effort to afford such a protection, this new review system includes opportunities for review procedures to be instigated following the initial 45-day commitment period, after each additional 90-day commitment period within the first year of hospitalization, and semi-annually thereafter.

It was felt that the initial burden of action should be on the division in seeking further hospitalization of an involuntary patient. Thus, at the end of each commitment period the division must, (1) release the patient, or (2) certify to the court "that the patient is still mentally ill and in need of further treatment."

If a further period of commitment is sought, the division is responsible for notifying the patient as per section 15 of this Act. This notification consists of delivering the certification to the patient by either a doctor or registered nurse from the facility. This method of service was favored over service by an officer of the court.

Once the certification has been properly served on the patient, the burden of affirmative action shifts to the patient. He must make known his intention to protest further commitment within 14 days of service of the certificate. Failure to protest will subject the patient to further hospitalization without a hearing. Section 15 promulgates the content of the certificate which is to be self-explaining and in "clear and simple language." The certificate itself is a key step in the periodic review system. It notifies the patient of the situation and explains the rights he has and procedures which he must follow in order to protest a further period of commitment.

Section 16 provides for notification by the division to the court and also provides for the safeguard of additional notice to the patient. The second notice is given by the court upon protest by the patient, and it re-emphasizes and explains the review procedures and rights. This section, along with similar notice requirements in section 15 of this Act, is aimed at insuring that the patient will be fully advised of the review procedure and its ramifications.

The hearing procedures are contained in section 17. Two important features of this section concern appointment of legal counsel and retaining an examining physician. Legal counsel is made mandatory at all certification hearings unless, as in ORS 426.100 (2) as amended by section 6 of this Act, it is "expressly, knowingly, and intelligently" refused. Section 17 also requires the appointment of both legal counsel and an independent examining physician for indigent patients without cost to such patients. These provisions were included in light of recent judicial decisions concerning such matters as the right to legal counsel.

After a full hearing, the court is charged with determining (a) whether the individual is still a "mentally ill person", and (b) whether the individual is in need of further treatment. The court, through (a), will be using the same criteria

for continued commitment as was used in the original court commitment and as defined in section 1 of this Act. This will therefore give true periodic reviews and rehearings to patients who request such. The second standard, (b), was included for situations in which the person may not have fully recovered and is thus within the definition of a mentally ill person but for whom further hospitalization will be of no value. Upon an affirmative finding of both (a) and (b), the court may then order a commitment for up to an additional 90 days, at which time the review system is repeated as per sections 15 through 17 of this Act.

#### SECTION 18

Recognizing the fact that some mentally ill persons remain hospitalized for years, the Task Force felt it was necessary to provide for less frequent certification for further commitment of such long-term patients. Instead of the 90-day commitment periods, section 15 provides for up to 180-day periods for persons who have been involuntary patients for greater than a year.

It should be emphasized that this section does not eliminate these persons from the periodic review system; rather they are included in the same procedures (sections 15 through 17) but may be committed for a longer period of time.

Persons on trial visit status are specifically limited to a maximum commitment period of 90 days notwithstanding the length of the patient's prior custody. This is necessary in light of a recent consent decree in which it was stipulated that no person on trial visit for greater than 90 days shall be denied a hearing prior to being returned to the treatment facility. Therefore, this limitation on length of trial visit will meet the requirements of the decree and provide for periodic review under sections 15 through 17 of this 1973 Act.

#### SECTION 19

So as not to penalize unfairly the counties in which the various treatment facilities are located, the present policy, ORS 426.310, of charging the costs to the county of the person's residence is continued with regard to the new periodic review system of this Act.

#### SECTION 20

Section 20 was added so as not to affect ORS 426.300, which allows the discharge of patients at times prior to the end of the commitment period.

#### SECTION 21

Section 21 amends ORS 426.160 to provide for a full account of the new review procedures of this Act in the court records.

SECTION 22

Since the courts, under this Act, commit a person to the Mental Health Division rather than to an individual hospital, the "division" is substituted for the "superintendent" in the discharging of patients from the committing court. This section also changes the criteria for such discharges in coordination with other provisions of this Act.

SECTION 23

Section 23 deletes a phrase in subsection (1) which allows for detention of alleged or adjudicated mentally ill persons in jails. The change follows the argument that jails should not be used to quarter any person being detained under the mental health statutes, even on a temporary basis. Unless also incarcerated on a criminal charge, a mentally ill person or one allegedly mentally ill is neither guilty of nor charged with any crime. Therefore, it is argued that jails are simply improper for detention of such a person.

Subsection (2) of ORS 426.140 is amended by substituting the word "community." This change will thereby not limit such confinements to "county" facilities. For more clarity, this subsection also narrows the designation of "health officer" by the addition of the word "county."

SECTION 24

Section 24 amends ORS 426.150 by conforming this statute to other changes in this Act. Specifically, the changes relate to section 2 concerning commitments to the "division," and Section 10, concerning the use of "qualified persons" as recommended by the division.

SECTION 25

Section 25 contains changes to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 26

Section 26 provides for coordination of the general conditions of a trial visit with the patient's treatment plan during his period of hospitalization. The length of a trial visit is limited to a maximum period of 90 days pursuant to section 18 of this 1973 Act.

The section also adds the doctor who takes administrative responsibility for a patient's release on trial visit to those persons who are exempt from liability for the patient's expenses or conduct while on trial visit. Also, there is the substitution of "division" for "superintendent," as well as the substitution of the word "facility" for "hospital" to conform with section 2 of this 1973 Act.

SECTION 27

Section 27 amends ORS 426.290 so as to conform with ORS 426.060 as amended by section 2 of this 1973 Act.

SECTION 28Patients' Rights

The Task Force has concluded that the status of a "mentally ill person" should not strip the person of certain rights. Section 28 of this Act is the promulgation of a patients' "Bill of Rights" and is to be posted in all the facilities housing such patients, as well as given to each patient upon admission and made available to other interested persons (section 31 of this Act).

Although most of the rights listed in this section are currently being adhered to throughout the state, the Task Force felt that a statutory guarantee would be in the best interest of patients, both present and future.

Section 28 is a codification of rights basic to every patient under treatment by the Mental Health Division. The rights found herein are the result of consideration of patients' rights provisions in mental health laws throughout the United States, proposed changes in other states, articles on patients' civil rights, as well as recent judicial decisions.

Under subsection (1):

(a) The right of communication is expanded from its present form. ORS 426.375 (1) (a) and (b) are the equivalent of the first two provisions in (a) of this subsection and are unchanged in handling of visitors and mail. Added to this right of communication is "reasonable access to telephones." This subsection was taken from the California patients' rights statute under section 5325, and was felt to be a necessary part of the communications right.

(b) The general policy throughout the mental hospitalization system is to encourage a certain degree of patient individuality. With this in mind, the Task Force has included the right to wear one's own clothing. This in no way changes the responsibility of the division to provide patients with proper personal clothing. Rather, it protects the personal choice of the patients as to the clothing he might wish to wear.

It should be understood that the reasonableness of the attire should be based not only on the patient's wishes, but also on the affect that the particular attire might have on other patients. "Reasonableness" should be within the discretion of the hospital authorities and the right subject to limitation for good cause, and any denial should be entered into the patient's treatment record.

(c) This section is similar to (b) in an effort to encourage individualization of patients during the hospitalization period. The right to keep personal possessions is considered necessary to encourage both the responsibility in the

patient and to aid in his self-respect. However, this section is not to be used in any manner which may be detrimental to the progress and treatment of any patient. The inclusion of "toilet articles" was taken from the California law and intended to be a guideline for the type of possessions to which this right applies.

(d) The right to religious freedom is basic throughout the country. It was felt to be of such nature that it should not be denied by reason of a person's mental condition.

(e) Providing for a private storage area goes hand in hand with subsection (c) in seeking patient responsibility and individuality, as well as security for personal possessions. The provided area should be of reasonable size to accommodate the patient's reasonable needs, but not so large as a "warehouse" for the patient's possessions.

(f) The right to a reasonable supply of writing materials and stamps is felt to be essential to carry out the guarantees of free communication by mail. Certainly without these items, right to use the mails would be meaningless to an indigent patient. The current policy of the state system is to issue one stamp per week for those who have none. Thus, there would be little change in the basic policy of making the mails available to all patients.

(g) This section should be considered an important step toward guaranteeing adequate treatment for all patients. A written treatment plan has been viewed as an essential safeguard by advocates of "right to treatment" theories. (Following this thinking, anyone hospitalized has the right to "adequate treatment," and if not so treated he should be released.) This provision furnishes a built-in protection against a person being cared for without any treatment guidelines or progress reports.

(h) The right to be represented by legal counsel is essential to every citizen, whether he is hospitalized, imprisoned, or a member of the general public. This section insures compliance with recent judicial decrees concerning patients' rights.

(i) The right to petition for a writ of habeas corpus, although provided for in other sections of the law, was felt to be necessary to make more complete this patients' rights section. Thus, this would merely re-emphasize and not change the present law on the subject.

(j) This section guarantees the continuation of the current hospital policies of not forcing any patient to work on routine labor tasks, unless such work is regarded by the hospital staff as an important part of the patient's treatment.

Following comments from staff personnel, the Task Force concluded that it is necessary to provide for the use of certain tasks in situations where the patient's treatment plan calls for some required work projects. The requirement of a written treatment plan in subsection (g), including such items as work treatment, affords protection against abuse of this exception.

(k) This provision was adopted by the Task Force recognizing the recent federal court decision in Alabama which held that patients be paid the federal minimum hourly wage for services performed beyond personal housekeeping duties. The feeling of the Task Force was that the patients should be paid a "reasonable compensation" on an efficiency scale in proportion to their output.

While this section is not meant to provide for patient employment during hospitalization, it is intended to allow the patient to realize some financial gain, regardless of the amount, as compensation for his labor efforts other than his personal housekeeping. In addition, staff personnel have advocated some form of compensation system to add to the patient's feeling of accomplishment and sense of personal worth in a type of "employer-employee" setting.

(l) This section allows the Mental Health Division to add, by regulation, certain rights to the statutory list. It provides for flexibility in addition to the patients' rights as posted, and still does not restrict or deny the statutory rights provided for in this act.

(m) This is no change from the present statutes under ORS 426.375 (1) (c). It is a general statement on the legal capacity of the mental patient.

(2) The right of a patient to have a voice in the type of treatment he will receive was the topic of much discussion, both within and without the Task Force sessions. Subsection (2) relating to this matter was felt to be of such nature that it should be set apart from the other patients' rights provisions. The proposed draft begins with a basic sentence from the Alabama "Right to Treatment" case, Wyatt v. Stickney, in protecting the patient from certain treatment procedures without his "express and informed consent."

In order to protect the interest of a patient who may be unable, by reason of his illness, to give such consent, but who may be in need of such treatment, the section adds the second and third sentences. These are similar to the procedure in the new California law, section 5326, in denying the right for "good cause only" and that any denial will be entered into the patient's treatment record, but goes even further as a safeguard, in that it requires "consultation with and approval of an independent examining physician." This will provide assurance that such treatments will not be performed without deliberation and consultation with a physician from without the staff of the facility.

Note: There was considerable discussion pro and con on the singling out of lobotomy and electro-shock therapy as treatments falling under this section. No lobotomies have been performed in state hospitals for more than 15 years. There was professional disagreement within the Task Force with regard to whether or not electro-shock therapy is "potentially unusual or hazardous." However, it was recognized that the general patient population has placed lobotomy and electro-shock therapy in the hazardous category, notwithstanding any professional opinions. Therefore, it is stressed that these treatments were not included because they are deemed "bad" treatments, but rather to allay specific fears which may have been associated with these treatments.

(3) Subsection (3) contains changes to conform with wording changes of this 1973 Act.

SECTION 29

ORS 426.375, the present patient rights section, is repealed and a more complete promulgation will be substituted in the form of ORS 426.385 as amended by Section 28 of this Act.

SECTION 31

Section 31 provides for the posting of the guaranteed rights which is felt to be essential in the protection of the rights of patients. The amendments proposed in Section 28 of this Act are for the benefit of the patient and would be little more than statutory rhetoric if the information is not made readily available to those persons affected.

The same rationale is used in requiring that a copy be given to each patient upon admission to a facility. Other persons may also be furnished with such a copy of the patients' rights in an attempt to further insure that these rights are not improperly denied.

SECTION 32

The peace officer provision, ORS 426.215, is amended by Section 32 to coordinate with the amendments of this Act and to add safeguards for persons to whom this section applies.

Subsection (1) (b) of ORS 426.215 is amended to include consideration of the effect removing the person to another county will have on the person's physical health. Also added to this subsection of ORS 426.215 is the requirement that the examination be conducted within the previous 24 hours so as to assure a current evaluation based on the person's current situation.

Subsections (2) and (4) add an "administrator" as the one who may be responsible for causing the person to be examined.

Subsection (3) is amended to provide for commencement of the investigatory procedures under ORS 426.070 as amended by Section 3 of this 1973 Act.

Subsection (5) is added so as to assure that such persons will receive necessary treatment as well as safeguards with regard to the use of treatments and drugs prior to a hearing (Section 8 of this 1973 Act). This subsection also places the responsibility for the prescription and administration of drugs on the treating physician and provides for notification and explanations concerning the use of any mechanical restraints on such persons.

## ATTACHMENT D

## MENTAL HEALTH DIVISION

## TASK FORCE ON IMPLEMENTATION AND FISCAL IMPACT OF SENATE BILL 510

<u>Name</u>	<u>Representing</u>	<u>City</u>
Warren B. Barnes	Oregon Sheriff's Association	Hillsboro
J. Albert Baxter, M.D.	Association of Oregon Mental Health Clinic Directors	Salem
E. W. Bloomquist	Association of Oregon Hospital Administrators	Astoria
D. K. Brooks, M.D.	State Hospitals	Salem
Vyvian Downer, P.H.N.	County Health Departments	Coquille
Therese Engelmann	Public	Eugene
R. L. Guiss, M.D.	State Hospitals	Wilsonville
John T. Herron, M.D.	Health Officers Association	Salem
William Kortge	Association of Oregon Counties	The Dalles
Fred E. Letz, MSW, Chairman	Mental Health Division	Salem
Josephine McWhirter	Mental Health Clinics	Portland
Helen Mead	Multnomah County Circuit Court	Portland
Alan Marek, MSW, ACSW	Association of Oregon Mental Health Clinic Directors	McMinnville
Judge Gregory Milnes	Oregon Circuit Judges' Association	Hillsboro
Thomas F. Nugent, M.S.	Association of Oregon Mental Health Clinic Directors	Eugene

<u>Name</u>	<u>Representing</u>	<u>City</u>
Marylyn Ruckwardt, R.N., M.N.	Mental Health Division	Salem
William L. Stacy, MSW	Association of Oregon Mental Health Clinic Directors	Baker
John Truett	Oregon Sheriff's Association	Roseburg

4-4-73

57th LEGISLATIVE ASSEMBLY - 1973

JOINT WAYS AND MEANS COMMITTEE

Record of Subcommittee Proceedings

Bill No: SB 510

Agency Name or Bill Description: Modifies provisions relating to involuntary com-  
ment of mentally ill persons. Defines "mentally ill person".

Analysts: Legislative Fiscal Wilburn Executive Caldwell

Date of Hearing

Comments and Action

6-22-73

Public hearing - DR Dray  
fiscal impact

recommend do pass

No AM END MEETS

Subcommittee Chairman \_\_\_\_\_

Designated to Carry: House Hanell Senate Stevenson Full Com. Stevenson

Legislative Counsel  
June 24, 1973

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL 510

On page 5 of the printed engrossed bill, after line  
15 insert:

"Section 4a. If Senate Bill 80 (1973 regular session) becomes law, section 4 of this 1973 Act is repealed and ORS 426.080, as amended by section 348, chapter \_\_\_, Oregon Laws 1973 (Enrolled Senate Bill 80), is amended to read:

"426.080. The person serving a warrant of detention or the citation provided for by ORS 426.090 shall, immediately after service thereof, make a return upon the original warrant or citation showing the time, place and manner of such service and file it with the clerk of the court. In executing the warrant of detention or citation, the person has all the powers provided by [ORS 133.290] section 71, chapter \_\_\_, Oregon Laws 1973 (Enrolled Senate Bill 80) and ORS 161.235 to 161.245 and may require the assistance of any peace officer or other person."

SENATE BILL 510

In 1972, a Mental Health Division task force comprised of representatives of Mental Health Division hospitals, the State Mental Health Advisory Board, and ten involved organizations made an exhaustive study over six months of the commitment laws of all 50 states and made recommendations for extensive revisions in the Oregon commitment statutes. This task force report is the basis for Senate Bill 510.

This entire bill is designed to encourage voluntary treatment within the community in preference to state hospitalization after commitment. Commitment is considered to be appropriate only for individuals who, because of mental illness, are dangerous to themselves or others or are unable to provide for their basic personal needs and are not receiving such care as is necessary for their health or safety.

If a person were committed under this bill, he would be committed to the Mental Health Division rather than to a specified state mental hospital as under current statutes. This allows the Division to arrange for his treatment either at a state mental hospital or within the community in a general hospital, day treatment program, nursing home, or other facility considered to be best suited to provide the treatment and supervision needed by the individual.

Under the proposed revisions, a preliminary investigation would be mandatory. Trained community mental health staff or public health nurses would visit the person, wherever he is, to assess and clarify the total situation and resolve the crisis on the spot if possible. Failing that, a plan for voluntary treatment or report to the court for further action would be developed.

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At all steps in the process, the person's civil rights are carefully protected. Representation by legal counsel becomes mandatory, except in unusual circumstances, to be paid for by the county if the person cannot pay.

At present, commitments are for an indefinite period of time. Under Engrossed Senate Bill 510, commitments would be for 180 days. Recommitments would also be for up to 180 days.

#### Fiscal Impact

Engrossed Senate Bill 510 can be implemented within the appropriation made available to the Division. Counties can anticipate reduced costs in some departments, such as the sheriff's department and possibly the courts. The significant increased workload and costs will be in the community mental health programs, which will be responsible for screening and alternative placement. The approved budget provides that the Mental Health Division may return to the Emergency Board or the Special Session, as appropriate, for transfer of funds from state hospital budgets to community mental health programs as an offset to these costs.

#### Summary

Senate Bill 510 represents a major departure from existing commitment procedures in ~~existing~~ <sup>Oregon.</sup> However, each proposed change is based on existing statutes in another state or on pilot programs in Oregon. No part of this bill should be considered to be experimental. There will

- 3 -

be additional initial costs to implement this bill, particularly for the community mental health clinics, which would be responsible for the preliminary investigations, some court-ordered examinations, disposition planning and follow up.

Over a period of years, this bill should result in a substantial reduction in state mental hospital costs, and facilitate early, voluntary treatment of mentally ill persons in their own communities.