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OBSERVATIONS ON POLICE POLICY AND PROCEDURES FOR EMERGENCY DETENTION OF THE MENTALLY ILL

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The following example related to us by a police chief from a surburban community north of Chicago summarizes the major problems in police handling of the mentally disabled:

> The trouble with being a cop is you get all the dirty jobs no one else will touch with a ten-foot pole. Take psychos and alkies. The hospitals won't take them, the doctors don't even want to talk to them, the relatives have given up trying. We're all that's left. We try to humor a guy, talk to them nice, but sometimes they're better off in jail with three squares and a roof over their heads. Next thing you know we've got lawyers and doctors around here screaming about civil rights and us cops keeping sick people in jail. We had a case the other day. This teen-age kid about 9 o'clock at night is playing poker in the middle of Main Street without a deck and with no other players. One of my men took this kid over to the hospital. They wouldn't admit him without a lot of red tape. I'm home watching T.V. when I get the word. Wait, I'll be right down. I get the run around from the clerk so I had him call his boss—the psychiatrist who runs the hospital—at home. He was pretty mad about being called at home. I told him we would let the kid go unless they took him for the night. He said he didn't have the authority to give the go ahead signal. "Okay," says I, "but I want your name and your official title so if anything happens to this kid we know where to send the reporters." The boy was admitted.

In the spring of 1963, the American Bar Foundation undertook an 18-month field study entitled "Mental Illness and Criminal Law."[1] The aim of the study was exploratory, to discover and identify the actual practices of the police and other agencies of criminal justice administration in use from state to state in dealing with the mentally disabled. This paper will discuss procedures used to move apparently mentally ill persons from the community to some place where care may be had and will explore some of the implications of these practices for professional police policy. A moment's reflection reveals that the police deal daily with all sorts of mentally disturbed persons, alcoholics, suicides, narcotic addicts, seniles, and the like. The issue of police handling of the mentally disabled is a legal one to the extent that laws specify the class of persons subject to apprehension, either for crime or for compulsory mental treatment, and establishes the procedures to be followed. It is also a medical one since much of the information legal officials act upon is based upon a medical model of mental illness and supplied by doctors. This is not to say that the police perform a ministerial function; as Egon Bittner has written:

> In real police work the provisions contained in the law represent a resource that can be invoked to handle certain problems. Beyond

[1] This paper was presented as a lecture to police executives who attended the Law Enforcement Policy Development Seminar held by the Law Enforcement Study Center of the Social Science Institute of Washington University, St. Louis at Bromwoods, Missouri, March 7, 1968, sponsored by the National Institute of Mental Health, the International Association of Chiefs of Police, the St. Louis Metropolitan Police Department, and the School of Continuing Education of Washington University. It also reflects the final draft of portions of the final report of the American Bar Foundation project, "Mental Illness and Criminal Law" (P.H.S. Grant MH 302-02, National Institute of Mental Health), that will result in a book to be published later this year.

> that, the law contains certain guidelines about the boundaries of legality. Within these boundaries, however, there is located a vast array of activities that are in no important sense determined by considerations of legality. In fact, in cases in which invoking the law is not a foregone conclusion, as for example in many minor offenses or in the apprehension of mentally ill persons, it is only speciously true to say that the law determined the act of apprehension, and much more correct to say that the law made the action possible. The effective reasons for the action are not located in the formulas of statutes but in considerations that are related to established practices of dealing informally with problems.[2]

As a practical matter, difficulties arise first from the fact that neither law nor medicine, at least until very recently, has articulated any consistent approach the police might follow with respect to the mentally disabled and, secondly, from the fact that the public, speaking through its legislatures, has not provided the resources for dealing with such persons other than through the ordinary criminal channels. We turn first to the legal aspects.

Emergency detention. In most cases of mental illness, the need for hospitalization is not immediate. Relatively little harm results, or is believed to result, from the delay consequent upon the initiation of plenary civil commitment proceedings, especially when the inconvenience of delay is balanced against the potential abuse inherent in summary procedure. Nevertheless, emergencies do arise when courts are closed or doctors unavailable, as when a serious suicide attempt is made or unprovoked violence occurs. In these circumstances, the police are usually called upon and must act forthwith since it may be inadvisable, impossible, or frankly dangerous to delay admission to a hospital in order to locate a judge or a doctor to authorize the necessary action. In such cases, the protections of formal procedures for civil commitment are considered to be inapposite; the need is for a simple, informal, and speedy remedy.

The remedy is that of emergency detention, a procedure that is a part of the statutory law of five of the six states included in this study.[3] Emergency detention statutes authorize the apprehension and involuntary retention in short-term custody (12 to 72 hours) of a person supposed by the police (or other designated public official) to be mentally disabled and an immediate danger to himself or others. The place of detention may be the physical custody of an individual police officer, a jail, a mental hospital, a psychiatric receiving hospital, or the psychiatric service of a general hospital. While in some states, such as Illinois, any citizen is authorized to act in such circumstances, the class of persons declared eligible to do so usually includes the police, and it is rarely anyone else except the police who will accept responsibility to act in such circumstances. The important characteristic of emergency detention procedures is that they authorize decisive action on the basis of what is essentially a lay judgment, typically that of a policeman, concerning the restrained person's mental condition. Thus, emergency detention must be distinguished from "temporary or observational hospitalization," with which it is often confused. The latter is a preliminary step in the civil commitment process which requires medical certification or judicial approval and whose purpose is to accommodate psychiatric diagnostic and screening procedure, including short-term treatment for as long as six months in some states.[4]

Authority for emergency detention of the dangerously mentally ill existed in common law prior to modern legislation. As a leading New York case on the subject has said:

> The common law recognized the power to restrain, summarily and without court process, an insane person who was dangerous at the moment. The power was to be exercised, however, only when "necessary to prevent the party from doing some immediate injury

[2] BITTNER, Police Discretion in Emergency Apprehension of Mentally Ill Persons, 15 SOCIAL PROBLEMS 278 (1967) 291. For the medical approach to these questions generally, see GLASSCOTE, et al., The PSYCHIATRIC EMERGENCY (1966), a publication of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health; SILBERT, Psychiatric Patients in the Admitting Emergency Room, 11 ARCH. GEN. PSYCH. 24 (1964); UNGERLEIDER, The Psychiatric Emergency, 3 ARCH. GEN. PSYCH. 593 (1960); PSYCHIATRIC EMERGENCIES AND THE GENERAL HOSPITAL (1965), a publication of the American Hospital Association.

[3] California, Illinois, the District of Columbia, New York, and Michigan.

[4] See LINDMAN AND MCINTYRE, THE MENTALLY DISABLED AND THE LAW (1961), 27, 38, 89–91; it is difficult to see how 6 months hospitalization can be characterized as an emergency measure. Georgia, Idaho, Missouri, Utah, and West Virginia have six-month provisions. Of the states included in this study the following periods were authorized: California, 60 days; Illinois, 30 days; Michigan, 60 days; New York, 60 days; District of Columbia, 30 days; Florida, 15 days.

either to himself or to others," and "only when the urgency of the case demands immediate intervention." On the other hand, insane persons who were not dangerous were "not liable to be thus arrested or restrained. And upon one who did the restraining rested the burden of showing in order to justify it, the urgency and necessity for the immediate restraint."[5]

One of the difficulties with emergency detention under the common law rule is that the person effecting the detention must be able subsequently, as in a suit for false arrest or malicious prosecution, to establish that the conditions in fact existed that would justify the detention. In point of fact, most of the case law on the subject is the result of such lawsuits, as the case cited previously from New York exemplifies. In another leading case on the subject, the Supreme Court of Illinois spelled out the potential liability:

> The weight of authority appears to be that an insane person may, without any adjudication, be lawfully restrained of his liberty when not to do so would endanger his own life or the life of others, but such right to restrain is limited to cases of actual insanity and immediate danger. Insanity which does not render the insane person dangerous to himself or others is not a lawful excuse for restraint without a judicial proceeding.[6]

Under emergency detention procedures established by statute, on the other hand, it is commonly provided that policemen and others authorized to make emergency detentions are legally immune if they have acted "in good faith." Such provisions are designed, among other things, to encourage the police to rely upon emergency detention on grounds of mental illness as opposed to the alternative of filing criminal charges against the person in question. In any event, even where statute authorizes emergency detention, the common law authority survives; in some jurisdictions it may be broader than the statutory power.[7] In Florida, where such a statute had been enacted and subsequently repealed, we found that the police continued to exercise the common law power when situations warranted[8] on the basis of an opinion by the Attorney General of Florida that the common law power survived repeal of the statutory provision.

Illustrative, in most respects,[9] of the statutes authorizing emergency detention is that of California:

> When any person becomes so mentally ill as to be likely to cause injury to himself or others and to require immediate care, treatment, or restraint, a peace officer, health officer, county physician, or assistant county physician, who has reasonable cause to believe that such is the case, may take the person into custody for his best interest and protection and place him as provided in this section. The person believed to be mentally ill may be admitted and detained in the quarters provided in any county hospital or state hospital upon application of the peace officer, health officer, county physician, or assistant county physician. The application shall be in writing and shall state the circumstances under which the person's condition was called to the officer's or physician's attention and shall also state that the officer or physician believes, as a result of his personal observation, that the person is mentally ill and because of his illness is likely to injure himself or others if not immediately hospitalized.
>
> The superintendent or physician in charge of the quarters provided in such county hospital or state hospital may care for and treat the person for a period not to exceed seventy-two hours, excluding Saturdays, Sundays, and holidays. Within said seventy-two hours the person shall be discharged from the institu-

[5] Warner v. State, 297 N.Y. 395, 79 NE2d 459 (1948).

[6] Crawford v. Brown, 321 Ill. 305, 151 N.E. 911 (1926).

[7] See Orvis v. Brickman, 196 F.2d 762 (D.C. Cir: 1952); Crawford v. Brown, supra, note 6; Warner v. State, supra, note 5; WEIHOFEN AND OVERHOLSER, Commitment of the Mentally Ill, 24 TEX. L.R. 307 (1946) 314: "It seems to be a clearly settled principle of law that a police officer or, indeed, any citizen, has the right at common law to detain in a suitable receptacle a person who is actually insane and as a consequence is dangerous by reason of his tendencies toward himself or others, if detention is temporary and continues only until legal proceedings for commitment can be instituted."

[8] Statutory authority for emergency detention was repealed in 1963; Florida Laws 1963 c. 63-10281. An emergency detention section was subsequently enacted effective May 1, 1967; Fla. Stat. 394: 20(2)(c).

[9] The documentation from the police point of view is of three types, the most formal being the "petition" required in Illinois, the least formal being the New York City procedure which requires no paperwork. The California requirement of an "application" falls somewhere between these two extremes.

tion unless a *petition* of mental illness is presented to a judge of the superior court and the court issues an order for detention of such person, or unless the person is admitted as a patient under any other provision of law.[10]

The other states studied, except Florida, also authorized emergency detention in their statutes. At the time of our study in 1963, Illinois had a similar statute, providing that "any person supposed to be mentally ill, or in need of mental treatment, and in such condition that immediate restraint is necessary for the protection for such person or others" [11] could be admitted for detention in a hospital for the mentally ill for a 24-hour period[12] upon presentation to the hospital superintendent of a verified petition to that effect, signed by "any reputable citizen" and stating that "no duly qualified physician is immediately available." The Illinois requirement of a "verified petition," completely at odds with the informal nature of emergency detention procedures, has helped to make the Illinois emergency procedure a dead letter; the requirement is an exceptional one. The Michigan statute provides that "any peace officer of this state with the approval of the prosecuting attorney" may "take into temporary protective custody and confine for a period of not to exceed 48 hours," any person believed to be "mentally ill manifesting homicidal or other dangerous tendencies";[13] the approval of the prosecuting attorney may be obtained within 24 hours following the action of the peace officer alone. The District of Columbia Code provision in effect at the time of this study provided an emergency detention procedure for mentally disturbed persons found in public places.

Where the arresting officer reasonably believed the person apprehended to be "insane" and "incapable of managing his own affairs or a menace to the public peace," the statute authorized his arrest and detention at what is now known as the District of Columbia General Hospital.[14] An additional provision empowered specified police officials to authorize emergency detention of "any indigent person alleged to be insane or of unsound mind or any alleged insane person of homicidal or otherwise dangerous tendencies" found elsewhere than in a public place.[15] In either case, detention up to 48 hours was permitted.

New York recognizes the common law right of emergency detention,[16] and its statutes further state that "any person, apparently mentally ill, and conducting himself in a manner which in a sane person would be disorderly, may be arrested by any peace officer and confined in some safe and comfortable place until the question of his sanity be determined." [17] When a detention is made under the statute, the police officer must notify the health officer, who must arrange for care and treatment.[18] In practice in New York City, the police consider this sufficient statutory authority to take mentally ill persons to receiving hospitals, such as Bellevue in Manhattan, without prior medical approval. The New York statute is of special interest because it assimilates the theoretically distinct conceptions of the criminal offense of disorderly conduct, on the one hand, and the "immediately dangerous" mentally ill person, on the other.[19] By implication the police officer observes behavior amounting to disorderly conduct but decides the person is not guilty by reason of insanity and then takes him to the hospital. In practice, which means from the policeman's lay point of view these concepts refer to indistinguishably similar conduct. It is worth noting that the New York statute defines a class of persons narrower than those subject to emergency detention under the common law power. In fact it was in just such a case cited earlier that the New York court was called upon to decide that the common law power did survive and was broader than the statutory power and, hence, a defense in a civil suit for false arrest.

The importance from the police viewpoint of a clear and expeditious emergency detection procedure can scarcely be exaggerated. Emergency detention offers the policeman a quick and simple

[10] Cal. Welfare & Inst'ns Code §5050.3 (1963); Presently §5880; italics added.

[11] Ill. Rev. Stat. Chapter 91-1/2, §6-1 (1959).

[12] *Ibid.*, §6-2 authorizes a 12-hour detention exclusive of the hours of 6 P.M. and 6 A.M.; in effect, then, for 24 hours.

[13] Mich. Stat. Ann. §14.809, Comp. Laws of 1948, §330.19; a prosecuting attorney acting under this statute in good faith has been held to be immune from liability under the civil rights act; Kenney v. Killian, 133 F. Supp. 571, (1955) aff'd Kenney v. Fox 232 F.2d 288 (6th Cir: 1956).

[14] D. C. Code §21-326. (1963).

[15] D. C. Code §21-327. (1963).

[16] See footnote 5 *supra;* additional authority for emergency detention was subsequently enacted in New York. See Mental Hygiene Law, §78.3 (1967).

[17] New York Mental Hygiene Law §81; Graniela v. City of New York, 211 NYS 2d 114 (1961).

[18] New York Mental Hygeine Law, §81(2)(b) (1962).

[19] See discussion in text at fn. 30, *infra.*

method of dealing with apparently dangerous persons who are unwilling or unable to go voluntarily to a hospital or some other place where care may be had. Once the patient is in the hospital, the emergency no longer exists; doctors are available to provide the medical assessment unavailable at the point of police contact and legal apparatus exists to review the basis of detention. When the medical judgment has been supplied, and if the person is diagnosed as indeed mentally ill, the policeman fills out either an "application," an informal document much the same as the criminal arrests form with which he is familiar, or a formal petition as in Illinois.

From the viewpoint of the person detained, there are corresponding virtues. He can be given immediate medical attention and held in an environment controlled by trained professionals rather than in a jail. Aside from the relatively short period that elapses between arrest and medical diagnosis at a treatment or reception center, unauthorized infringement of liberty is infrequent or nonexistent. The patient's rights to review by legal process can be satisfied once he receives the emergency medical attention, and the statutes are careful to see that these rights are protected. While the possibility of abuse is theoretically a real one, the real danger seems no greater than that present when the police take the elderly or the injured or others in need of first aid to hospitals.[20]

For the case of abuse of the emergency detention authority, a civil action exists which it seems has been overly effective in making the police and doctors cautious. The police, according to our observation do not act unless there is real reason—from a lay point of view—to do so. Where there is such reason, the police will act—the people who have summoned the police, the police themselves, and the public expect them to do so. If the police do not have clear-cut authority to make an emergency detention on grounds of apparent mental illness, or if the emergency detention procedure is cumbersome—as it was under the Illinois Code during the time of our study—the police fall back on the criminal arrest for disorderly conduct—hardly an advancement of civil liberty.

Plenary civil commitment. Emergency detention on grounds of mental illness is important to criminal law administration because it is a viable alternative to criminal arrest and initiation of the prosecutorial process. Civil commitment is important to criminal law administration because it is an alternative to criminal prosecution in the case of a person already under arrest and detention.[21] As such it is generally of less importance to the police than to the prosecutor. But because civil commitment procedures determine whether the people brought to the hospital by the police will be admitted or not, it is necessary to look briefly at the civil commitment process.

Commitment on the ground of mental illness is a civil (as opposed to criminal) procedure for the compulsory custody and care (including therapeutic measures) of a person found by a judicial or administrative tribunal to be mentally ill and in need of such care.[22] Civil commitment is not

[20] A real safeguard against abuses is that the hospital will examine the patient before actually admiting him. Hospitals are crowded and it is frequent for persons to be turned away not because they are not mentally ill and in need of treatment but because they are not "emergencies."

[21] If the criminal charges are minor or the presence of mental illness is clear, a prosecutor is often willing to dismiss the criminal charges and institute commitment proceedings instead. For example, a prosecutor in Chicago dropped charges of armed robbery and aggravated kidnapping lodged against a woman who forced two men to drive her to a supermarket to attempt a holdup there after having previously taken $111 from a credit company. The woman maintained that she had turned to crime to feed her five hungry children. The psychiatric clinic found the children were a figment of her imagination. Formal commitments to mental institutions of upwards of 1,600 persons a year in the city of Chicago result from the filing of criminal charges in this manner. Yet in Washington, D.C. for example, such a practice is virtually unknown. Hence it becomes important in attempting to understand criminal law processing of the mentally disabled to examine the procedures for civil commitment. While differences in statutory procedures for emergency detention and formal commitment are not a full explanation of the differences between Chicago and Washington, D.C., they are of practical significance as formal determinants of the actual practices followed in each jurisdiction.

[22] An excellent note in the YALE LAW JOURNAL defines "formal involuntary commitment" as "a final order of commitment to a mental hospital for an indefinite period of time"; Comment Analysis of Legal and Medical Considerations in Commitment of the Mentally Ill, 56 YALE L.J. 1178 (1947), 1190. Szasz defines commitment as "... Compulsory or involuntary detention of a person in an institution designated as a mental hospital. ... Unlike imprisonment, commitment ostensibly serves a medical-therapeutic, rather than a judicial-punitive, purpose"; SZASZ, LAW, LIBERTY AND PSYCHIATRY (1963) 39. Lindman and McIntyre write: "Involuntary hospitalization describes the removal of a person judged to be mentally ill from his normal surroundings to a hospital authorized to detain him"; *op. cit. supra*, 17. Curran speaks of "Commitment for an indefinite period" as indicating "that the hospitalization is obtained through state action and not through individual action, regardless of whether the person involved is passive or opposed to the state's action";

necessarily "involuntary," (although it may be), in the sense that the patient resists or opposes the decision to hospitalize him; it is compulsory in the sense that once the decision to hospitalize him is reached,[23] the patient is under a legal obligation to comply. All states have laws for the compulsory hospitalization of the mentally ill. The civil commitment statutes of many states authorize a variety of initiating steps and procedures—sometimes a bewildering number, and it is impossible, except at great length, to describe all the variants nor it is necessary to do so for present purposes. Nevertheless it is necessary to consider the nature of the petition which initiates civil commitment to contrast the documentation required with the informal character of emergency detention.

The procedure for civil commitment is initiated by a "petition," a written document under oath stating the facts upon which it is believed the person is mentally ill and the names of persons having knowledge of the facts. A "petition" is the equivalent of the complaint in a civil action and the indictment or information in a criminal action in that it initiates the lawsuit. The petition must allege that the person is presently mentally ill as that phrase is used in the applicable statute. One of the oddities of the Illinois statute, it will be recalled is that the term 'petition' is used to describe the initiating document for both civil commitment and emergency detention. In some states "any reputable citizen" or "any person" may petition; in others only specified persons such as relatives, friends, physicians, and health and peace officers. Typically, the petition must give the name and address of the spouse of the alleged mentally ill person, or of close relatives who may be responsible for his "care, support and maintenance," so that these interested parties can be notified of the proceedings and so the state department of mental health will know where to look for reimbursement. In some jurisdictions the offiicial having custody of the alleged mentally ill person must also be named; in some, a copy of the petition must be sent to the superintendent of any hospital to which admission is sought. Upon the filing of the petition with the appropriate court (and, if it is required, the medical certificate), notice of hearing is given the alleged mentally disturbed person. If he is not already in custody, an order for his detention may be issued—a step for which in most jurisdictions a medical certificate is an obligatory foundation. Typically the police bring the individual into custody. Medical examination, a hearing, and a decision on hospitalization follow.

Police Procedures for Emergency Situations

In making decisions concerning persons who are or are thought to be mentally ill, the policeman's perception is nearly identical with that of the ordinary lay person of similar age and background. Generally, the training the police receive in handling mentally ill persons is limited to cataloging major psychological symptoms that mentally ill persons display and learning to handle violently abnormal people. Two major attitudes, somewhat in conflict, color police activity in handling supposed mentally ill persons: (1) that mentally ill persons are sick persons and should receive medical attention;[24] and (2) that mentally ill persons are

Curran, Hospitalization of the Mentally Ill, 31 N. C. L.R. 274 (1953), 279, 280. The difficulties of adequately defining "commitment" are due to an attempt to state substantive and procedural elements at the same time; to the varieties of procedures by which hospitalization is accomplished; and to the differing conditions of custody embraced by the term.

[23] In practice, just as most persons charged with crime choose to plead guilty instead of going to trial, most persons alleged to be mentally ill do not contest hospitalization. The care and custody of mentally ill persons may be on a basis less than 24-hour inpatient hospitalization; for example on an outpatient basis, on weekends, or only during the week. Commitment is often discussed as being for an indefinite or indeterminate period, thus connoting that it is "without end." This is not an essential characteristic of commitment and many "commitments" are for stated periods. A final order of commitment may never be made even through a person is hospitalized involuntarily many times during his life. This is because alert physicians, lawyers, and judges are consciously trying to avoid the civil disabilities such a final order may bring. In much the same way that a criminal court may sentence a person to an institution for a stated period of time or for an indefinite period or place him on probation under supervision, so also a civil court ordering commitment may order alternatives to full-time hospitalization, and in some instances may be obliged to do so. For example, in Lake v. Cameron, 364 F.2d 657 (D.C. Cir: 1966), the court held that 24 hour hospitalization was a last resort to be allowed only when other alternatives had failed. The D.C. Court of Appeals has articulated a difference between "harmless" and "dangerous" patients, reminiscent of the California statute; Ragsdale v. Overholser, 281 F.d2 943 (D.C. Cir: 1960), Millard v. Cameron, 373 F.2d 468 (D.C. Cir: 1966), Rouse v. Cameron, 373 F.2d 451 (D.C. Cir: 1966); Darnell v. Cameron, 348 F.2d 64 (D.C. Cir: 1965). Cf. Crawford v. Brown, *supra*, note 6. The California statute allows "commitment" to the care and custody of the counselor in mental health if the court finds the person to be "... mentally disordered and bordering on mental illness but not dangerously mentally ill"; Cal. Welfare & Inst'ns Code §5076 (1963).

[24] See "Handling Abnormal People," Chicago Police Department Training Bulletin II-S (1962): "Your job,

dangerous and the sooner someone else takes custody (and hence responsibility) the better.[25] Police perception of mental illness is shaped by these attitudes with the result that mental illness, as perceived by the policeman, consists either of violence or of highly abnormal behavior. It tends, in other words, to parallel quite closely the substantive requirements articulated in the common law standard of emergency detention.

The initial contact of the criminal law with the mentally ill person is usually made by the policeman who is confronted daily with the behavior of persons who are or may be mentally ill. The policeman may ignore this behavior or deal with it informally short of official action; handle it as a civil matter by attempting to provide some medical or social help; or proceed according to the ordinary processes of the criminal law. All three alternatives were present in the following example which occurred in New York City.

> Looking back on what had happened, the officer, a young man with a sense of humor, wondered why he had gone to so much trouble. He had been standing on a corner observing people go about their usual activities, he recalled, when he noticed a young Negro who appeared a bit drunk, very intently talking to himself. When the man punctuated this conversation by punching his fist through the window of an empty automobile parked at the curb, the officer approached and inquired the reason for his behavior. The man acted "strangely," and either could not or would not answer, leading the officer to think he was "a psycho case." The officer led him to the hospital which was nearby and told this story to the psychiatric resident who examined the man. In response to specific questions the man said he was drinking and out of work and added that he had been hospitalized at this hospital recently for a period of two weeks; he seemed quite content to spend the night at the hospital, but the doctor said that since he was only drunk there was no basis for hospitalization. However, the doctor would take his temperature and would keep him, at least over night, if he showed a temperature. Finding that the patient did not have a temperature, the doctor informed the police officer that the man could not be admitted.
>
> Regardless of what the man had told the doctor or what the doctor thought, he was "still crazy" in the officer's judgment, and the officer passed on these sentiments to the desk officer at the precinct when he called for instructions. The officer at the precinct told him to use his own discretion. Reasoning that although there was damage to the car, he did not know to whom the car belonged and that consequently there would be no complaining witness, the officer told the man he was free to go. After once blinking his eyes in mild disbelief, the man wasted no time in making his exit which evoked a good natured laugh from the officer.

There are numerous situations where the policeman will ignore the behavior of persons who are apparently mentally ill or will not take any official action unless forced to do so when the behavior in question becomes threatening, violent, or criminal, or because a citizen makes a complaint. This particular officer had no desire to handle what happened as a criminal matter and called the precinct only to protect himself. If the man had not broken the window, it would have been possible for the officer to completely ignore the behavior.

Police frequently receive phone calls, sometimes on a regular basis, from persons who are under the delusion that others are trying to harm them. When a serious crime such as murder which receives publicity occurs, the police are besieged by persons ready to confess. Many of these are known to the police from past experience as harmless. The stories of other persons are checked out, and they are subsequently released. It is a common practice for the police, in order to protect against false confessions, not to release certain items of evidence to the press and in some cases to release false or ambiguous items. Although falsely confessing to a crime could constitute interference with the police and obstruction of justice, criminal proceedings are never instituted against these people and civil proceedings are rare.

The police may be called by a family member or by some neighbor who has perceived a disturbance. It is often the case that the family member or neighbor has called the police not because he seri-

as a police officer, is to get the disturbed persons safely to a hospital where successful ways of treating and curing mental cases are available."

[25] See *ibid:* "The quiet and unassuming behavior of a mentally ill person is not an absolute guide to his degree of probable dangerousness. Atrocious crimes have been committed by the mentally ill. On the whole, however, only a very small portion of the mentally ill are a menace to others."

ously wants the person in question to be arrested but because he can no longer tolerate the sick person's behavior and is reaching for outside intervention. The police sometimes are able to mediate family and neighbor disputes and settle the problem so that no official action is taken, or the family or the neighbors decide to proceed with a civil commitment on their own without further police involvement. In these situations either there is no criminal infraction, or no one is willing to sign a criminal complaint. Many police officers actively discourage persons from signing a disorderly conduct complaint pointing out that the result is a criminal arrest record and a night spent in jail, both of which the patient is likely to resent in the future. Furthermore, the police are reluctant to take the initiative themselves in these cases, feeling that the responsibility is with the family member, who should not be allowed to pass the buck by calling in the police. As a general rule, then, the police will not take official action unless the family member or neighbor agrees either to sign a criminal complaint or sign a petition for civil hospitalization, in which case the police will help to transport the person to the hospital, if no other means of transportation is available.

Workable procedures: New York City and San Francisco. When the policeman decides on the necessity for care, he initially apprehends the person, brings the person to some place where care may be had pending a decision whether or not to hospitalize him, and by providing information, helps the doctor to decide whether the person requires admission to a mental health facility.

It is at the hospital that most police problems arise. No matter how well defined is the policeman's authority to detain a mentally ill person in an emergency, unless he can get the person admitted, his efforts will have been futile. Typically the policeman will take no official action unless there are pressing reasons for doing so, but once a law enforcement officer has decided to take the person to a mental health facility he feels he has "assumed responsibility" by taking the person into his custody. The policeman will stay with the case and see it through—as did the officer in the example—until there has been some final resolution of the situation. A decision by a policeman to use emergency detention is influenced by a number of pragmatic considerations in addition to the seriousness of the offense and the person's potential for violence. The policeman must be concerned with whether there is room at the hospital, whether the orderly or the intern on duty at the hospital will accept this person or not, and how much of his time alternative courses of action will consume. In addition to statutory authority to act at all, the policeman needs a procedure that is workable; one that will provide an authoritative medical resolution of the situation following the initial apprehension and transporting the person to a mental health facility. The following example illustrates the procedure for emergency admission in New York City.

> The policeman agreed with the store owner that stealing grapes in plain sight was odd especially when the man then dared the owner to call the police. The two had been talking only a few minutes when the man in question returned to the store. The officer suggested that the hospital was where the man belonged, and the store owner said he would not file any criminal charges if the officer thought this was best. As the officer left, he told the store owner that he would let him know what happened.
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> When brought to the hospital, the patient told the doctor that he did not say to the policeman that angels were going to kill him because he was the devil. Furthermore, the doctor had no right to hold him; he would call his lawyer and sue the city. He loudly and profanely protested this violation of his civil rights and the unjust treatment he was receiving. After his examination the doctor said the best thing would be for him to be admitted to the hospital, but the patient threatened the doctor and refused to go. One officer took hold of the patient from behind bringing him to the floor while another officer and an attendant took a firm grasp on his arms and legs; in this fashion they carried him into the elevator which would take him to the admitting ward.

Under the New York emergency admission procedure, the decision of the physician on duty at the Bellevue psychiatric admitting desk is sufficient legal[26] authority to hospitalize the patient. When the doctor on duty at the admitting desk admits or refuses to admit the person, he assumes the responsibility for that decision; the policeman simply tells the doctor the facts that have occurred up to the point of bringing the patient to the hospital. The admission is based less on those facts than

[26] New York Mental Hygiene Law §81 (1962).

on the psychiatric examination that takes place at the admitting desk. The point to be noticed about this procedure is its simplicity from the police point of view: No paperwork, no red tape, no petition, no application, no medical certificate, and no mandatory court appearances. The doctor takes over once the policeman gets his "problem" to the hospital. The New York City procedure has proved a workable alternative to criminal arrest.

Practice in San Francisco suggests that effective police handling of the mentally disabled is more than a matter of paper work. In California, since 1939, as the statute quoted earlier indicates, emergency admission does not require a petition. Hospitalization of up to 72 hours is authorized on the "application" of a police officer under section 5050.3 of the Welfare and Institutions Code. At the end of 72 hours the patient is entitled to immediate release unless judicial commitment proceedings are initiated by filing a "petition" for court commitment. According to an official of the California department of mental hygiene: "Prior to 1939, when a police officer apprehended an obviously mentally ill person trying to kill himself or others or one who was causing a serious disturbance, he took him to jail since there was no alternative; the new procedure provided they be taken to the hospital". In San Francisco, the California statute has proven workable because the doctors at the admitting desk there, like their counterparts in New York City, take responsibility for the decision to admit. A lieutenant on the San Francisco police department who served as an advisor on legal matters explained the procedure to us:

> The officer on the beat and the sergeant at the station level have absolute discretion whether to take to a hospital or to jail a person who may have committed a crime but is also mentally distracted. Police do not sign petitions for the commitment of mentally ill individuals. We feel this is the responsibility of the district attorney. A person obviously mentally ill but causing a disturbance would be taken into custody on the authority of section 5050.3 and taken to the hospital. No charges would be filed. We have been successful in getting the doctors to decide who should be admitted.
>
> If the police officer, instead, arrests the person, no information as to mental illness or symptoms of mental illness is communicated to the court; this is on the theory that if the individual is sufficiently showing symptoms of mental illness, a decision to take him to the hospital would have been made. If the doctors think the symptoms are not enough to warrant hospitalizing him, at least for observation, we do not think there would be enough to present to a judge.

Red tape and paperwork. Admission to a mental health facility on an emergency basis is not always as uncomplicated as it might appear from the examples in New York and San Francisco. The New York City procedure is in fact atypical.[27] Bellevue is a large teaching hospital staffed at night by psychiatric residents who are medical school graduates, have spent one year training in general medicine, and have had two years of psychiatric internship. They are, consequently, well qualified to make the necessary judgment. Not all facilities designated for emergency admissions are staffed by people as competent or as experienced. In most cases the facility involved is either a county or municipal general hospital with a psychiatric wing. During daylight hours, when experienced doctors are available to make the decision, no serious problems seem to arise. However, at night and on weekends the authority and consequently the responsibility for admissions is delegated sometimes to a medical resident, sometimes to an orderly, a nurse, or a clerk. The power of emergency detention clearly authorizes initial apprehension by the police and police custody while an emergency situation exists, including transportation to some place where care may be had. But it is equally clear, both at common law and from reading the modern statutory provisions, that the power of "emergency detention" when exercised by the police is not sufficient authority for involuntary admission to a mental hospital—the point at which the police relinquish their physical control over the person. This issue is mooted in New York City and San Francisco because the admitting facility can, and, in practice does, take full responsibility for the admission. Under the California and Illinois statutes however, the policeman is required to "apply for admission" and "petition for admission" respectively, the functional equivalent in criminal law of signing a complaint against the person. When a petition or written application is required, as it is in many jurisdictions, whoever signs it (the police or mental

[27] The procedure is not even typical of New York State. Outside the City of New York different procedures apply.

health official from the admitting institution) accepts the legal responsibility. The person effecting the admission must be able subsequently (as in a suit for false arrest or malicious prosecution) to establish that the conditions in fact existed that would justify admission. From the point of view of the admitting institution, the simplest and safest procedure for escaping this legal responsibility is to persuade somebody—anybody—to sign a formal petition which initiates civil commitment. This shifts the legal responsibility to the petitioner and obviates the doctor's appearance in court. If a relative will sign a petition or if the patient himself is capable and willing to complete a voluntary admission form, admission follows. The policeman, if handy, will do. But the police are generally not willing to sign a petition for civil commitment—and for good reasons. In the absence of a petition (or a court order), the responsibility for accepting the patient is squarely placed on the admitting institution. Some institutions flatly refuse to admit a person without a signed petition. If the person making the decision for the mental health facility is inexperienced, or if he is accustomed only to limited authority and is not comfortable making the decision to admit on an emergency basis, he is unlikely to be willing to assume the responsibility, making admission difficult. Typically, an impasse develops at the mental health facility while the policeman and the orderly wait for a psychiatrist to come.

In some areas admission is complicated by the fact that psychiatric beds in the county or municipal facility are scarce and only those in serious need of treatment will be accepted; some persons will be rejected even though they may be quite disturbed and in need of treatment. Because police usually arrive at the mental health facility at night or early in the morning, they must frequently wait hours before they obtain any sort of medical advice. Since interns rotate quite frequently, the policemen find themselves dealing with different people every week. No consistent policy about admissions emerges, and almost every case comes down to a decision on its individual facts. On the other hand the police are normally quite reluctant to take mentally ill persons, even if violent, to police lockups. In some cases where the police could not effect admission to the mental health facility, they tracked down family members and persuaded them to take the person home for the night instead of having the police take him to jail. Then in the morning the patient is brought to the same facility and admitted without difficulty.

Just how difficult admission may be when the police refuse to sign a petition, and the hospital refuses to admit without a petition, can be seen in the following example from Chicago.

> A well-dressed man told the desk officer he was mentally ill and asked to be taken to the hospital immediately explaining: "When I am going to be sick I can feel it coming on."
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> The officer preferred not to argue and said he would oblige. As another officer was closing the door of the police van, the man jumped upon him from inside the van, knocking both officers to the ground. They were unable to restrain the man who now seemed to have "superhuman strength," until two nearby policemen helped.
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> At the hospital the four officers waited for the interne on call to be awakened by phone; the orderly on duty said he did not have authority to make an admission unless a "petition" was signed. Meanwhile the patient became docile. When the interne did arrive he concluded the man was not a fit person for emergency admission because he was not actually violent at the moment. The officers reacted with surprise and anger. One officer said: "There we were, four police officers who would usually be dressed very neatly, standing in front of him completely disheveled, dirty, cut, and bruised and here was another person whom we claimed was mentally ill who was also disheveled, dirty, dusty, and bruised." The interne's behavior violated the officers' notions of common sense.
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> The police, who had witnessed the violence decided they would have to take the man to the police lockup. As they were about to leave the man grabbed the interne by the throat and pulled his tie tightly around his neck. Only the quick work of the police officers saved the interne from serious injury. The interne was then convinced and admitted the man.

The police finally enjoyed the humor and poetic justice of this situation, but the problems they find in admitting people to local mental health facilities are frequently much more irritating, with the result that they stop bringing such persons to mental health facilities and take them instead to jail where procedures are available to hospitalize them—a

psychiatric examination ordered by the criminal court. There were 89 such cases in one month during 1963 when we visited Chicago.

It is evident from talking to policemen that, in addition to the reasons which the police explicitly give for not signing petitions, there are other motivations present. Policemen are sometimes afraid of mentally ill persons generally; fear of signing petitions appears to be closely connected with their fear of violence and of reprisal. The policeman who advises a family member that a disorderly conduct complaint will irritate the disturbed person, and possibly result in reprisal, may also be expressing his own fears. Police also feel out of their element when defining people as mentally ill. While they feel their experience does equip them to spot a "criminal," they do not feel it equips them to spot a "mental case," except where the person is obviously disturbed. The ambivalence the police show in handling mentally ill persons is reinforced by the difficulties they face in dealing with local mental health facilities. The practical effect of difficulty in securing admission to the mental health facility is that the police begin to use other, more familiar, alternatives and take the prisoner to jail instead of to the hospital, or in some cases, release him. This is not to imply that the police should decide who should be admitted; their complaint is that the doctors will not decide and will not take the responsibility. The trip to the hospital consumes time that could be devoted to other police work and may tie up not only one but several officers, and police equipment as well, especially if there is violence. On the other hand, since the only alternative to the hospital is the police lockup, there is pressure to hospitalize because of the trouble such persons may cause when placed behind bars, because police officers, like citizens generally, balk when obviously sick people are denied medical care, and because the critical decision about hospitalization is merely being temporarily postponed.

Implications for Police Policy

Police training. The job of dealing on a mass scale with the mentally ill, however narrowly or broadly one defines this class, is constantly left to the police. The problem of inadequate medical facilities, inadequate public provision for the old, the destitute, the helpless, and countless other social problems receive concrete expression by a complaint to the policeman on the beat. So it is in the case of the mentally disabled, and so it is likely to remain for some time. Police need education in the principles of mental health, but the extent to which one could increase police training for handling and recognizing the mentally ill is almost without limit. While some training in this area is essential for all police officers, we cannot, nor should we, attempt to make doctors or psychiatrists out of policemen. The experience state hospitals have had in training "attendants" to be mental health workers indicates that police as well can be trained in the basics of mental health technique. Special squads for mental health problems may be helpful in some larger departments.[28] But there is no reason why all policemen should not know exactly where to take mentally disabled persons, and under what conditions and at what times people are likely to be admitted. The National Association for Mental Health booklet, "How to Recognize and Handle Abnormal People" is a start, but every city should supplement this with a catalog of the local medical facilities available. Such a booklet, "Emergency Hospitalization for the Mentally Ill," used by the police in Cleveland, Ohio, lists the name, address, and telephone of the available community mental health facilities, together with the type of service available, any special conditions on the service, and the hours when these services are available. The police

[28] See Rock, Hospitalization and Discharge of the Mentally Ill, 97–105, for a discussion of the special squad in Los Angeles. One of the many complications of this complicated problem is the difference in police practices within a single state. In Los Angeles, (not included in this study), Rock, *ibid.*, 103–4, reports:

> The willingness of the Los Angeles Hospital detail officers to act as commitment petitioners deserves special attention since it represents a departure from the police reluctance or refusal observed elsewhere.... Later, if continued hospitalization seems necessary, the officer is willing once again to supply the necessary act of executing a petition for commitment. He does not feel that he is committing the person; the doctors of the court do that—he merely supplies a necessary formality. The police hospital detail—if its officers take any note of the legal implications of petitioning at all—is apparently content to continue to rely on the medical judgment that the person needs hospitalization....
>
> In the Los Angeles arrangement the doctors provide the medical judgment and the police through a specialized unit supply the person willing to assume responsibility as a petitioner.

Yet the San Francisco Police, (included in this study but not in Rock's study) never sign commitment petitions and are reluctant to execute even the 72 hour emergency admission "application." The Los Angeles experience suggest, again, that the key problem is getting the person to a doctor who will assume responsibility for the judgment whether hospitalization is indicated.

department of Winston-Salem, North Carolina, uses a similar booklet that gives detailed information about all social agencies in that area. Such manuals could easily be written with peculiar application to particular localities, except for very small police forces where existence of these facilities is a matter of common knowledge among police officers.[29]

Adequate community mental health facilities. In our experience there is less problem with the police recognizing persons who are mentally ill than in dealing with persons everyone would agree are mentally ill and in need of medical attention. There is little point to heightening police perception of mental illness unless concomitant measures give policemen some realistic hope of being able to dispose of such cases other than by the traditional method of criminal arrest. In many communities the key problem is a lack of medical facilities; either there are no medical facilities at all, or they are unwilling to take the kinds of cases the police bring in, or they are not open when business is at its peak, that is at night and on weekends. It is the lack of such facilities that accounts for the fact that mentally ill persons are sometimes housed in local jails supervised by police departments where only inadequate facilities can be maintained despite the good will of many policemen.

What the police need most is a workable procedure that allows them to take persons they reasonably suspect to be dangerously mentally ill to some place where expert evaluation of the policeman's lay judgment can be had with reasonable dispatch. From the police point of view where the procedures are cumbersome, where they fail quickly to identify the person in question as being mentally ill, where they fail to provide doctors willing to assume responsibility for the person's care, where in short the collective police experience is one of futility, the route of mental health care for the mentally ill offender is unlikely to be followed. This must, of necessity, remain the case until the public provides community mental health facilities consistent with the recognition that mentally ill persons should be handled by civil rather than criminal process and provides workable procedures to that end.

Legal authority for emergency detention and emergency admission. Despite the fact that most state laws appear to give policemen adequate legal protection when apprehending persons they reasonably suppose to be dangerously mentally ill and in need of medical attention, some emergency detention statutes are unnecessarily complicated and confusing. Whether we should hold the policemen to the standard of "probable cause" or the standard of "good faith" in detaining the mentally ill depends on whether one wants to encourage the police to take mentally ill persons to mental hospitals. In the case of the genuine emergency when doctors and judges are not available, the police, acting in good faith, should have clear statutory authorization to take persons thought mentally ill and dangerous at the moment to local mental health facilities or state hospitals for a preliminary examination without fear of civil liability. Many policemen say they fear the possibility of a civil suit for damages. Insurance protection, if necessary, should be provided policemen. If, as we think, such suits are seldom successful, coverage should be available at a modest cost.

Some statutes, such as that in New York, are substantively defective. Hawaii, for example, recently copied the New York definition of persons mentally ill and "disorderly" that, as we saw, does not include the non-disorderly but dangerous mentally ill person. It was, in fact, just such a gap that led to the New York decision that the broader common law power survived enactment of the New York emergency detention statutes. But substantive coverage should not have to wait on appellate decisions. Emergency detention statutes should be as broad as the common law power.[30]

Our findings indicate that the problem is less substantive than procedural. Moreover our observations indicate that no *emergency detention procedure* will be effective unless there is also a workable *emergency admission procedure.* So far as we can discover the difficulties of the police are not precipitated by a failure of the emergency detention power but by the practical failure of the emergency admission procedures, a failure due to medical unwillingness to accept the responsibility for who will be admitted. This finding has been confirmed in a 1968 study of rural areas in Illinois that concluded as follows:

> Emergency situations are usually not handled by the emergency detention and admis sion procedures of Article VII of the Menta.

[29] This assumption has been drawn into question by a 1968 American Bar Foundation study, "Rural Criminal Justice," in which 7 of 8 law enforcement officers interviewed did not know of the existence of ongoing local community mental health centers; see fn. 31, infra.

[30] Cf. fn. 7, 19, and text, supra.

Health Code which authorizes admission for as long as 24 hours upon presentation of an emergency petition without more. This is so despite the fact that the 24 hour admission on petition alone, first enacted in 1952, has undergone several revisions in recent years designed, according to statements of those who drafted the revisions, to informalize the procedure and encourage its use. The major reason for this seems to be that the 24 hour emergency procedure requires the presence of hospital and judicial personnel at mandatory court hearings held in the county in which the hospital is located. Judges in counties in which hospitals are located must hear cases from all the counties in the zone served by the hospital. These judges have pressured the hospitals to reduce the number of emergency admissions. Hospital administrators comply not only to preserve good relations with the judge but also because they too consider mandatory hearings at best a burden and often unnecessary. Who is to pay the cost of these hearings—the state, the county in which the hospital is located, or the county in which the patient resides—is also an issue of considerable importance.

Voluntary admissions are preferred to emergency admissions because they require less paper work and "red tape." On the operational level, this preference becomes a reluctance to admit persons on an emergency basis. While other studies of urban areas have indicated police are reluctant to execute emergency petitions when called upon to do so, this does not seem to be the case in the areas we studied. Hospital officials interviewed were unaware of any such reluctance. Police and sheriffs said they have no objection to executing emergency petitions. In fact, they do execute a few in practice, but infrequently for several reasons: 1. Executing an emergency petition is a futile gesture if the hospital will not accept an admission; 2. Relatives or others are typically available for that purpose; 3. In one of the counties studied, the states attorney signs them instead. The hospital will refuse emergency admission under Article VII but grant "voluntary" admission if the police can "persuade" the prospective patient to execute a voluntary application. Some police officers second-guess the hospital by having a friendly local doctor examine the psychiatric emergency in the local jail and execute a physician's certificate, in which event the hospital automatically admits the person.

Despite the hospitals' systematic avoidance of Article VII procedures, difficulties from the law enforcement point of view are minimal since nearly every police referral of a mentally ill person results in admission to the hospital. Police expressed neither reluctance about bringing disturbed persons to the hospital nor doubt about whether they are legally authorized to do so. We have found no evidence that obviously mentally ill persons are being criminally charged prior to referral to the state hospital. Moreover, the only time they spend in local jails is waiting to be examined by a local doctor pending medical certification, a period that may be as short as an hour or as long as overnight.[31]

The police do not want—nor should they have—the authority or the responsibility for effecting admission to the hospital; this is a medical responsibility, which is what the debate over signing petitions is all about. The emergency detention power is sufficient for getting the person to the hospital pending medical examination. State law might take a cue from the policeman in our first example and fasten responsibility for what happens thereafter onto the medical institution when the police present the person at the admitting desk. Doctors should be as responsible for mistakenly refusing a person admittance as they are for mistakenly admitting a person.

Responsibility for who is admitted to a mental hospital is not, need not, and should not, be a police responsibility. The law should require that the critical decision—whether to admit the person—be made by the doctor (without the formalities of a petition, an application, or a medical certificate). Appropriate procedural protections against unwarranted admission are inapposite in an emergency; they can wait until the next day. Experience has shown that, when the law in its attempt to protect the civil rights of its citizens has sought to impose its procedural protections at the point of initial decision, the emergency admission procedure will not be efficacious. Such procedures protect all the citizens rights save one—his right to prompt medical attention.

[31] BRAKEL, SOUTH AND MATTHEWS, DIVERSON FROM THE CRIMINAL PROCESS IN THE RURAL COMMUNITY (American Bar Foundation: 1968) 70.