Police Initiated Emergency Psychiatric Detention in Michigan

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Recommended Citation
Available at: https://repository.law.umich.edu/mjlr/vol5/iss3/12
POLICE INITIATED EMERGENCY PSYCHIATRIC DETENTION IN MICHIGAN

I. THE MICHIGAN STATUTE

While performing his duties a police officer may frequently be confronted with the behavior of an individual which threatens or has resulted in self-inflicted injury, or which poses an imminent threat to the safety of others. Under such circumstances an officer may determine that criminal arrest is inappropriate but that some form of restraint is necessary. Michigan has provided an alternative course of action by authorizing temporary emergency psychiatric detention of an individual whom a police officer deems to be "mentally ill and manifesting homicidal or other dangerous tendencies."3

Unfortunately, this emergency power has been invoked under state statutes similar to the Michigan law when the officer's conclusions as to sanity and dangerousness were unjustified and the

1 See, e.g., Orvis v. Brickman, 196 F.2d 762 (D.C. Cir. 1952), where an officer responding to a call discovered a woman bleeding profusely from cuts on her wrists. She claimed that she accidentally cut herself with a razor blade while removing a callus from her foot but added that she was glad the accident occurred and regretted that she was discovered. An inspection of her feet revealed no callus. The officer then invoked the police power and transported the woman to a hospital for a psychiatric examination.

2 See, e.g., Dix, Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study, 1968 WASH. U.L.Q. 485, 507 (1968), in which the author reports an incident observed in Washington, where the officers responded to a call from an individual claiming that her neighbor had chased her with a hatchet. During questioning, the hatchet-wielding suspect stated: "This is the hatchet Mr. Robinson used to kill me. I died once. I do not know how I came back into this world." The officers in this instance were able to locate the suspect's family and thus elected not to invoke the police power to detain the individual.

3 MICH. COMP. LAWS ANN. § 330.19(a) (Supp. 1971):
Any peace officer of this state with the approval of the prosecuting attorney, obtained within 24 hours of the taking into custody and confinement, is authorized to take into temporary protective custody and confine in any veteran's hospital, state hospital, or any licensed hospital in the state or some other place which shall be designated by the county or district health officer or mental health authority but not to include the county jail, for the purpose of confinement and medical or psychiatric treatment excluding shock treatment for a period of not to exceed 48 hours, not counting Sundays and legal holidays, a person believed to be mentally ill manifesting homicidal or other dangerous tendencies. Proceedings under this act, temporary or permanent, shall be instituted within 48 hours, not counting Sundays and legal holidays.

Nationwide, police are involved in about one-fourth of all psychiatric hospitalizations. Their participation takes two forms: that of direct intervention, the focus of this article, where as a result of on-the-street encounters they initiate psychiatric hospitalization; and that of secondary involvement where upon request of others initiating commitment proceedings they assist in transporting the patient to the proper facility. R. ROCK, M. JACOBSON & R. JANOPAUL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL (1968).
subsequent detention therefore unlawful.\textsuperscript{4} This suggests that similar problems arise in Michigan. Thus, while in some situations the statute may offer an alternative to the possible neglect,\textsuperscript{5} or conversely, to the criminal incarceration of the mentally ill,\textsuperscript{6} in others emergency psychiatric detention may raise numerous issues of both practical and constitutional dimensions.

The statute provides for forty-eight hour emergency psychiatric detention.\textsuperscript{7} Upon concluding that a person is mentally ill and

\textsuperscript{4} Numerous cases indicate questionable decisions by police officers regarding the imposition of restraints upon those they conclude are dangerously mentally ill. See, e.g., Collins v. Jones, 131 Cal. App. 747, 22 P.2d 39 (1933), where a mother whose young son had been missing for about six months had refused, after caring for almost three weeks for a child found by the police, to accept the child as her own. After unsuccessfully attempting to convince the woman that the child was her son, a police officer, doubting her sanity, had her detained at a psychiatric ward. The officer was later held liable for false imprisonment.

In Whaley v. Jansen, 208 Cal. App. 2d 222, 25 Cal. Rptr. 184 (1962), a man distributing an inflammatory letter pursued a door-to-door campaign attempting to expose wrongdoers in government. He voiced his grievances and boldly requested the use of homes to call and gather neighbors to attend his lectures and fund solicitations. The officer answering the complaint felt compelled to take affirmative action and chose temporary psychiatric detention rather than bringing criminal charges. The court upheld the police officer’s use of emergency detention under a California statute paralleling the Michigan law upon the questionable finding that the officer had acted reasonably. Just as in most suits for false criminal arrest, the court was reluctant to find that a police officer detained without reasonable cause. This California code provision has since been repealed and replaced by a modified version of the same statute, Cal. Welf. and Inst’ns Code § 5150-2 (West 1971), which more explicitly spells out post admission procedures and safeguards.

See also Brecka v. State, 14 Misc. 2d 317, 179 N.Y.S.2d 469 (Ct. Cl. 1958), where an officer invoked the police power to restrain a woman and bring her before a health officer for examination. The woman had refused to stop burning wood on property the officer believed belonged to another. In fact the woman had owned the property for five years and had even acquired the necessary burning permit. The court nevertheless found that the officer had probable cause for the detention.

An interesting unpublished 1960 case where a police officer seemingly abused the psychiatric detention power is reported in Kutner, The Illusion of Due Process in Commitment Proceedings, 57 Nw. U.L. Rev. 383, 384 (1962). In this particular case a Polish immigrant, living with her husband in Chicago, discovered money had been stolen from their apartment. Suspecting the Janitor as the culprit, since he possessed the only other key to the apartment, she proceeded to his room and demanded he return the money. The Janitor responded by calling the police and upon their arrival stated that the husband and wife were both insane and should be committed to a mental institution. Without any further examination the police seized the couple and took them in handcuffs to Cook County Mental Health Clinic. At the institution, unable to answer questions in English and thereby to defend themselves, the pair were duly pronounced mentally ill. Six weeks later the husband hung himself. See Willie, Why Refugee Asked for Ticket to Russia, Daily News, Mar. 29, 1962, at 10, col. 1.


\textsuperscript{5} There may be instances where the police officer will simply ignore the behavior of persons who are apparently mentally ill though indications of their behavior reveal possible future danger. See Matthews, Observations on Police Policy and Procedures for Emergency Detention of the Mentally Ill, 61 J. Crim. L.C. & P.S. 283, 284 (1970).

\textsuperscript{6} Unless there is an emergency detention statute, an individual may find himself confined to a cell for having committed a minor offense such as disturbing the peace, when in fact mental illness was clearly the cause of his behavior. Psychiatric attention is needed rather than punishment. See Curran, Hospitalization of the Mentally Ill, 31 N. Car. L. Rev. 274, 285 (1953).

\textsuperscript{7} While other methods of initiating emergency psychiatric detention without the prelim-
manifesting homicidal or other dangerous tendencies, in other words, that his presence on the street endangers his own life or the lives of others, the police officer may lawfully invoke the statutory power. Having made this determination, the policeman will transport the person to any licensed hospital in the state, private or public, where a doctor will conduct an examination to determine whether the individual's mental condition merits hospitalization. Such examinations, while extremely significant to detention procedures, are not required by the statute but are carried out pursuant to hospital policy. Additionally, at some time during the first twenty-four hours of detention the police officer must obtain the approval of the prosecuting attorney to legitimize his course of action. Finally, unless the officer commences an involuntary commitment proceeding by petitioning the probate court within forty-eight hours of detention, the detainee must be released.

Theoretically, the hospital admission policy and the prosecuting attorney's approval serve as screening devices, eliminating the possibility of wrongful detention. However, in practice similar "safeguards" have proved ineffective in other states as the detention power has been used in non-emergency situations, and there is little reason to believe that such is not the case in Michigan. Thus an individual may be detained for a forty-eight hour period and subjected to psychiatric treatment when there was, in fact, no legal basis for his detention.

Furthermore, despite the absence of statutory authorization, it appears that in many instances an individual for whom an officer has instituted involuntary commitment proceedings within the forty-eight hour statutory period may actually be detained until the commencement of his commitment hearing, a period that frequently exceeds the forty-eight hour maximum detention. It also appears that forty-eight hour detention is frequently converted into five day detention upon the certificate of a city or county physician under the questionable authority of another statutory safeguard of a hearing are provided in addition to police initiated detention by Mich. Comp. Laws Ann. § 330.19 (Supp. 1971), they are beyond the scope of this article.

9 For special concerns arising from the use of private hospitals see note 54 infra.
11 See notes 40-48 and accompanying text infra.
13 Id.
14 See note 4 supra.
16 See notes 51-52 and accompanying text infra.
utory provision,\textsuperscript{17} thus undermining the specific time restrictions imposed upon police detention. That such possibilities exist indicate the need for reevaluation of the present statutory scheme and consideration of additional procedural safeguards to assure compliance with constitutional protections.

\section*{II. The Procedure in Practice}

\textit{A. The Initial Encounter}

The combination of vague statutory language and a police officer's limited qualifications as a diagnostician\textsuperscript{18} present serious problems in applying the Michigan statute. The language authorizing detention of those believed to be mentally ill and manifesting homicidal or other dangerous tendencies in essence endows the police officer with a broad discretionary power; it is simply unclear what behavior falls within the literal language of the statute. Moreover, the statute does not specify whether the police officer himself must witness some aspect of the deviant behavior.\textsuperscript{19} It may be argued, and one court has in fact suggested, that the officer's belief that the individual is mentally ill and has manifested dangerous tendencies may be based on the testimony of witnesses.\textsuperscript{20} The questionable reliability of witnesses under these circumstances\textsuperscript{21} makes such a procedure suspect in the absence of an opportunity for the detainee to confront them.

\textsuperscript{17} See notes 53–54 and accompanying text infra.

\textsuperscript{18} Matthews suggests that the average police officer is no more qualified to judge an individual's mental health than is the average citizen:

In making decisions concerning persons who are or are thought to be mentally ill, a policeman's perception is nearly identical with that of the ordinary lay person of a 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. Matthews, \textit{supra} note 5, at 288.

\textsuperscript{19} The statute authorizes detention by a police officer of an individual "believed to be" mentally ill and manifesting homicidal or other dangerous tendencies. There is no restrictive language indicating that this belief must be based on first hand observation, and the terminology seems to invite reliance on witnesses when an officer arrives after a disturbance. \textsc{Mich. Comp. Laws Ann.} § 330.19(a) (Supp. 1971).

\textsuperscript{20} See Whaley v. Jansen, 208 Cal. App. 2d 222, 229, 25 Cal. Rptr. 184, 188 (1962), where the court interpreted a California statute similar to that presently in force in Michigan and concluded that "reasonable cause to believe" did not limit the officer's authority to detain to situations where he personally witnessed the occurrences:

The authority contained in [the detention statute] does not confine the test of reasonable cause to acts committed in the presence of the officers. In determining whether there was reasonable cause for an arrest without a warrant, police officers are justified in taking into account the past conduct, character and reputation of the person suspected.

\textsuperscript{21} Often family members will call the police not because they feel endangered or feel an
Even when a police officer's first hand observation reveals peculiar or seemingly abnormal behavior, the average officer may not be capable of discerning mental illness or of distinguishing mental illness as the source of aberrational conduct from inebriation or drug use. Perhaps more significantly, the prevalence of symptoms of mental illness in the members of society at large casts serious doubt on the usefulness of the very label of mental illness he attempts to apply. It may well be that mental illness is too elusive a criterion to be utilized by a non-professional when important rights are at stake. Additional problems in applying the statute arise in that the officer may be unable to identify homicidal or other dangerous tendencies in the absence of the actual commission of a crime. It has been suggested that a police officer would prefer to invoke the detention power rather than to arrest a person in certain borderline cases where grounds for criminal arrest are questionable or non-existent.

Furthermore, it is arguable that the police officer is not held to an objective standard of reasonableness in invoking this discretionary detention power. The Michigan statute merely requires the "belief" of the officer. In light of the fact that the officer's decision to detain results in a forced deprivation of liberty that in many cases is equally as objectionable to the detainee as arrest is to an alleged criminal offender, there seems to be little justification for applying other than the objective standard of probable cause arrest is necessary but rather because they can no longer tolerate the presence of the sick individual. Matthews, supra note 5, at 290.

A study conducted in New York City based on a home survey in Manhattan disclosed revealing statistics regarding the presence of symptoms of mental illness in the general population. Several categories of severity were established. Fewer than one in five of those individuals surveyed—18 percent—appeared free of significant symptoms of mental pathology; 58.1 percent were categorized as mild or moderately symptomatic of mental illness; and 23.4 percent were classified as mentally impaired. L. SROLE, T. LANGER, S. MICHAELS, M. OPLER & T. RENNIE, MENTAL HEALTH IN THE METROPOLIS 138 (1962). Another study revealed that one-tenth of the non-hospitalized population exhibited "obvious mental illness." Pasamanick, Roberts, Lemkav, & Kruger, A Survey of Mental Disease in an Urban Population: Prevalence by Race and Income, in MENTAL HEALTH OF THE POOR 39, 48 (F. Riessman ed. 1964). Statistics that reveal such a large portion of the populace displaying significant symptoms of mental illness not only indicate the difficulty an officer faces in determining mental illness as a causative factor of behavior but also suggest the dubious nature of the mental illness label itself.

Faced with a persistently troublesome minor offender, the officer might resort to emergency psychiatric detention which could conceivably result in commitment for an undetermined period rather than make an arrest for vagrancy or disturbing the peace which could result at most in a ninety day loss of liberty. Similarly, an aroused officer might invoke the detention power to disrupt the incitive activities of a political antagonist in a seemingly volatile situation where no crime has been committed.

Mich. Comp. Laws Ann. § 330.19(a) (Supp. 1971). It is arguable that a requirement of reasonableness is implicit in this provision and thus that the standard is objective. Nevertheless, use of the term "belief" clearly seems to import a subjective standard.
required for lawful arrest.\textsuperscript{25} The common law required objective probable cause or at least the objective standard of a reasonable cause to believe one was mentally ill and dangerous before an officer could invoke the police power to detain.\textsuperscript{26} If the standard of the Michigan statute is subjective, then it may encourage police utilization of the detention power because of the virtual impossibility of establishing abuse of discretion, but the adoption of such a subjective standard does little to encourage the cautious, thoughtful utilization of an emergency power that may result in such serious consequences.\textsuperscript{27}

**B. Approval of the Prosecutor**

The Michigan statute requires that the prosecuting attorney approve the detention within twenty-four hours of its inception.\textsuperscript{28} In Detroit the practice has developed whereby the police officer normally phones the prosecutor's office from the scene of the disturbance to receive the necessary approval for detention.\textsuperscript{29} The

\textsuperscript{25} The mere belief that an individual has committed a crime cannot justify his arrest under the standards established in Beck v. Ohio, 389 U.S. 89, 91 (1964):

> Whether that arrest was constitutionally valid depends in turn upon whether at the moment the arrest was made, the officer had probable cause to make it. that is, whether at that moment the facts and circumstances within his knowledge and of which he had reasonably trustworthy information were sufficient to warrant a prudent man in believing that the suspect had committed or was committing an offense.

The extension of the probable cause standard to emergency detention situations seems compelling in light of the resultant police initiated loss of liberty:

> The test as to reasonable grounds for making an arrest for a felony without a warrant was described... as follows: "Proper cause for arrest has often been defined to be a reasonable ground for suspicion, supported by circumstances sufficiently strong in themselves to warrant a cautious man in believing the accused to be guilty."

> The reasoning inherent in the foregoing statement seems equally applicable to the case of apprehension of a person purportedly "so mentally ill as to be unsafe to be at large."


\textsuperscript{26} See, e.g., Van Deusen v. Newcomer, 40 Mich. 90 (1879); Crawford v. Brown, 321 Ill. 305, 151 N.E. 911 (1926); see also the compilation of cases in Annot., 92 A.L.R.2d 570 (1963).

\textsuperscript{27} The police officer should not use the detention power under the assumption that an error in his judgment will be rectified by a later professional examination of the detainee:

> The layman usually assumes that his conception of mental illness is not the important definition, since the psychiatrist is the expert and presumably makes the final decision. On the contrary, committed persons are brought to the hospital on the basis of lay definitions and once they arrive their appearance alone is usually regarded as sufficient evidence of illness.


\textsuperscript{29} Interview with Peter Karpathian, Chief Assistant Prosecuting Attorney for Wayne County, in Detroit, Mich., Jan. 14, 1972.
prosecutor, hardly an impartial neutral adjudicator, logs the time, the date, and the police officer’s version of the incident and makes a decision as to the propriety of detention on the sole basis of this phoned report. The police officer thereby obtains the approval of the prosecutor prior to any hospital examination of the detainee. Thus the requisite approval of the prosecuting attorney is rendered a meaningless formality that can prevent wrongful detention in only the most glaring cases. The prosecutor’s office in Detroit has indicated that many police officers prefer this method of approval since the possibility of any liability for abuse of discretion is immediately shifted to the prosecutor’s office. While this may minimize the detaining officer’s fears of civil liability, the victim of an illegal detention will find little solace in this arrangement, as it is doubtful that any civil liability for violation of the statute will rest in the prosecutor’s office.

A different method of gaining the approval of the prosecutor was previously used in Detroit and may still be used in districts outside of that city. The procedure developed whereby a doctor at the detaining hospital telephoned the prosecutor to confirm the policeman’s initial diagnosis of mental illness and dangerousness. Without hospital confirmation the prosecutor would not grant his approval, and the police officer would be forced either to resort to criminal charges or to terminate custody. While such a practice may appear to satisfy the need for an effective safeguard against invalid detention by revitalizing the prosecutor’s approval as a viable screening device, the procedure has several shortcomings. The questionable reliability of the admitting doctor’s diagnosis seriously diminishes the effectiveness of this practice. Furthermore, by relying on the admitting doctor’s determination this process merely duplicates the only other existing safeguard, that of hospital admission, rather than serving as an independent check.

30 Id. The possibility of civil liability for abuse of discretion would seemingly arise only if a court were to hold that the statute imposes upon the officer an objective standard of reasonableness.
31 In Kenny v. Killian, 133 F.Supp. 571 (W.D. Mich. 1955), the defendant Michigan prosecuting attorney, who had approved the confinement of the plaintiff under the Michigan detention statute after a police officer had represented that the plaintiff was insane and manifesting homicidal or other dangerous tendencies, was held immune from civil liability. The decision rested on the fact that the defendant had rendered his approval in the good faith exercise of his discretion as prosecuting attorney and had acted within the scope of his statutory authority.
33 Id.
34 Id.
35 See note 48 infra.
Finally, it is important to note that there may be a substantial period of time between the original detention of the individual by the police officer and the determination by the hospital as to whether the individual should be admitted for treatment. In fact, the Director of the Emergency Department of Detroit General Hospital has suggested that an individual brought to that institution under the detention statute will receive no examination priority unless he is violent or uncontrollable.36 Otherwise, it appears that he must wait with the police officer until he is called for examination in the regular emergency ward rotation, a time consuming delay that is compounded by the tremendous backlog of patients awaiting attention at the overcrowded facility.37 Furthermore, no psychiatric care or diagnosis is conducted until the detainee has undergone a complete physical examination, a process which might take well over three hours.38 As a result, in practice a detainee is in custody for a significant period of time under adverse circumstances and subjected to a physical examination before a psychiatrist ever evaluates his mental capacity or would be in a position to verify the police officer's judgment to the prosecuting attorney.39 Thus, even if the prosecuting attorney were to require psychiatric diagnosis before rendering approval, that diagnosis might not be possible for an extended period of time and, therefore, this mode of approval does not eliminate all of the evils of unauthorized detention.

C. Admission to the Hospital

The manner in which the prosecutor approves of emergency detention indicates that if there is any effective check on the police officer's discretionary decision to invoke the detention power it must occur after the detainee is brought to the emergency ward where the hospital conducts its initial examination to determine whether the detainee's condition in fact necessitates hospitalization.40 However, in actual practice, the criteria for hos-

36 Interview with Dr. Ronald L. Krome, Director, Emergency Department, Detroit General Hospital, Detroit, Mich., Jan. 14, 1972.
37 Id.
38 Id.
39 In many instances this delay has the additional undesirable result of removing an officer from the streets for a substantial period of time. It appears that officers frequently feel that their responsibility for the detainee continues until an admission decision is made. However, it was noted by the Wayne County Prosecutor's Office that in localities where fewer officers are on duty the necessity of adequately patrolling the streets would, as a rule, preclude an officer's remaining with the detainee.
40 Speaking of the situation in Washington, D.C., Dix states that only one-third of those
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Emergency Detention may be different from those established for the original detention. The hospital will give a general psychiatric examination to detect mental illness, and it appears that this need not reveal manifestations of homicidal or other dangerous tendencies to meet hospital admission requirements. Even if a diagnosis of dangerousness is a prerequisite to hospitalization, such a diagnosis may be ineffective as a safeguard, for some doctors apparently feel requiring treatment is merely being helpful and thus have little difficulty in concluding that a detainee who is suffering from any form of mental illness is likely to injure himself or others because of his illness. Moreover, a doctor's ability to make a determination of dangerousness that would satisfy legal standards is highly questionable. In any event, there are strong indications that the quality of these psychiatric examinations at large state hospitals is so inadequate that a reliable diagnosis may be the exception rather than the rule. The existence of a lesser stan-

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Presented to the acute facility were admitted to full time hospitalization and concludes that the admission procedure constitutes a significant safeguard. See Dix, supra note 2, at 520. See also Matthews, supra note 5, at 290–91.

41 Interview with Dr. Ronald L. Krome, supra note 36.

42 This may be a common response of doctors who view forced psychiatric care in terms of benefits to a patient rather than in terms of an individual's loss of liberty. See Comment, Liberty and Required Mental Health Treatment, 114 U. PA. L. REV. 1067, 1073 (1966).

43 The ability to predict suicidal behavior with any degree of accuracy is extremely questionable and has been frequently debated among members of the medical profession. There are those who contend that there are no valid psychological test indicators capable of predicting future suicidal behavior. Piotrowski, Psychological Test Predictions of Suicide, in SUICIDAL BEHAVIOR, DIAGNOSIS AND MANAGEMENT 198, 199 (H. Resnick ed. 1968).

Equally difficult to predict is dangerousness: "Dangerousness," then, cannot in any sense be regarded as a clinically observable symptom of a proposed patient. In short, psychiatric predictions of "dangerousness" to others are at least as tenuous as predictions of serious self destructive tendencies. As one study of patients who had committed homicide concluded:

[I]n extremely few cases was there anything that would enable the psychiatrist to predict accurately the subsequent ... offense. ... [T]he discipline of psychology has not yet developed valid criteria of sufficient degree of predictive reliability to justify hard and fast distinctions, before the act, between the ... [mentally ill] individual who is likely to commit ... violence such as rape or homicide, and the one who will not translate this emotional conflict into aggressive destructive behavior.

Dix, supra note 2, at 527 (citations omitted).

In Guttmacher, A Review of Cases Seen by a Court Psychiatrist, in THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 17, 27 (J. Rappeport ed. 1967), a court psychiatrist concluded on the basis of case studies of six parties who committed homicide that he was "unable to decipher in these cases any symptoms which they presented in common that might act as warning signs of impending disaster."

44 In a discussion dealing with the examination process that may result in a physician's certification of insanity, one authority described the inadequacies of present practices:

The flaw is that the so called "examinations" are made on an assembly-line basis, often being completed in two or three minutes and never taking more than ten minutes. Although psychiatrists agree that it is practically impos-
standard for admission, the inherent uncertainties of detecting dangerousness, and the questionable quality of the examination limit the value of hospital admission as a safeguard against unlawful detention.

Some authorities have further pointed out that a doctor attempting to determine the mental status of the detainee may be influenced by the very fact of his detention and the accompanying reports of his actions, in other words, that these factors create a suggestive atmosphere for the psychiatric examination. Indeed the situation is more suggestive than the non-emergency commitment examination, for here the doctor is dealing with detention based on what he believes is the unbiased report of a specific incident by an objective observer, the police officer, rather than with detention arising from the non-emergency written application of family or individuals whom he realizes may conceivably have ulterior motives for desiring permanent commitment. Also, non-medical influences are more likely to have an effect on the limited examinations that determine the necessity of temporary hospitalization than on the extensive psychiatric examination ordered by a court to determine the need for actual commitment for a possibly indeterminant period of time.

liable to determine a person's sanity on the basis of such a short and hurried interview, doctors at the Mental Health Clinic recommend confinement in 77% of the cases. It appears that in practice the alleged-mentally-ill is presumed to be insane and bears the burden of proving his sanity in the few minutes allotted to him.

Kutner, supra note 4, at 385.

Additionally, it may be noted that Mich. Comp. Laws Ann. § 330.19(a) (Supp. 1971) authorizes the officer to bring a detainee to private hospitals as well as to state hospitals.

It may be significant that such institutions are not supported by state funds and depend on the fees received for the extended care of patients for their very existence. Therefore, "whenever a doubt as to a patient's condition would arise, it would probably be resolved in favor of his further detention." See Note, Civil Commitment of the Mentally Ill, 107 U. Pa. L. Rev. 668, 680 (1959).

Unfortunately, the officer's report of the incident does not merely serve as a basis for examination, but may, in effect, be conclusive of the detainee's mental condition:

Both the abstract nature of the physician's theories and the time limitations imposed upon him by the institutional structure of which he is a part make it impossible for him to make a rapid study of the patient's illness, or even to ascertain if illness in fact exists. Instead it becomes necessary for him to assume the illness of the patient and to apply some label to the alleged, if not recognized symptoms. The consequences are that the basic decision about illness usually occurs prior to the patient's admission to the hospital and the decision is more or less made by a non-professional member of the community.

Mechanic, supra note 27, at 69. See also Dix, supra note 2, at 509.


See note 21 supra.

III. INADEQUACIES OF THE MICHIGAN STATUTE

The factual basis for a police officer's diagnosis of an individual's mental illness and dangerousness may remain unchecked; the detainee may never have the opportunity to refute the officer's conclusions. Furthermore, the detainee may have been admitted to the hospital without a professional confirmation of the likelihood of future dangerous behavior; even if a determination of dangerousness were to be required for admission there is strong support for the contention that the reliability of such a determination would be dubious at best.\(^4\)

If a hearing were to be held immediately after the detainee's admission to the hospital to substantiate the officer's report before any further action could be instituted in reliance upon it, summary detention, even though arguably based upon a vague subjective standard, might not prove so distasteful. However, such is not the present practice, for at this point psychiatric treatment may immediately begin and the detention has, in effect, been deemed lawful. Proponents of the present statutory scheme would argue that this brief forty-eight hour detention is justified when used to determine whether commitment proceedings should be instituted by the police officer, especially when the alternative to such detention is the freedom of a potentially dangerous individual. They would contend that even were the statutory and practical safeguards effective in distinguishing the mentally ill from the mentally ill who are dangerous, upon the detainee's release for failing to meet the statutory criteria of dangerousness, an officer who believed that the individual was mentally defective could immediately institute non-emergency involuntary commitment proceedings that would only require a finding of mental illness to justify institutionalization.\(^5\) Thus, they would conclude, since the same hearing will ultimately result regardless of whether the individual is detained or not, the forty-eight hour detention is justified when balanced against the safety of the individual and of the public.

While it is true that the officer is authorized to initiate non-emergency involuntary commitment proceedings, it must be emphasized that such proceedings involve no pre-hearing detention\(^5\) — the allegedly insane individual is only required to appear

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\(^4\) See note 43 supra.
\(^5\) MICH. COMP. LAWS ANN. § 330.21 (Supp. 1971) authorizes a peace officer to petition the probate court to commence involuntary commitment proceedings of a non-emergency nature upon the belief that an individual is mentally ill.
\(^5\) The Michigan statute provides only that notice of the time and place of hearing be
in court on the designated day. When contrasted with the realities of emergency detention this fact underscores a primary defect in the present statutory scheme. While the emergency statute authorizes detention before the commencement of commitment proceedings for a period not to exceed forty-eight hours, in reality the loss of liberty may extend well beyond this statutory time limit, for the statute ignores the disposition of the detainee between the time the officer has commenced the formal commitment process and the date of the resultant hearing.\textsuperscript{52} Since the court is dealing with an allegedly dangerous individual there is little likelihood that he will be released pending his hearing. Thus, in effect, the period of preventive detention may extend well beyond the statutory limit once emergency detention has been authorized and commitment proceedings begun. If this is not the case and detention is not extended until the date of the hearing the statute makes little sense. The situation would develop whereby an individual who was detained because his presence on the street was deemed a danger to himself or others would be released at the conclusion of forty-eight hours to pose the same threat until the date of his hearing. Surely this was not the intent of the drafters.

In addition to this problem concerning the disposition of the detainee between the commencement of commitment proceedings and the hearing, it appears that the courts have frequently permitted the extension of the forty-eight hour time limit for detention and the commencement of commitment proceedings upon the certificate of an examining city or county physician. While statutory provisions do provide for five day emergency detention upon such a certificate\textsuperscript{53} the language clearly indicates that this is to be served on the individual at least twenty-four hours before the hearing, but does not authorize prehearing detention. MICH. COMP. LAWS ANN. § 330.21 (Supp. 1971).

\textsuperscript{52} The statute requires the police officer to petition the probate court within forty-eight hours but fails to consider whether the detainee is then to be released pending his hearing or kept in the hospital until the date of the hearing. There is a high probability that several days will pass before the necessary examinations have been conducted and the proper notice completed.

\textsuperscript{53} MICH. COMP. LAWS ANN. § 330.19(b) (Supp. 1971) states:

\begin{quote}
The regularly appointed official physician of any city or county who shall find, after careful examination, that any person in such city or county is mentally diseased and that the immediate detention of such person for examination, treatment and proceedings under this act, is necessary for public safety or the safety of the individual, shall make a certificate to that effect, which shall contain the facts and circumstances showing the mental condition of such person and why such action is necessary, and deliver the same to any peace officer of such city or county, who shall forthwith take such person into custody and transfer him to a hospital for confinement, examination and treatment or to some other place for detention if a hospital is not available, as the physician may direct. Any person taken into custody and confined under the provision of this section may be detained until proceedings as provided in
utilized as a wholly separate means of instituting psychiatric detention rather than as a mechanism to extend the time limit of police initiated detention. Furthermore, the provisions authorizing police detention state that "proceedings under this act, temporary or permanent, shall be instituted by the police officer within forty-eight hours." This language clearly indicates an intent to limit the duration of police initiated detention, and the absence of any provisions authorizing extension of the forty-eight hour limit substantiate this fact, especially in light of the specific language providing for extension in other parts of the statute. Thus it seems that any extension authorized by a court of the forty-eight hour time limit may be regarded as a purposeful evasion of the statutory mandate.

Finally, the commitment hearing that will be ultimately convened will implicitly presume the validity of the original detention, dealing only with the question of legal sanity. Thus, throughout the entire process the initial determination of the detaining officer may remain unreviewed despite the fact that it may result in a significant deprivation of liberty for the detainee and expose him to psychiatric treatment against his will. Due process seemingly requires more effective safeguards as well as some opportunity to challenge the basis of detention before it is deemed lawful and leads to a serious loss of liberty.

It should be emphasized that the police officer's authority to impose emergency psychiatric detention upon one clearly endangering his own life or the lives of others is not questioned; the police power clearly sanctions such detention. It is generally

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54. MICH. COMP. LAWS ANN. §§ 330.19(a) and (b) (Supp. 1971) both provide that the period of detention shall not exceed five days unless the probate court by special order extends the time.

55. The hearing deals solely with the question of mental illness, never considering the validity of the original detention:

The court shall . . . take proofs as to the alleged mental condition . . . of such person, and fully investigate the facts, and if no jury is requested, the probate court shall determine the question of such alleged mental disease of such person. If it shall appear to the court or jury from evidence contained in the doctor's certificates or from evidence produced in court that such person is mentally diseased . . . .


56. It has been clearly established that due process is not violated by a temporary confinement where immediate action is necessary and for the protection of others or for the welfare of the alleged mentally ill person. See Fhagen v. Miller, 65 Misc. 2d 163, 317 N.Y.S.2d 128 (Sup. Ct. 1971); In re Coates, 9 N.Y.2d 242, 213 N.Y.S.2d 74, 173 N.E.2d 797 (1961). For other instances where the police power authorizes summary action to protect the public without a prehearing, see American Cold Storage Co. v. Chicago, 211 U.S. 306 (1908) (seizure of spoiled food); Ewing v. Mytinger and Casselberry, Inc., 399 U.S. 594 (1950) (seizure of mislabeled vitamin products).
agreed that emergency detention based on dangerous mental illness is a legitimate exception to the requirement of a hearing preceding any deprivation of liberty for reason of insanity.\textsuperscript{57} However, the police power does not authorize any further denial of the rights to which any other detainee would be entitled once the supposed emergency has passed.\textsuperscript{58} Thus, an equal protection attack on the statute is based upon the contention that one who is allegedly insane cannot be deprived of the right to challenge involuntary detention that was initiated because his alleged actions have fallen within certain statutorily designated guidelines. Just as the mentally competent suspect has the right to challenge involuntary state detention based on prohibited acts, so should the allegedly insane. There is no justification for the circumvention of any procedural safeguards ordinarily provided to the criminal arrestee when the psychiatric detainee seeks to challenge his detention.\textsuperscript{58} The statute should not be upheld upon the erroneous assumption that it will only be invoked in situations where the detainee is senseless or so seriously disturbed that he will be unable or unwilling to challenge his detention.

Thus, when the claimed threat of danger has been overcome by police intervention and the removal of the individual to the hospital, the need for summary action has passed and the detainee immediately acquires the right to challenge the decision that

\textsuperscript{57} This belief, originating under the common law police power, see cases cited in note 26 supra, has been codified in most states by dispensing with the requirement of a pre-detention hearing under emergency circumstances. For statutes paralleling the Michigan law authorizing emergency police detention of the dangerously insane, see D.C. Code § 21-521 (1967); Ill. Ann. Stat. § 7-2 (Smith-Hurd Supp. 1972); and N.Y. Mental Hygiene Law § 72 (McKinney 1971-72 Supp.).

\textsuperscript{58} Once the detainee has been removed to the hospital the emergency has ceased, since doctors can provide medical attention unavailable at the point of public contact and the legal apparatus exists to review the basis of detention. See Matthews, supra note 5, at 287. After the detainee has been removed to the hospital, there is no longer a compelling reason to deprive the detainee of the rights to which he is entitled if he possesses the competency to demand these rights.

\textsuperscript{58} In Fhagen v. Miller, 65 Misc. 2d 163, 317 N.Y.S.2d 129 (Sup. Ct. 1971), plaintiff challenged the constitutionality of New York's emergency psychiatric detention statute, arguing that a hearing was required for the question of the necessity for and propriety of the emergency hospital admission. An intermediate appellate court reversed the findings of the lower court and concluded that the habeas corpus provision of New York's Mental Hygiene Law adequately protected the rights of the detainee, providing him with a means for "reasonably testing" his emergency admission.

Initially it must be questioned whether habeas corpus adequately protects the detainee's due process rights. Even if the petitioner is successful on his habeas petition, the detainee has still undergone statutorily authorized treatment immediately upon his admission to the hospital. Only a prior examination of the basis of detention can appropriately validate the police officer's determination so that treatment may be commenced.
resulted in his loss of liberty. In Goldberg v. Kelly the Supreme Court ruled that a recipient of public assistance payments must be afforded an evidentiary hearing before the benefits are terminated. The initial determination of a caseworker and her superior could not alone justify the state's discontinuance of welfare payments, and the recipient had a right to challenge the determination. Similarly, in the emergency detention situation the initial determination by the police officer and admitting physician should not justify the state's commencement of detention or the right of a hospital to begin treatment before the detainee has had the right to challenge these determinations.

To meet the requirements of due process the Michigan non-emergency involuntary commitment statutes provide that before commitment is authorized there must be a legal review of the medical determinations of insanity. No order for commitment may be granted without judicial review of the propriety of the medical findings. It follows that the commencement of psychiatric treatment and detention should not be permitted until a hearing, if requested, has confirmed that the emergency detainee's actions merited detention, that the approval of the prosecutor was more than a perfunctory gesture, and that the admitting physician's determinations resulted from a proper examination that in fact revealed the dangerous tendencies of the patient as well as his mental illness.

IV. RECOMMENDATIONS FOR STATUTORY REFORM

The breakdown of the present safeguards against unlawful de-
tention and the need for some form of check on a police officer's
decision to detain necessitate modification of the statutory fram-
ework. First, the statute should be amended to provide that a
police officer be held to an objective standard of reasonableness in
invoking the discretionary detention power. The present statutory
language, requiring merely the officer's "belief" that an individual
is mentally ill and dangerous, suggests that the standard is now
subjective. 64 Such a modification would engender a higher degree
of caution in an officer's considering the invocation of the deten-
tion power, a caution possibly arising more from an increased
fear of civil liability for false arrest than from the language itself.

Second, provision should be made for an individual to challenge
his detention. This might best be accomplished by allowing the
detainee upon his admission to the hospital to question the valid-
ity of his detention before a magistrate, and requiring that the
police officer inform the detainee of such right. A hearing would
be held only upon the cognitive request of the detainee, alleviating
any fear of having to present the violent or insensible before the
court, while at the same time preserving the rights of those ca-
pable of questioning their loss of liberty.

This procedure would be established by amending the detention
statute to require the approval of a magistrate rather than that of a
prosecuting attorney. The judge could automatically approve
those whom the admitting doctor verified as violent or in-
sensible, 65 but would require a hearing before granting approval in
all other cases where one was requested. 66 Thus, the rights of the
detainee would be preserved and the present process of mechan-
ically acquiring the prosecutor's approval would be terminated. 67
Court approval would also provide a legal check on the question-
able medical admission procedure, 68 just as the hearing in non-

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64 See notes 27-29 and accompanying text supra.
65 This is not to be confused with the lesser standard of mere dangerousness, the
requisite standard for invoking emergency detention.
66 See, e.g., D.C. CODE §§ 21-523 to -527, -541 (1967). This statutory procedure pro-
vides for close judicial supervision over the emergency detention process. Detention must
be terminated at the end of forty-eight hours unless the hospital administrator petitions the
court for an order authorizing seven days of continued hospitalization for emergency
observation and diagnosis. Within twenty-four hours of receiving this petition the court
will order continued hospitalization or the detainee's release after evaluating the officer's
report, the physician's report and any other relevant material. If further hospitalization is
ordered the court will grant a hearing within twenty-four hours of a detainee's request. At
the conclusion of the seven days of hospitalization the hospital will petition the court to
commence formal proceedings or release the detainee.
67 See note 29 and accompanying text supra.
68 See notes 42-48 and accompanying text supra.
emergency involuntary commitment proceedings reviews the findings of the examining physicians.69

Third, the statute should provide that a hospital can admit an individual pursuant to a police officer's emergency detention power only upon a finding of the examining physician that the individual is mentally ill and dangerous. It appears that some hospitals will now admit an individual under these circumstances merely upon a finding that he is mentally ill. Hospital admission policies cannot be relied upon to serve as a filtering mechanism to reduce alleged detention. The standard for hospital admission pursuant to the emergency detention power should be the same as that imposed upon a police officer invoking the power.

Fourth, it is also suggested that the responsibility for commencing formal commitment proceedings be shifted from the police officer to a physician at the receiving hospital. Such a change would encourage a more extensive psychiatric examination by the hospital staff and result in a more meaningful decision to commence proceedings than leaving this responsibility to the police officer.

Fifth, the right to begin treatment during the forty-eight hour detention period should be withdrawn. This period should instead be utilized for further diagnosis and examination directed toward determining the need for commitment since no justification for initiating treatment exists before a judicial determination of the validity of detention.

The possibilities of unlawful detention and the subsequent commencement of unwarranted treatment and extended detention pending commitment proceedings clearly exist. Therefore, certain modifications in the statutory scheme are needed. The loss of liberty, whether resulting from alleged criminal acts or from actions that apparently authorize emergency detention, is too great an injury to suffer at the hands of the state without the opportunity to confront those alleging the statutory grounds for arrest or detention. Similarly, additional statutory safeguards must be provided to prevent detention upon an erroneous initial determination by the police officer. Only when the statute provides the right to confrontation and other procedural safeguards will it preserve the necessary balance between the rights of the individual and the interests of society.

69 Mich. Comp. Laws Ann. § 330.21 (Supp. 1971). See, e.g., D.C. Code § 21-522 (1967) where hospital admission is authorized only if the admitting doctor certifies that he has examined the person and is of the opinion that he has symptoms of mental illness and as a result thereof is likely to injure himself or others, unless immediately hospitalized.
Unfortunately, though the statutory changes suggested here may be deemed a necessary end in themselves, the inherent problems of psychiatric detention transcend the prescriptive language of a code. Proper adherence to required procedure will only be accomplished when police training produces officers better prepared to detect mental illness and more proficient in dealing with the special problems they will encounter with the mentally ill. Similarly, only when judges make more extensive investigations of facts and carefully review medical reports to determine the sufficiency of examination techniques before authorizing psychiatric detention or commitment will their roles in the commitment process be fulfilled. Finally, until the facilities of the general receiving hospital are improved, until state hospitals are properly staffed and, most importantly, until a greater sensitivity of the institution to the particular needs of the mentally ill is achieved, statutory language, no matter how precise and carefully drawn, will prove ineffective.

—Mark F. Mehlman