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## Preventing the Detention of Noncriminal Mentally Ill People in Jails: The Need for Emergency Protective Custody Units

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## I. INTRODUCTION

On a brisk March night, the police are called to a downtown Lincoln, Nebraska location. Upon arriving, they find a disheveled young man sitting against a building, speaking unintelligibly. When the police approach him and ask a few questions, the man rises to his feet and becomes agitated. After more questioning, the police realize that the man is completely incoherent. The police smell no liquor on the man's breath, and do not see any evidence of drug use. Fearing for the man's safety, they apprehend him and place him in the back seat of the cruiser. So begins the quest for an appropriate facility in which to place the young man. Unfortunately, the local state hospital is operating well in excess of maximum capacity and staff refuse to admit him. The general hospital does not have adequate facilities either. So, with no alternative except to release the man, the police decide to place him in jail until he can be assessed more fully.<sup>1</sup>

Until recently, the above scenario was relatively commonplace in Lincoln — and many other cities in the United States. Indeed, the presence of people who are apparently disruptive and perhaps mentally ill perplex both law enforcement officers and the public. Often, some law enforcement officers and other members of society believe that mentally ill people should be temporarily institutionalized — for their own good, of course. For over ten years members of the City of Lincoln, and other members of Lancaster County, lobbied the Nebraska state legislature to end the detention of mentally ill citizens in jails.

Prior to 1988, there was no appropriate community facility in Lancaster County for housing mentally ill people who were in need of services, and had been involuntarily detained, but had not been civilly committed.<sup>2</sup> Thus, the need for an alternative facility to evaluate and treat persons placed in Emergency Protective Custody (EPC) was evident as state psychiatric hospitals remained full and persons continued to be placed in jail awaiting evaluation and treatment.

In order to stop the practice of detaining non-criminal mentally ill people in jails, the Nebraska State Legislature passed Legislative Bill 257 ("L.B. 257") in 1988.<sup>3</sup> L.B. 257 prohibits the detention of non-criminal mentally ill people in jails. Although the provisions of L.B. 257 do not become effective until January 1, 1991, Lancaster County (Region V) opened the Crisis Center Program ("Crisis Center") on March 6, 1989 in order to satisfy the requirements of L.B. 257 and serve as a model program for other communities.

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1. This scenario is a composite of a number of cases which occur regularly in communities throughout the United States.
  2. See *infra* notes 57-60 and accompanying text.
  3. L.B. 257, §§ 2-6, 90th Leg., 2d Sess., 1988 NEB. LAWS 109 (codified at NEB. REV. STAT. §§ 83-1020, -1028, -1039, -1070, -1078 (Cum. Supp. 1988)) [hereinafter L.B. 257].

The purpose of the Crisis Center is threefold. Foremost, the Crisis Center holds and evaluates allegedly mentally ill and dangerous persons while they await their Mental Health Board hearings (*i.e.*, civil commitment hearings). Second, the Crisis Center provides intensive, short term mental health treatment aimed at avoiding commitment or long-term hospitalization of mentally ill individuals. Finally, the Crisis Center sometimes serves as an evaluation unit for mentally ill persons, for whom an emergency protective custody order has been filed, and who have been incarcerated in jail pursuant to legal charges.

This article will provide some foundational information concerning jails and the detention of mentally ill persons in jails. We first discuss the prevalence of mental illness in jails to demonstrate the general need for alternative facilities to house mentally ill people. The article then compares the provisions of L.B. 257 to similar legislation in other jurisdictions. After describing the operation of the Crisis Center Program, preliminary descriptive information about the center and its clients is provided.

## II. THE JAIL EXPERIENCE AND ITS PSYCHOLOGICAL EFFECTS

Jails<sup>4</sup> are the most common form of detention facility in the United States, with an estimated daily national population exceeding 275,000 inmates.<sup>5</sup> Although jails are an integral part of the criminal justice system, they have typically operated under less-than-optimal conditions. At least half the jails in the United States are over 30 years old<sup>6</sup> and they are generally administered by counties, which frequently results in insufficient funding.<sup>7</sup> Further, there is no generic model of a

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4. Jails and prisons are very different institutions. Prisons are generally reserved for inmates who have been sentenced to serve a term of at least one year. Jails, by contrast, are multipurpose facilities holding: (1) defendants prior to arraignment or trial; (2) defendants who cannot post bond or who are deemed too dangerous to be released during the period between arrest and conviction or acquittal; (3) convicted offenders sentenced to terms generally less than one year; and (4) a miscellaneous group of others who may not have been charged with an offense but are thought to pose a risk to themselves or others if not incarcerated (*e.g.*, mentally ill people, indigent people, juvenile delinquents when there is no other facility available, homeless people in inclement weather).
  5. Ogloff & Otto, *Mental Health Intervention in Jails*, in INNOVATIONS IN CLINICAL PRACTICE 357 (P. Keller & S. Heyman eds. 1989). See also H. STEADMAN, D. MCCARTHY & J. MORRISSEY, *THE MENTALLY ILL IN JAIL: PLANNING FOR ESSENTIAL SERVICES* 3 (1989).
  6. H. STEADMAN, D. MCCARTHY & J. MORRISSEY, *supra* note 5; *New Jails: Boom for Builders, Bust for Budgets*, BUS. WK. 74 (Feb. 9, 1981). See generally AMERICAN CORRECTIONAL ASSOCIATION, *JAILS IN AMERICA: AN OVERVIEW OF ISSUES* (1985).
  7. National Advisory Comm'n of Criminal Justice Standards and Goals, *Local Adult Institutions*, in CORRECTIONAL INSTITUTIONS 61 (R. Carter, D. Glaser, & L. Wilkins eds. 1985). Commentators have also noted that the "operation of the jail is only one of a variety of responsibilities shouldered by the county sheriff, an

"jail." Instead, the 4,000 jails in the United States vary in size from one or two person lockups to huge urban facilities with daily populations in excess of 8,000 inmates.<sup>8</sup>

Because of the wide variety of jails and the range of inmates housed in them, it is impossible to generalize about the specific psychological effects incarceration will have on any given individual. It is clear, however, that entry into jail is typically more unexpected and more disorganized than entry into a prison.<sup>9</sup> As Ogloff and Otto note:

Inmates [entering jails] suffer an abrupt loss of freedom and their activities become severely restricted. Attempts to become settled or gain information about one's status are often frustrated. Traditional sources of support are unavailable because contact with significant others (i.e., spouse, children, employer) is strictly limited, if not severed completely. Little support can be garnered from staff, who bear responsibility for large numbers of inmates. Further, due to the rapid turnover of inmates, there is little chance that support can be elicited from fellow inmates.<sup>10</sup>

In addition to the chaotic nature of initially being admitted to jail, the physical condition of the jail may also have negative effects on the inmate; "[m]any jails are antiquated, poorly lit and ventilated, and often there are few recreational distractions available."<sup>11</sup>

Jail inmates are 3-1/2 times more likely to commit suicide than individuals in the general population.<sup>12</sup> After analyzing 419 reported suicides from a national sample of jails, Hays and Kajdan reported that the modal inmate who had committed suicide was a 22-year-old, single white male arrested for public intoxication.<sup>13</sup> The modal suicidal inmate had no significant history of prior arrests and no history of mental illness or suicide attempts. The suicidal inmate was typically found dead within three hours of incarceration.

Given that the number of jail inmates in the United States is growing,<sup>14</sup> it is not surprising that jail overcrowding is a major problem,

elected official. Obviously, law enforcement duties are much more visible to the public than jail conditions. Consequently, jail management is frequently assigned a lower priority in many counties." Ogloff & Otto, *supra* note 5, at 357.

8. H. STEADMAN, D. MCCARTY & J. MORRISSEY, *supra* note 5.

9. Gibbs, *Problems and Priorities: Perceptions of Jail Custodians and Social Service Providers*, 11 J. CRIM. JUST. 327 (1983); Wilkerson, *Consideration of Suicidal Trauma in a Detention Facility*, in JAIL HOUSE BLUES 119 (B. Danto ed. 1973).

10. Ogloff & Otto, *supra* note 5, at 358.

11. *Id.*

12. JAIL HOUSE BLUES (B. Danto ed. 1973); Ogloff & Otto, *supra* note 5, at 359. A petition for certiorari has recently been filed with the United States Supreme Court to decide whether a correctional officer and his superiors are immune from 42 U.S.C. § 1983 liability for having failed to screen a pretrial inmate — who later committed suicide — for suicidal tendencies, and to take steps to prevent the suicide. *Danese v. Asman*, 875 F.2d 1239 (6th Cir. 1990), *petition for cert. filed*, 58 U.S.L.W. 3567 (1990).

13. L. HAYS & B. KAJDAN, FINAL REPORT TO THE NATIONAL INSTITUTE OF CORRECTIONS ON THE NATIONAL STUDY OF JAIL SUICIDES (1981).

14. During the 10 year period ending in 1986, the jail population had increased by

and the number one concern of jail managers and mental health professionals working in jails.<sup>15</sup> The results of jail overcrowding can be devastating, for both inmates and the institution.<sup>16</sup> Upon reviewing the records of four state prison systems,<sup>17</sup> Paulus and his colleagues discovered that the rates of death, suicide, disciplinary problems, and psychiatric commitment were greatest in prisons with high population densities.<sup>18</sup> The rates of the above problems also increase as a prison's population increases. The more inmates per cell and the less privacy each inmate has, the greater their problems.<sup>19</sup> Objective autonomic nervous system measures such as blood pressure, and subjective measures including complaints of illness are higher among inmates in crowded prisons.<sup>20</sup> Because of the poor physical conditions and the overcrowded situation of many jails, between 11% and 33% of all jails in the United States are under a court order or consent decree forcing compliance with jail standards or constitutional deficiencies.<sup>21</sup>

Together, the above factors combine to create a psychologically and physically stressful atmosphere.<sup>22</sup> It is constitutionally permissible to subject one who has been convicted of an offense — or who is not eligible for bail — to serve a sentence in a jail.<sup>23</sup> However, it is questionable whether any state interest warrants the detention of mentally ill

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approximately 73%, from 158,394 in 1976 to 274,444 in 1986. H. STEADMAN, D. MCCARTY & J. MORRISSEY, *supra* note 5, at 3.

15. Gibbs, *supra* note 9. Johnson, *Comment*, 3 J. OF PRISON & JAIL HEALTH 89 (1983), writes that 51% of jail detainees are housed in cells with less than 60 square feet of floor space. Often, more than one inmate — and as many as four inmates — will be housed in the cramped cell.
16. As this article was being written, an intense controversy developed surrounding an overcrowded Massachusetts jail. A sheriff has commandeered a National Guard armory against protests from the state. In an effort to "keep the peace," the sheriff used the armory to temporarily house inmates. The Hamden County jail was designed to hold 279 inmates, but currently has over 500 prisoners. There is a federal court order that restricts the county from housing more than 500 prisoners at the jail. N.Y. Times, Feb. 18, 1990, at 17.
17. P. PAULUS, V. COX & G. MCCAIN, PRISON CROWDING: A PSYCHOLOGICAL PERSPECTIVE (1988).
18. *Id.* at 569.
19. *Id.*
20. *Id.*
21. K. KERLE & F. FORD, THE STATE OF OUR NATION'S JAILS (1982).
22. See generally H. SELYE, THE STRESS OF LIFE (1956) for a comprehensive discussion of the effect that stress has on the psychological and physical well-being of people. All of the factors that characterize jails and the process of being incarcerated in a jail (e.g., disorganization, unknown contingencies, poor physical environment, transiency, and overcrowding) play a significant role in increasing the inmate's level of stress which results in psychological and physical illness.
23. See generally *Robinson v. California*, 370 U.S. 660 (1962) (Court held that punishment, including incarceration, can be imposed for bona fide criminal offenses). The great majority of people detained in jails (75%), are detained because they are unable to post bond. NATIONAL CRIMINAL JUSTICE INFORMATION AND STATISTICS SERVICES, CENSUS OF JAILS AND SURVEY OF JAIL INMATES (1979).

persons in jail.<sup>24</sup> Indeed, if one assumes that mentally ill inmates are more psychologically (and perhaps physically) vulnerable than other members of the population, then the negative effects of incarceration are exacerbated for them. The following section will discuss the general prevalence of mentally ill people in jail.

### III. DETAINING MENTALLY ILL PEOPLE IN JAILS

Whether mentally ill people are entering jails in increasing numbers is debated. Nonetheless, a great deal of concern has been expressed concerning the detention of mentally ill people in jail. Indeed, a recent survey indicates that jail managers consider mentally disordered inmates to be one of the most pressing problems today, second only to overcrowding.<sup>25</sup>

#### A. The Prevalence of Mental Illness in Jails

Estimates of the prevalence<sup>26</sup> of mental illness in the jail population vary widely,<sup>27</sup> and numerous problems have plagued attempts at accurate estimation. For example, many studies have not employed random samples of the jail population, but have instead included only those persons referred for psychiatric or psychological evaluation; not surprisingly, higher prevalence rates are reported in these studies. The categories of mental illness used, and the criteria for defining them, vary considerably from study to study.<sup>28</sup> Many studies have employed too few subjects to permit accurate prevalence estimates to be

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24. Of course, mentally ill people may be civilly committed to secure facilities which, although often structurally similar to jails, are conceptually very different. See generally *Addington v. Texas*, 441 U.S. 418 (1979) (discussing the constitutional requirements for civilly committing a mentally ill person), G. MELTON, J. PETRILA, N. POYTHRESS & C. SLOBOGIN, *PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS* § 8.02(d) (1987) (reviewing the constitutionality of committing mentally ill people); A. STONE, *MENTAL HEALTH AND THE LAW: A SYSTEM IN TRANSITION* 45 (1975) (specifying four social goals to which commitment is responsive and provides a broad overview of mental health law generally); Morse, *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978) (analyzing the foundation for committing mentally ill people). See *infra* notes 57-60 and accompanying text.

25. See *supra* note 9 and accompanying text.

26. Prevalence refers to "the number of existing cases of a disease in a given population at a specified time." *STEDMAN'S MEDICAL DICTIONARY* (24th ed. 1980).

27. Prevalence rates of mental illness among randomly-selected inmates vary between 16% and 66%, depending upon such factors as sample size and criteria of mental disorder or illness. Gibbs, *supra* note 9; Teplin, *The Criminalization of the Mentally Ill: Speculation in Search of Data*, 94 *PSYCHOLOGICAL BULL.* 54 (1983).

28. R. OTTO & J. OGLOFF, *A MANUAL FOR MENTAL HEALTH PROFESSIONALS WORKING WITH JAILS* 5 (1988).



made.<sup>29</sup> Sometimes it is not clear whether jail or prison populations are being studied; prevalence rates of the two types of institutions are probably different.<sup>30</sup> Given these and other problems, it is not surprising that there is widespread disagreement on the matter.

One finding common to most jail studies, however, is a high rate of antisocial personality disorder, alcohol dependence/abuse, and drug dependence/abuse.<sup>31</sup> The high rate of antisocial personality disorder — formerly known as psychopathy — is not surprising, given its definition and diagnostic criteria.<sup>32</sup> The high rate of drug and alcohol abuse should also be expected, given the relationship between substance abuse and crime, and the fact that possessing illicit drugs is a crime.<sup>33</sup>

Greater disagreement exists concerning the prevalence in the jail population of the most serious forms of mental disorder, the psychoses.<sup>34</sup> Some claim that psychosis is more common in jail popu-

29. Teplin, *supra* note 27, at 63.

30. Indeed, while it is not uncommon to find mentally ill people who have not been arrested detained in jail during inclement weather or at other times when the jail is the only available facility in which they may be housed, it is highly unlikely — and legally impermissible — for a prison to incarcerate individuals who have not been convicted of a crime punishable by imprisonment. *See Robinson v. California*, 370 U.S. 660 (1962) (the Court considered it cruel and unusual punishment to impose criminal sanctions on an individual whose only “offense” was addiction to narcotics). *See supra* note 4 and accompanying text for a discussion of the differences between jails and prisons.

31. R. OTTO & J. OGLOFF, *supra* note 28, at 6-11. *See also* Ogloff & Otto, *supra* note 5, at 359.

32. “The essential feature of this disorder is a pattern of irresponsible and antisocial behavior beginning in childhood or adolescence and continuing into adulthood.” AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 342 (3d ed. Rev. 1987) [hereinafter DSM-III-R]. One of the diagnostic criteria of the disorder is behavior that “fails to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing antisocial acts that are grounds for arrest.” *Id.* at 345. Thus, a high proportion (as high as 76%) of prison and jail inmates meet the DSM-III-R criteria for antisocial personality disorder. *See* Hare, *Comparison of Procedures for the Assessment of Psychopathy*, 53 JOURNAL OF CONSULTING & CLINICAL PSYCHOLOGY 7 (1985) (this article reviewed the criteria for antisocial personality disorder described in a previous issue of the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1980); however, the substantive criteria for the disorder were not revised in the DSM-III-R).

33. BETHESDA COMMUNITY MENTAL HEALTH CENTER, *THE MENTALLY ILL IN JAILS* (1986); R. OTTO & J. OGLOFF, *supra* note 28, at 6-11; Guy, Platt, Zwerling & Bullock, *Mental Health Status of Prisoners in an Urban Jail*, 12 CRIM. JUST. & BEHAV. 29 (1985); Ogloff & Otto, *supra* note 5, at 359.

34. “Psychotic” is defined in DSM-III-R as follows: “Gross impairment in reality testing and the creation of a new reality. . . . When a person is psychotic, he or she incorrectly evaluates the accuracy of his or her perceptions and thoughts and makes incorrect inferences about external reality, even in the face of contrary evidence.” DSM-III-R, *supra* note 32, at 404.

lations than in the general population.<sup>35</sup> But upon reviewing more recent studies, Monahan and Steadman concluded that "the weight of the evidence appears to support the assertion that the true prevalence rate of psychosis among inmate populations does not exceed the true prevalence rate of psychosis among class-matched community populations."<sup>36</sup> In sum, except for antisocial personality disorder and drug and alcohol abuse, there is widespread disagreement over the prevalence of mental illness in jails, particularly regarding whether prevalence is higher in the jail population than in the general population.

## B. The Criminalization Hypothesis

A number of researchers have suggested that mentally ill people are entering the criminal justice system in increasing numbers, a view sometimes termed the "criminalization hypothesis."<sup>37</sup> Several events have taken place over the past twenty-five years which make the criminalization hypothesis plausible. Among the most frequently mentioned are:

- (1) The phenomenon of deinstitutionalization.<sup>38</sup> This process of releasing mentally ill persons from hospitals into the community began in the late 1960s and early 1970s. The advent of new treatment techniques and changes in the ideology of mental health professionals has been associated with the release of mentally ill persons from state hospitals.<sup>39</sup>
- (2) Legal restrictions on psychiatric treatment. Many states

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35. "Many studies on mentally ill persons were made in Germany from 1850 on. . . . During this period it was first scientifically recognized that the prevalence of mental illness and suicide among inmates was far greater than in the general population, a finding that still holds true." Cormier, Morf & Merserau, *Psychiatric Services in Penal Institutions*, 40 LAVAL MED. 939 (1969).

36. Monahan & Steadman, *Crime and Mental Disorder*, 4 ANN. REV. CRIME & JUST. 168 (1982)

37. Teplin, *supra* note 27.

38. Deinstitutionalization involves:

- (1) the prevention of inappropriate admissions to facilities for the mentally handicapped through the provision of community alternatives for treatment;
- (2) the release or transfer to the community of those institutionalized patients who had been adequately prepared for the change;
- and (3) the establishment and continued maintenance of community support systems for noninstitutionalized persons receiving mental disability services.

2 M. PERLIN, MENTAL DISABILITY LAW 560-61 (1989).

39. See 2 THE PRESIDENT'S COMM'N ON MENTAL HEALTH, TASK FORCE REPORT: NATURE AND SCOPE OF THE PROBLEM 55-56 (1978); Kiesler, *Public and Professional Myths about Mental Hospitalization: An Empirical Reassessment of Policy Related Beliefs*, 37 AM. PSYCHOLOGIST 1323 (1982); Kiesler & Sibulkin, *Episodic Rate of Mental Hospitalization: Stable or Increasing?*, 141 AM. J. PSYCHIATRY 44 (1984).

have enacted more stringent civil commitment statutes<sup>40</sup> so that some persons who formerly would have been institutionalized are being arrested instead. The right of people who have been civilly committed to refuse treatment, which has emerged over the last few years,<sup>41</sup> may lead to the same result.

- (3) A reduction in funds for mental health programs. With fewer mental health services available, mentally ill persons may be at greater risk to be processed through the criminal justice system. For example, mentally ill persons who go untreated may be more likely to behave in ways that bring them to the attention of the criminal justice system.

There is some evidence to support the criminalization hypothesis. Bonovitz and Guy<sup>42</sup> investigated whether a stringent commitment law adopted in Pennsylvania led to an increase in the arrest and imprisonment of mentally ill persons. They found, *inter alia*, that in the year following the implementation of the new commitment law, the number of requests for psychiatric consultation from Philadelphia County jails increased, and that admissions to a jail psychiatric unit in Philadelphia also increased. They also found changes in the characteristics of persons hospitalized in the jail psychiatric unit that they interpreted as being consistent with their hypothesis.

On the other hand, Steadman and Ribner<sup>43</sup> found no evidence supporting the criminalization hypothesis. Upon comparing the psychiat-

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40. For example, the Virginia Code requires that a judicial hearing be held within 48 hours of the initial detention of an individual undergoing civil commitment. If the court finds that the individual meets the criteria necessary to be committed, the individual may be committed for a period up to 180 days after which he or she will be provided with another judicial hearing. VA. CODE ANN. § 37.1-67.3 (Supp. 1983). Although more restrictive civil commitment laws are mentioned to corroborate the criminalization hypothesis, some research suggests that changes in civil commitment laws do not have much impact on the total number of commitments. See Luckey & Berman, *Effects of a New Commitment Law on Involuntary Admissions and Service Utilization Patterns*, 3 LAW & HUM. BEHAV. 149 (1979) (presenting a study which found that 18 months after instituting legislation which made the civil commitment procedures in Nebraska more stringent, the total number of civil commitments returned to the same level as that which had existed prior to the legislative changes).

41. *E.g.*, *Mills v. Rogers*, 457 U.S. 291 (1982); *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983) (en banc). By contrast, the United States Supreme Court recently held that it is constitutional to give prison inmates psychotropic medication against their will. *Washington v. Harper*, 110 S. Ct. 1028 (1990).

42. Bonovitz & Guy, *Impact of Restrictive Civil Commitment Procedures on a Prison Psychiatric Service*, 136 AM. J. PSYCHIATRY 1045 (1979).

43. Steadman & Ribner, *Changing Perceptions of the Mental Health Needs of Inmates in Local Jails*, 137 AM. J. PSYCHIATRY 1115 (1980).

ric histories of offenders released from correctional institutions in Albany County, New York, in 1968 and 1975, they found no significant increase in the percentage of released offenders with a history of mental hospitalization over this period. They concluded that "there is little empirical evidence to show that the mental health problems of inmate populations at local or state correctional institutions has changed."<sup>44</sup> They suggested that "the changes may have occurred in the perceptions and expectations of the correctional staffs rather than in the characteristics of the inmates."<sup>45</sup>

### C. Importance of Addressing Mental Health Concerns in the Criminal Justice System

Regardless of the precise prevalence rate of mental illness in jails, or whether or not the prevalence has increased, the problem of mentally ill persons in the criminal justice system is an important one. Indeed, mentally ill people require services which are usually not available in many jails.<sup>46</sup> Steadman and his colleagues report that most of the jail inmates in the United States do not have access to adequate mental health care.<sup>47</sup>

In jail settings where security concerns are paramount, even a few mentally ill persons can be seriously disruptive. The problem of detaining *any* mentally ill persons in jails is recognized even by those who are skeptical of claims of high or increasing prevalence rates of mental illness. For example, Steadman and his colleagues acknowledge that "mentally ill inmates constitute a significant population in need of [mental health] services."<sup>48</sup>

An informal study by Gibbs<sup>49</sup> supports the assertion that the mere presence of any mentally ill persons in jails presents a great deal of concern within the criminal justice system. Gibbs surveyed thirty-five participants attending a workshop on jail standards concerning the seriousness of each of twenty-four problems at their respective institutions. About half of the participants were wardens, lieutenants, or sergeants; another quarter were social service providers (psychologists, social workers, etc.); and the remaining quarter held a variety of other positions. The problem of inmates who experience psychological problems was ranked second in level of seriousness; only "overcrowding" was deemed a more pressing concern.

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44. *Id.* at 1116.

45. *Id.*

46. Ogloff & Otto, *supra* note 5.

47. H. STEADMAN, D. MCCARTY & J. MORRISSEY, *supra* note 5, at 7. *See also* C. NEWMAN & B. PRICE, *JAILS AND DRUG TREATMENT* (1977); Morgan, *Developing Mental Health Services for Local Jails*, 8 CRIM. JUST. & BEHAV. 259 (1981).

48. H. STEADMAN, D. MCCARTY & J. MORRISSEY, *supra* note 5, at 7

49. Gibbs, *supra* note 9.

The significance of the problems which arise when mentally ill people are detained in jails has also been recognized by the American Bar Association, the American Medical Association, the American Association of Correctional Psychologists, and the National Correctional Health Care Association, which have adopted specific guidelines for mental health care in prisons and jails.<sup>50</sup> Finally, it is widely acknowledged that delivery of mental health services is very difficult in jails and other correctional settings.<sup>51</sup>

#### D. Criminal Justice System or Mental Health System?

When is a person who is exhibiting signs of mental illness likely to enter the criminal justice system rather than the mental health system? One important consideration is obviously whether the person has committed a serious crime. A person who has committed a felony is likely to be arrested regardless of the degree of mental disorder exhibited.<sup>52</sup> For misdemeanants, a number of factors are important,<sup>53</sup> including the gravity of the offense, the apparent dangerousness of the defendant, and the availability of beds in the local jail or mental health facility.

In addition to detaining people in jail who have been charged with or found guilty of committing offenses — felonies or misdemeanors — some suggest that it is not an uncommon practice to detain people in jail who have not committed any offense.<sup>54</sup> For example, it is conceivable that some law enforcement officers have placed mentally ill per-

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50. AMERICAN BAR ASS'N, CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (1989); AMERICAN CORRECTIONAL ASS'N, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS (1981); AMERICAN MEDICAL ASS'N, STANDARDS FOR HEALTH SERVICES IN PRISONS (1979); AMERICAN PUB. HEALTH ASS'N, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS (1976); American Ass'n of Correctional Psychologists, *Standards for Psychology Services in Adult Jails and Prisons*, 7 CRIM. JUST. & BEHAV. 81 (1980).

51. Dank & Kulishoff, *An Alternative to the Incarceration of the Mentally Ill*, 3 J. PRISON & JAIL HEALTH 95 (1983), go so far as to say that "a prison is for punishment and . . . effective psychiatric treatment cannot take place within its walls." *Id.* at 95.

52. Although all accused felons are likely to be arrested, obviously mentally ill ones may sometimes be detained in secure mental health facilities rather than in jails. Indeed, jail managers are well aware of the extra care a mentally ill inmate will require and they may often attempt to have the mentally ill person transferred out of the jail and into a secure psychiatric facility. See generally Gibbs, *supra* note 9 (noting the concern that jail managers have regarding mentally ill people in jails). It should be noted that the United States Supreme Court has held that prison inmates must receive an administrative hearing prior to being transferred to a psychiatric facility. *Vitek v. Jones*, 445 U.S. 480 (1980). It is unclear whether *Vitek* applies to inmates who are in jail prior to arraignment or trial.

53. See Lamb & Grant, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES OF GEN. PSYCHIATRY 17, 20 (1982).

54. Ogloff & Otto, *supra* note 5, at 358.

sons in jail if they are concerned about the well-being of the person, and if there are no available alternatives.

It is understandable, and legally permissible, to jail mentally ill people who have been charged with felonies.<sup>55</sup> Indeed, some accused felons may display an increased risk of harming others. However, one must question the appropriateness — and the legality — of holding mentally ill misdemeanants or innocent people in jails simply because treatment alternatives are not available.

Generally speaking, only two classes of citizens may have their liberty taken by the state. The first class contains those people who are being detained without bail, cannot make bail, or who have been convicted by an offense punishable by imprisonment. The United States Supreme Court has held that punishment can be imposed only for bona fide criminal offenses.<sup>56</sup> The second class of people who may be detained against their will consists of mentally ill individuals who have been detained under emergency protective custody proceedings or have been involuntarily civilly committed. The general requirements of involuntary civil commitment include:<sup>57</sup>

- (1) The existence of a mental disorder;<sup>58</sup>
- (2) Dangerousness to self or others, as a result of the mental disorder;<sup>59</sup> or

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55. *Robinson v. California*, 370 U.S. 660 (1962). Indeed, the state has the authority under its police power to incarcerate and punish those people who violate the law and present a threat to the well-being of the society. G. MELTON, J. PETRILA, N. POYTHRESS & C. SLOBOGIN, *supra* note 24, at 211.

56. *Robinson v. California*, 370 U.S. 660 (1962). *Cf.* *Schall v. Martin*, 467 U.S. 253 (1984)(Court upheld the preventive detention of juveniles).

57. For a comprehensive review of the criteria for involuntary civil commitment, see, 1 M. PERLIN, *MENTAL DISABILITY LAW* §§ 2.05-2.22 (1989). *See also, Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190 (1974)[hereinafter *Developments*].

58. *Jackson v. Indiana*, 406 U.S. 715, 736 (1972). Although this requirement is a hallmark of the civil commitment process, it is often stated that there is no acceptable definition of mental illness. *See* M. PERLIN, *supra* note 57, at § 2.05; G. MELTON, J. PETRILA, N. POYTHRESS & C. SLOBOGIN, *supra* note 24, at § 8.03(b). The Court of Appeals for the District of Columbia offered a definition of mental illness in *United States v. Brawner*, 471 F.2d 969, 983 (D.C. Cir. 1972)(en banc)(quoting *McDonald v. United States*, 312 F.2d 847 (1962)): "mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls." Even this definition, however, is relatively unclear and nonspecific, requiring courts to rely on a mental health professional's opinion to determine whether the defendant is mentally ill. Despite the difficulties defining mental illness, the existence of a mental illness or disorder has been "universally required to justify involuntary hospitalization." *Developments, supra* note 57, at 1202.

59. The United States Supreme Court has held that a state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975). *See also*

(3) Grave disability or inability to care for oneself as a result of the mental disorder.<sup>60</sup>

To the extent that incarceration in a jail constitutes punishment, mentally ill people who have not committed a bona fide crime, yet are incarcerated, are being punished unconstitutionally. In *Addington v. Texas*,<sup>61</sup> the Supreme Court held that although commitment involves a constitutionally significant loss of liberty, states have authority, via their *parens patriae*<sup>62</sup> and police powers,<sup>63</sup> to involuntarily hospitalize mentally ill people. The Court also attempted to distinguish civil commitment from criminal incarceration: "In civil commitment state power is not exercised in a punitive sense. Unlike the delinquency proceeding . . . a civil commitment proceeding can in no sense be equated to a criminal prosecution."<sup>64</sup> Thus, while states have the authority to civilly commit mentally ill people, they do not have the authority to punish them by detaining them in jail unless they have

*Addington v. Texas*, 441 U.S. 418 (1979). Like the definition of mental illness, the meaning of "dangerousness" is elusive and rather subjective. See M. PERLIN, *supra* note 57 at § 2.07; Monahan & Geis, *Controlling "Dangerous" People*, 423 ANNALS 142 (1976); Petrunik, *The Politics of Dangerousness*, 5 INT'L J. L. & PSYCHIATRY 225 (1982). Commentators have suggested behavioral definitions of dangerousness; for example, Monahan, who was called "the leading thinker on this [dangerousness] issue," *Barefoot v. Estelle*, 463 U.S. 880, 916, 918-19 (1983) (Blackmun, J., dissenting), describes fourteen alternative approaches for defining dangerousness. Some courts have attempted to narrow the meaning of dangerousness by requiring "imminent harm" before one may be involuntarily civilly committed. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975), *reinstated*, 413 F. Supp. 1318 (E.D. Wis. 1976); *State v. Krol*, 68 N.J. 236, 344 A.2d 289 (1975).

60. Although the state cannot involuntarily civilly commit one to improve one's living conditions, the United States Supreme Court has reaffirmed the state's authority to confine people who are gravely disabled or unable to meet their basic needs. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

61. 441 U.S. 418 (1979).

62. *Parens patriae* authority enables the state to commit individuals who have not committed a criminal offense. In contrast to police power, "[t]he grounds for intervention [justified by the *parens patriae* authority] have been focused on the needs of the *individual*, not society." G. MELTON, J. PETRILA, N. POYTHRESS & C. SLOBOGIN, *supra* note 24, at 211. Traditionally, the *parens patriae* power enabled the sovereign to act as guardian of incapacitated persons. *Id.* at 214. See also *Developments, supra* note 57, at 1207-08.

63. The state has the authority, via its police power, to incarcerate and punish individuals in order to protect the community. In contrast to the state's *parens patriae* power, "[t]he state's police power . . . enables it to act as protector of the community — to make law and regulations for the protection of public health, safety, welfare, and morals. When a state action is meant to vindicate a societal interest rather than to further the interest of an individual, it constitutes an exercise of the police power." (footnotes omitted). G. MELTON, J. PETRILA, N. POYTHRESS & C. SLOBOGIN, *supra* note 24, at 214. See also *supra* note 24 and accompanying text.

64. *Addington v. Texas*, 441 U.S. 418, 428 (1979).

either been accused of, or have committed, an offense punishable by imprisonment.

#### IV. ALTERNATIVES TO DETAINING MENTALLY ILL PEOPLE IN JAILS

Although it is tempting to fault law enforcement officers and others in the criminal justice system for jailing the mentally ill, further consideration forces us to identify what alternatives they have. Imagine a law enforcement officer who encounters a situation similar to the scenario described at the outset of this article.<sup>65</sup> The law enforcement officer may have been inadequately trained to handle the situation. Because of the young man's condition, the law enforcement officer may be genuinely concerned about his well-being. Further, the officer has a duty to maintain public order. What is he or she to do? Given that the officer may perceive the young man as mentally ill and dangerous to himself or others, the officer may believe that it is necessary to take the man into custody.<sup>66</sup>

Although the law enforcement officer's decision to take an apparently mentally ill person into custody is a difficult one, it pales in comparison to the officer's next dilemma: What to do with the individual once he or she has been taken into custody? The choices are limited to one or more of the following: Secure mental hospitals, general hospitals, private hospitals, other institutions (*e.g.*, mental health centers, group homes, etc.), crisis centers (or similar facilities), and jails. Each of these alternatives will be discussed below.

##### A. Secure Mental Hospitals

Some jurisdictions have secure mental hospitals which are equipped to manage and treat mentally ill people during a crisis period or prior to their civil commitment hearings. Unfortunately, many states have a limited number of secure facilities, making it difficult to transport mentally ill people to the facilities quickly.<sup>67</sup> Transporting mentally ill people great distances in order to treat them separates them from their sources of social support. For example, it is very diffi-

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65. *See supra* note 1 and accompanying text.

66. Some states explicitly permit police officers to do essentially what the hypothetical police officer did — take the person into custody. For example NEB. REV. STAT. § 83-1020 (Cum. Supp. 1988), requires that “[w]henver any peace officer believes that any individual is a mentally ill dangerous person . . . such peace officer may immediately take such individual into custody.” *See also* ARK. STAT. ANN. § 20-47-101 (1987) which specifies that “[i]t shall be the duty of all peace officers to arrest any insane or drunken persons whom they may find at large and not in the care of some discreet person.”

67. For example there are only three state mental hospitals in Nebraska. Therefore, some people have to travel as many as 400 miles to be transferred to a secure unit.



cult for family members and friends to visit patients who have been transported hundreds of miles away from their home communities. As a result, the patients may feel even more isolated and lonely than when they were in familiar surroundings.

In addition to the above considerations, many mental health facilities are plagued by inadequate budgets and crowding, making it impossible to care for all of the mentally ill people who could benefit from their services. As a result, law enforcement officers may be required to find an alternative placement for the mentally ill person.

## B. General Hospitals

General hospitals with psychiatric units can be employed to house and treat mentally ill people who are gravely disabled or apparently dangerous. Unfortunately, many general hospitals do not have psychiatric units, and those that do may not have secure mental health units,<sup>68</sup> particularly those in rural areas.<sup>69</sup> Further complicating the problem is the shortage of psychiatrists in rural areas throughout the United States.<sup>70</sup>

Because of the often disruptive nature of some mentally ill people, general hospital administrators may be reluctant to allow mentally ill dangerous people to be treated in their facilities. Similarly, mentally ill dangerous people may pose an increased risk (liability) for the hospital. Thus, again, the law enforcement officer must continue to look for an alternative facility in which he or she may place the mentally ill person.

## C. Private Hospitals and Mental Health Facilities

Although states or counties can contract with private general or psychiatric hospitals to provide treatment for mentally ill persons during emergency situations or prior to their civil commitment hearings, this is a costly solution.<sup>71</sup> Moreover, private hospitals may be unwill-

68. In initial discussion regarding where to locate the Lancaster County Crisis Center, some people thought that the most suitable facility would be the Lincoln General Hospital ("LGH"), which adjoins the Lancaster County CMHC. However, the LGH did not have adequate secure mental health facilities.

69. Given the fact that the LGH, located in Nebraska's second largest city, did not have secure mental health facilities appropriate for housing mentally ill dangerous people, it is unlikely that any general hospitals located in less populated counties would have such facilities.

70. See H. STEADMAN, D. MCCARTY & J. MORRISSEY, *supra* note 5.

71. A recent proposal in which an outlying Nebraska county plans to contract with a private hospital for providing short-term mental health services, lists a per day cost of \$350.00, without psychiatric services. By contrast, the daily cost of housing and treating a patient at the Lancaster County Crisis Center is \$185.00. Current information regarding costs is available from Denise Bulling, one of the authors of this article.

ing to risk admitting potentially disruptive, mentally ill people. In addition, rural communities are not likely to have private hospitals, especially ones with secure facilities necessary for housing potentially dangerous, mentally ill people.

#### D. Other Institutions

Some communities may have alternative facilities available which are appropriate for serving mentally ill people in crisis situations. For example, some community mental health centers have inpatient facilities, or may be affiliated with general hospitals which have the necessary facilities. Also, some jails have mental health units which are suitable for temporarily detaining mentally ill people prior to their civil commitment hearings or during crisis situations. As is apparent from the description of other facilities, rural communities are often less likely to have appropriate facilities simply because the small number of mentally ill persons in such communities does not make it economically feasible to provide adequate facilities.

#### E. Emergency Protective Custody Facilities

For a variety of reasons, crisis center facilities similar to those mandated by Nebraska's L.B. 257<sup>72</sup> are the most appropriate alternative for accommodating detained mentally ill people. First, law enforcement officers and others in the criminal justice system will know immediately where to take a mentally ill person whom they take into custody. Second, staff who work exclusively or primarily in crisis centers can develop skills which best meet the needs of mentally ill persons in crisis. Third, such facilities may be able to obtain adequate state and/or county funding to provide services which would be unique to, or routine, in such facilities (e.g., civil commitment assessments, crisis intervention, etc.). Fourth, crisis center facilities are potentially less stigmatizing than state mental hospitals or jails.<sup>73</sup> Fifth, providing crisis services in specialized facilities costs less per capita than providing similar services in private or general hospitals. Finally, because they can vary greatly in size and sophistication, crisis centers can be uniquely tailored to the needs of the community. Therefore, mentally ill people do not have to be transported great distances to receive treatment.

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72. See *supra* note 3 and accompanying text.

73. Following this reasoning it might also be true that having a crisis center affiliated with a general hospital may even be less stigmatizing than a crisis center affiliated with a correctional facility or state psychiatric hospital.

## V. STATUTORY RESTRICTIONS FOR DETAINING MENTALLY ILL PEOPLE IN JAILS

In addition to the previously noted constitutional arguments against detaining non-criminal mentally ill people in jails,<sup>74</sup> some states have enacted legislation intended to keep such people out of jails. The vast majority of states, however, have no such legislation.<sup>75</sup> Legislation prohibiting the detention of non-criminal mentally ill people in jails falls into five general categories: (1) legislation clearly prohibiting the detention of the non-criminal mentally ill; (2) legislation which permits the detention of non-criminal mentally ill people in jails pending transfer to other facilities; (3) legislation providing for the detention of non-criminal mentally ill people in hospitals or community mental health centers; (4) legislation providing for the emergency detention of non-criminal mentally ill people in facilities approved by the state department of mental health or the like; and (5) legislation providing for crisis centers for emergency evaluation and treatment of the non-criminal mentally ill.<sup>76</sup>

### A. Legislation Prohibiting the Detention of the Non-criminal Mentally Ill in Jails

At least two states and the District of Columbia expressly prohibit the detention of the non-criminal mentally ill in jails.<sup>77</sup> The District of Columbia Code, for example, provides that "[a] person apprehended, detained, or hospitalized under any provision of this chapter [hospitalization of the mentally ill] may not be confined in jail or in a penal or correctional institution."<sup>78</sup> Such prohibitions are important and clearly reflect the legislature's position on the issue. However, unless the prohibitions are accompanied by specific guidelines for alternative placement, law enforcement officers are placed in the dilemma described above.<sup>79</sup> If there is no alternative facility available, and the law enforcement officer may not jail the mentally ill person,

74. See *supra* notes 51-57 and accompanying text.

75. It should be emphasized that the lack of a statute prohibiting the detention of mentally ill people in jails does not necessarily mean that mentally ill people are being held in jails. Indeed, administrative guidelines or actual practice in a jurisdiction, may already prohibit detaining mentally ill people in jails.

76. In addition to these categories, virtually every state has traditionally had a process for taking into custody and detaining persons who are deemed to be in need of "emergency" civil commitment. M. PERLIN, *supra* note 57, at § 3.74. Only those state statutes that explicitly or implicitly prohibit the detention of noncriminal mentally ill people in jails will be discussed below.

77. See FLA. STAT. ANN. § 394.459(1) (West 1986); LA. REV. STAT. ANN. § 28:50(6) (West 1989); and D.C. CODE ANN. § 21-585 (1981).

78. D.C. CODE ANN. § 21-585 (1981).

79. See *supra* notes 65-66 and accompanying text.

the officer's only choice may be to release the mentally ill person.<sup>80</sup> When the psychological effects of jails are considered, it may be better for the mentally ill person to be released — even if he or she is apparently mentally ill and dangerous.<sup>81</sup> This is especially true given the increased risk of suicide among jail inmates.<sup>82</sup>

In addition to prohibiting the detention of non-criminal mentally ill people in jails, it is important to ensure that there are appropriate alternative facilities for accommodating such people.

#### B. Legislation Permitting the Detention of the Non-criminal Mentally Ill in Jails Pending Transfer to Other Facilities

The legislation described above shows that by simply prohibiting the detention of non-criminal mentally ill people from jail, the states may be forcing law enforcement officers to release people in need of services. To some extent, then, it is practical to allow law enforcement officers to detain mentally ill people in jails until they can be transferred to more appropriate facilities.

At least seven states permit the detention of a non-criminal mentally ill person in jail pending transfer to a more appropriate facility.<sup>83</sup> Many of the statutes are broadly written, providing little detail regarding the maximum length of stay, or the transfer procedures. For example, Alabama's statute provides that "[i]n addition to convicts

80. It is quite possible that in those jurisdictions with blanket prohibitions against detaining noncriminal mentally ill people in jails, alternative treatment facilities are available by convention even if not legislatively mandated. *See generally* LA. REV. STAT. ANN. § 28:50 (West 1989) (outlines the state's policy of examination, admission, commitment, and treatment of persons suffering from mental illness and substance abuse).

81. *See supra* notes 6-20 and accompanying text.

82. *See supra* notes 12, 13, 17 and accompanying text.

83. *See* ALA. CODE § 14-6-3(6) (1975); ARK. STAT. ANN. § 20-47-104 (1987); KAN. STAT. ANN. § 59-2908(a), (b) (Cum. Supp. 1988); MO. ANN. STAT. § 546.540 (Vernon 1987); MONT. CODE ANN. § 53-21-120(3) (1987); TEX. REV. CIV. STAT. ANN. art. 5547-27 (Vernon Cum. Supp. 1989); VA. CODE ANN. § 37.1-73 (Cum. Supp. 1989). NEB. REV. STAT. § 83-1020(2)(a), (3) (Cum. Supp. 1988) currently allows noncriminal mentally ill dangerous people to be held in jails (1) in counties with cities of the first class (*i.e.*, more than 5,000 people), "only if they cannot be adequately protected in other facilities;" and (2) in counties other than those with a city of the first class. In counties that do not have a first class city, once a noncriminal mentally ill person

is placed in a jail, the person in charge of the jail shall immediately notify the community mental health center for the area that the individual is being held and is in need of placement in an appropriate facility. The community mental health center shall identify an appropriate placement . . . . Until a placement is identified, the community mental health center shall report to the jail every twenty-four hours on the status of the placement. Once an appropriate placement is identified, it shall be implemented within twenty-four hours.

NEB. REV. STAT. § 83-1020(3) (Cum. Supp. 1988).

sentenced to imprisonment in the county jail, the jail is used as a prison for the safekeeping or confinement of the following persons: [i]nsane persons, pending transfer to a mental hospital or other disposition. . . ."<sup>84</sup>

Although detaining mentally ill people in jail pending transfer to a more suitable facility makes some practical sense, two important concerns arise. First, in order for this type of legislation to be effective at limiting the number of non-criminal mentally ill people held in jail, the legislation must limit the length of time the person may be detained in jail pending transfer.<sup>85</sup>

Second, research suggests that many suicides among jail inmates occur shortly after the initial incarceration.<sup>86</sup> Therefore, detaining non-criminal mentally ill persons in jails that do not have adequate protection against risks of suicide may threaten their well-being. Jail administrators must ensure that jail staff are adequately trained in identifying inmates who may be suicidal. As Ogloff and Otto note:

[T]raining [correctional officers] in the identification of the symptoms associated with affective disorders (especially depression) may be most important due to the symptoms' general prevalence, their potential to go unnoticed, their treatability, and the possible consequence of failure to intervene (e.g., suicide). Correctional officers are valuable sources of information [in identifying inmates in need of mental health services] because they see inmates under a variety of circumstances for extended periods of time.<sup>87</sup>

In addition, special care should be given to those inmates who are apparently mentally ill.<sup>88</sup> By making special efforts to identify mentally ill people and to keep them under close surveillance while they

84. ALA. CODE § 14-6-3(6)(1975).

85. E.g., KAN. STAT. ANN. § 59-2908(b) (Cum. Supp. 1988), which restricts the duration for detaining a mentally ill person in jail:

[I]f there is no treatment facility available to receive the [mentally ill] person within the territorial limits of the law enforcement officer's jurisdiction, the law enforcement officer may detain the person in any other suitable place until the close of the first day the district court of the county is open for the transaction of business. . . .

See also ARK. STAT. ANN. § 20-47-104(b) (1987). Although Arkansas requires that "any insane or drunken persons" be arrested, *supra* note 66, legislation also requires that the officer who takes an insane person into custody "shall immediately give notice thereof to the city or county attorney whose duty it shall be to take the proper proceedings for having the insane person sent to the State Hospital."

86. See *supra* notes 12, 13, 17 and accompanying text. See also Christiansen, *In Prison: Contagion of Suicide*, 219 NATION 243 (1974); Cooper, *Suicide in Prisons: The Only Way Out For Some*, 24 CHITTY'S L.J. 58 (1976); Fawcett & Marrs, *Suicide at the County Jail*, in JAIL HOUSE BLUES 83 (B. Danto ed. 1973); Malcolm, *Today's Problem in Penology*, 75 N.Y. ST. MED. 1812 (1975); Tracey, *Suicide and Suicide Prevention in New York City Prisons*, 4 PROBATION & PAROLE 20 (1972).

87. Ogloff & Otto, *supra* note 5, at 362.

88. *Id.* at 359, 364-65 (the authors describe how correctional officers may intervene in crisis situations involving mentally ill people in the jail).

are in jail, correctional officers can prevent inmates from harming themselves or disrupting others.

**C. Legislation Providing for the Emergency Detention of Non-criminal Mentally Ill People in Hospitals or Community Mental Health Centers**

Most states have legislation permitting peace officers to take apparently mentally ill and dangerous people into custody and to "transport the individual to a hospital for examination . . . or . . . notify the community mental health emergency service unit for the purpose of requesting mental health intervention services."<sup>89</sup> Although many states have similar statutes, only Michigan clearly prohibits the officer from taking a non-criminal mentally ill person to jail. Instead, the Michigan statute specifies alternative facilities in which a mentally ill person may be accommodated. Therefore, officers are not placed in the dilemma of trying to find an appropriate facility for the mentally ill person.

The Michigan statute specifies that the officer may take the mentally ill person to a hospital, or request community mental health services.<sup>90</sup> Thus, the statute appropriately places the onus of caring for the mentally ill person on mental health professionals.

However, one major shortcoming of the Michigan statute is that it does not create a special receiving facility for non-criminal mentally ill people. Consequently, some of the problems described earlier may arise again.<sup>91</sup> For example, although the Michigan statute allows the peace officer to take a mentally ill person to a hospital, it does not specify particular facilities, and the statute does not provide for the development of an appropriate receiving facility. Thus, there will undoubtedly be occasions when the mentally ill person will not receive adequate treatment. This might be expected to occur particularly in rural areas where there is no general hospital or community mental health center with secure facilities. Nonetheless, the Michigan statute is progressive and is likely to be of great benefit in a majority of situations.

**D. Legislation Providing for the Emergency Detention of Non-criminal Mentally Ill People in Approved Facilities**

California and Colorado have both adopted legislation which specifies that people who are apparently mentally ill and dangerous—or gravely disabled<sup>92</sup>—may be taken into custody and placed in an "ap-

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89. MICH. COMP. LAWS ANN. § 330.1427(1) (West 1980).

90. *Id.*

91. See *supra* notes 63-66 and accompanying text.

92. Under the laws of California and Colorado, a person can be involuntarily civilly

proved" facility for a seventy-two hour treatment and evaluation period.<sup>93</sup> Both statutes designate the person or agency responsible for approving the facility. In California, the state Department of Mental Health<sup>94</sup> approves facilities in Colorado and the executive director of institutions performs this function.<sup>95</sup> In addition to the general provisions stated above, the California statute requires that a finding must be made, by probable cause, "that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled"<sup>96</sup> before being detained.

To the extent that the California and Colorado statutes prevent the detention of non-criminal mentally ill people in jails<sup>97</sup> and establish some standards for placement facilities, they are superior to the statutes discussed previously. The statutes could, however, be improved by specifying the development of emergency protective custody facilities to accommodate the non-criminal mentally ill during crisis situations or pending a civil commitment hearing.

#### E. Legislation Providing for Emergency Protective Custody Units for the Evaluation and Treatment of the Non-criminal Mentally Ill

Maryland, Minnesota, and Nebraska all have statutes requiring that non-criminal mentally ill people be held in emergency facilities rather than jails.<sup>98</sup> Both Minnesota and Nebraska provide for the development of a "facility for confinement of persons held temporarily

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committed if, *inter alia*, the person is "gravely disabled." CAL. WELF. & INST. CODE § 5150 (West 1984); COLO. REV. STAT. § 27-10-105 (1989). The term gravely disabled is defined as being a "condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing, and shelter." CAL. WELF. & INST. CODE § 5008(h)(1) (West 1984). This provision has been upheld by the Ninth Circuit. *Doe v. Gallinot*, 486 F. Supp. 983 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981). In *Gallinot* the district court upheld the apprehension and commitment of a plaintiff detained by police for acting in a "bizarre" manner. The district court held that California's "gravely disabled" standard was not unconstitutionally vague because it implicitly requires a finding of harm to self arising from "neglect and inability to care for oneself." *Id.* at 991 (quoting *Doremus v. Farrell*, 407 F. Supp. 509, 515 (D. Neb. 1975)).

93. CAL. WELF. & INST. CODE § 5150 (West 1984); COLO. REV. STAT. § 27-10-105(1)(a)(1989).

94. CAL. WELF. & INST. CODE § 5150 (1984).

95. COLO. REV. STAT. § 27-10-105(1)(b)(1989).

96. CAL. WELF. & INST. CODE § 5150 (West 1984).

97. Given that neither the California nor the Colorado statute explicitly prohibits the detention of noncriminal mentally ill people in jail, it is conceivable that the 72-hour treatment and evaluation facilities could be jails, if the facilities are approved by the State Department of Mental Health and the executive director of institutions respectively.

98. MD. HEALTH-GEN. CODE ANN. § 10-624 (1990); MINN. STAT. ANN. § 253B.11 (West 1982 & Supp. 1989); NEB. REV. STAT. § 83-1020 (Cum. Supp. 1988).

for observation, evaluation, diagnosis, treatment, and care."<sup>99</sup>

Statutes requiring the development of emergency facilities resolve many of the dilemmas identified earlier. First, there are specific facilities where law enforcement officers may deliver non-criminal mentally ill people. Second, the burden of caring for the mentally ill person is removed from the criminal justice system (*i.e.*, law enforcement officers, jail guards, etc.) and placed onto individuals in the mental health system (*i.e.*, community mental health center staff, etc.).<sup>100</sup> Thus, the officer is not likely to have much difficulty having a non-criminal mentally ill person admitted to a suitable facility. Third, because the statutes specifically designate agencies or facilities responsible for admitting and treating the non-criminal mentally ill person, it is unlikely that a situation would arise where no accommodations are available for a particular person.<sup>101</sup> Fourth, staff in the facility are likely to develop the required skills to best meet the needs of the non-criminal mentally ill person who requires short-term care or a psychological evaluation.

There are some potential difficulties with statutes that provide for specific emergency protective custody facilities. For example, law enforcement officers may be less reluctant to take into custody a non-criminal person who is apparently mentally ill and dangerous if there is a facility which will admit and accept responsibility for the individual. Thus, development of emergency protective custody units might result in an increased number of non-criminal mentally ill people being inappropriately detained and treated.

Another concern arises from the possibility that some people, who do not quite fit the involuntary civil commitment criteria, may be routinely taken into custody by law enforcement officers and transported

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99. MINN. STAT. ANN. § 253B.11(2)(West 1982 & Supp. 1989); NEB. REV. STAT. § 83-1020 (Cum. Supp. 1988) provides:

(2)(b) Commencing January 1, 1991, a county with a city of the first class within its boundaries shall contract with medical facilities inside or outside the county to provide a place where [noncriminal mentally ill dangerous] individuals . . . shall be held. Such individuals in such counties shall not be placed in a jail.

A city of the first class is defined as one with between 5,000 and 100,000 citizens. NEB. REV. STAT. § 16-101 (1987).

100. Such a distinction may be legally significant given the distinctions that have been made between criminal incarceration and civil commitment. See *supra* note 59 and accompanying text.

101. With other statutory arrangements, facilities that may—but are not required to—admit non-criminal mentally ill dangerous people, may simply refuse to admit individuals when the facility is full. By contrast, those facilities which are statutorily obligated to receive non-criminal mentally ill people may not refuse to admit individuals. Instead, if the facility becomes full, the administrators of the facilities are held responsible for finding a suitable alternative. Thus, the law enforcement officer is not forced to proceed from facility to facility seeking one that will admit the individual she or he has taken into custody.



to the emergency facility, only to be released soon thereafter. Such people may become dependent upon the facility for short-term treatment—or simply occasional meals and sleeping accommodations.

When considering the possible disadvantages associated with the statutory requirement for the development of emergency protective care facilities, it is important to weigh these concerns. First, the importance of having a facility available to both law enforcement officers and mentally ill persons when legitimate crisis situations arise must be weighed against the costs of establishing and maintaining such a facility, and the possible abuses of the facility by law enforcement officers and others. Given the constitutional importance of separating civil from criminal incarceration,<sup>102</sup> and the risk of harm to patients and those around them,<sup>103</sup> it seems that the potential for abuse is of far less significance than the benefits provided by an emergency protection facility.

As discussed above, the development of emergency protective facilities to accommodate non-criminal mentally ill dangerous people appears to be beneficial as compared to alternative statutory methods for dealing with such individuals. Therefore, it is useful to examine L.B. 257, which provides a progressive example of the procedural and substantive requirements for emergency protective facilities.<sup>104</sup>

#### VI. NEBRASKA LEGISLATIVE BILL 257 — THE DEVELOPMENT OF EMERGENCY FACILITIES FOR THE TEMPORARY DETENTION OF NON- CRIMINAL MENTALLY ILL DANGEROUS PEOPLE

On March 17, 1988, Governor Kay Orr signed into law L.B. 257. Among other provisions, the bill was developed to “change placement provisions for mentally ill dangerous persons.”<sup>105</sup>

Substantively, L.B. 257 made four major changes to prior existing law, all of which take effect January 1, 1991:<sup>106</sup>

1. The bill requires counties with cities of the first class (*i.e.*,

102. *See supra* notes 61-64 and accompanying text.

103. *See supra* notes 12-17 and accompanying text.

104. L.B. 257, §§ 2-6, 90th Leg., 2d Sess. 1988 NEB. LAWS 109 (codified at NEB. REV. STAT. §§ 83-1020, -1028, -1039, -1070, -1078 (Cum. Supp. 1988)).

105. *Id.*

106. L.B. 257 amended the law governing the detention of mentally ill dangerous people prior to the onset of civil commitment procedures, *Id.* § 83-1020, during the period after a warrant has been issued to take the individual into custody, *Id.* § 83-1028, and after one has been adjudicated as a mentally ill dangerous person and pending final disposition, *Id.* § 83-1039. Because the substantive provisions of the above sections are practically identical, and the focus of this article is primarily upon the detention of mentally ill people prior to the onset of commitment proceedings, *Id.* § 83-1020 will be emphasized.

- between 5,000 and 100,000 inhabitants<sup>107</sup>) to contract with medical facilities to provide placements for mentally ill dangerous people prior to civil commitment proceedings;<sup>108</sup>
2. The bill prohibits the detention of non-criminal mentally ill people in jails in counties with cities of the first class;<sup>109</sup>
  3. Counties without a city of the first class may temporarily detain non-criminal mentally ill people in jails pending transfer to an appropriate facility. Immediately upon detaining a non-criminal mentally ill person, the person in charge of the jail must notify the community mental health center. The community mental health center must find an alternative placement and must report to the jail every twenty-four hours on the status of the placement. Once an alternative placement has been found, the individual must be transferred within twenty-four hours.<sup>110</sup>
  4. Community mental health centers must collect data on all of the individuals detained under the above provisions.<sup>111</sup> Each of the above provisions will be discussed in turn.

**A. Counties With Cities of the First Class Must Contract With Medical Facilities for the Placement of Non-criminal Mentally Ill People**

This provision requires counties with first class cities to provide a place where non-criminal mentally ill dangerous people can be held.<sup>112</sup> As noted above,<sup>113</sup> this provision is exemplary because it permits officers to place mentally ill people whom they have taken into custody in an appropriate facility which is mandated to care for them.

Because this provision also specifies that the county need not contract with a facility within the county to provide services,<sup>114</sup> counties cannot continue to jail non-criminal mentally ill people by claiming that there is no facility available in the county. For example, in Lancaster County, the secure unit of the Lincoln Regional Center was consistently filled to—or beyond—capacity. Thus, law enforcement officers were often told that there simply was no room for the men-

107. *Id.* § 16-101.

108. *Id.* § 83-1020(2)(b).

109. *Id.*

110. *Id.* § 83-1020 (3).

111. *Id.* § 83-1020 (4).

112. *Id.* § 83-1020(2)(b). Until January 1, 1991, counties with cities of the first class "may contract with medical facilities . . . to provide a place where [noncriminal mentally ill] individuals may be held." *Id.* § 83-1020(2)(a)(emphasis added). Note that the only difference between this section in the new provision and the old one is that the provision which takes effect on January 1, 1991 substitutes the word "shall" for "may". *Id.* § 83-1020(2)(b).

113. See *supra* notes 100-101 and accompanying text.

114. NEB. REV. STAT. § 83-1020(2)(b) (Cum. Supp. 1988).

tally ill person in the secure unit. Now, however, the statute requires that mentally ill individuals be placed in appropriate facilities, even if none exist within the county. The response of Lancaster County and the state was to develop the Lancaster County Crisis Center, which will be discussed and evaluated in detail below.<sup>115</sup>

Requiring counties with cities of the first class to contract with, or develop, facilities ensures that non-criminal mentally ill individuals will be placed in facilities which are uniquely qualified to accommodate them. Indeed, as has happened at the Lancaster County Crisis Center, a variety of non-criminal mentally ill individuals will begin to enter such facilities. Consequently, the staff will develop the skills and resources necessary to accommodate these people. As discussed previously,<sup>116</sup> the development of a facility which is mandated to provide services to non-criminal mentally ill people alleviates many of the concerns which arise out of alternative placement settings.

#### B. Non-criminal Mentally Ill People May Not Be Detained in Jails in Counties With Cities of the First Class

Earlier,<sup>117</sup> the importance of prohibiting the detention of the non-criminal mentally ill in jails was noted. The Nebraska statute explicitly proscribes the detention of non-criminal mentally ill people in jails: "[s]uch individuals [mentally ill] in such counties [with cities with populations in excess of 5,000 people] shall not be placed in a jail."<sup>118</sup> Indeed, such plain language is not vulnerable to administrative or judicial gloss. This provision also takes effect on January 1, 1991.<sup>119</sup>

#### C. Non-criminal Mentally Ill People May be Temporarily Held in Jails in Counties Without Cities of the First Class

Unfortunately, the statute allows counties that do not have a city with a population exceeding 5,000 to continue to detain non-criminal mentally ill people in jails.<sup>120</sup> As described above,<sup>121</sup> even the temporary detention of mentally ill people in jail can be harmful to the mentally ill person, as well as the jail atmosphere itself. Further, it is likely that mentally ill people in rural areas without cities of the first class will be detained in jails, while those who are fortunate enough to

115. See *infra* notes 136-47 and accompanying text.

116. See *supra* notes 72, 73, 101 and accompanying text.

117. See *supra* note 73 and accompanying text.

118. NEB. REV. STAT. § 83-1020(2)(b) (Cum. Supp. 1988).

119. *Id.* Until January 1, 1991, "[s]uch [mentally ill] individuals in such counties may be placed in a jail only if they cannot be adequately protected in other facilities." *Id.* § 83-1020(2)(a).

120. *Id.* § 83-1020(3). See also *supra* note 83.

121. See *supra* notes 83-88 and accompanying text.

reside in a county with cities of the first class will not be placed in jails. It is of the utmost importance that correctional officers in rural areas be trained in the identification of mental illness and suicidal behavior, and in crisis intervention techniques.<sup>122</sup>

There may be some situations where it is *impossible* to transport non-criminal mentally ill persons to any facility other than a jail. By enabling law enforcement officers to detain mentally ill people in jails, mentally ill people will not be released from custody simply because there is *no* place to hold them.<sup>123</sup>

Although the Nebraska provisions permit the detention of some mentally ill people in jails, the provisions include some procedural protections which are designed to ensure that an appropriate placement is made without delay.<sup>124</sup> When a non-criminal mentally ill "individual is placed in a jail, the person in charge of the jail shall immediately notify the community mental health center [CMHC] for the area."<sup>125</sup> This requirement ensures that mental health professionals learn that a mentally ill person is being held in a jail. It may well be that mental health professionals who work in CMHCs in close proximity to the jail will visit the jail immediately.<sup>126</sup>

Once the CMHC has been informed that a non-criminal mentally ill dangerous person is in the jail, the CMHC "shall identify an appropriate placement."<sup>127</sup> Thus, the onus is appropriately placed on mental health professionals to obtain an appropriate placement for the individual.

The requirement that the CMHC "shall report to the jail every twenty-four hours on the status of the placement"<sup>128</sup> keeps law enforcement and jail personnel aware of the status of the detainee. By requiring the CMHC to report to the jail every twenty-four hours, the chances that the individual will be "lost in the system" are greatly reduced. Finally, once the CMHC locates an appropriate placement, the placement "shall be implemented within twenty-four hours."<sup>129</sup> Thus, the CMHC and jail personnel must act quickly to transfer the individual once an appropriate placement is identified.

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122. See *supra* note 87 and accompanying text.

123. See *supra* note 80 and accompanying text.

124. See, e.g., NEB. REV. STAT. § 83-1020(3) (Cum. Supp. 1988).

125. *Id.*

126. This is true, for example, in Gage County, Nebraska, where the director of the Blue Valley Mental Health Center, a clinical psychologist, maintains close contact with the Sheriff of the Gage County Jail. Whenever a mentally ill person is detained in the jail, the director immediately goes to the jail to evaluate the individual. Similarly, The Community Mental Health Center of Lancaster County maintains 24-hour coverage of mental health emergencies to the jail and community by professional emergency mental health counselors.

127. NEB. REV. STAT. § 83-1020(3)(Cum. Supp. 1988).

128. *Id.*

129. *Id.*

Even with all of the procedural protections noted above, Nebraska's statute is still flawed on at least three counts. First, the statute does not explicitly mandate *any* assessment of the mentally ill individual.<sup>130</sup> Although one would assume that a mental health evaluation would be necessary to locate an "appropriate placement,"<sup>131</sup> the CMHC may simply begin to find a placement that is not in a jail, waiting to conduct a formal examination for up to thirty-six hours. Again, because of the high risk of suicide and other harm which may occur shortly after the individual's detention,<sup>132</sup> the law should require that the individual be assessed as quickly as possible. Further, as an added protection, it would be desirable to require counties to train their jail staff about suicidal behavior and crisis intervention skills with mentally ill inmates.<sup>133</sup>

The second major weakness of the statute is that it does not limit the length of time a non-criminal mentally ill person may be detained in a jail before being transferred to an "appropriate placement."<sup>134</sup> This omission is particularly unfortunate because of the very sensitive emotional and physical state of the mentally ill person. As mentioned numerous times previously, the risk of suicide is greatest immediately following incarceration.<sup>135</sup> Thus, it is vital that the mentally ill person be transferred to a treatment facility as quickly as possible.

Finally, although L.B. 257 requires the CMHC to report to the jail every twenty-four hours regarding the status of the placement, CMHC personnel are not required to periodically review the mental status of the mentally ill person. Thus, in addition to requiring an initial assessment of the inmate, the statute should require CMHC personnel to meet with the inmate periodically.

#### D. CMHCs Must Collect Data On Detainees

The final provision simply requires that the CMHC collect data on all individuals who are detained in jails according to the statutory provisions reviewed above.<sup>136</sup> The CMHC must regularly report these

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130. However, emergency protective custody orders require that the individual undergo psychiatric examination within 36 hours of admission. Nonetheless, given the purpose of L.B. 257, it would have been beneficial to have mandated a more immediate psychiatric evaluation.

131. The words "appropriate placement" seem to be subject to statutory interpretation. For example, appropriate placement may mean a placement which is appropriate based on the unique needs of the individual being detained. On the other hand, the "appropriate placement" requirement may be interpreted as meaning placement in any facility other than a jail.

132. See *supra* notes 12-17 and accompanying text.

133. See *supra* notes 87-88 and accompanying text.

134. NEB. REV. STAT. § 83-1020(3) (Cum. Supp. 1988).

135. See *supra* notes 12-17 and accompanying text.

136. NEB. REV. STAT. § 83-1020(4) (Cum. Supp. 1988).

data to the Department of Public Institutions (DPI).<sup>137</sup> This procedure ensures that DPI, the state agency which oversees mental health services, evaluates the practice of detaining non-criminal mentally ill individuals in jails under the provisions of L.B. 257.

After reviewing the provisions of L.B. 257, it appears that the statute should have beneficial effects. Specifically, it prohibits the detention of many non-criminal mentally ill people in jails. In so doing, it also requires that counties with cities with populations in excess of 5,000 people contract with appropriate facilities in which mentally ill individuals may be placed. Thus, law enforcement officers will know where to take non-criminal mentally ill people who are in need of services. The individuals will be transported to facilities staffed by personnel who are experienced in providing these services.

Unfortunately, L.B. 257 still permits the detention—albeit temporary—of non-criminal mentally ill persons apprehended in counties without cities of the first class. Arguably, this provision is justified, based on the difficulty the county sheriff would have transporting a mentally ill person to a designated emergency protective care unit outside of the county. However, such a justification is flawed to the extent that it is important to both prohibit mentally ill people from being detained in jail and to provide such people with mental health services.

Because of the advantages of detaining non-criminal mentally ill people in emergency protective custody units rather than in jails and other “general-purpose” secure mental health facilities, it is useful to describe the Lancaster County Crisis Center Program at this point. After providing information about the program, some data will be presented and discussed which will provide a picture of the individuals who have been detained in the Lancaster Crisis Center Program since its inception.

## VII. THE LANCASTER COUNTY CRISIS CENTER PROGRAM

Lancaster County opened the Crisis Center Program on March 6, 1989. The Community Mental Health Center of Lancaster County administers the program which is funded primarily through state and county allocations. Patient fees are assessed, although no profit is sought or made by the program.

The Crisis Center is a secure, ten-bed inpatient facility designed for the assessment and rapid stabilization of persons placed in Emergency Protective Custody (“EPC”)<sup>138</sup> or detained under Nebraska Civil Commitment Statutes<sup>139</sup> pending a Mental Health Board Hearing.

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137. *Id.*

138. *Id.* § 83-1020.

139. *Id.* §§ 83-1011 to 83-1078.

Crisis Center patients are generally assessed and treated while awaiting their Mental Health Board hearing. A few Crisis Center patients have been admitted directly from jails after being charged with crimes.

When the Crisis Center Program was being developed, there were few free-standing facilities from which to model. Most similar programs were part of a larger hospital which afforded greater resources than those available to the Crisis Center. Thus, those persons involved in the planning and development of the Crisis Center were required to design an innovative facility.

The Crisis Center is licensed as a community mental health center rather than a hospital. Although the Crisis Center is not affiliated with a hospital, it has cooperative agreements with public and private facilities for the provision of services such as radiology, laboratory work, emergency medical services, dietary consultations and laundry.

The Crisis Center is staffed by a program supervisor, a nursing director, a half-time psychologist and a half-time psychiatrist. A registered nurse or a licensed practical nurse and two mental health technicians staff each shift.<sup>140</sup> In addition to the treatment and program staff, a full-time secretary is employed at the Crisis Center. No security officers are employed by the Crisis Center; however, Crisis Center staff may call on the Lancaster County Sheriff's office in emergency situations.

Patients with a variety of diagnoses are admitted to the Crisis Center. Persons who are allegedly mentally ill and dangerous as well as those believed to be alcoholic and dangerous are served by the Crisis Center. Intoxicated individuals are initially held at Cornhusker Place Detoxification Center in Lincoln before being admitted to the Crisis Center. Once individuals who were intoxicated test at a 0.0 breath alcohol level, they are admitted to the Crisis Center.

Although only persons aged 18 years or older are served at the Crisis Center, occasional exceptions have been made when alternative facilities were not available. While the Crisis Center does not routinely do so, persons from the county jail with criminal charges pending are accepted on a case by case basis. Factors such as the nature of the charges and the level of violence exhibited by the person determine whether admission is granted (*e.g.*, dangerous felons are not admitted to the Crisis Center).

#### A. The Lancaster County Crisis Center Screening Process

Figure 1 depicts the Crisis Center screening process. Prior to placement at the Crisis Center, there is a procedure for screening and making appropriate referral for persons experiencing mental health

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140. The Crisis Center operates three eight-hour shifts each day.

emergencies. This process is a cooperative endeavor involving the local CMHC's crisis response team, law enforcement officers, and emergency room personnel.

The crisis response team evaluates a person's mental status upon the request of law enforcement officers or medical professionals. This assessment may result in outpatient referrals or inpatient hospitalization.

Law enforcement officers may decide, in consultation with mental health professionals, that the person is mentally ill, alcoholic, or dangerous to self or others, and in need of emergency protective custody placement.<sup>141</sup> The officer may then opt to place the person in emergency protective custody and access the Crisis Center program.

Often the individual in a mental health emergency receives adequate support and information from the emergency counselor, resolving the crisis and avoiding invocation of emergency protective custody. When the subject is determined to be mentally ill and non-dangerous, the crisis response counselor may try to secure voluntary hospitalization or follow-up with a mental health professional in the community.

#### B. Evaluation and Treatment Within the Crisis Center

The goal of the Crisis Center program is to quickly assess the mental state and adjustment of each person admitted. A nursing assessment is accomplished immediately upon intake. Each patient is assigned a primary caregiver who gathers relevant information about the patient's personal and social history, and coordinates the patient's care for the duration of his or her stay.

Each patient is evaluated by the psychiatrist within thirty-six hours of admission. The psychiatric evaluation includes a physical examination and clinical interview. Psychological testing is initiated as soon as possible and an interview with the psychologist is arranged. The psychiatrist and psychologist meet with the patients regularly to assess their progress and plan treatment.

Daily activities are arranged according to the diagnostic mix of the population on the unit. All staff are trained to lead psychoeducational groups on a variety of topics including anger control, stress management and assertiveness training. Typically, there are a minimum of five groups run each day. Leisure activities such as arts and crafts, movies, games, and supervised visits from friends and family are encouraged to complement the milieu therapy offered.<sup>142</sup>

Formal, individual psychotherapy is not offered at the Crisis Center since the primary mission of the program is to assess and stabi-

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141. NEB. REV. STAT. § 83-1009 (1987).

142. For a description of the process of milieu therapy, see generally, M. JONES, *THE PROCESS OF CHANGE* (1982).



lize patients, and quickly return them to the community, or to refer them to an appropriate treatment facility. Patients are referred for social services, psychotherapy, chemical dependency treatment or inpatient psychiatric treatment upon discharge from the Crisis Center.

Because of the unique nature of L.B. 257, and the development of the Lancaster County Crisis Center, it is important to assess the program's operation. The information about the Crisis Center should be helpful to jurisdictions developing similar facilities. Thus, the next section will present a substantial amount of data in order to increase the understanding of the Crisis Center.

### C. Data From the Lancaster County Crisis Center

*Admissions Information.* The Lancaster County Crisis Center made a total of 515 contacts with individuals between its opening on March 6, 1989, and December 31, 1989. Of the 515 contacts made, there were 323 admissions. A total of 282 persons were served. Thirty-six admissions involved persons who had been admitted to the Crisis Center more than once.

Seven of the Crisis Center admissions were voluntary. The majority of admissions (287) were initiated through Nebraska's Emergency Protective Custody statute.<sup>143</sup> Twenty-nine of the patients were admitted after having been taken into custody based on a warrant issued from the Mental Health Board.<sup>144</sup> The average length of stay for patients admitted to the Crisis Center was 7.35 days.

Most patients admitted to the Crisis Center were residents of Lancaster County; fifty-one patients were admitted from other counties.

*Demographic Characteristics of Patients.* The Center admitted 155 males and 127 females. The overwhelming majority were white (257); ten blacks, seven Native Americans, five Hispanics, and three Asians were also admitted. The marital status of patients admitted is as follows: 135 single; fifty-three married; twenty-one separated; sixty-eight Divorced; four widowed; and one unknown.

*Diagnostic Categories of Patients.* Patients received primary diagnoses which fit into the following four major categories: mental illness (181 patients); mental retardation (three patients); chemical dependency (seventy-nine patients); and the dual diagnosis of mental illness and chemical dependency (fifty-one patients).

*Physical Condition of Patients.* The majority of Crisis Center patients were not in need of major medical care for their physical condition. However, eleven of the patients admitted to the facility were found to be medically (physically) unstable and were transferred to a general hospital during their stay. Ten persons were admitted to the

143. NEB. REV. STAT. § 83-1020 (Cum. Supp. 1988).

144. Such warrants are issued based on the provisions of *Id.* § 83-1028.

Crisis Center from a detoxification facility.<sup>145</sup>

*Crisis Center Incidents.* The number of incidents, including accidents, altercations, property damage, etc. has been quite low in the Crisis Center. There were 120 reported incidents related to patients during the first 300 days of operation of the Crisis Center. Seclusion was used on only fifteen occasions and restraints (physical and/or mechanical interventions) were employed nineteen times. These numbers are relatively low considering that there were 323 admissions to the Crisis Center during this period.

The Lancaster County Sheriff's office was called for emergency assistance twenty-nine times and the Lincoln Police Department was called on four occasions. The fire department was contacted on three occasions and the emergency telephone line, 911, was called three times. These figures are not high—especially if one considers that all of the people detained at the Crisis Center are considered "dangerous" and there are no security officers employed by the Crisis Center.

*Disposition of Patients at the Time of Discharge.* Most patients (163, 50.5%) were discharged to the community following their stay at the Crisis Center. The next largest group of patients (70, 21.7%) were involuntarily civilly committed to an inpatient facility. An additional nine patients (0.03%) were involuntarily civilly committed to an outpatient facility. Fifty-six patients (17.34%) were transferred to other facilities prior to resolution of the civil commitment process. Eight of the individuals (2.5%) were discharged following a civil commitment hearing when the Mental Health Board determined that the individual did not meet the commitment criteria. Four of the patients (0.12%) were being held for counties outside the Crisis Center service area and were transferred back to their home county. Four patients (0.12%) voluntarily admitted themselves to an inpatient facility from the Crisis Center.

*Patient Destination at Discharge.* One hundred sixty-three patients were discharged to the community. Forty patients were discharged to chemical dependency facilities. A total of 102 patients were admitted to an inpatient psychiatric facility. Thirteen patients were released to jail or medical facilities.

The above data suggest that the Crisis Center is filling a previous void in the provision of mental health services in Nebraska. A relatively large number of patients were discharged to the community without undergoing civil commitment proceedings. Thus, it is likely that those people simply required short-term mental health care. Without the Crisis Center, those people would have been detained in

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145. This is the number of people receiving detoxification treatment prior to being admitted to the Crisis Center since August 1989, because this information was not recorded prior to that time.

jails—or admitted to a general or state hospital if space was available. Since many patients were eventually involuntarily civilly committed (70), it seems unlikely that law enforcement officers are arbitrarily detaining people who do not actually require services. In fact, only eight of the patients were discharged after the Mental Health Board determined that they did not meet civil commitment criteria. Further, 192 people with whom Crisis Center staff made contact were not admitted to the facility. This supports the contention that Crisis Center staff are not arbitrarily admitting people who are not in need of services.

The low mean length of stay (7.35 days) suggests that the Crisis Center is fulfilling its goal of providing short-term treatment to patients pending a civil commitment hearing.<sup>146</sup> Another advantage of the Crisis Center is that patients were received from 13 counties in addition to Lancaster County, where the Crisis Center is located. Thus, the facility provides valuable services to many counties.

It is hard to evaluate the efficacy of the Crisis Center without considering what was occurring in the jails before and after the Crisis Center opened. Therefore, the following section will present some information about CMHC personnel contacts with the Lancaster County jail and the number of mentally ill people being held in the jail and Lincoln Regional Center before and after the opening of the Crisis Center.

#### D. Data From Lancaster County Corrections and the Lincoln Regional Center Before and After the Opening of the Crisis Center

This section compares Emergency Protective Custody ("EPC") and mental health detention in the Lancaster County Jail for the six month periods preceding and following the March, 1989 opening of the Lancaster County Crisis Center. Similarly, the number of EPC and mental health board detainees in the Lincoln Regional Center are compared during the period before and after the opening of the Crisis Center. The data presented above may reflect some information about the role that the Crisis Center is playing in Lancaster County. However, it is important to note that because the full provisions of L.B. 257, *viz.*, the prohibition of detaining non-criminal mentally ill people in jail,<sup>147</sup> do not become effective until January 1, 1991,<sup>148</sup> the jail

146. Prior to the opening of the Crisis Center, individuals under Emergency Protective Custody ("EPC") were admitted to the Lincoln Regional Center ("LRC"). The mean length of stay for individuals under EPC at the LRC, a state psychiatric hospital, hovered around 40 days. Thus, the Crisis Center is somehow able to move patients through the system much more efficiently than was previously the case.

147. NEB. REV. STAT. §§ 83-1020(2)(a), 83-1028(2)(a), 83-1039(2)(a)(Cum. Supp. 1988).

148. *Id.*

figures may be somewhat misleading. That is, there should be *no* non-criminal mentally ill people detained in the Lancaster County Jail after January 1, 1991.

As was hoped, the number of mentally ill people without criminal charges held in the Lancaster County Jail apparently decreased after the Crisis Center opened. For the six month period preceding the opening of the Crisis Center, fifteen non-criminal mentally ill people were detained in the jail on an EPC order. That number dropped to four for the six month period following the opening of the Crisis Center. Thus, even though the statute prohibiting the detention of mentally ill people in jails in cities of the first class was not effective during this period, the number of mentally ill people without criminal charges being held in the jail actually decreased.

Prior to the opening of the Crisis Center, persons being detained under EPC and persons awaiting Mental Health Board Hearings ("MHBH") were often transferred from the Lancaster County Jail to the Lincoln Regional Center ("LRC"). Therefore, it is useful to compare the numbers of people being transferred from the jail to the LRC and the Crisis Center to determine what effect the opening of the Crisis Center has had on admissions to the LRC.

The total number of mentally ill people (some of whom had criminal charges pending) transferred from the jail to the LRC prior to the opening of the Crisis Center was twenty-four. This number fell to eighteen for the six month period following the opening of the Crisis Center. The Crisis Center had twenty-three people transferred from the jail during the same period, making the total number of mentally ill people transferred from the jail forty-one. Thus, there was an overall increase in the number of mentally ill people transferred from the jail. Although it is not known whether this overall increase is because the Crisis Center offered law enforcement officers an alternative placement to the jail, this is a plausible explanation.

Although some individuals are still transferred directly from the jail to the LRC, that number is diminishing and people are instead being transferred to the Crisis Center.<sup>149</sup> Overall, in the six month period following the opening of the Crisis Center, eighteen people were transferred from the jail to the LRC and twenty-three others were transferred to the Crisis Center.

A month-by-month comparison of these figures demonstrates the trend towards transferring people to the Crisis Center rather than the LRC. Table 1 depicts the number of people transferred to the Crisis

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149. There will likely always be some people who are transferred to the LRC because it is an accredited hospital, unlike the Crisis Center, which is licensed as a mental health center and does not have the same spectrum of resources available to it as does the LRC (*e.g.*, more complete medical services). Likewise, the Crisis Center is not generally able to handle combative mentally ill people.

Center and the Regional Center during the first six months the Crisis Center was in operation. There was an inverse relationship between admissions to the LRC and the Crisis Center during the first six months the Crisis Center was open.

Table 1

Transfer of Mentally Ill People from the Lancaster County Jail to the Lincoln Regional Center (LRC) and the Crisis Center

<u>Month</u>	<u>LRC</u>	<u>Crisis Center</u>
April, 1989	4	1
May, 1989	4	3
June, 1989	3	1
July, 1989	0	3
August, 1989	2	7
September, 1989	5	8
Total	18	23

The data presented support the contention that the Crisis Center is serving an important role in Lancaster County. The number of non-criminal mentally ill people being detained in jail has decreased, and the Crisis Center is being used as a facility to transfer patients who may have otherwise remained in jail, or may have been transferred to the LRC. Also, the average length of time a person spent in jail before being transferred to the Crisis Center is 1.06 days. This quick transfer should help reduce the chance of detainees harming themselves or causing disturbances in the jail. Finally, the above information refutes the prediction made by some that development of the Crisis Center would only lead to an increase in mental health admissions and increased use of mental health services.

VIII. CONCLUSIONS AND RECOMMENTATIONS

This article has demonstrated the need for the placement of non-criminal mentally ill persons in facilities other than jails. A review of alternative placement facilities indicated that it may be advantageous to develop emergency protective care units designed to provide assessments and short-term care of people suffering mental health crises. The discussion noted the importance of legislation that prohibits the detention in jails of mentally ill people without criminal charges. Further, such legislation must mandate alternative placements, or there is the risk that those people who do require short-term mental health treatment will simply go without.

A review of statutes prohibiting the detention of mentally ill people in jails demonstrates that statutes such as Nebraska's L.B. 257 may be effective in keeping mentally ill people out of jail *and* providing an appropriate short-term care facility. Data obtained from the Lancaster County Crisis Center and the Lancaster County Jail show that the

Crisis Center is indeed meeting its goals. Patients are treated on a short-term basis and are then discharged to the community or transferred to another treatment facility according to their needs. The number of mentally ill people detained in the Lancaster County jail has decreased, as has the number of non-criminal mentally ill transferred from the jail to the state psychiatric hospital.

The Nebraska statute described, L.B. 257, and the Lancaster County Crisis Center appear to be good models for treating non-criminal mentally ill people who require short-term care. Although the Lancaster County Crisis Center has been open for little more than one year, the preliminary data suggest that other communities in Nebraska and throughout the United States could benefit from following the Crisis Center's lead.

IX. APPENDIX

LANCASTER COUNTY CRISIS CENTER SCREENING PROCESS



