Involuntary Hospitalization and Police Referrals to a Psychiatric Emergency Department

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This study compares the demographic and clinical characteristics of police referrals with referrals from other sources to the psychiatric emergency department of a university hospital and the demographic and clinical characteristics of police referrals who were involuntary hospitalized with police referrals who were discharged from the emergency department (ED). In our study, 182 cases were seen in the psychiatric ED over the one-month period; 32 (17.6%) were police referrals. Police referrals were not more frequently hospitalized than referrals from other sources. Police referrals were, however, more likely to have been violent towards others preceding admission (59.4% versus 20.0%; $\chi^2 = 20.8$; $df = 1$; $p < .01$) and to be intoxicated on presentation (31.3% versus 10.7%; $\chi^2 = 91$; $df = 1$; $p < .01$). Police referrals also were significantly more likely to be violent in the psychiatric ED than referrals from other sources (37.5% versus 3.4%, $\chi 2 = 36.5$, $df = 1$, $p < .01$) and to be restrained or secluded (34.4% versus 4.0%; $\chi^2 = 28.8$; $df = 1$; $p < .01$). Involuntarily hospitalized police referrals were significantly more likely to be suffering from a major psychiatric disorder than police referrals not hospitalized (83.3% versus 11.8%; $\chi^2 = 14.7$; $df = 1$; $p < .01$). They also were significantly more likely to have been violent towards other ED (66.7% versus 23.5%; Fisher test, $p < .05$) and to have been restrained or secluded in the ED (58.3% versus 23.5%; Fisher test, $p < .05$) than police referrals who were not admitted.

Violence in the emergency department appears to be an escalating and not uncommon problem in U.S. hospitals.[1, 2] Although the literature on violence in the emergency department setting is limited, this issue is receiving increasing attention. Recent literature has studied the prediction,[3–5] prevention,[6, 7] and management[8, 9] of violent behavior by patients. Among hospital settings, the psychiatric emergency department is a particularly high-risk environment for the occurrence of violent behavor,[10, 11] and thus the reduction of violence in this setting may help to reduce significantly the overall rate of hospital violence.

Police referrals to the psychiatric emergency department represent a significant and increasing proportion of patients seen in this setting.[12] The assessment and management of police-referred patients can present difficulties; police often wish to

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leave the emergency department before the patient's assessment is complete,[13] there may be a disagreement over whether the patient represents a "psychiatric" or "legal" problem, and the clinician may struggle with the liability issue of discharging a patient referred by police for violent behavior.[14]

Other studies have compared the demographic and clinical characteristics of police referrals to the psychiatric emergency department with referrals from other sources.[4, 16] The goals of this paper are twofold. The first is to compare the demographic and clinical characteristics of patients brought in by police for assessment to the psychiatric emergency department with patients referred for assessment by other sources and to compare these findings with McNeil's study[4] of police referrals to a psychiatric emergency room in San Francisco, California. The second purpose of this study is to compare and contrast the demographic and clinical characteristecs of police referrals who were involuntarily hospitalized with police referrals not hospitalized following assessment to better understand the decision-making process in the psychiatric emergency department.

Methods

This retrospective study was performed on data from the psychiatric emergency department of Strong Memorial Hospital, a private, nonprofit general teaching hospital in Monroe County, NY. Monroe County, with a population of 713,968, divides its psychiatric and medical care into four catchment areas. Strong Memorial serves catchment area A, an area with 174,469 residents of which 77.3 percent are white, 18.8 percent are African-American, and 3.9 percent are of other racial origin.[17]

The sample studied consisted of all patients seen in the psychiatric emergency department during September 1991. The sample was divided into two groups, patients referred to the psychiatric emergency department (ED) by the police ("police referrals") and patients referred by all other sources ("referrals from other sources"), which will be our comparison group. Police referrals included patients who were accompanied by police to the psychiatric ED on a voluntary basis and those under a mental hygiene arrest (MHA). An MHA occurs when police bring in individuals from the community for psychiatric assessment. Under Section 9.41 of the New York State Mental Hygiene Law, a police officer may detain an individual for observation and care in a hospital when there is reason to believe the individual has a mental illness that is likely to result in serious harm to him/herself or others.[18] For part two of the paper, the police referral group was subdivided into two groups, police referrals who were involuntarily hospitalized after assessment in the psychiatric ED and those who were discharged.

All demographic and clinical data were obtained from a review of the psychiatric ED charts. Identifying data were coded to maintain patient confidentiality. If a patient had multiple visits to the psychiatric ED during the study period, only the first visit was included in this review. Clinical data included the primary DSM-III-R diagnosis[19] with the Global Assessment of Functioning Scale (GAF Scale) score; the

presence or absence of suicidal ideation or behavior in the two weeks preceding assessment; whether the patient was restrained or secluded during the psychiatric ED visit; the presence or absence of intoxication and/or an identified drug or alcohol problem at the time of assessment and disposition; and criteria for involuntary hospitalization. Violence during the two weeks before the psychiatric ED visit was rated according to the modified form of McNeil.[20] The demographic and clinical characteristics were compared between involuntarily hospitalized police referrals and police referrals not hospitalized after assessment in the psychiatric ED.

Results are presented as the mean (± standard deviation). Differences between groups were considered significant for $p < .05$; statistical tests employed were the chi-square distribution analysis, the Fisher exact probability test, and the unpaired t test.[21] The Fisher exact probability test was used instead of the chi-square test when the smallest expected frequency was less than five. The frequency distribution of psychiatric diagnoses was statistically analyzed after grouping of diagnoses into broad diagnostic categories. The use of broad diagnostic categories was based on the known limitations of diagnostic reliability in an emergency room setting and the findings of others that acceptable diagnostic reliability can be obtained in the emergency room setting when broad diagnostic categories, such as psychosis, depression, and alcoholism are used.[22, 23]

Results

Police Referrals Versus Comparison Group In September 1991, 182 cases were seen in the psychiatric emergency department. Thirty-two (17.6%) of the 182 cases seen were police referrals, with the MHA group representing 90.6 percent (N = 29) of the police referrals. The remaining 150 cases, the comparison group, were referred by a variety of sources: 34.7 percent (N = 52) were self-referred; 27.3 percent (N = 41) were referred by family; 16.7 percent (N = 25) by their therapist; 12.0 percent (N = 18) by a social agency; 6.0 percent (N = 9) by another hospital; 2.0 percent (N = 3) by family doctor; and 1.3 percent (N = 2) by friends. The place of residence as defined by catchment area significantly differed between the police referrals and the comparison group, with 59.4 percent (N = 19) of police referrals residing in catchment area A versus 41.3 percent (N = 62) of the referrals from other sources ($\chi^2 = 4.75$, $df = 1$, $p < .05$).

Demographic Characteristics Age did not differ significantly between groups. Gender did not differ significantly between police referrals and the comparison group; 50.0 percent (N = 16) of police referrals were female. Racial characteristics did not differ significantly between the referral groups; 78.1 percent (N = 25) of police referrals seen were white, 18.8 percent (N = 6) were African-American, and 3.1 percent (N = 1) were of other racial origin. For the comparison group, 74.7 percent (N = 112) were white, 21.3 percent (N = 32) were African-American, and 4.0 percent (N = 6) were of other racial origin. It was not possible to determine precisely socioeconomic, employment, or marital status from the psychiatric ED charts. However, from the incomplete data obtained, both

employment and marital status appeared similar between groups, with approximately 43 percent of police referrals being unemployed and approximately 58 percent of police referrals being never married. Living arrangements did not differ significantly between police referrals and the comparison group; 15.6 percent (N = 5) of police referrals lived alone, 65.6 percent (N = 21) lived with family (significant other or family of origin), and 18.8 percent (N = 6) had other living arrangements (i.e., with a roommate or having no fixed address).

Clinical Characteristics As shown in Table 1, both police referrals and referrals from other sources had a similar history of visits to the psychiatric ED. The time of presentation to the psychiatric ED did not differ significantly between groups. Police referrals were significantly more likely to have presented intoxicated to the psychiatric ED than were the other referrals (31.3% versus 10.7 percent; $\chi^2 = 9.1$, $df = 1$, $p < .01$). Although intoxication included drug intoxications, the vast majority of intoxications diagnosed were alcohol induced. Psychiatric diagnoses did not differ significantly between the two referral groups. GAF scores also were not significantly different between groups. The mean GAF score for the police referral group was 44.5 (± 13.7), with a range of 20 to 64. For the other referrals, it was 44.1 (± 11.2), with a range of 20 to 70.

Police referrals, who were either transported by police with the individual's agreement or under MHA, were significantly more likely to have been under MHA (detained involuntarily) for psychiatric assessment than the comparison group (87.7% versus 4.0%; $\chi^2 = 120.9$, $df = 1$, $p < .01$). Police referrals were no more likely than the other referrals to have exhibited suicidal ideation or behavior before assessment. Police referrals, however, were much more likely than the comparison group to have exhibited violent behavior over the two weeks preceding assessment in the psychiatric ED, with 59.4 percent of police referrals committing physical attacks or threatening others over this period ($\chi^2 = 20.8$, $df = 1$, $p < .01$). This tendency toward violence in the police referral group continued in the psychiatric ED, with 37.5 percent of the police referral group engaging in violent behavior during the initial 24 hours of assessment versus 3.4% for referrals from other sources ($\chi^2 = 36.5$, $df = 1$, $p < .01$). Police referrals also were significantly more likely to have been restrained or secluded in the psychiatric ED than the comparison group of referrals (34.4% versus 4.0%; $\chi^2 = 28.8$, $df = 1$, $p < .01$). Police referrals were, however, no more likely to have been hospitalized than the comparison group (46.9% versus 52.0%; $\chi^2 = 0.25$, $df = 1$, NS). Twelve of 15, or about 80 percent, of the hospitalized police referrals were hospitalized on involuntary status. A similar rate of involuntary hospitalization (50 [64%] of 78) was found for the comparison group.

Police Referrals Involuntarily Hospitalized Versus Police Referrals Not Hospitalized After Assessment The demographic and clinical characteristics of involuntarily hospitalized police referrals (N = 12) and those police referrals who were not hospitalized (N = 17) were compared. It was found that the catch-

Table 1
Clinical Characteristics of Police Referrals to the Psychiatric Emergency Department Versus Referrals from Other Sources

	Total		Police Referrals		Referrals from Other Sources	
	N	%	N	%	N	%
Variable						
Previous psychiatric ED visits						
Never	76	41.8	15	46.9	61	40.7
Within past three months	29	15.9	6	18.8	23	15.3
Before last three months	68	37.4	11	34.4	57	38.0
Unknown	9	4.9	0	0.0	9	6.0
Time of presentation						
Day (7 a.m.–3 p.m.)	56	30.8	8	25.0	48	32.0
Evening (3 p.m.–11 p.m.)	89	48.9	15	46.9	74	49.3
Night (11 p.m.–7 a.m.)	37	20.3	9	28.1	28	18.7
Diagnosis						
Affective illness						
Major depression	26	14.3	4	12.5	22	14.7
Bipolar disorder	12	6.6	1	3.1	11	7.3
Psychotic illness						
Schizophrenia	30	16.5	7	21.9	23	15.3
Other psychoses	15	8.2	1	3.1	14	9.3
Substance abuse	33	18.1	10	31.3	23	15.4
Other disorders						
Adjustment disorder	43	23.6	7	21.9	36	24.0
Other	22	13.7	2	6.2	20	14.0
Intoxication present*						
Yes	26	14.3	10	31.3	16	10.7
No	156	85.7	22	68.7	134	89.3
Drug or alcohol problem						
Yes	61	33.5	15	46.9	46	30.7
No	121	66.5	17	53.1	104	69.3
Variable						
Legal status on assessment†						
Voluntary	148	81.3	4	12.5	144	96.0
Involuntary	34	18.7	28	87.5	6	4.0
Prepsychiatric ED suicidal behavior						
Yes	106	58.2	17	53.1	89	59.3
No	76	41.8	15	46.9	61	40.7
Prepsychiatric ED violence†						
Physical attacks	14	7.7	7	21.9	7	4.7
Fear-inducing acts	35	19.2	12	37.5	23	15.3
No violence	133	73.1	13	40.6	120	80.0
Violence in the psychiatric ED†						
Physical attacks	5	2.7	4	12.5	1	0.7
Fear-inducing acts	12	6.6	8	25.0	4	2.7
No violence	165	90.7	20	62.5	145	96.6
Seclusion and/or restraint†						
Yes	17	9.3	11	34.4	6	4.0
No	165	90.7	21	65.6	144	96.0
Disposition						
Hospitalization	93	51.1	15	46.9	78	52.0
Discharge	89	48.9	17	53.1	72	48.0

*$p < .05$ (Police referrals versus referrals from other sources)
†$p < .01$ (Police referrals versus referrals from other sources)

ment area of residence did not differ between these two groups, with 41.7 percent (N = 5) of the involuntarily hospitalized police referrals residing in catchment area A versus 64.7 percent (N = 11) of the police referrals who were not hospitalized.

Demographic Characteristics Age and gender did not differ significantly between these groups; 50.0 percent (N = 6) of the involuntarily hospitalized police referrals were female. Race did not differ significantly between groups; 75.0 percent (N = 9) of the involuntarily hospitalized police referrals were white, 16.7 percent (N = 2) were African American and 8.3 percent (N = 1) were of other racial origin. For the police referral group not hospitalized, 76.5 percent (N = 13) were white and 23.5 percent (N = 4) were African American. Living arrangements did not differ significantly between groups; 25.0 percent (N = 3) of the involuntarily hospitalized police referral group lived alone versus 11.8 percent (N = 2) of the police referrals not hospitalized. Catchment area of residence did not differ significantly between these two groups, with 41.7 percent (N = 5) of the involuntarily hospitalized police referrals residing in catchment area A versus 64.7 percent (N = 11) of the police referrals not hospitalized.

Clinical Characteristics As shown in Table 2, involuntarily hospitalized police referrals were as likely to have been previously seen in the psychiatric ED as police referrals who were not hospitalized. Both groups were equally likely to have been brought to the ED on MHA status. The time of presentation to the psychiatric ED did not differ significantly between the two groups. GAF scores did differ significantly between the groups ($t = 6.44$, $df = 25$, $p < .01$). The mean ± SD GAF scores for the involuntarily hospitalized police referral group was 31.2 ± 8.7, with a range of 20 to 45. For police referrals not hospitalized, it was 53.8 ± 9.1, with a range of 25 to 64. Police referrals who were involuntarily hospitalized were not more likely to have been intoxicated on presentation to the psychiatric ED nor to have a greater frequency of an identified drug or alcohol problem than police referrals not hospitalized. Involuntarily hospitalized police referrals were, however, more like to have been diagnosed as suffering from a major psychiatric disorder (major depressive episode, bipolar affective disorder, schizophrenia, or other psychoses) than the police referrals not hospitalized (83.3% versus 11.8%; $\chi^2 = 14.7$, $df = 1$, $p < .01$).

Involuntarily hospitalized police referrals were no more likely than police referrals who were not hospitalized to have exhibited suicidal ideation or behavior nor to have exhibited violent behavior over the two weeks before assessment in the psychiatric ED. Involuntarily hospitalized police referrals were, however, significantly more likely to have been violent toward others in the psychiatric ED than police referrals not hospitalized (66.7% versus 23.5%; $\chi^2 = 5.3$, $df = 1$, $p < .05$). Involuntarily hospitalized police referrals also were significantly more likely to have been restrained or secluded in the psychiatric ED than police referrals not hospitalized (58.3% versus 23.5%; Fisher test, $p < .05$). For the group of involuntarily admitted police referrals, 41.7 percent

Table 2
Clinical Characteristics of Hospitalized Police Referrals to the Psychiatric Emergency Department Versus Police Referrals Not Hospitalized

	Total		Hospitalized Police Referrals		Police Referrals Not Hospitalized	
	N	%	N	%	N	%
Variable						
Previous psychiatric ED visits						
No	12	41.4	4	33.3	8	47.1
Yes						
Within past 3 months	6	20.7	3	25.0	3	17.6
Before last 3 months	11	37.9	5	41.7	6	35.3
Time of presentation						
Day (7 a.m.–3 p.m.)	11	37.9	4	33.3	7	41.2
Evening (3 p.m.–11 p.m.)	15	51.7	7	58.3	8	47.1
Night (11 p.m.–7 a.m.)	3	10.4	1	8.4	2	11.7
Diagnosis*						
Major psychiatric illness						
Major depression	4	13.8	3	25.0	1	5.9
Bipolar disorder	1	3.4	1	8.3	0	0.0
Schizophrenia	6	20.7	5	41.7	1	5.9
Other psychoses	1	3.4	1	8.3	0	0.0
Other disorders						
Substance abuse	9	31.3	1	8.3	8	47.1
Adjustment disorder	6	20.7	0	0.0	6	35.3
Other	2	6.7	1	8.3	1	5.9
Intoxication present						
Yes	19	65.5	9	75.0	10	58.8
No	10	34.5	3	25.0	7	41.2
Drug or alcohol problem						
Yes	13	44.8	4	33.3	9	52.9
No	16	55.2	8	67.7	8	47.1
Legal status on assessment						
Voluntary	3	10.3	2	16.7	1	5.9
Involuntary	26	89.7	10	83.3	16	94.1
Prepsychiatric ED suicidal behavior						
Yes	14	48.3	5	41.7	9	52.9
No	15	51.7	7	58.3	8	47.1
Prepsychiatric ED violence						
Yes						
Physical attacks	7	24.1	1	8.3	6	35.3
Fear-inducing acts	12	41.4	7	58.3	5	29.4
No	10	34.5	4	33.3	6	35.3
Violence in the psychiatric ED†						
Yes						
Physical attacks	4	13.8	3	25.0	1	5.9
Fear-inducing acts	8	27.6	5	41.7	3	17.6
No	17	58.6	4	33.3	13	76.5
Seclusion and/or restraint‡						
Yes	11	37.9	7	58.3	4	23.5
No	18	62.1	5	41.7	13	76.5

*$\chi^2 = 14.7$, $df = 1$, $p < .01$.
†$\chi^2 = 5.3$, $df = 1$, $p < .05$.
‡Fisher exact probability test, $p < .05$.

(N = 5) were admitted on the grounds of imminent danger to self, 25.0 percent (N = 3) on the basis of dangerousness to others, and 33.3 percent (N = 4) on the basis of danger both to self and to others.

Discussion

The results of this study are in agreement with the results of McNeil[4] with regards to the dangerousness of police referrals. In both studies, this group was found to be significantly more likely to be violent, both before arriving in the psychiatric ED and during assessment, than referrals from other sources. Police referrals also were more likely to be restrained or secluded during the psychiatric ED visit. These findings are at variance with Steadman's study of psychiatric patients evaluated in the emergency room of a large general hospital in Manhattan.[15] Steadman found police referrals were less seriously disordered than individuals referred by other sources. Steadman's study found that police referrals were less likely to be hospitalized than other referrals. The present study and McNeil's study[4] found no significant difference in the rates of hospitalization between these groups, whereas Feinstein's study[24] of a large municipal hospital found police referrals more likely to be hospitalized than other referrals.

It is interesting to note that the present study found that the police referrals did not differ significantly from the comparison group in age, whereas McNeil's study found that police referrals were a significantly older group. This study also found that the police referrals and the comparison group were as likely to have manifested prepsychiatric ED suicidal behavior, whereas McNeil found that police referrals were less likely to have done so.

Our study found that the group of involuntarily hospitalized police referrals differed from the group of police referrals not hospitalized by a number of clinical characteristics but not on the basis of demographic characteristics. We found that involuntarily hospitalized police referrals were significantly more impaired, as measured by the GAF score, and significantly more likely to have a diagnosis of a major psychiatric disorder (major depressive episode, bipolar affective disorder, schizophrenia, or other psychoses) than the group of police referrals not hospitalized. The involuntarily hospitalized police referrals were significantly more likely to have been violent toward others in the psychiatric ED, and to have been restrained or secluded during assessment. These findings are in general agreement with other studies of emergency room decisionmaking.[16, 25–27] In our study, the proportion of police referrals admitted involuntarily for reasons of imminent danger to self (41.7%, N = 5), danger to others (25%, N = 3), or danger both to self and to others (33.3%, N = 4) was similar to the findings of the McNeil study[28] of involuntary admissions from all sources to an acute psychiatric inpatient unit.

In the present study, it was not possible to locate information regarded as important when assessing for the likelihood of violent behavior, namely, the history of violence, including legal history.[29] The retrospective nature of the present study did not permit the statistical analysis of this information or of a number of

other sociodemographic variables, because these variables were not uniformly recorded in the psychiatric ED charts. It has been noted that although sociodemographic variables affect referral and admission rates,[30] this information may not be routinely recorded by psychiatric residents during emergency room assessments.[31]

In summary, we agree with McNeil[4] that police bring inappropriate patients to the psychiatric ED: both police referrals and the comparison group had a similar distribution of psychiatric diagnoses and rates of hospitalization. We also agree with McNeil that police referrals are significantly more likely to be violent both before and during psychiatric assessment. The findings of our study, which took place in a medium-size city of 280,000 in New York state, and McNeil's,[4] which took place in a larger city of 750,000 in California, are similar, and differ from the Steadman[15] study of a New York City hospital. This suggests that the influence of police practices and attitudes towards the mentally ill as well as the availability of hospital resources may be more significant than differences in mental health statutes in determining the clinical characteristics of the police referrals. A prospective study comparing police and other referrals to the psychiatric ED is planned and should help address some of the research problems associated with the emergency room setting[22] and thus further define the demographic and clinical profiles of patients. It is hoped that further information about demographic and clinical variables will help improve the delivery of psychiatric care to these patients.

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