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Police Emergency Commitment Powers in Cases of Persons Experiencing Mental Health Crisis in "Public Spaces": Review of the Commitment Process in England and Wales, in Comparison to the Practice in the United States of America (USA)

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Abstract

Police emergency commitment powers for detention of persons in the community perceived to be seriously mentally ill for further specialist examination in a designated facility have always raised interest in medical and legal circles on both sides of the Atlantic. The objective of this article is to detail the police commitment procedure in England and Wales, as dictated by the mental health act of 1983 (MHA 1983) amended in 2007 (MHA 2007); and compare this with similar legal provisions as prevails under current state mental health statutes in the United States of America (USA). The comparative review of the commitment processes in England and Wales to that of the USA reveals that the process in England and Wales seeks to primarily ensure that persons with mental disorder (PWMD) in crisis are directed to a specialist hospital for evaluation and appropriate specialist care. In the USA such persons in a good number of cases may end up in the criminal justice system due to application of the "dangerousness" standard. Additionally whereas in England and Wales the commitment law is uniform in law and application, the federal system in the USA is such that the commitment law may have minor variations depending on the individual states. The minor variation in state commitment laws may engender a situation where the commitment law in England and Wales may seem relatively equitable and just towards PWMD in crisis, compared to the state commitment laws in the USA.

Keywords

Mentally Disordered Persons, Public Places, Police, Emergency Commitment Powers, Evaluation, Law/Statutes

1. Introduction

Person's who appear to be experiencing a mental health crisis or persons with a mental disorder (PWMD) in crisis, in what may be considered public spaces apart from feeling distressed, may pose a possible danger to self, or to other persons in their vicinity. In most instances, the police may be called to assist with the situation. In a few cases the police may be able to successfully assist in calming the situation, and additionally help such persons in distress to seek appropriate help. In a good number of cases unfortunately, the initial attempts by the police officers may unfortunately not help the person in crisis immediately. In these situations, the police officers may then resort to police commitment powers to help convey such persons to the appropriate centres, in order for the individual(s) to be professionally evaluated towards arriving at a final disposition plan.

2. Police Commitment Powers, England and Wales

In England and Wales, police assistance in such situations is governed by an act of parliament "the mental health act" (MHA), the current version in force being the act of 1983 (amended in 2007). Under section 136 (S136) of the act, prior to the amendment to the Police and crime act of 2017, the police were empowered to transport persons found in public places deemed by the police officer(s) to be "mentally disordered" to a "place of safety" for assessment. The exact wording of the section stated: "If a constable finds in a place to which the public has access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 136" [1]. A place of safety, as was defined under section 136 of the act then, could be either "a residential accommodation provided by the local social services, a hospital as defined by the National Health Services Act of 1977, a police station, a mental or nursing home or residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the person" [1]. In practice, the places of safety used most commonly were the police station, a psychiatric hospital [2] and the accident and emergency (A&E) department of a general hospital [3].

However with the enactment of the Policing and crime act 2017 (as it pertains to the mental health act 1983 [places of safety] regulations 2017 no. 1036) [4], the above provision was changed for various reasons. Following the policing and

crime act 2017, the wording "public access" was modified to empower the police to use S136 anywhere except a "private dwelling". Additionally the "places of safety" definition was expanded, with the additional instruction that persons under 18 years old should not be placed in police stations for the purpose of place of safety) [4]. Beginning 11th December, 2017 when the change in law became effective, under the 2017 policing and crime amendment, whereas previously the MHA required that persons detained under the act could be detained up to 72 hours for the purpose of enabling them to be assessed; the requirement post the 2017 amendment, limits the period of detention for purpose of assessment to only 24 hours. Additionally the 2017 amendment required that before the police removed such a detained individual from the place of occurrence of the crisis to a place of safety, the police are required to consult with a specialist mental health professional an "approved health professional", so defined in the act, unless it is improbable to do so [4]. Once the individual is placed on a S136 detention, the officer is obliged to take such an individual to a place of safety as identified for the particular locality (for purpose of the act), in which the S136 detention was effected. A joint assessment by a registered medical practitioner (preferably a registered medical practitioner with "section 12 approval", under the MHA) and an approved mental health professional (AMHP) is then performed to determine the disposition of the patient and to make any necessary arrangements for his treatment or further care, where indicated (Section 136.2) [4].

For policing purpose only and not under the MHA 1983 [*as amended in* 2007], *use of the section by the police officer*(*s*) *is technically a power of arrest for the purpose of the Police and Criminal Evidence Act of* 1984 (*PACE*), *U.K.*; and gives no power to impose treatment without consent [5].

The multi-disciplinary/professional assessment in a place of safety will determine if, based on clinical grounds the person needs to be further detained or committed under a different section of the MHA as an involuntary admission to a psychiatric hospital (or in a minority of cases voluntary to a psychiatric hospital, if appropriate); or discharged to home if deemed appropriate. Once the person has been duly evaluated and necessary disposition arrangements made within the stipulated 24 hours legislated period, the authority for detention under S136 lapses.

3. Police Commitment Powers in the U.S.A.

In the United States of America (USA) on the other hands, the various states have slight variations in laws dealing with the emergency commitment process for perceived mental health related emergencies in the community. These emergencies are handled in accordance with the appropriate mental health emergency commitment laws of the individual states, specifically their civil emergency commitment statutes/codes [6] [7] [8] [9] [10]. This emergency commitment law or statutes/code can go by different names as emergency holds, psychiatric

hold, a temporary detention order or a petition, and has no legal authority to necessarily initiate or enforce treatment [8]. It is a power to detain on the basis of presumption of the person having a mental disorder, that necessitates that person being held for Assessment by a mental health specialist professional [7] [8] [9]. Despite the individuality of state legislations, there appears to be a common trend in matters of police intervention in cases of perceived mental health related emergencies in the community. In most states, the police officer/officer of the peace has emergency powers to take persons in such situations into custody, or to a designated place/facility for examination by a licensed professional without a warrant [6]. There are a few states in which a police officer needs to appear before a magistrate to swear an affidavit or obtain a warrant, in order to apprehend such a person to a designated place of assessment/safety, for examination by a licensed professional [8] [9] [10]. Once in the custody of the police under the emergency detention or mental health hold, most states stipulate a specialist assessment within seventy-two hours [6]. A few states stipulate specialist assessments within twenty-four hours. Washington and New Hampshire states have the shortest time stipulations for medical assessments for those under police commitment powers, three and six hours, respectively [7].

4. The Basis of Police Emergency Commitment Powers

Western civilization-based legal tradition from which the mental health laws are derived draws upon among others, two roles of the state or government; specifically, "police powers" and "parental role" [11]. Police powers derives from the concept of "de praerogativa regis" which is a thirteenth century statute that gave the King (of England) the power of custody over the person and or property of the then called "lunatics and idiots" [11]. The current interpretation of this in the light of emergency mental health situations is the recognised role of government to protect its citizens from the injurious actions of others, otherwise called "the police power". Hence, in the case of persons with perceived mental health problems presenting a danger to others (or self) in the community or public places, the police (as the policing arm of government) exercise the powers of removal of such individuals to places of safety. Additionally the parental role of the government in this sense is seen to provide a benevolent role of last resort with the responsibility to care for the disabled, as a parent would for a child, the role of "parens patrie" or father of the country [11]. In England and Wales that role is exercised, where the person detained under S136 ends up after assessment to be involuntarily detained and admitted to a psychiatric hospital when deemed appropriate. The patient may then be admitted under a section 2 (admission for continued assessment and treatment if appropriate), or section 3 (admission of a known patient in crisis for treatment).

Against this background, sprung the laws relating to police detention for purpose of evaluation of persons deemed as a consequence of their behaviour in a public place, to have impaired judgement or pose a likelihood of serious harm

to self or others; due to mental illness/crisis.

5. Discussion

The police routinely exercise their powers under the mental health act of England and Wales 1983 (amended 2007), and 2017 (to include provisions of the policing and crime act amendment to S136). In the United States of America, these police powers are exercised under the diverse state mental health statutes or codes which intend principally to remove the individual to a place of safety. Additionally this action is to offer the individual the opportunity to be assessed by a qualified mental health professional. In the implementation of police management of community mental health emergencies in the U.S.A. and specifically in public areas in England and Wales, it is clear that there are differences in practice.

Whereas in England and Wales management of such situations is uniformly regulated, as spelt out under S136 of the MHA (2007), such uniform federal regulation does not exist in the U.S.A. This is because in the U.S.A. under their federal system of government, and under the tenth amendment of the U.S. constitution, individual states are responsible for enacting state specific laws; including among others policing, and hence statutes on the management by law enforcement, of mental health crises situations [12]. Hence management of such situations involving the interface of the police and mental health patients in emergency situations is not under a USA federal statute. Regarding the issue of appropriate place of safety under S136 (MHA 1983), in England and Wales, there continued to be an ongoing debate as to whether S136 detainees need to be seen and evaluated in a police station, or in a hospital, or for that matter the accident and emergency unit (A& E) of a general hospital. A Royal College of Psychiatrists (RCPsych) report indicated that the A&E department should not be the preferred place of safety, as A&E staff is usually busy and preoccupied with medical emergencies and the area is not "secure" [13]. On the basis of the RCPsych report some authors have stated that a police station on the other hand should be the preferred place of safety [14]. The issue of place of safety has now been clarified by the PACE act of 2017 as it pertains to the MHA S136. Especially for England and Wales, any potential conflicts of compatibility between S136 police commitment powers under the MHA (England and Wales), and patients' rights under the (European) human rights act (HRA), is resolved under article 5.1(e) of the HRA which ensures that S136 of the MHA is compatible with the HRA [15]. Of note in the English and Wales system is the common pathway for handling issues of disturbances in public places, attributable to persons perceived to be suffering from a mental disorder of some sort.

In comparison to the U.S.A. a similar situation will be handled depending on the state's specific mental health legislation/statutes in force. This raises the potential for patients to be processed and handled differently in similar circumstances, but under different state legislation. However in the majority of states,

there is a similar procedural pathway of some sort in managing such patients. Some authors in the U.S.A. have highlighted difficulties faced by police officers in appropriately undertaking commitment proceedings [16]. Other authors have commented on the frustration on the part of police officers in the interface with mental health systems. For example, most police officers in most states will act to initiate commitment procedures on grounds of "imminent and substantial danger". Then, on taking the person to a hospital, the police are confronted sometimes by hospital and mental health personal using another standard of judgement, specifically "gravely disabled" [12]. Hence, what might seem appropriate to the police may not be judged to qualify for further commitment by mental health staff. Others have identified other reasons of contention between the two sectors [17] [18] [19].

This seems to suggest that the system in England and Wales is relatively more equitable without systems or procedural prejudice; compared to that of the U.S.A. However in large part they are similar. There have been some instances that an audit of the police commitment procedure in England and Wales has shown some drawbacks for the police due more to attitudinal problems on the part of health staff, as opposed to procedural or legislative problems [20]. Thankfully, overall this constitutes a minority of cases.

Of note previously in the USA, the legal criterion predominantly used in situations of civil commitment or emergency commitment procedures by police officers was the criterion of "dangerousness" [18] [21]. This criterion could have influenced police or peace officers in their interface with PWMD in crisis in the community to be managed via the arrest and criminal pathway, and probably occasioned use of force. On the other hand the use of police emergency commitment powers (S136) as used in England and Wales, is actually a protective practice to facilitate getting the PWMD in crisis specialist help, in the first instance [1] [4].

Of course due to concerns around the police PWMD in crisis interface in the USA, (sometimes with very bad outcomes even resulting in death) [22] [23] [24], the concept of a police specialist mental health profession and community partners teams, came into being about thirty years ago. These specialist teams named "crisis intervention teams" (CIT) are supposed to foster an inter-agency collaborative model that is supposed to attend to and manage community mental health crisis incidents safely whilst steering the person in crisis to the appropriate mental health specialist service and away from the criminal justice system/pathway [25]. Despite positive review's, CITs have in a few cases attracted negative press from a few [24] who argue that in some cases due to inadequate training, they may not respond appropriately in encounters with PWMD in crisis. This notion along with other reports that CITs is just about training of specialist police teams, as well as reports that CITs may have little impact on use of force, arrests or injuries in encounters with PWMI in crisis has been challenged by other authors [26].

On the issue of PWMD in crisis death "following contact with the police", it is not only a USA policing problem. There have been relatively rare instances where PWMD in crisis resident in England and Wales, have unfortunately died following contact with the police [27] [28] Granted these incidents in England and Wales policing are relatively infrequent, a researcher found two principle points of interest: 1) that in such encounters resulting in death a principal culprit was the use of restraints especially prolonged "prone restraint positioning" of the PWMD; 2) black and ethnic minority (BAME) PWMD in crisis, were over-represented amongst those that died [27]. In England for sake of completion around matters of police, PWMD in crisis interface, increasingly in some parts a police and mental health professional team alliance of managing such incidents using the method of "street triage", has been used as a way of avoiding the use of the S136 pathway and the issue of "place of safety" whilst providing specialist mental health assistance at the locus of incident [28]. A systematic review of this pathway, showed a "lack of evidence to of effectiveness of street triage and the characteristics, experience and outcomes of service users", as well as variations in the implementation of the programme [29]. Similar programmes of the co-responder types exist in the USA too [30] [31], and are described variously as mobile crisis teams, mental health first aid teams or pre-booking diversion programs. The primary aim of these teams being to interface and help PWMD in crisis with the aim of getting them specialist mental help assistance whilst avoiding otherwise, the arrest/criminal justice pathway.

As to the situation as currently exists in the USA, in relation to issues of emergency detention or mental health holds by the police/peace officers within the context of emergency involuntary commitment, an author suggested a move from the current individual states commitment statutes to a uniform law/federal law, along the lines of a suggested "uniform mental health commitment act" [32]. A reason for this among others, being evidence of different outcomes in such situations of police PWMD interface, albeit all with the same intentions of managing the crisis at hand [33]. In as much as individual states may not want to be dictated to as to how to manage local issues [34], such a move will contribute to the national effort to de-stigmatise mental health patients/problems, whilst trying to bring uniformity and equity in police management of PWMD in crisis. In this instance under the suggestion of a uniform law, vulnerable patients found in crisis situations deemed to require emergency psychiatric evaluation will hopefully have access to an equitable, uniform, and ethically based justice procedure of assessment, management and disposition. Lastly in England and Wales in a further attempt to empower PWMD even in the face of involuntary commitment, following the Sir Simon Wessely independent review of the MHA in 2018, the government just released a white paper on the proposed reforms to the MHA [34]. This white paper in broad terms seeks to stress even for commitment procedures, the following: "-choice and autonomy, -least restriction, -therapeutic benefit and -the person as an individual". In this proposed white paper the government in "consultation question 19" seeks to ensure that PWMD

in crisis can be "temporary held in hospital A&E" for specialists mental health professional assessment, without necessarily resorting to police hold intervention. This shows that even in attempts to reform and give patients more choice/power, the government still recognises the need to use the "parens patrie" powers of the state to help PWMD in crisis towards obtaining professional, equitable and appropriate care.

6. Conclusions

From the discussion on the police emergency commitment laws as currently written and enforced, it is apparent that the England and Wales S136 law ensures equity and justice to PWMD in crisis in public areas, compared to similar state commitment laws in the fifty (50) states of the USA and the Washington District of Columbia (Washington, D.C.). Especially for the USA where there have been struggles in the past for parity in the overall delivery of mental health care/services compared to physical health services; mental health policy makers, advocates and state and federal level legislators should strive towards legislating for a uniformed emergency commitment bill, for PWMD in crisis. This singular act if accomplished in case of PWMD in acute crisis, will eliminate the state variations in procedural administration and "holding" times of such persons who are situationally vulnerable, already liable to stigmatisation by virtue of their mental state, and often times deemed "dangerous" and subjected to arrest. This hopefully will end the sometimes awful tragic outcomes of such interaction, minimise the sometimes criminalisation of PWMD in crisis who then end up in police custody, instead of a specialist assessment and management clinic/hospital.

Finally the suggestion of a "uniform emergency commitment bill/statute" in the USA I acknowledge, will not sit well with state legislators as it may pose a challenge to their powers, considering the federal nature of the USA constitution. However it may be the plausible pathway for the equitable and just resolution of issues raised around the problems of the emergency commitment of PWMD in a crisis situation in the USA. This is in addition to other measures already in place, as well as hopefully eliminating the variations in state emergency commitment laws and international disability rights legislation.

Conflicts of Interest

The author has no interest to declare.

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