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Using the police cell as intervention in mental health crises: Qualitative approach to an interdisciplinary practice and its possible consequences

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Abstract

Purpose: The aim of this study was to analyze the views of patients, police-officers and emergency mental health workers on the use of the police cell as intervention in a mental health crisis.

Design and Methods: We analyzed interviews with individuals involved in police cell interventions, found first labels and categorized them in concordance with the four principles of biomedical ethics and compared them to relevant scientific literature.

Findings and Practical Implications: Professionals should know that emergency mental healthcare aimed at controlling the situation is not enough to provide good care. It probably generates better outcomes for patients in the short and long term when patient experiences are taken into consideration.

KEYWORDS

crisis, emergency mental health, ethical dilemma's, police cell

1 | INTRODUCTION

Police-officers are often the first responders in psychiatric emergencies in the community.[1,2] Internationally there are claims that police interference in these situations are increasing.[3,4] Individuals experiencing a crisis episode are regularly taken to police stations and kept in temporary custody until emergency mental health services can assess them. Using the police cell as intervention in mental health crises is widespread.[5,6] There has been an ongoing international discussion about task alignment between police officers and emergency mental healthcare workers in these crisis situations.[7]

This particular practice puts individuals with a serious health problem in a secluded place without psychiatric care. This aspect confronts involved professionals with several ethical dilemmas because instead of care the person gets the same procedures as a criminal. Biomedical ethical principles[8] as autonomy, nonmaleficence, beneficence and justice are likely to come into play in this scenario.

Completely eliminating the police cell as an intervention, when there are no criminal offenses committed, turns out to be extremely challenging.[9,10] Although involved stakeholders value this as a controversial practice; the police cell is still used frequently in the Netherlands. In 2019 more than 2000 individuals, in a mental health crisis, were temporary kept in a police cell.[11]

Little is known about the lived experience of key persons involved in the use of police cells during mental health crises. Therefore we looked into views and dilemmas experienced by patients,

police officers, mental health professionals in the Dutch context. Such insights are necessary to help develop new care trajectories in scenarios of interdisciplinary practice between police and emergency mental health services. It can also be helpful for colleagues with similar challenges outside the Netherlands.

This qualitative study addresses the following research question: what are perspectives of patients, police officers and emergency mental health workers on the use of the police cell as an intervention in escalating psychiatric emergencies?

2 | DESIGN AND METHOD

We have applied an exploratory qualitative approach based on the methodology of[12] which "researchers use to probe a topic when the variables and theory base are unknown." The data collection consisted of semi-structured interviews as well as focus group interviews.

2.1 | Participants and procedures

Representatives of all the relevant groups actively involved in the particular situation were invited to participate in this study.

Individual patients ($N = 4$) were selected from the crisis resolution team medical records and invited by telephone to volunteer after given information about the project by the junior researcher. The inclusion criterion was being kept in the police cell in the prior 6 months. These individual interviews were conducted by the junior researcher and were audio recorded. Three patients were interviewed at home alone and one patient was interviewed in a separate room at a psychiatric admission ward in the company of a family member. The individual interviews with patients aimed at a detailed description of their personal experience.

Focus group interviews were held to test opinions and examining consensus on the issue of the police cell being used as an intervention during a mental health crisis. The first focus group consisting of members of the local patient council ($N = 7$) was approached through their contact person. She was asked to disseminate the project idea and to invite members to volunteer. All participating members had a history as patients requiring acute mental health care. In addition gatekeepers of both organizations, police and the crisis resolution team of the regional mental healthcare organization, were contacted. We have asked them to disseminate the project idea and recruit potential participants in their organization or department on a voluntary bases. This resulted in a second focus group consisting of police officers ($N = 3$, i.e., a community police officer, an assistant public prosecutor and an officer from the emergency room), and a third focus group of emergency mental healthcare workers ($N = 7$, i.e., five community mental health nurses and two psychiatrists). All focus group interviews were audio recorded and took place separately in a quiet room and lasted approximately 1 h. Focus group interviews were conducted by one junior researcher and one moderator.

Additional individual interviews with staff members aimed at a detailed description of prevailing policy and the organization's mission were conducted. These individual interviews consisted of a staff member from the police ($N = 1$) and staff members of the acute mental healthcare departments ($N = 3$). The junior researcher conducted these interviews alone and audio recorded them. They all took place in a quiet room.

The interviews with all the participants and focus groups were based on a list of topics to explore their views on the cause of the discussed crisis, their opinion about the input of police involvement, and their perceived interaction in the specific situation from their specific role. In addition, when the conversation continued after closure of the interviews and points of interests emerged, field notes were made. All interviews lasted approximately 1 h.

The family council was also contacted but they themselves saw no particular interest, at that time, in participating in these interviews.

2.2 | Data-analysis

Data analysis was conducted according to Mayring.[13] First 25% of the verbatim interview scripts were open coded by the junior researcher and peer reviewed by two senior researchers. After open coding cross-checking took place. In this stage analysis was inductive and first labels emerged: crisis as a concept, roles and expectations, procedures, a police cell as a mean, contact, and communication. Based on first labeling it appeared that the findings could readily be matched with the four principles of biomedical ethics.[8] The lived experiences regarding this specific situation impressed the researchers in relation to ethical issues or sometimes the lack of ethics in responses.

From that stage interviews analysis was deductive, using ATLAS.TI 7 software. Quotations were coded, labeled, counted and imported into one of the four categories based on the principles of biomedical ethics,[8] that is, (1) respect for autonomy, respecting and supporting autonomous decision- making, (2) nonmaleficence or not harming others, (3) beneficence or preventing harm and contributing to well-being in health care and research, (4) justice or equal access to health care in relation to costs.

The interviews were conducted in Dutch. The selected quotations were translated into English applying the guidelines set by Beaton et al.[14]

2.3 | Ethical considerations

Authorization[15] for the research protocol was obtained from the local Medical Ethics Committee for Scientific Research of the mental health organization Altrecht in Utrecht, where it was conducted. All participants signed an informed consent document.

3 | FINDINGS

All interviewed participants shared their perspective on experiencing or observing a mental health crisis and the use of a police cell as intervention during the crisis until the emergency mental healthcare workers arrived.

The first labels that emerged: *crisis as a concept*, *roles and expectations*, *procedures*, *a police cell as a mean*, *contact*, *and communication*. Some of the first labels apply in more than one category and interact with each other. For instance when someone is put in a cell and is not informed about what is going to happen, it has consequences for the sense of autonomy but also for beneficence. When procedures lead to an action of entire loss of autonomy it interacts with the lived experience of crisis and has also consequences for beneficence and non-maleficence. The selected quotations below are categorized into the four biomedical principles (*respect for autonomy*, *non-maleficence*, *beneficence*, *and justice*).

3.1 | Respect for autonomy

According to Beauchamp and Childress[8] (p. 101) respect for autonomy means respecting and supporting individuals' autonomous decision-making in health care and research, both as patients and as subjects (or "participants"). In the interview data, quotations related to this principle were selected from all the participants.

As a clear pattern these aspects were expressed far less by emergency mental healthcare workers and police officers (PO) than patients (P) and patient council members (PC; Table 1). Below we present some of the views about entire *loss of autonomy* expressed by an interviewed patient and patient council member about their crisis:

> "*A phenomenon you have no power over, you can't control it*" (PC 1).

> "*At one time I said I could also wait sitting on a chair and they didn't need to put me in a cell but they said it wasn't possible*" (P 1).

We found two opposed reactions in our data from participants: Staying in the police cell felt like an *autonomous decision* because it was the effect of one patient council member's own refusal to be admitted to a hospital. She ran away and was tracked down by the police.

> "*According to me it was just something I did all by myself, I'm here (at the police station) and not there (at a hospital)*" (PC 4).

Another *autonomous decision* was expressed in seeking contact with the police and likely to be taken to a police station to get help as a result.

> "*Standing on the street at a central point in the city acting loony, you know the police will come and then the emergency mental health care services will follow*" (PC 3).

From the perspective of police officers and emergency mental healthcare workers, a patient's *impaired judgment* to make the right decisions during a crisis influences the decision about transporting the patient to a police station. The patients acknowledged their *loss of executive capabilities* due to the crisis but being in a police cell intensified *the loss of autonomy* even more. Below are some of the relevant quotations:

> "*Someone or his relatives can't cope, don't know what to do" (EMHW 1). "Someone is not making adequate decisions. That's how we come into contact with these situations*" (PO 1).

According to the patients, the *lack of information and communication* during their stay in the police cell is hard to endure and they attribute this to a sense of *losing grip of the situation*. The lack of information and communication only made their crisis even worse.

TABLE 1 Quotations

Respondents / Values	Patients (*N*=11) Individual patients (*N*=4) (P 1–4) Focus group: Patient council (*N*=7) (PC 1,2,3,4,5,6,7)	Police personnel Staff member Police (*N*=1) (SMP) Focus group: Police officers (*N*=3) (PO 1,2,3)	Emergency mental health workers Staff member mental health (*N*=2) (SMMH 1, 2) Focus group: Emergency mental health workers (*N*=7) (EMHW 1,2,3,4,5,6,7)	Total quotations
Respect for autonomy	28	11	8	47
Nonmaleficence	37	6	9	52
Beneficence	36	27	22	85
Justice	19	28	28	75
Total quotations	120	72	67	259

"*If I'd only known we were just going to wait here, nothing was going to happen and it would take so much time, it would have been different*" (P 1).

"*Just sitting in a cell for two or three hours, what can you do, no one says anything to you*" (P 3).

"*It makes you angry because of the domineering way they question you. You don't have a way out and then the door is closed. No one comes to sit beside you and then the waiting*" (P 2).

"*Being put in a cell, not talking to you, door closed, no information because I'm crazy according to them. I felt so bad*" (PC 2).

3.2 | Nonmaleficence

"Non-maleficence refers to not harming others and not causing a risk of harm" (Beauchamp & Childress,[8] p. 154). It is not the same as beneficence, which means preventing harm. Nonmaleficence is the avoidance of any action that could have a negative effect.

Again the focus on this ethical aspect of an enforced stay in a police cell waiting for help during a crisis was more prominent in the data of patients and patient council members (Table 1).

Using a police cell as an intervention for specific reasons is something all the groups recognized as a *necessary evil*, sometimes to keep the individual *safe* from aggression or where *legal* aspects need to be settled. However, there also appeared to be other motivations for the *procedure*. Below are some examples of relevant quotations:

"*When someone is very aggressive, I'm glad they are in this place*" (EMHW 5).

"*First establish what someone is going to do, whether it is safe*" (PC 5).

"*When there is another crisis call at the same time and that other person is at home. The person in the cell has to wait. I know he's safe*" (EMHW 1).

But it looks like people in a mental health crisis *don't feel safe* being in a police cell, even though workers tend to think they are:

"*If you are in a psychosis, it is so frightening being in that place*" (P 2).

"*I was not a suspect but I was treated like one. I even had to sign for it*" (P 1).

"*To prevent the whole stupid procedure of frisking if it is not necessary*" (EMHW 4).

"*Someone who was quarrelling through the intercom and pushing the button 100 times, only because he was scared*" (EMHW 2).

The specific police cell environment seems to impede the *well-being* of the person inside who already has a mental health problem.

3.3 | Beneficence

Actively *doing the right thing*, *preventing harm* and *contributing to well-being* are all characteristic of the principle of beneficence (Beauchamp & Childress,[8] p. 202). As one of the four principles, it was by far most frequently mentioned by all the participants.

The *right thing* for patients seems to be a *respectful and non-judgmental approach*. Experiences with the police and crisis services can evoke *mixed feelings*. Below are some relevant quotations:

"*Some time later there was this police officer who told me the emergency services were coming and that was re-assuring*" (P 4).

"*Then the police came and asked me questions in a way that you cannot answer, so intimidating*" (P 3).

"*The attitude of the people from the emergency services was condescending, very nasty*" (PC 6).

"*The emergency services are getting the honors, they listened to me*" (P 4).

Risk avoidance shaped the *decision-making process* on the part of the police and emergency mental health services. Patients doubted whether the right choices were made for their *well-being*. The police and emergency mental health services tended to agree with the patients and shared this doubt:

"*If you are in a mood to hurt yourself, a cell isn't the place to be*" (PC 5).

"*We think if you welcome people in a different way, they are likely to exhibit different behavior*" (SMMH 1).

"*This young girl was in a suicidal state, the health care center was closing at 5 pm and the emergency mental health services were busy and couldn't see her until later that evening. The people at the health care center asked us to take her and put her in a cell for her own safety. It's not a good story in my opinion*" (PO 2).

In this last quotation, it appears that risk reduction as a beneficence has a strained relation with non-maleficence.

3.4 | Justice

This last principle focuses on equal access to health care in relation to costs and thus has two dimensions. "This perspective recognizes the legitimacy of trade-offs between efficiency and justice" (Beauchamp & Childress,[8] p. 293). It was the second most frequently mentioned principle at the meetings (Table 1).

All participants liked the idea of a fair distribution of means, benefits, risks and costs. The *availability* of police and emergency mental health services is limited even when they are open 24/7. It is also linked to *access to crisis care*. All the participants had had their own experiences:

> "*One problem is that it is not until after you've spoken to your general practitioner or his replacement after hours that you have access to the emergency services*" (PC 6).

> "*The psychiatrist asked the police if they could stay to start the procedure to admit me to the hospital. They couldn't wait, so they brought me to the police station where I wound up in a cell*" (P 1).

The police stated that they critically review their own *deployment of resources* and not just the use of cells.

> "*When you are dealing with a vulnerable individual and there is a care network, the care network is obliged to this individual and to society to do what is decent and not just during office hours*" (PO 3).

In addition to cases of aggression and in trade-off situations when there are *two referrals at the same time*, emergency services can also use a cell as an intervention for patients under the influence of alcohol or drugs. It is a *mean to gain time* before they arrive and decide whether or not to commit to the case. It can also be used in situations where legal aspects play a role and there is an *intersection* between illness and criminal aspects or behavior.

> "*Sometimes as soon as you establish that someone is psychotic, it is as if the legal aspect vanishes. So it would be a shame if the individual could no longer be put in a cell*" (SMM 2).

3.5 | Discussion and Conclusion

In the interviews, all the participants agreed that a police cell is not the proper place to manage a nonviolent mental health crisis. Our three groups of stakeholders may agree but accents seem to differ.

It is still not common practice to reject the police cell as intervention in scenarios of this kind. There is an implicit assumption of beneficence in all medical and healthcare professions according to Beauchamp and Childress.[8] Agreements made in 2012 between police and the national organization of mental healthcare[16] were necessary to start thinking of changing this practice. Before that no initiative was taken by mental healthcare professionals in the Netherlands to change this practice. The rationale behind the use of a police cell as intervention in our interviews mainly were expressed by emergency mental healthcare workers as a result of pragmatic deliberations. When they observed fear with the patient as a reaction on his or her situation in the cell they felt sorry. They did not question the method during the interviews. This was confirmed in the story of a police officer when she was requested by care professionals to put a young suicidal patient in a cell.

Even after the agreements, made by the national police and the national mental health organization, it is still common practice in some parts of the Netherlands to assess crisis cases in a police cell regardless the nature of the crisis or its phenotype. We have searched in literature to find a possible explanation for the ongoing use of a police cell in a mental health crisis which was also a theme in the several interviews. The perspectives in our interviews do not legitimize this practice.

The limitations of our study are based on a modest sample size in just one city. On the other hand all the invited participants who play an active role in this situation accepted the invitation to participate in this study except the family council. To our knowledge this is the first published study addressing the views of several stakeholders about patients being kept temporarily in a police cell waiting for help. The spin-off of this study was that the findings evoked meaningful national debates about designing "best practices" in such situations.

An individual in a crisis is perceived by all participants involved in our study as "losing grip or being unable to cope with the situation without the help of others" according to the several participants. They all use their own vocabulary: "no control, not enough coping, not making adequate decisions." These findings coincide with the well-known theory of crisis formulated by Caplan and Caplan[17] that high tension, hopelessness and a sense of losing control increase when coping mechanisms fail.

Interview data from our study suggests that having a joint definition of the concept of crisis is not automatically associated with a mutual sense of urgency among stakeholders in several case scenarios. Patients and police officers complained about 'not be taken serious' in their observations. They felt dependent on the judgment of others than themselves to arrange help. Patients and police officers complained about "not treated seriously" in their observations or request for support or assistance. They felt dependent on the judgment of others than themselves to arrange mental health assessment or help. Our findings are parallel to some outcomes of a relevant study conducted by Paton et al.[7] These divergent interpretations may explain the difficulties in interdisciplinary collaboration.

In a national discussion on the estimated care gaps in emergency mental health care in the Netherlands, the level and control of

present or imminent danger is the prioritized main objective. The discussion seems to focus on public safety and tends to identify individuals with mental health problems as "dangerous." Indeed research indicates that police officers tend to see people with mental health problems as dangerous and unpredictable.[18] In turn the presence of police during a mental health crisis possibly provokes an antagonistic response on the part of patients. Although their presence is sometimes essential for safety reasons, active police participation could also increase the risk of escalation.[4]

One might wonder when and how short-term risk assessment is actually accomplished in these situations by police and emergency mental health workers. It is also unclear whether short-term risk assessment is performed methodically and whether the two parties use the same conceptual framework. In our data, most emergency decisions in these situations seem to be driven by working procedures, logistic capacity, tacit knowledge, and personal assumptions. In our interviews aggressive behavior was mentioned several times as a criteria for the use of the police cell by emergency mental health workers. However the participating professionals did not differentiate in terms of context or mental state characteristics. A member of the patient council used the same argument stating that when aggressive a police cell can provide safety to observe what "someone is going to do." Police officers explained that they are insufficiently equipped to distinguish whether a person is "bad or mad." For them the presence of judicial aspects is of crucial importance whether to commit to the case or not.

All participants agreed on the use of police cells as an intervention in the event of clear signs of public safety and issues requiring further investigation. According to the national agreement, this conduct is currently regarded as a penal act.[16] Individuals with psychiatric disorders are more likely to get in trouble with the police. They get more often to be arrested and prosecuted for minor misdemeanors but are also more often victims than perpetrators.[6,19] Associating mental instability with danger or imminent danger without refining it, could lead to misconceptions and prejudices. Stigma and discrimination are presumed to be factors in patients' failing to seek help.[20]

Does an emphasis on the control of danger or imminent danger lead to less of a focus on ethical aspects in the care of individuals in crisis? Based on the patient interview data, being in a police cell during a mental health crisis is clearly a stressful event. It does not contribute to a sense of mental well-being. On the contrary, the patients expressed an extra burden on their actual suffering of a crisis. In fact, the result of the current study show that all four principles of ethics are challenged. Trade-offs between respect and autonomy or nonmaleficence and beneficence are probably unavoidable in certain situations.

In a situation where an individual's capacity to make autonomous decisions is disturbed, it still is important to pay attention to ethical aspects and substantiate the choices made. The testimonials make clear that the alternative is very unsettling for patients.

An ethical point of view does not necessarily lead to a radical rejection of the police cell as an intervention. This is explicit in situations dominated by safety or criminal aspects. Despite these aspects, it is preferable to pay attention to the patient's role in decision-making. The patients we interviewed felt being left to their own devices. Ignoring the patient preferences and anxieties can lead to negative experiences for him and can even have consequences to avoid care in times of need. Dahlqvist-Jönsson et al.[21,22] Despite experiencing a crisis; not having a share in managing the situation can have a negative effect on the patient's well-being.

The patients in our study note that they experienced a stay in a police cell as stigmatizing, stressful, and frightening. This was also triggered by a lack of information about what was going to happen in the following minutes or hours. They state that it increased their suffering at the peak of the crisis and created an extra burden in addition to all their other problems at that moment. Nonmaleficence and beneficence came under pressure in this situation. These results are the same as in other studies on seclusions in psychiatric wards.[23] Varelius[24] claims that tailored shared decision-making helps prevent traumatic experiences and promotes the recovery process.

According to our participants' feedback, respectful treatment and proper information management could prevent a great deal of harm. The value of self-determination and autonomy is clear from the contribution of a patient council member who *arranged* her own stay in a police cell and had a more positive assessment in retrospect.

There is conflicting feedback on how police and emergency mental health services acted. It is positive in the experienced situations where patients felt they were seen and heard and negative when they experienced the opposite. Various studies confirm the advantages of de-escalating and respectful contact in the patients' acceptance of a past situation of despair and crisis.[25,26]

In the focus group interviews with emergency mental health service workers, there is no specific reflection found on using a police cell in relation to the consequences of the recovery process of the patient. A possible explanation could be that an enforced stay in the police cell can be conceived as a logical first step towards involuntary care. However mental health professionals could play an important role in reducing coercion in crisis care.[1,27] The lack of attention for how a stay in the police cell can affect recovery is possibly also driven by prioritizing the avoidance of confrontation with aggression in scenarios of this kind. It is known from the literature that aggression can lead to professionals' disengagement and demoralization.[28] Confrontations with seriously disruptive behavior can influence the perception of emergency mental healthcare workers. It can lead to a *separated* assessment of the disorder and situation and a failure to see the patient as a person. In other words context and person become two separate things. From this separated point of view, decision-making only takes place based on the observed situation. Starting involuntary care is supposed to be easier from this perspective.[29]

Equity in access to acute mental health care is internationally a major challenge[30] but low threshold access to crisis care is highly appreciated by patients and their families.[31] This is confirmed by the current findings. It is not only appreciated by patients and their families, police officers also have their incentives while it is not certain that better access to these services reduces police involvement in

crisis situations.[7] Although the general debate frequently focuses on task alignment between emergency mental health services and the police, police officers note that their actions in situations involving individuals in a crisis are *part of their job*.[32] For the police, this is historically the "gray zone" between serve and protect.[33]

4 | IMPLICATIONS FOR (EMERGENCY MENTAL HEALTH) NURSING PRACTICE

Despite agreements to restrict the use of police cells for individuals in a mental health crisis, it is still not common practice. To avoid the use of the police cell imminent danger and judicial aspects should be the only justification for failure to do so. Assessment on these aspects need to be done in a systematic and transparent way. Our interviews and the relevant literature show that interventions of this kind based on other assumptions are undesirable. This practice can add distress for individuals already in a crisis and thus be harmful. It reduces the patient's autonomy at a moment already characterized by a loss of control. A lack of information and a feeling of being stigmatized and made powerless can have implications in the future of the patient's recovery. The deployment of the police cell should therefore be based on balanced deliberations on the risks involved. Professional deliberations should be associated with the prevention of iatrogenic damage to patients in a severe crisis. Respect for autonomy, nonmaleficence, beneficence and justice thus play a serious role in emergency mental health care.

As our data reveal, stakeholder consensus papers or joint agreements alone are not enough to change this practice. Task alignment and collaboration between the police and emergency mental healthcare services should be aimed at achieving the outcomes that are important to patients in times of crisis. To do so, it is essential to include the patient's experiences and their input on the subject. Professionals should be aware that emergency mental health care solely aimed at controlling the situation is not enough *to provide good care*. The patient as a person should be included in the deliberations to manage the situation and whenever possible, in dialog with the patient based on proper information management.

This is why nurses and various stakeholders can benefit from incorporating the four principles of biomedical ethics in their daily practice. They can also be used for retrospective case analysis and integration of lessons learned in the interdisciplinary practice between police and emergency mental healthcare services. Moral awareness can contribute to recovery-based health care in mental health crisis scenarios.

DATA AVAILABILITY STATEMENT

The data sets generated and analyzed during the current study are not publicly available due them containing information that could compromise research participant privacy/consent. For questions and/or information the corresponding author (CS) is available.

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