Patient Perspectives of being detained under Section 136 of the Mental Health Act: Findings from a Qualitative Study in London.

Abstract

Introduction: Detention under Section 136 (1) of the Mental Health Act 1983 allows for police to arrest a person from a public place and remove them to a "place of safety", typically an emergency department or mental health unit if it is "in the interests of that person or for the protection of other persons in immediate need of care or control".

Aims/Objective: To describe the views and perceptions of the process for people with lived experience of mental distress who have been detained under Section 136 of the Mental Health Act 1983.

Design and Setting: Semi-structured interviews were conducted with a non-probability sample of people with lived experience of mental distress who have been detained under Section 136 across Greater London. Interviews were transcribed and thematically analysed using Grounded Theory.

Participants: 58 people with lived experience of mental distress detained under Section 136 including four carers.

Results: Three interwoven themes were identified: (1) Process or procedural issues; (2) the Professional-Patient relationship; and (3) the importance of a supportive therapeutic environment.

Conclusion: The length of time, multiple assessment points and processes juxtapose against the need for a humane physical environment and supportive therapeutic interactions from all professional agencies. It is unclear how changes proposed in the Policing and Crime Act 2017 will address these patient needs.

Authors:

Arun Sondhi*, Therapeutic Solutions (Addictions) Ltd, 4 Old Park Lane, London W1K 1QW.

Dr. Lisa Luger, LLC Consultancy CIC, London

Lina Toleikyte, Health Equity Unit, Health Improvement Directorate, Public Health England.

Emma Williams, Deputy Director Canterbury Centre for Policing Research. Canterbury Christ Church University

*corresponding author arun.sondhi@therapeutic-solutions.org.uk

Introduction

Concern has been raised as to the extent and nature of mental health crises affecting the general public across England and Wales, alongside the effectiveness and availability of service provision. The rising use of involuntary detentions under the Mental Health Act, 1983 has been noted with the financial and operational repercussions of this increased demand[1] [2]. For people suffering from mental health disorders in a public place, detention under Section 136 (1) of the Mental Health Act 1983[3] allows for the police to hold that person and remove them to a "place of safety" if it is "in the interests of that person or for the protection of other persons in immediate need of care or control". However, it should be noted that police will utilise Section 136 legislation based on their perception of mental health need rather than the decision relying on a clinical diagnosis[4].

"Places of Safety" within the Act now include "residential accommodation provided by a local social services authority", a hospital, police station, "an independent hospital or care home for mentally disordered persons or any other suitable place"[5]. Typically places of safety have been specialist mental health units or the emergency department within a general hospital but has contentiously included use of police cells[6] [7]. The Mental Health Act Code of Practice[8] (or 2016 Code of Practice for Wales) requires a place of safety to be a health-based environment where specialist mental health services can be provided.

An arrest under Section 136 leads to an assessment process that is shared across organisations. The statutory requirement is for an examination by a doctor and, unless there is no mental disorder, an interview conducted by an approved mental health professional (AMHP). If appropriate, arrangements will be made for the detainee's treatment or care.

Although the legal requirement is for an examination by just one doctor, who does not have to be approved under Section 12 of the Act as having special experience in the diagnosis or treatment of mental disorder ('a Section 12 approved doctor'), the Code of Practice of the Mental Health Act 1983 recommends the use of Section 12 approved doctors. So, in practice the process often includes examination by two Section 12 approved doctors.

The process starts with the arrest or detention by the police under Section 136 and leads to the person being conveyed to a place of safety. Conveyance should be by an NHS ambulance in accordance with the Ambulance Chief Executive's 'National Mental Health Act 1983 (revised 2007) Section 136 Protocol', although it is reported that in London this has occurred for only one in two episodes of care[4]. A physical examination may be conducted as part of the required medical examination and, if this does not confirm the presence of mental disorder, the authority to detain ceases immediately whether or not the AMHP has conducted an interview. If the presence of mental disorder is confirmed, the appropriate level of care or treatment can range from formal admission under Part II of the Act, through voluntary or 'informal' admission to some form of care in the community, such as under the care of a locality-based home treatment team.

The Policing and Crime Act 2017 has amended how Section 136 is applied by prohibiting the use of police stations as places of safety for persons aged under 18 years and by restricting their use for adults to "exceptional circumstances". The amendment also widens the definition of a place of safety, for example to include facilities provided by what are known in the United Kingdom as 'third sector' organisations (neither public sector nor private sector, such as charities and voluntary organisations). It extends the application of Section 136 to private property such as railway lines, workplaces and building rooftops. It reduces the

maximum detention time from 72 to 24 hours (with the option of an extension to 36 hours). It places a requirement on the arresting police officer to consult a health professional or other specified person where this is practicable. It also explicitly excludes its application in a person's home or someone else's home.

However, studies have highlighted significant issues and wide national variations in the delivery model[7 9]. Police have been seen to lack adequate awareness of mental health disorders[10] with too many detainees being turned away from a place of safety or waiting too long for admittance due to staffing or capacity issues[11 12 13]. Inadequate pathways have also been noted for children and young people and for intoxicated detainees. From a London perspective, use of police cells as a place of safety has reduced in recent years, but significant problems were described in relation to conveyance, the accessibility to a place of safety, and the facilitation of Section 136 assessments under the Mental Health Act[4].

Studies of detainee perspectives[14 15 16] pointed towards broad dissatisfaction with the treatment and care received from both mental health professionals and the police. Individuals reported that they received little attention, were regarded as a nuisance, and had few treatment options. From a patient perspective the detention process is seen as a frightening and traumatic experience with potentially long-lasting consequences, especially when within a chaotic emergency department or police custody environment[17 18 19 20].

Despite this evidence, comparatively few studies have examined the perspectives and experiences of individuals detained under Section 136 and of those that do have been criticised as too London-centric [13 14]. Despite this emphasis on the capital, London faces complex issues in developing an adequate response across a large geographical area that

encompasses multiple organisational boundaries across 33 boroughs, nine mental health trusts and three police force jurisdictions. Moreover, London has sizable transport hubs in central locations that has been shown to much higher than expected levels of Section 136 activity which in turn create a dislocation from treating a patient in their local area[4].

Studies are also relatively small in sample size and few have understood patient perspectives across the entire detention process. For example, taking into account the interactions with police at the point of detention, conveyance and subsequent arrival to a place of safety. This study also places the patient perspective within the changing context of the Police and Crime Act 2017.

Study Objectives

The aim of the study was to understand the process of being detained under Section 136 from the perspective of patients with direct or lived experience of mental distress.

Methods

Design

Participants who had been detained under Section 136 were recruited through a non-probability sampling method. Semi-structured interviews were undertaken between April and December 2016. The interview process was guided by an initial pilot with one NHS service user group that established the need to create interview guides as part of the semi-structured framework to allow time for participants to recall specific events and to enhance the flow of

the conversation. The interviews were introduced to participants as a study to help inform the development of services for people detained under Section 136 legislation. The interviews were guided by a topic framework to allow for a full understanding of the entire process from detention to arrival at a place of safety (Table 1).

Ethical Considerations

NHS Health Research Authority (March 2014) stated that this study fell within a 'service evaluation'. Ethical oversight and governance was provided by the Healthy London Partnership (NHS England) Project Board. Each participant was provided with written information and signed a consent form prior to interview. Any identifiable information was deleted prior to transcription and each participant was given a unique number for analysis purposes.

#Insert Table 1 about here#

Recruitment and Setting

Voluntary organisations and hospital service-user groups were contacted to discuss the feasibility of recruiting participants. A NHS service user representative was involved to broker introductions to various NHS and Third Sector organisations. Non-probability sampling was deployed to recruit as many participants as possible. This method was chosen to derive a sample of interviewees amongst hard-to-reach groups who may be reluctant to engage in research due to perceived stigma associated with their condition[21]. A third sector organisation, the National Survivor User Network, directly recruited participants through an

advertisement in their in-house magazine. A small number of participants (n=5) were also recruited by "snowballing" techniques[22] whereby individuals recruited were asked to nominate another person also detained under Section 136 legislation. Participants were offered an incentive (£20 voucher) for their participation and signed an Informed Consent sheet that detailed the purpose of the study and how information would be used. There were no refusals to undertake an interview following this initial discussion of the project. 58 people with direct or lived experience of Section 136 were interviewed including 4 family members or carers. These family members were included in the sample as they had first-hand experience of the detention process (for example, accompanied the patient in an ambulance). Interviews were undertaken face-to-face in either a group or one-to-one setting (n=55); telephone including Skype (n=2) and email (n=1). Interviews were taken at the location of choice for the individual participant that included hospital Patient Liaison offices or public places such as a café. The discussion using email was included as part of an ongoing dialogue as the respondent was uncomfortable meeting in a public venue.

Data Analysis

The qualitative interviews utilised 'grounded theory' to describe and understand participants' views. The aim of this approach was to develop a data-driven approach to understand what is happening and to avoid any preconceived bias [23] [24] [25]. This allows for the researcher to be immersed in "real-time" data that allows for "constant comparisons" to be made to develop new theoretical frameworks[26].

Interviews were audio-recorded and transcribed verbatim onto Microsoft Word. One participant refused to have the interview recorded and notes were taken instead, and one

person replied to the interview over email which was also transcribed. NVivo 10 was used to organise and analyse the data. A thematic analysis was undertaken[27] that allowed for creation of a coding frame that corresponded to the key points in the process highlighted in Table 1. Audio recordings and line-by-line reading allowed for familiarity with the data and the capture of significant events or issues within the detention process.

RESULTS

Participant Characteristics

The majority of the participants were female (69%, n=40), white (90%, n=52) with an average age of 44.1 years. This differs from the characteristics of the overall Section 136 population which are more likely to be male (60%), with greater black and minority ethnic representation (41%) and more likely to have a modal age of between 25-34 years[4].

Themes

Three themes were identified: (1) Process or procedural issues; (2) Creating a Professional-Patient relationship; and (3) Importance of a supportive therapeutic environment.

Theme 1: Process or Procedural Issues

A large number of participants (76%, n=44) explicitly stated that the process they faced to get to a place of safety was too long and overly complicated. In London, this has been shown to be due to delays in accessing the London Ambulance Service and problems finding a suitable

location when a place of safety is full[4]. A smaller but notable number (21%, n=12) of participants also highlighted the lack of equivalence with physical conditions believing that their mental health was not treated as seriously.

Despite the acute nature of their condition, participants were cognisant that process complexities led to multiple contact points with a range of professionals across many disciplines. For example, participants described a degree of anxiety dealing with a range of professionals from emergency department or mental health clinical staff and AMHPs. Given the relative high usage of alcohol and illicit drugs prior to their mental health episode, many participants also expressed frustration at being denied access to a place of safety to be "medically cleared" at an emergency department, which often required additional travel across hospital sites[4]. There was a consensus among participants that entry into an acute emergency department was a negative experience due to lengthy waiting times when they were in a crisis and in need of urgent assessment and treatment. The multiplicity of professional contacts was seen to artificially create inconsistences in the process. These procedural issues facilitated and compounded blockages through duplication of assessment or triage processes which were not clear or transparent as to the roles and responsibilities of individual professionals:

> It was all too long in the back of an ambulance and no one gave me any information as to what was going on...I became paranoid that I was being abducted…and this time they [the police] were in on it with him, do you know what I mean? They took me to [Hospital A] when I started to hyperventilate, and I tried to self-harm there and only then did I calm down. [Interview #98]

The absence of meaningful information provided throughout the process from detention to arrival at a place of safety was a major concern for many interviewed:

> It's just one big black hole that assessment room they keep you in, nothing, no information as to what is going to happen, by when and who is doing it. Dump you in the room to be stared at like some sort of strange animal. [Interview #88]

In this context, participants highlighted the importance of message consistency to reinforce therapeutic nature of the intervention. The absence of meaningful information at the point of discharge was also cited as major barrier to engaging with services in the community which is consistent with other research on Section 136 detainees[17]. For example, leaflets with wrong or out-dated addresses were sometimes provided and inconsistent or incorrect information as to the nature of follow-up services were also cited. Moreover, information provided by place of safety staff was perceived to be more about fulfilling their obligations than informing their patient as to what was happening to them, compounded the negative experience of the detention process:

> She [the nurse] didn't come near me. She stayed at the door. I probably told her not to come any further…I'd already been in September and I'd walked out, discharged myself. I never got any follow-up or offer of follow-up either anymore because…I felt threatened by the situation, so she was just part of that. I've no idea what she wrote down, except [that] I was sectioned. [Interview #52]

Theme 2: Creating a Therapeutic Professional-Patient relationship

For interviewees detained under Section 136, the initial engagement with police was vital in relation to some patient's perceived stigma of mental ill-health that framed their subsequent experience (along with previous experiences of being admitted to, or detained in, hospital under the Act). Where it worked well was when police officers offered humane treatment and support. Overall, participants reported a mixed picture of the initial point of detention and the engagement of police in relation to their mental distress. Where police contact worked well was when there was emphasis on the therapeutic nature of their involvement, such as focusing on access to NHS services. This initial contact was pivotal and acted as a 'reassurance' that their condition was accepted and treated seriously:

> The police were excellent, really, really, great, I can't fault them one little bit. The policemen…talked to me not as a criminal but as a human being and that was nice at that time because I needed it. I also asked them to stay with me [at the place of safety] whilst they sorted me the bed at [the] hospital and they did that too. [Interview #78]

In around one-third of all cases (31%, n=18), interviewees explicitly stated that police engaged well with them although there were exceptions where an individual felt they were treated as a 'criminal' which is consistent with other research[16 17]. The memory of the detention, and their actions leading up to detention, was often fragmented or missing due to their worsening mental health condition, exacerbated by substance use[28 29]. For those interviewed, the need to establish an immediate rapport and therapeutic relationship based in trust was paramount.

Despite highlighting the stigma of mental ill-health, interviewees stated that they were willing to divulge confidential information to police officers about their mental health condition including their medication regimen, if it helped their condition to be taken seriously and to facilitate access to treatment. Moreover, the point of arrival at a place of safety also helped frame participants' subsequent experience. For many the initial point of contact with clinical NHS teams was an essential component of the therapeutic process. Participants highlighted the 'reassurance' of seeing NHS ambulance staff and arriving at a hospital. However, concern was raised by some interviewees that at the initial point of contact, participants perceived staff viewed them as "trouble", especially when the place of safety was busy, which concurs with Jones and Mason's (2002) findings[15].

> The nurses were all so busy which seemed strange as I was the only one in there at the time, they had no time for me and were cold and distant. I seemed to annoy them when I asked for anything and it said to me don't bother asking. [Interview #84]

However, some highlighted the 'human touch' needed to make the experience more therapeutic:

> I arrived and was seen by a male nurse…He was reassuring straight away, and I trusted him. That was important because I felt that he cared and was interested in me as a person. I remember he said something like, 'we are now going to make you better' or something like that and I remember feeling that at last someone was looking after me. [Interview #78]

Yet despite this 'human touch', participants also described the process of arrival into a place of safety as "cold", unduly clinical and linked to their detention as a "paper exercise":

> It's a paper exercise you know, a tick-box exercise from start to finish. They need to fill in their paperwork and everything else second and that's not right is it? If I throw myself into the Thames I know their concern would be how quickly they need to write up their blue, green or red forms. [Interview #71]

For participants, there was little awareness of the assessment process other than a series of questions that may be asked for more than once. Interviewees did not distinguish between acute or mental health trust staff at the point of their detention, therefore when referrals were made across hospital sites (for example, to an emergency department) the sequencing of assessment questions was perceived as confusing and unnecessarily convoluted. The nature of the questions asked was also seen as overly clinical and participants expressed frustration at the duplication of questions asked. When information had been shared across departments (e.g. from mental health trust to emergency department), this provided "professional" reassurance, which helped frame their conception of the treatment they had received.

Theme 3: Importance of a Supportive Therapeutic environment

Participants provided insights into the need for a therapeutic environment to support individuals through the detention and treatment process. Although at the time of study some places of safety were in the process of being upgraded, there was wide disparity in the views of the physical environment which often compounded feelings of fear and intimidation. The environment was also seen as integral to an individual's treatment:

> I've been sectioned before and held in a police cell before and that was bad, it was cold and dank and miserable, and I just curled up on those bunks and cried my eyes out. The place they take you now is only a little better, it's not as cold and they don't make you wear those paper suits but it's still like a police interrogation room than a place where you should be getting better. [Interview #74]

Participants who attended an emergency department either as place of safety or to treat medical needs highlighted the busy and chaotic environment which was seen to worsen a person's wellbeing. Participants reported being held in cubicles alongside other patients and if more than one person was being detained at the same time, the highest risk patient will be put into an 'observation room' which was often described as "unpleasant". Many raised concerns over breaches in confidentiality and a lack of privacy by having assessments undertaken within earshot of other patients. Examples were also cited of participants being taken to an emergency department in handcuffs. The range of comments pertaining to the emergency department environment included "really scary"; "terrifying"; "more like a prison" and "like a dungeon". The following quotation was typical:

> In those holding pens I call them, there's nothing to do…you're in a kind of tiny little room with really angular sofas that are really uncomfortable. And then you've got the camera outside to make sure I stay in. And you just get more and more frustrated because you can hear other people in the other rooms, you can actually hear patients in physical pain screaming, you could hear someone next to me in the other suite having an assessment. So, it's a really unpleasant experience. [Interview #7]

Discussion

The study offers insight into the views of people detained under Section 136 legislation with a focus on the various stages of the detention process (from initial detention, through conveyance to a place of safety, to subsequent medical and AMHP input). This study is one of the few to examine the views of people detained under Section 136 legislation. Three main themes emerged from the research. Participants highlighted the negative effect of excessively long times to arrive at a place of safety with the need to ensure that the interactions with professionals (police, clinicians) are caring and humane. A third theme emphasised the need to create a therapeutic atmosphere through an appropriate physical environment that it not chaotic, designed for patients in crisis and creates space for confidential issues to be aired.

Several limitations to the study should be noted. The sample of participants interviewed was a non-probability sample and is not representative of the Section 136 population with an emphasis on older, white and female respondents. This reflected the nature of recruitment through existing service user or survivor networks. There is little in the wider literature that suggests different demographic groups have differing experiences, but this hypothesis needs further testing with other population segments.

For participants detained under Section 136, there was also fragmentary recall which was the consequence of a traumatic episode often affected by drug and alcohol consumption[28 29]. To address this fragmentary recall problem, the interview guide allowed for the conversation to flow naturally and to focus on areas where the participant had greater awareness of the process. Participants however, did not always differentiate between the various processes. For example, there was little cognisance that a place of safety and admission to a hospital in-

patient department were separate parts of the process. Most participants instead referred to a 'the hospital'. This affected the ability of participants to comment in detail on difference between entry to a place of safety and admission to a Mental Health ward or unit. Prompts were given to elicit this information as far as possible. It should also be noted that the study is also London-centric[13 14] and the findings may not be generalisable to other parts of the UK.

This study has confirmed the findings from previous research that emphasises the broad negative experience of people detained under Section 136 all of which should be placed in the context of often an acutely traumatic experience [15 17 18]. The findings from this study enhance previous research by describing these experiences at various stages in the detention process prior to admission as an inpatient. The wider literature has described how a traumatic episode such as involuntary mental health treatment can lead to lower treatment satisfaction levels and weaker therapeutic relationships [30 31 32 33]. Satisfaction rates are a key indicator of positive treatment outcomes up to one year later through amelioration of symptoms and reducing readmission [34 35].

The findings in this study highlight the importance of each human interaction (police, clinician) with the physical environments that frames the treatment experience. The role of the professional's behaviour in this context has focused on an appropriate style of communication needed for patients in crisis[36 37]. Although studies have measured satisfaction levels at the start of inpatient treatment, we contend that consideration should be given to creating a satisfactory therapeutic environment prior to admission as an inpatient. There may be opportunities to initiate an enhanced relationship through the requirement to engage mental health professionals in the initial use of Section 136 legislation. This however may

need be balanced against what is now the 24-hour limit to the detention (which only exceptionally can be extended to 36 hours).

Moreover, cross-organisation responses are juxtaposed against multi-layered procedures that were perceived to compound the length of time taken to ensure an individual reaches a place of safety and treatment. The length of time spent within a place of safety under Section 136 has been subject to previous comment [13 38 39] with delays to admission to an in-patient facility attributed to shortages and lack of availability of staff; episodes occurring outside of office hours and the effect of intoxication as a risk factor[39]. Where these procedures broke down, the therapeutic interaction desired by participants was effectively lost.

There is something quite incongruous about reception at a place of safety being delayed pending 'medical clearance'. In effect the detainee has to be 'medically cleared' in order to have a medical examination. This is at least bad practice. At worst, if 'medical clearance' involves being examined by a doctor and the doctor does not determine the presence or absence of mental health disorder, it is arguable that the detainee's rights are being violated in that the purpose of having the detainee medically examined under Section 136 is to ensure, as soon as possible, that there are valid medical grounds for denying them the right to freedom that has been taken away by a non-medically qualified police officer.

If 'medical clearance' means waiting for the detainee's state of intoxication to subside, this is also questionable. Intoxication, whether with alcohol or other substances, may complicate the assessment but it should not delay it. Doctors are trained to diagnose intoxication and Section 12 approved doctors should have the skill to distinguish between the effects of intoxication and the manifestations of a co-existing mental disorder. Furthermore, doctors are also trained

to diagnose conditions which may appear to be states of intoxication but are not, what might be called 'false positive' diagnoses, as may occur in cases of head injury, spinal injury, pneumonia, cerebrovascular accident, hypoglycaemia, etc[40].

The Policing and Crime Act 2017 makes provision to reduce the time spent at a place of safety and enhances the role of mental health professionals at the point of detention. However, it is unclear how these requirements will fulfil the needs of people detained under Section 136 by ensuring that the process from start to finish creates a therapeutic experience. The length of time taken to complete the detention process alongside multiple contact and assessment points with an array of professionals, created problems imparting clear patient-level information.

The interviews suggested there is a compounding effect of the time taken to complete the detention process, how well professionals interacted with the patient alongside problems with the physical environment (particularly within the emergency department). In these settings, participants perceived the environment as inappropriate for their needs with the relative chaos of an emergency department for instance, acting to worsen their symptoms. The effect of the physical environment was to compound feelings of dissatisfaction. Another qualitative study[41] highlighted how negative events accumulate to frame an individual's perception of their treatment. Long detention times and variable professional interactions resulted in patients being more likely to be critical of the immediate physical environment.

Outcome studies have focused on ensuring patient satisfaction as an inpatient[34], yet it is suggested that the first point of contact with a patient prior to a hospital admission should also be considered critical in developing a reassuring and potentially therapeutic interaction.

Further work is required assessing whether there is a correlation between patient satisfaction prior to arrival at a place of safety and long-term outcomes such as readmission rates. Although the Policing and Crime Act 2017 requires the police officer, if practicable, to consult a health professional, or some other specified person, it remains unclear how far this approach will facilitate any more of a therapeutic interaction with a patient. For interviewees the feeling of being 'cared for' was paramount echoing other studies[42] and this was largely described in terms of simple, empathetic human responses. Further research is required to understand the subtle interactions between patient satisfaction with the time taken to process an individual and perceptions of a 'suitable' physical environment in which to treat a patient. Patient experiences can be seen to differ from initial police contact, conveyance, arrival to a place of safety and the emergency department. More work is required to compare the 'whole' experience on a multi-centre basis so that patient experiences in London can be compared to provincial towns/cities and rural communities.

Declaration of Conflicting Interests

The study was funded by Healthy London Partnership (NHS England). The Authors declare that there is no conflict of interest.

Acknowledgements

Many thanks to Terry Harper, Sinead Dervin, Emily Treder (Healthy London Partnership) and the National Survivor User Network for their work and support in obtaining interviews. Julie Aristidou transcribed all interviews; Professor Betsy Thom (Middlesex University) and Michael Brown (College of Policing) commented on earlier drafts.

References

1 Care Quality Commission (2016), Monitoring the Mental Health Act in 2015/16. (accessed June 20, 2017). http://www.cqc.org.uk/sites/default/files/20161122_mhareport1516_web.pdf.

2 Allison S., Bastiampillai T., Fuller DA. (2017), Should the Government change the Mental Health Act or fund more psychiatric beds? *The Lancet Psychiatry*, Vol. 4, Issue 8, 585 – 586.

3 Department of Health. The Mental Health Act 1983. London: The Stationery Office, 1983.

4 Therapeutic Solutions (2016), Section 136 and Mental Health Crisis Presentations in Emergency departments in London, unpublished report to NHS England.

5 Section 135 Paragraph 3B Subsection 6. Department of Health. The Mental Health Act 1983. London: The Stationery Office, 1983.

6 The Lancet. (2013) Section 136 and police custody—an unacceptable situation. *The Lancet*. 2013; 381: 2224.

7 HM Inspectorate of Constabulary (2013) A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs. A joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales. HMIC: London.

8 Department of Health (2015) Mental Health Act 1983 Code of Practice. Department of Health.

9 HM Inspectorate of Constabulary (2015) 'Welfare of Vulnerable People in Police Custody'. HMIC: London.

10 Independent Commission on Mental Health and Policing (2013) The Adebowale Report. Report by Lord Victor Adebowale CBE, Chair of Independent Commission on Mental Health and Policing.

11 Care Quality Commission (2014) A safer place to be: Findings from our survey of health-based places of safety for people detained under section 136 of the Mental Health Act. October 2014.

12 Royal College of Emergency Medicine (2014) 'Investigation into care of people detained under Section 136 or the Mental Health Act who are brought into Emergency departments in England and Wales'.

13 Borschmann, R.D., Gillard, S., Turner, K., Chambers, M. and O'Brien, A. (2010) Section 136 of the Mental Health Act: a new literature review. *Medicine, Science and the Law 2010;* 50: 34–39.

14 Laidlaw, J., Pugh, D., Riley, G., & Hovey, N. (2010). The use of Section 136 (Mental Health Act 1983) in Gloucestershire. *Medicine, Science and the Law*, 50(1), 29-33.

15 Jones, S. and Mason, T. (2002) Quality of treatment following police detention of mentally disordered offenders. *Journal of Psychiatric and Mental Health Nursing* 2002; 9: 73–80.

16 McGuinness, D., Dowling, M., & Trimble, T. (2013). Experiences of involuntary admission in an approved mental health centre. Journal of Psychiatric and Mental Health Nursing, 20(8), 726-734.

17 Riley, G., Freeman, E., Laidlaw, J. and Pugh, D. (2011) 'A frightening experience': detainees' and carers' experiences of being detained under Section 136 of the Mental Health Act. *Medicine, Science and the Law*. 2011; 51: 164–169.

18 Durcan, G. (2014) Review of Sections 135 & 136 of the Mental Health Act: The views of professionals, service users and carers on the codes of practice and legislation. Centre for Mental Health: London.

19 Wyder, M., Bland, R., Blythe, A., Matarasso, B., & Crompton, D. (2015). Therapeutic relationships and involuntary treatment orders: Service users' interactions with health- care professionals on the ward. International Journal of Mental Health Nursing, 24(2), 181-189.

20 Jaeger, S., Pfiffner, C. & Weiser, P. (2013). Long-term effects of involuntary hospitalization on medication adherence, treatment engagement and perception of coercion. Social Psychiatry and Psychiatric Epidemiology, 48, 1787–1796.

21 Sadler, G. R., Lee, H. C., Lim, R. S. H., & Fullerton, J. (2010). Recruitment of hard- to-reach population subgroups via adaptations of the snowball sampling strategy. Nursing & health sciences, 12(3), 369-374.

22 Faugier, J. and Sargeant, M. (1997), Sampling hard to reach populations. Journal of Advanced Nursing, 26: 790–797.

23 Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory; Strategies for qualitative research. Chicago: Aldine Publishing.

24 Glaser, B. G. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press.

25 Corbin J. and Strauss, A. (1990). Grounded Theory Research: Procedures, Canons, and Evaluative Criteria. Qualitative Sociology, Vol. 13, No. 1, 1990.

26 Charmaz, K. (2006) Constructing grounded theory: A practical guide through qualitative analysis. London: Sage.

27 Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101.

28 Menkes, D.B. and Bendelow, G.A., (2014), Diagnosing vulnerability and "dangerousness": police use of Section 136 in England and Wales. Journal of Public Mental Health, 13(2), pp. 70-82.

29 Opsal, A., Kristensen, Ø., Larsen, T. K., Syversen, G., Rudshaug, E. B. A., Gerdner, A., & Clausen, T. (2013). Factors associated with involuntary admissions among patients with substance use disorders and comorbidity: A cross-sectional study. BMC Health Services Research, 13(1), 57.

30 Katsakou, C., Bowers, L., Amos, T., Morriss, R., Rose, D., Wykes, T., & Priebe, S. (2010). Coercion and treatment satisfaction among involuntary patients. Psychiatric Services (Washington, D.C.), 61(3), 286.

31 Roche, E., Madigan, K., Lyne, J. P., Feeney, L., & O'Donoghue, B. (2014). The therapeutic relationship after psychiatric admission. The Journal of nervous and mental disease, 202(3), 186-192.

32 Smith, D., Roche, E., O'Loughlin, K., Brennan, D., Madigan, K., Lyne, J., Feeney, L. and O'Donoghue, B., 2014. Satisfaction with services following voluntary and involuntary admission. Journal of Mental Health, 23(1), pp.38-45.

33 Strauss JL, Zervakis JB, Stechuchak KM, Olsen MK, Swanson J, Swartz MS, Weinberger M, Marx CE, Calhoun PS, Bradford DW, Butterfield MI. (2013). Adverse impact of coercive treatments on psychiatric inpatients' satisfaction with care. Community mental health journal, 49(4), 457-465.

34 Priebe, S., Katsakou, C., Yeeles, K., Amos, T., Morriss, R., Wang, D., & Wykes, T. (2011). Predictors of clinical and social outcomes following involuntary hospital admission: a

prospective observational study. European archives of psychiatry and clinical neuroscience, 261(5), 377-386.

35 Kallert TW, Katsakou C, Adamowski T, Dembinskas A, Fiorillo A, Kjellin L, Mastrogianni A, Nawka P, Onchev G, Raboch J, Schützwohl M. . (2011). Coerced hospital admission and symptom change—a prospective observational multi-centre study. PloS one, 6(11), e28191.

36 Wyder, M., Bland, R., Blythe, A., Matarasso, B., & Crompton, D. (2015). Therapeutic relationships and involuntary treatment orders: Service users' interactions with health- care professionals on the ward. International Journal of Mental Health Nursing, 24(2), 181-189.

37 Bradbury, J., Hutchinson, M., Hurley, J., & Stasa, H. (2017;2016;). Lived experience of involuntary transport under mental health legislation. International Journal of Mental Health Nursing, 26(6), 580-592. 10.1111/inm.12284

38 Pugh, D and Laidlaw, J. (2016) Sections 135 and 136: Running a health-based place of safety in Gloucestershire. Medicine, Science and the Law, 2016, Vol. 56(2) 99–106.

39 Docking, M. (2009) The use of section 136 to detain people in police custody. Journal of Mental Health Law. Spring 2009:33.

40 Rix, KJB. (1989) 'Alcohol intoxication' or 'drunkenness': Is there a difference? Medicine, Science and the Law 29: 100-106.

41 Nyttingnes, O., Ruud, T., & Rugkasa, J. (2016). ‘It's unbelievably humiliating’—Patients' expressions of negative effects of coercion in mental health care. International Journal of Law and Psychiatry, 49, 147-153. 10.1016/j.ijlp.2016.08.009

42 Katsakou, C., & Priebe, S. (2007). Patient's experiences of involuntary hospital admission and treatment: a review of qualitative studies. Epidemiology and Psychiatric Sciences, 16(2), 172-178.

Table 1: Interview Topics and Sample Questions

Interview Topic	**Sample Questions**
Point of detention	•Can you please describe to me in your own words, the point at which you were detained by police on a Section 136
Transportation	•When you were taken to the place of safety by ambulance or by the police, what were your thoughts at this point? •Did you get taken to a hospital or place of safety by the police or by ambulance? •When you were taken to the place of safety by ambulance or by the police, what were your thoughts at this point? •Can you remember how long the journey to a hospital or place of safety took? •If you can recall, was the journey length about right or too long?
Arrival at a Place of Safety	•Tell me in your own words about what happened when you arrived at a hospital or place of safety? •How did the hospital staff make you feel when you arrived? •What services or support did they offer you?
Acceptance into a Place of Safety	•Can you tell me your experiences once you had been accepted into a Place of Safety? •What support did you receive? Were you satisfied with that support? •What worked well for you and what worked less well?

Discharge	• What was your experience when discharged from the Place of Safety? • Were you satisfied with the discharge process? • What worked well for you and what worked less well?