University of Brighton

Sussex Partnership NHS Foundation Trust

Section 136 in Sussex

Professor Gillian Bendelow, Claire Warrington, Anna-Marie Jones

School of Applied Social Science, University of Brighton

DRAFT

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Contents

	Page
List of Tables and Figures	2
Acknowledgements and Thanks	2
1. Background and Context	3
2. Funding, Aims and Roles	7
3. Design, Methods and Dissemination During Project	9
4. Findings and Key Themes	13
5. Conclusions	27
6. Further Information and Continuation of Research Programme	30
7. References	32

List of Tables and Figures

	Page
Table 1 National uses of Places of Safety	4
Table 2 Highest Uses of Police Custody by County	4
Table 3 Characteristics of Individuals Detained in 2012	12
Table 4 Key Themes	10
Table 5 Characteristics of Interview Sample	10
Table 6 Characteristics of Individuals detained Repeatedly in 2012	15
Table 7 Intoxication and Reason for Detention	17
Table 8 Places of Safety Use in Sussex by Region 2012 and 2015	20
Figure 1 Sussex Places of Safety at time of Study	5
Figure 2 Summary of Research Design	8
Figure 3 Time and Day of Detention	11
Figure 4 Range of Interviewees' Reflections on S136	19

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1. Background and Context

1.1 National context

During the period of this research study, 'out of hours' general emergency health care has been a public issue of great concern. Long waiting times at A&E and ambulances stacked up due to lack of triage beds have been widely reported through media coverage across the UK. In conjunction, there has been a widespread reduction of mental health hospital beds and increasing pressures on mental health trusts to treat people in community settings. This has resulted in acute and unprecedented demands on emergency mental health care services which crisis resolution home teams have largely been unable to contain outside of 'normal' working hours (Lancaster 2016). Within that context, 'blue light' emergencies may be routed via the police and if a person is deemed by police officer to be a danger to themselves or others, Section 136 of the 1983 Mental Health Act (S136) can be used to detain that person to a designated Place of Safety.

Concerns about policing and mental health have been sharpened since the Adebowale Report in 2013 and the limited research literature with a focus on S136 had mainly focused on the coercive nature of the use of S136 from the 1980s in relation to the excess of Black and Minority Ethnic (BAME) detentions, especially those of young black men in London (see for Rogers 1990, Pipe et al 1991).

In contrast, more recent research by the lead author with police response officers in North Wales, Sussex and the South West of England suggests that S136 has become a 'default response' for police to manage highly distressed individuals in public places when no other services are available (Menkes and Bendelow 2014). In other words, police use S136 largely as a suicide prevention strategy outside of London and other large urban conurbations (see also review by Borschmann et al 2010).

The dominance of the biomedical approach to mental health tends to focus on individual pathology (Colombo et al 2003) and whereas it is the case that 'completed suicides' are more likely to be recorded for people who have had previous contact with mental health services, more recent research has recognised the role of social context and social marginalisation in vulnerability (Barnes et al 2016). Factors such as economic hardship, relationship breakdown and lack of social support in an increasingly divided society can be perceived as major 'triggers' to severe emotional distress and suicidal behaviour (Samaritans 2016). The Parity of Esteem agenda recognises the inherent inequalities between physical and mental health, in particular in seeking help and the burgeoning crisis in emergency mental health care has been a major focus of national concern with the establishment of the Crisis Care Concordat issuing the following edict:
'No one experiencing a mental health crisis should ever be turned away from services' (Closing the Gap: priorities for essential change in mental health, Department of Health 2014)

Hence S136 has become subject to increasing scrutiny since the widespread development of NHS Place of Safety suites from 2007, as a response to the rising numbers of police detentions across the UK since the millennium (Bather et al 2008, RCP 2011, 2013, Menkes and Bendelow 2014). In particular, the continued use of police custody as a place of safety has been continually highlighted as a major area of concern by the government, the Care Quality Commission (CQC) and the media during the life of this study (Lancet 2013).

Table 1 shows that the number of those detained under S136 in England and Wales who went to a police cell or to a health based place of safety in the last three years.

Table 1: National Uses of Places of Safety

Year	Total	Police Cell	Health
2011-12	25,000	9,000	16,000
2012-13	22,834	7,761	15,073
2013-14	24,489	6,028	18,461

Source: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/20204.htm

The Mental Health Act 1983 Code of Practice on the use of S136 states that police cells should be used as a place of safety only on an exceptional basis, and that a *'police station should not be assumed to be the automatic second choice if the first choice place of safety is not immediately available'.*

1.2 Context of S136 in Sussex: setting up the feasibility study

Initial collaboration in 2012 with the Chief Constable of Sussex Police and Sussex Partnership NHS Trust (SPFT) confirmed that there was an ever-increasing problem for both the police and the mental health services. In the worsening climate of deep cuts to both NHS and police services, there were concerns that considerable numbers of people who were detained under S136, with heavy use of resources, were not seen as meeting the criteria of mental health professionals for admission to psychiatric units. Despite the historically effective joint working between police and mental health professionals in Sussex, in particular at strategic and managerial levels, there were some entrenched positions expressed by both sides of the 'front line' with statements like:

'Police use 136 because it's easier than arresting drunks' (NHS psychiatrist)

'All too often mental health professionals don't recognise vulnerability- being suicidal is not a mental health problem apparently' (Police Response Officer).

Already an area of concern for both the police and SPFT, detention rates in Sussex were under the spotlight of the Home Office during the life of the project, and this focus intensified when the Crisis Care Concordat was launched with the assertion that 'police custody should not be used' and issuing the instruction that the use of cells as places of safety was to be reduced to less than half of the 2011/12 number within the year (Crisis Care Concordat 2014).

Table 2: Highest Uses of Police Custody by County

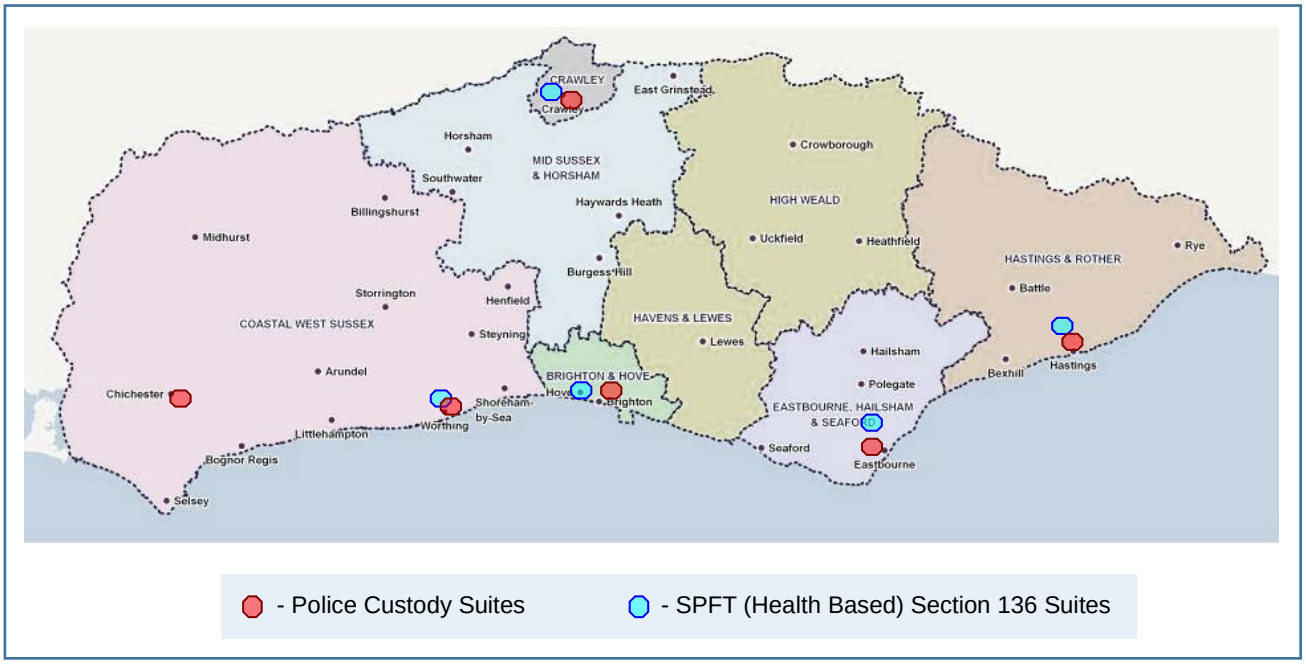
Police force	2013-14	2012-13
Sussex	855	941
Devon & Cornwall	765	790
Avon and Somerset	420	646
West Yorkshire	380	673
Hampshire	340	593

Source: http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/20204.htm

Data on S136 detentions have been systematically collected by SPFT and Sussex Police for over 10 years, in contrast to many other UK regions. Monthly meetings are held in Brighton and Hove, East and West Sussex with representatives from SPFT, Sussex Police and Local Authority Approved Mental Health Professionals (AMPHs). These meetings monitor the use of S136 and are used to develop joint working policy and practice. There are also quarterly Mental Health Act monitoring meetings attended by the relevant agencies across the whole of Sussex.

At the time of the study, there were eleven designated Places of Safety across Sussex (five single bed suites adjacent to acute wards at SPFT hospital sites and six police custody suites, see Figure 1). In common with other coastal regions, a considerable proportion of S136 detentions involve highly distressed people from outside Sussex (i.e. other regions of the UK, the rest of Europe and occasionally beyond).

Figure 1: Sussex Places of Safety at time of Study



Detentions in the Crawley area are notoriously high, with the proximity of Gatwick Airport, as are those in the suicide 'hotspots' notably Beachy Head and other cliffs of the Sussex coast, the multi-storey car parks and the rail networks serving the coastal towns, including the much visited city of Brighton and Hove, with its elevated rates of substance misuse and 'non-stop party' reputation. The spectacle of someone being detained from a public place by the police is a large part of what makes the incident so visible and controversial. These circumstances are often heightened by situations being 'blue light' emergencies, which may involve multiple agencies on the cliffs, highways, railway lines, transport hubs, car parks and so forth, with many such incidents being triggered by 999 calls to police by concerned members of the public or carers. Hence there may be more awareness and faster response in the above mentioned 'hotspots' across Sussex, notably Gatwick Airport, which has the highest S136 rates of all. Awareness is also heightened at Beachy Head, a notorious suicide site which draws highly distressed people as well as tourists to its picturesque cliffs, from all over the world as well as elsewhere in the UK. The Beachy Head Chaplaincy Team try to maintain a 24 hour service by patrolling patrol the cliffs to intercept and provide help with an average of one incident a day, many of which result in S136 detentions. East Sussex County Council convene a committee with the front line workers to work together to balance the needs of risk management with the status of Beachy Head as a key tourist site for the region.

Given these complex social and geographical factors, S136 detentions in Sussex frequently do involve multiple agencies including ambulances, coastguards and social care services with high financial burden to the public. The study's stakeholders estimated that each detention in Sussex costs on average £1200.

However, whilst the consistently high rates of S136 detentions across Sussex (around 1500 per annum between 2007-14) may to some extent reflect the idiosyncratic local phenomena alluded to above, it does not fully explain why the ratio of detentions in custody to health places of

safety have consistently remained at two thirds to one third, in contrast to most other areas of the UK, which have seen this trend reversed in the wake of the Crisis Care Concordat.

This research study was not designed to provide definitive answers as regards to the inflated rates of detention and the excessive use of police custody as a Place of Safety, but rather to utilise a multi-method approach to reveal the complexity of factors involved in S136 detentions in Sussex in order to aid policy making and highlight existing good practice.

2. Funding, Aims and Roles

2.1 Funding and Ethics

This research project was funded initially for a year by a British Academy/Leverhulme Senior Research Fellowship, held by the lead author from September 2012. The purpose was to develop a collaborative programme of research with SPFT and Sussex Police.

The study was sponsored by SPFT Research & Development Department (R&D) and received Patient and Public Involvement (PPI) guidance from Ruth Chandler, Involvement Lead for R&D.

The project was adopted onto the National Institute for Health Research portfolio and was approved by City Road & Hampstead NHS Ethics Committee (Ref 12 LO 2031).

2.2 Research Aims

The research aims were to:

- conduct a detailed secondary analysis of the existing records to reveal the social patterning of S136 detention across Sussex in relation to gender, age, geographical location and any other available information, as well as to establish the extent to which some individuals were repeatedly being sectioned under 136;
- collect qualitative interview data from people who had been detained, as well as police, mental health professionals and other relevant services regarding their views of 'appropriate' use of S136 in Sussex
- provide an overview of 'out of hours' crisis intervention practice and provision for vulnerable adults conducted by SFPT, Sussex Police and other services across Sussex
- build upon and influence good practice and to feed into current debates of S136, both locally and nationally.

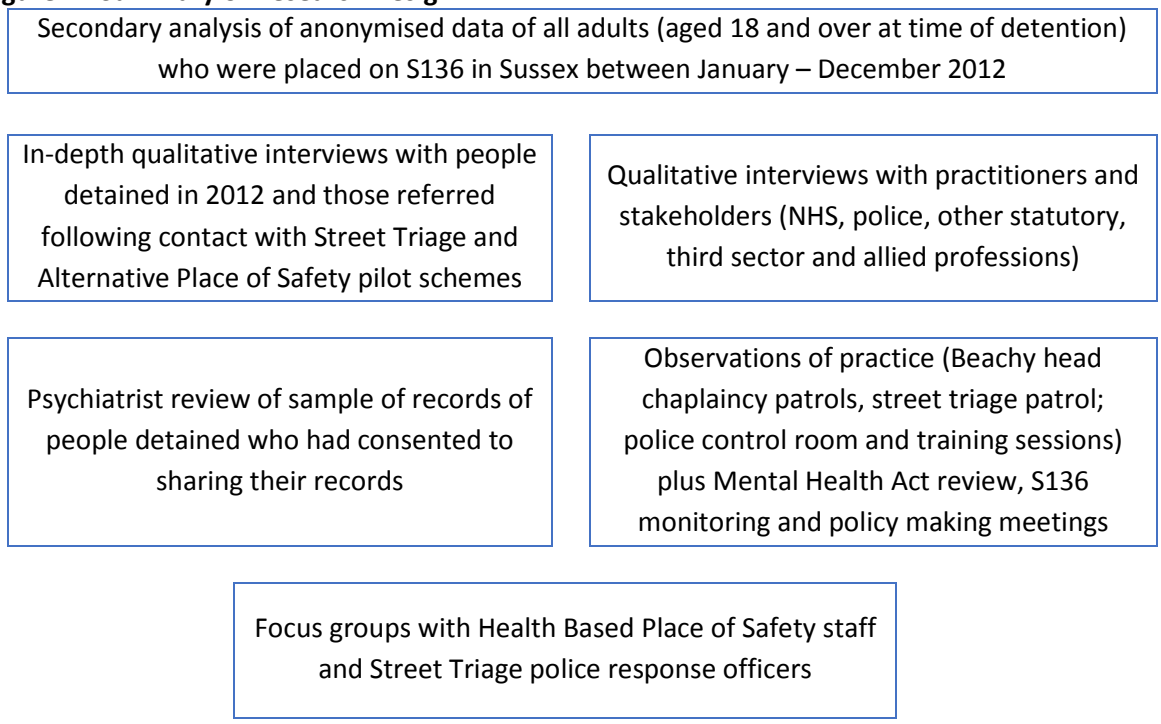
2.3 Roles

In April 2013 Gillian Bendelow as Principle Investigator (PI) was awarded a three-year Honorary Senior Research Fellowship with SPFT to take the project forward. The support from the Mental Health Research Network enabled Claire Warrington to be employed as a dedicated Research Assistant. Anna-Marie Jones provided ongoing methodological and analysis support through R&D, as well as advising on the development of the programme of research arising from this study alongside her colleague Claire Rosten at the NIHR Research Design Service based at University of Brighton.

3. Design, Methods and Dissemination During Project

This research was designed as a mixed methods study incorporating secondary analysis of all S136 detentions in Sussex during 2012 and qualitative data collected between 2012-2015. Figure 2 displays the different elements of the study.

Figure 2: Summary of Research Design



3.1 Recruitment and Participants

Ethical approval to conduct the empirical work was granted in January 2013, and the subsequent response from all groups of stakeholders who were invited to take part in the research was overwhelmingly enthusiastic, resulting in a much larger data collection than originally envisaged.

Data was gathered through three main routes.

3.1.1 Route 1: Creation of quantitative dataset

Ethical approval was granted to analyse the anonymised records of all adult (18 and over) S136 detentions between January and December 2012. This was completed with the help of both SPFT R&D and the Social Care Specialist Services team.

Collation of the existing records of each detention into a new, anonymised dataset was carried out by Sarah Wickenden, PA to Head of Social Care Specialist Services, Marian Trendell from June 2013. As chair of the county-wide Mental Health Act monitoring board, Marian's team oversees this information, however, the S136 figures are not compiled across the place of safety sites in a standardised method, so this process was far more difficult and time consuming than expected and consequently was not completed until April 2015. Similar problems have been recorded in some detail by a recent S136 audit completed by SPFT (Harlow 2016)

3.1.2 Route 2: Data collection with people who had been detained, assessed by Street Triage or stayed at the Alternative Place of Safety

Whilst recognising the distressing circumstances leading to detention and the often harrowing nature of the experience, the most significant aspect of the study design was the recording of 'lived experience' though narrative interviews with detainees, to provide a much needed perspective to feed into the policy agenda.

Alongside compiling the dataset, Sarah sent out letters of invitation to participate in the qualitative research with pre-paid return envelopes, to all those with viable addresses recorded at the time of detention.

Out of a total 67 people responded to the invitation letter expressing willingness to participate in the study. Responses were received through SPFT R&D to interview 58 members of the public who had been detained under S136. Very sadly, the PI was also contacted by the relatives of three people who had been detained in 2012 who had since killed themselves. Each felt very strongly that this research was important and wanted the experiences of their loved one to be included. A further six people took part having been advised of the research following contact with either the Eastbourne Street Triage or Alternative Place of Safety Pilot schemes.

As anticipated, a small number of people (4) also responded to R&D who were either angry at being contacted or to say that the memory was so traumatic they could not take part in the study. This was regrettable but was felt to be balanced by the overwhelming enthusiasm and commitment of the 67 people who did consent to participate, largely motivated by the desire to improve the experience for others.

It was not possible to meet with or interview all those who consented: 25 people did not respond to further contact by phone or email and five arranged appointments but subsequently were unable to take part. Participants were offered the choice of coming to the university or taking part in a telephone interview. Home visits and interviews at alternative locations were arranged through a lone working policy adapted in collaboration with R&D for five participants with mobility problems or who were unable to travel to the university. A further four interviews took place by phone and detailed written accounts were sent by another five people in preference to meeting face to face. Those who visited the PI at the university were given the choice to bring carers, relatives or friends with them and participants were asked about the support systems they had in place in case of distress triggered by the interview. The PI carried out all the interviews, a selection of which were fully transcribed and the remainder were selectively transcribed. Each participant was then assigned a pseudonym by the PI.

All except one of the 37 participants were highly motivated and expressed having been pleased to be consulted:

> *'Being asked to take part in this research made me feel as if I actually mattered, which is a rare experience'*. Siobhan, 34

This was a self-selecting sample, most of whom were organised and articulate. It is also of note that all but five of those who consented to take part had come to police attention because of their perceived risk of suicide at the point of S136. Given these factors, it must be acknowledged that the sample is unlikely to be entirely representative of all who experience detention under Section 136.

3.1.3 Route 3: Data collection with services and professionals

Qualitative data was collected through 250 hours of observations of practice, meetings and training sessions, as well as conducting focus groups and individual interviews. This phase involved a total of 79 police officers including the Deputy Chief Constable, custody sergeants and response officers and 160 NHS and allied health professionals (managers, nurses, psychiatrists, A&E staff and paramedics) and local authority and voluntary sector workers (AMHPs, Councillors, public health officials, coastguards, Samaritans, Beachy Head chaplains, MIND, YMCA and Grassroots Suicide Prevention).

3.2 Data Analysis and Dissemination During the Study

Three types of data analysis were used to produce both quantitative and qualitative findings

- A descriptive summary and exploratory analysis was carried out on the anonymous dataset. Participants who consented to sharing their personal data were identified within the anonymised datasheet by Sarah Wickenden.
- Thematic analysis (Pope et al 2000) was used to analyse the qualitative data collected from service professionals and other workers (transcripts, fieldnotes and minutes of meetings), illuminating a range of key issues for the operation of S136 in Sussex and for joint agency working practice;
- Transcripts from the semi-structured narrative interviews were analysed using Interpretive Phenomenological Analysis (IPA) (Willis 2007) which allows the researcher to elicit and interpret participants' views of the meanings of emotional experiences.

As part of the process of keeping the voice of the person with lived experience central to the work on the study, a 'Deliberative Workshop' was hosted at University of Brighton, Falmer Campus on 15th July 2015. This event was developed in collaboration with Ruth Chandler, Involvement Lead for SPFT R&D. The day long consultative workshop was attended by eight people who had lived experience of accessing emergency mental health care, most of whom had also been interviewed as part of the study. Ruth facilitated the event, in which discussion groups followed presentations by the PI and Research Assistant on the themes emerging from initial analysis of the data. Consultants' deliberations have been incorporated into the findings presented herein.

One of the key aims of the research was to feed into the fast moving policy agenda and so initial findings were fed back to stakeholders during the project through a series of events:

6th February 2014 Mental Health and Policing: Parity of Esteem

Held at Slaugham Manor, this event was hosted jointly by SPFT and Sussex Police with a Keynote Address from Lord Adebowale. Following the successful engagement from the wide range of delegates, two follow up events were hosted by the project at the Falmer campus of University of Brighton over consecutive years:

5th February 2015 Mental Health and Policing in Sussex: Emergency Mental Health - Progressing Parity of Esteem

72 attendees including senior police and NHS managers, commissions, mental health professionals and emergency response workers, with representatives from Home Office and NHS England

1st April 2016 **Mental Health and Policing: Progressing Parity of Esteem - Inter-Agency Working in Emergency Mental Health Response**

32 attendees including senior managers and representatives from Sussex Police, SPFT, South East Coast Ambulance, and a range of third sector partnership agencies

In addition, contributions to the wider policy agenda were made during the project through the PI's involvement by invitation in the following:

- Brighton and Hove Suicide Prevention Strategy Committee Brighton & Hove County Council
- Beachy Head Risk Management Group, East Sussex County Council
- Kent Surrey and Sussex Mental Health Clinical Advisory Group, South East Coast NHS England
- Home Office Department for Safeguarding Vulnerable People/NHS England Roundtable Consultation on the operation of Section 135 and 136
- Mental Health Triage National Conference Home Office/ NHS England, London
- National Mental Health Crisis Care Concordat Team South East Coast Strategic Clinical Network (Input into policy document single point of access for emergency mental health care)
- NHS England/Royal College of Psychiatrists /National Centre for Collaboration in Mental Health member of Expert Reference Group Achieving Better Access to Mental Health Services by 2020 programme (ongoing)

The research work has been further highlighted through the following awards:

SPFT Positive Practice Awards
(The Dome, Brighton, June 12th 2015)
Gold Award for Research and Teaching for the S136 in Sussex Research and Parity of Esteem Event at University of Brighton (5th February).

Kent, Surrey and Sussex NHS Leadership Academy
(Sandown Racecourse, November 12th 2015)
Winner of NHS Outstanding Collaborative Leader of the Year between Health and Local Government

The work also received a finalist nomination at the National NHS Leadership Recognition Awards (Senate House London, 8th March 2016) for Outstanding Collaborative Leader of the Year

4. Findings and Key Themes

4.1 Social Patterning of People Detained in 2012

One of the original aims of the research was to explore some of the social patterning of those detained. Analysis of the detention data revealed that there were 1421 detentions across Sussex, with more males being detained than females (see Table 4).

Table 3: Characteristics of Individuals Detained in 2012

Gender:	
Male	683 (59%)
Female	458 (40%)
Not stated	1 (.08%)
Age & Gender:	
Males Range (median)	18 – 86 (38)
Females Range (median)	18 – 84 (38)
Ethnicity:	
White British	907 (79%)
Other including Black & Minority Ethnicity	122 (11%)
Missing / Unknown / Not stated	113 (10%)
Area of residence:	
Brighton	210 (18%)
East Sussex	214 (19%)
West Sussex	380 (33%)
Out of Area	172 (15%)
No Fixed Address	24 (2%)
Missing / Unknown / Not stated	142 (12%)

This analysis was conducted on the individuals within the data set (i.e. each person detained more than one time in 2012 was included in the analysis only once). The age range was 18-89 years with a mean of 38 for both men and women (5% of people were aged between 18 - 20, and 6% were over 60).

Much of the extant research on S136 has focussed on single urban areas, for example specific boroughs of London or cities elsewhere in the UK. Many of these studies have reported a BME bias in those detentions. Ethnicity data was not available for 10% of detentions (not stated 29 detentions, missing data 94 detentions). The ethnicity categories recorded were White British (1158); White Other (76); Black -including Black British, Black Caribbean, Black African and Black Other (24); Asian -including Asian, Asian Pakistani, Asian Other (20); Mixed ethnicity (16); Other (4).

Another element of particular relevance to S136 in Sussex is the number of people detained in the area who do not live in Sussex. In the target year 172 people (15% of those detained) were from outside Sussex. The highest number of people detained had West Sussex addresses (33%). Home area information was not given or missing from the records for 12% of people.

Alongside the characteristics detailed above, four notable and important findings emerged from the secondary analysis which are presented here and will be elaborated upon in more detail through the qualitative data:

Table 4: Key Themes

1. Most (81%) S136 detentions in 2012 took place 'out of hours'.
2. There were 1421 detentions but 1142 individuals detained; a third of detentions were attributable to 142 people who were detained more than once that year.
3. Most detentions (80%) were because of the perceived risk of suicide but only 29% were deemed to be intoxicated.
4. Over two thirds of detentions were initially to police custody, rather than to a health based Place of Safety

4.2 The Lived Experience of Being Detained under Section 136

Central to this study was the feedback from the courageous men and women from Sussex and further afield who consented to take part in the in-depth interviews about their experiences. Table 7 (below) gives the information on the backgrounds of the 31 people who took part in face to face or telephone interviews. In addition, written information was received from a further three individuals and three relatives of people who had completed suicide since having been detained in 2012 (see section 3.1 for further description).

Table 5: Characteristics of Interview Sample

14 Females *(average age 35)*
3 Brighton & Hove
5 East Sussex
2 West Sussex
4 Out of Area
12 Males *(average age 47)*
2 Brighton & Hove
4 East Sussex
3 West Sussex
3 Out of Area
5 Females from Street Triage or alternative place of safety pilots *(Average age 49)*
3 East Sussex
1 West Sussex
1 Out of Area

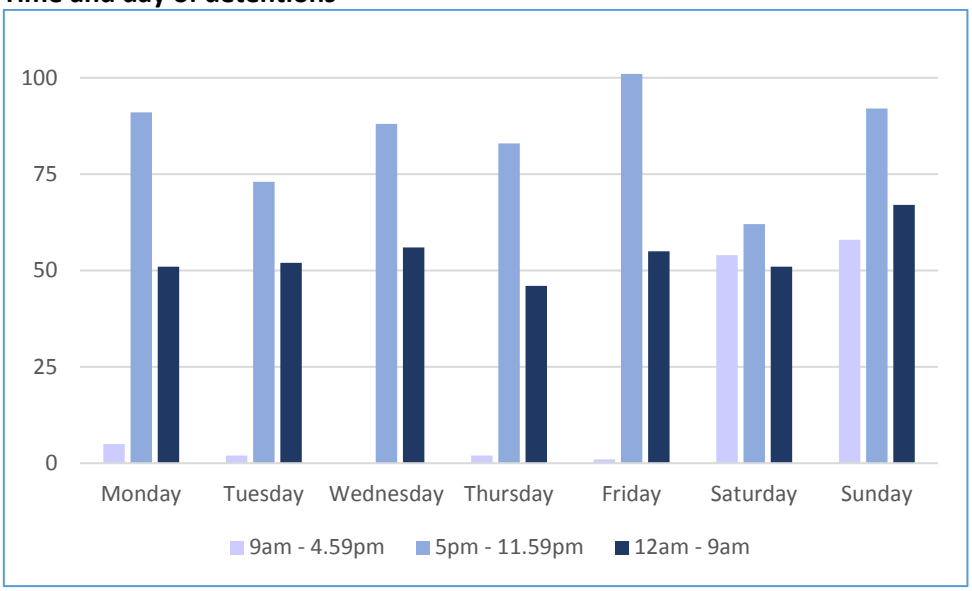
4.3 The 'Out of Hours' Emergency Mental Healthcare Crisis

As outlined in the introduction, the rise in demand for emergency mental health services and the lack of availability of these, especially outside weekday working hours, has resulted in a national crisis.

The dataset revealed that 81% of S136 detentions in Sussex in 2012 took place 'out of hours'. Although more S136 detentions took place on Fridays and Sundays, there was not a wide variation in detentions by day of the week (range between 179 – 227 detentions). However, the data clearly shows that time of day was extremely important with regard to 'normal' working hours (see figure 3).

Although there is variation in the operating times of crisis teams and other mental health services across Sussex, four times as many detentions (81%) took place 'out of hours' (i.e. after 5pm on weekdays and at weekends), which would support the claims from the pilot research that police use S136 as an emergency mental health intervention when no other service is available.

Figure 3: Time and day of detentions



In common with many other mental health trusts, SPFT tries to offer a 24-hour crisis response service, but ever increasing demands and ever diminishing resources mean that out of hours (and sometimes even within 'normal' working hours) support is often focussed towards people already within the services. Hence for many mental health staff, it is impossible to meet the Crisis Care Concordat Parity of Esteem goal that no-one should be denied help in a mental health crisis. This is further exacerbated by the broad definition of what constitutes a mental health crisis, namely 'extreme panic attacks, psychotic episodes (including hallucinations and hearing voices), other behaviour that seems out of control or irrational and that is likely to endanger the self or others' (Mind 2011).

Nevertheless, people in extreme emotional distress expect to receive help immediately, whether or not they are known to services. Even if they had supportive family members or friends, there were several cases where interviewees felt they were unable to ask for this 'informal support' the middle of the night, and when seeking help from other sources out of hours, they were often advised to present at A&E or call 999. Rejection by A&E staff, or inadequate responses to help-seeking, appears often to have then escalated desperate behaviour in many of these accounts and culminated in situations that resulted in S136 detention.

4.4 People Detained Repeatedly

Analysis by the anonymous case number assigned by Sarah Wickenden to each person in the dataset revealed that the 1421 adult detentions in 2012 corresponded to 1142 individuals. Although the greatest majority of people (87%) were detained only once, 142 people accounted for 422 of the S136 episodes (30% of the total number of detentions). The number of times each person was detained in the year ranged from 2 – 24. Table 5 shows the sociodemographic characteristics of this group of individuals.

Over half of the interviewees in the study had been detained on multiple occasions, five of whom were detained only once in 2012. Whereas the overall figures for 2012 show that 60% of those detained were men, looking only at people detained more than once in the year, the

gender gap closes and women appear almost exclusively in the highest frequency detention group (those detained six or more times in the year).

Table 6: Characteristics of Individuals Detained Repeatedly in 2012:

Gender
74 Males (52%) 69 Females (48%)
More males than females were detained twice, three and four times
An equal number of males and females were detained five times
One male was detained six times, the remaining eight people with six or more detentions were female
Ethnicity
127 (89%) of those detained more than once were White British
9 (6%) were White Other
3 were Black or Asian
4 had no ethnicity recorded or data was missing for each of the nine occasions they were detained
Home Area
68 West Sussex (48%)
35 Brighton and Hove (24%)
23 East Sussex (16%)
3 No Fixed Address (2%)
8 Out of Area (6%)
6 no address recorded / data missing (4%)

Women also constituted nearly a third of the qualitative sample (ages ranged between 19 to 65). The in-depth interviews pursued with this particular group revealed many common themes, namely:

- Complex history of often multiple diagnoses including personality disorder (Borderline or Emotionally Unstable Personality Disorder); Dissociative Identity Disorder; Bipolar Disorder and Complex Post Traumatic Stress Disorder;

- History of traumatic childhood experiences, in many cases sexual abuse, often by a family member, domestic violence, disrupted schooling and poor adult attachments;

- Disenfranchisement from mental health services with a sense of abandonment and social marginalisation ‘we are the dregs of society’ (Sally, aged 41), further exacerbated by frustration at not being able to access appropriate therapy;

- Recurrent experiences of chronic depressive and sometimes dissociative episodes which lead to feelings of desperation and suicide attempts, often in public places and the recognition that, for some, restraint was often needed as they may ‘scream, kick, bite or lash out’ (Alice, aged 24) in these situations;

- The sense that being sectioned by the police was frequently the only recourse, that police were more likely than mental health professionals to take their distress seriously, to treat them with kindness and compassion and, crucially, not to accept false assurances made about their own safety; whereas (most) mental health professionals regarded them as ‘a nuisance’ or worse, seeing them as a diagnosis or behavioural category rather than a person. Several respondents in this group also reported feeling they were contained more safely when in police custody.

The women in this group who were over 30 also described the experience of living with personality disorder in terms of their downward mobility and poor general health and

comorbidity. The younger women were very critical of support from Child and Adolescent Mental Health Services (CAMHS) especially with regard to sexual abuse, and nearly all the women with this history felt that statutory adult mental health services were unable to offer the help they needed to manage their dissociative episodes or address the traumas underpinning their mental health problems. 'CMHT are under-resourced and, in my most recent meeting with them I was told that if I'm in crisis, the only option is to call the police!' Nina, 18).

There was also a feeling among several interviewees that both mental health assessments and services in general, frequently failed to adequately consider the longer-term issues triggering a metal health crisis. In contrast, the women who had been able to access specialist services, for example through the SPFT led centres (the Lighthouse in Hove and Bluebell House in Burgess Hill, which offer a comprehensive range of psychological therapy, key work and social support for patients diagnosed with borderline or emotionally unstable personality disorder) had found this incredibly helpful. Unfortunately, all but one of those who had been referred to specific therapists outside Sussex had seen this support withdrawn for various, predominantly funding related, reasons. 'So many doctors have said I need to be in a residential place … to have [longer term] therapy to get through my traumas but… it's all about money' (Sally, aged 41).

4.5 Section 136 as Suicide Prevention in the Community

Rapidly assessing the risk an individual may pose to themselves or others, especially with little or no prior knowledge of that person, is obviously a highly complex task, for mental health professionals, as well as the police. As in other studies, officers readily acknowledged both their lack of knowledge and the ethical difficulty of making such judgements about mental disorder. Recognising their inability to make 'expert' diagnoses, they generally felt that experience enabled them to tell intuitively when something was wrong with someone's mental state. In these instances, the criteria of serious risk of harm to self or others were paramount, and was generally seen as the only way to contain potentially life-threatening situations. However, the police response to extreme emotional distress often contrasts with that of the mental health professionals (AMHPs and psychiatrists) who subsequently carry out the assessments and who may be more focused on treating diagnosable mental illness than managing associated psychosocial disturbance.

Our secondary analysis shows that 80% of the detentions in 2012 appear to have been actioned by the police responding to people who were presenting as suicidal. In line with previous research outside of London and other large urban areas (Menkes and Bendelow 2014) this confirms that S136 is widely used as a suicide prevention measure. Detentions were coded as 'Suicidal' if the records had stated the person was detained because of concerns that they intended to end their life, had taken an overdose etc. or that they had been detained from an obvious 'suicide spot' unless the notes indicated otherwise; 'Not suicidal' was coded if the person was detained for making threats of violence to others or where detention was on the basis of apparent psychotic symptoms or similar concerns. 143 detentions were marked 'Unknown' as it was not possible to determine whether threat to life was the reason for detention due to missing or incomplete notes.

4.5.1 Suicide Prevention strategies

In addition to the SPFT Sussex wide Suicide Prevention Strategy, each of the three County Councils in Sussex has its own Suicide Prevention committee in partnerships with voluntary

organisations such as Grassroots, the Samaritans, MIND and the YMCA as well as Sussex Police, SECAM, Fire Service and coastguards. Grassroots, a Brighton based organisation is working strategically with national and international suicide prevention agendas, including working with the Transport Police to implement initiatives in the 'hotspot' sections of the rail network, and in developing a very successful suicide prevention app (Staying Alive) which can be downloaded free and provides local information on sources of help as well as advice on how to approach someone who may be suicidal.

4.5.2 Substance Misuse

A related matter of concern is whether people were intoxicated when detained. Within the 2012 dataset only 417 people were recorded as 'Intoxicated'. It was unclear whether alcohol or drugs had been a factor at the time of detention in the notes of 32 detentions and 163 cases were excluded as data was missing or it was not possible to determine status of intoxication, suicidal intent or both, therefore the analysis below is on 1258 cases. The figures very clearly show that 98% of those who were intoxicated were first detained in police custody rather than a health based S136 suite, whether or not the individual was detained for perceived suicide risk (see Table 6).

Table 7: Intoxication and Reason for Detention

Reason for detention and intoxication	Place of Safety		Totals
	Police custody	Health based suite	
Intoxicated & suicidal	360	3	363
Intoxicated & not suicidal	50	4	54
Not intoxicated & suicidal	433	212	645
Not intoxicated & not suicidal	119	77	196

A recurrent theme emerging from the qualitative data also highlighted the use of alcohol as a barrier to receiving adequate help, a finding that was similarly highlighted in the CQC report on places of safety (2014). This was not only for those who had a known addiction and were referred back to Substance Misuse Services (in some cases with a three month wait for an appointment) when they were in crisis, but also for those who were not previously known to services who were self-medicating with alcohol to cope with their distress. Three of the younger men who consented to take part in the study (two by sending email accounts rather than by interviews) were paraplegic or wheelchair bound due to injuries they had sustained whilst being intoxicated and suicidal.

Since the research study began, extensive training for police officers and nurses in the health based suites has had a dramatic impact in changing the culture locally. In particular, the shared learning around restraint in cases of violent and aggressive behaviour, and more tolerance towards the use of alcohol by those in extreme distress have resulted in improvements to practice and more appropriate access to the health based suites. This shift has been further enhanced by the development of the Street Triage teams, where co-working has been observed to have facilitated better communication, understanding of roles and trust and respect between frontline workers.

4.6 High use of Police Custody in Sussex

In 2012 984 detentions (69%) were first to police custody, with only 31% (437) to the health based S136 Suite. There were 110 detentions in which people were transferred between places of safety: 98 from custody to a health based suite, 10 from health based suites to custody and two from custody to a health based suite and back to custody. Table 8 shows the first place of safety used for each detention. Of the eleven places of safety operating in the year, the highest number of detentions were to Brighton Custody followed by Eastbourne Custody, Crawley Custody and Worthing Custody.

Many interviewees vividly expressed the feeling of being degraded and sense of shame at being taken into custody which still haunts several of the participants:

Barney aged 28 described how anxieties about his sexuality in his late teens, with no-one to confide in, had led to problems with excessive alcohol use which culminated in being imprisoned for being drunk and disorderly when aged 18. The shame of this incident motivated him to '*clean up my act'* and he successfully completed a university degree and embarked on a career in the music industry. However, his anxieties re-emerged later in life and he was detained under S136 during a very troubled phase which built up over several months. Feeling '*desperate'*, he had initially sought help from A&E but was turned away, and subsequently drove to Beachy Head where he was approached by the chaplains. Although he felt he had been treated with 'real kindness and sympathy' by both the chaplains and police, the S136 suite was already occupied so he was detained in custody. Evoking earlier troubles, he vividly described the humiliation and disgust with himself that he felt, which were exacerbated by being imprisoned, *'I still burn with shame whenever I think about it'* and although he feels he has now '*turned my life around'*, he feels very strongly that anyone in his position should never be subjected to the stigma of custody, especially when there are health based places of safety available.

Astrid, a nurse aged 39, with no previous mental health history was taken to a hospital place of safety rather than custody when she was sectioned under S136 on Beachy Head. In describing her gratitude at being '*rescued'* from her suicidal impulses she said:

'the experience will haunt me forever …. I can really tell you if I had been in a prison instead of in hospital I would never be able to recover from the experience, from the shame, it's difficult enough. I was thinking I would be in the newspapers, worrying about my workplace hearing about it'.

She still fears that employers will find out about the detention and worries whether it will be revealed by Disclosure Barring Service (DBS) checks in the future.

4.7 The use of Section 136 as 'Appropriate'

Only three of the interviewees felt that S136 had been completely inappropriate. In two cases the interviewee felt that the Beachy Head chaplains had overreacted as, although they had both been distressed at the time, they were not suicidal and felt that the subsequent involvement of the police leading to S136 detention had been disastrous, to the extent that one participant had made a formal complaint to the Independent Police Complaints Commission. The third interviewee felt that the police should not have responded to concerns of his psychiatrist, despite an alleged history of impulsive and violent behaviour, and that his S136 detention was a 'miscarriage of justice'. Notwithstanding the experiences above, the majority of participants considered their detentions to have been appropriate and

indeed a compassionate response to a time of intense and unbearable emotional pain in their lives. Nonetheless, many described the incident as 'harrowing' or 'shameful'.

Although over half of the interviewees had long histories of contact with mental health services, 13 of the participants had not previously experienced mental illness. They often described a series of events or triggers, often involving relationship breakdown and misuse of alcohol, which culminated in a 'perfect storm' reaching a point where life felt completely unbearable. This group of seven males and six females vary in age between 20 to 65; in their social circumstances, from being on benefits to highly paid professionals and in the level of social connectedness they described. Six of these men and women were from outside Sussex and had travelled purposefully to Beachy Head at the time of detention**.**

Although their experiences of S136 detention were extremely varied (see Figure 4 for a summary of the range of viewpoints) a common theme emerged as the episode was spoken of as an 'epiphany' or turning point in their lives. For instance, Alistair aged 49 felt he was on a path of self-destruction through alcohol and substance abuse but the shame of being detained in a police cell triggered him to make positive changes, whereas Norman, aged 54, feels he will never recover from the stigma of the experience and has since become unemployed, but acknowledges that he was 'in such a terrible place', it was necessary.

Figure 4: Range of Interviewees' Reflections on S136

'S136 saved my life'

'it was terrible but it made me turn my life around'

'it will haunt me for the rest of my days'

'the only way of keeping me safe is 136ing me'

'it was a complete overreaction'

'it was very sad [that it] *happened but I have learned a lot'*

'it was a travesty and it has ruined my life'

Many of the participants had sought help before the episode and felt that refusal of help escalated their impulsivity and desperation.

Molly, aged 37, was referred by her GP to a psychiatrist who diagnosed her with bipolar disorder, before her follow up appointment two months later she wrote down an account of how desperate she felt at not being able to manage her increasing anxiety and desperation. *'So I'd put this all on paper, and we got there… I was just hoping that they would stop me feeling suicidal… just desperation.'* However, the psychiatrist was running late and rushed the appointment, essentially sending her away telling her to keep taking the medication. She described how three days later she felt her only option was to end her life*: 'I felt so calm… I didn't want to be found it wasn't a cry for help. I was definite, I couldn't go on like that.'* She was rescued by the coastguards from the sea, having taken an overdose of tablets and drink. After being medically discharged she was taken to the 136 suite but recalls the feeling of humiliation of being taken through the building in only a hospital gown to the police car that conveyed her to the S136 suite *'…all my dignity, everything, was… I just think that was really unnecessary. I felt shame, and ashamed.'* Following the suicide attempt she describes

herself and her life now as very '*different',* she has put the incident behind her and says although some of the factors that triggered the incident are still present she feels her perspective is different: '*I'm happy now'*.

Greta, aged 34, a mother of three young children, had waited four months for an 'emergency' assessment, using increasing amounts of alcohol to cope with her anxiety and despair. On being advised *to 'go home and eat chocolate'*, she slashed her wrists in front of her children, she was subsequently diagnosed with bipolar disorder and has been able to access successful treatment. She was extremely grateful for the care she has since received and proud to be in recovery, although worries about the effect of the events on her children.

Although a small number of interviewees expressed a preference for being detained in police custody as it gave them a feeling of safety (see section 4.2) most of the participants who were not taken to the hospital suite felt very strongly that ending up in a police cell when they had committed no crime was extremely stigmatising and distressing.

4.8 Alternatives to S136 Since 2012: Joint Working and Good Practice

During the life of the study a range of policy and practice initiatives were developed to address the high rates of S136 through multi agency teams led by SPFT (Marian Trendell) and Sussex Police (Sarah Gates). These measures have not only contributed to an overall reduction in the total number of detentions by almost one third but have also enabled the number of people detained to police custody to be drastically cut overall (see Table 8). Furthermore, following a local agreement between Sussex Police and SPFT in 2015, Eastbourne custody has stopped receiving S136 detentions in all but truly exceptional cases. In the year 2015/16 it was used as a place of safety on only 7 occasions.

Table 8: Places of Safety Use in Sussex by Region 2012 and 2105

Place of Safety	Type	Number of detentions 2012	Number of detentions 2015
Brighton & Hove	**All**	**397**	**255**
Brighton custody	Police	253	60
Mill View Hospital	Health	144	195
East Sussex	**All**	**425**	**322**
Eastbourne Custody	Police	223	20
Department of Psychiatry	Health	101	171
Hastings Custody	Police	84	30
Woodlands	Health	17	101
West Sussex Coastal	**All**	**297**	**181**
Chichester Custody	Police	57	16
Meadowfield	Health	87	150
Worthing Custody	Police	153	15
North West Sussex	**All**	**302**	**205**
Crawley Custody	Police	214	47
Langley Green	Health	88	158
Total number of Police-custody detentions		984	188
Total number of Health-based detentions		437	775
Total number of Detentions		**1421**	**963**

Joint working between SPFT and Sussex Police, has a well-established history and embraces effective partnership working across Sussex, alongside the other 'blue light services' (South East Coast Ambulance, Sussex Fire Service and Coastguards) as well the three Local Authorities, including Councillors and Public Health officials as well as the voluntary sector (Beachy Head chaplains, Samaritans MIND, YMCA and Grassroots Suicide Prevention organisation). Probably the highest profile, and visibly most successful initiative during the study period has been the Eastbourne Street Triage pilot, which was subsequently rolled out to all regions of East and West Sussex, with a more recent pilot in Brighton and Hove.

4.8.1 Sussex Street Triage

The East Sussex model uses a dedicated street triage car with trained police officers and a specialist mental health nurse to respond to mental health crisis out of hour's incidents, on call between 5-11pm from Wednesday to Friday and from 8-11pm at weekends. As one of the original NHS pilots, Street Triage in Sussex began in the Eastbourne area in September 2013 and by April 2016 had taken 1540 referrals, with an estimated avoidance of 383 detentions under S136. Building on this success, funding was obtained for further pilot teams in Hastings from September 2014 (712 referrals, 98 S136 avoided) and January 2015 in West Sussex (404 referrals, 111 S136 avoided). Hence the introduction of the Street Triage pilot has resulted in an estimated avoidance of 1206 S136 detentions since the Sussex pilot began. An evaluation has concluded that the model is beneficial to services and people in need and that costs were offset by reductions in the use of S136, particularly reducing the use of custody (Heslin et al 2016). Moreover, preventative work around incidents involving homelessness, substance misuse and learning disabilities are also undertaken by the teams. This latter work is more difficult to formally evaluate but no doubt contributes to effectively reducing the need for S136.

Focus group work with both officers and nurses at the initial training day was followed by a focus group with response officers six months into the pilot. This gave an insight into the experiences of developing this novel way of joint working. Whereas initially the statements of some officers indicated reluctance to be involved and concerns over the scheme:

> *'I came into the police to catch criminals'*
>
> *'we only have six units in any given shift, how can we do this?'*

At the second session, the responses (including from those quoted originally) were overwhelmingly positive about the benefits of Street Triage, both in terms of resources and in providing effective help and support*:*

> *'Nobody has a bad word to say about it. I was sceptical at first but it's unbelievable the amount of time it's saved. We have to keep it.'*
>
> *'it gives us another option that we always needed… the amount of people I can probably continually count over my years in the police, who I've detained under 136 and I've said to whoever I'm working with "this is the worst thing we can do for them: lock em up" … people who are having a hard time who don't know how to get out of it – put them in a cell? so I think we* [Street Triage] *give a much better service to people with mental health.'*
> *'…And not just to them but to families as well… they're kind of part of the process now whereas when you're detaining someone, they're not part of the*

> *process… they've asked for help and we've come along and they think we're arresting them and they're not criminals.'*
>
> *'100% they need to keep it and they need to roll it out amongst other forces.'*

Given the wide variation in the experience of being detained under S136, those who were interviewed having had contact with the Street Triage team in Eastbourne were also markedly positive:

Sinita, an allied health professional aged 35 from London described a similar pattern to Astrid in that she had been drawn to Beachy Head with disturbing suicidal thoughts after 'feeling low and depressed' for nearly six months, which had not lifted despite support from her GP:

'I was looking at all these websites about Beachy Head and had driven there… my mother had called police and I was picked up within 5 minutes of parking there... I have nothing but praise, police were every sensitive, the nurse who did the assessment was wonderful, talked to me for ages' and eventually arranged an informal admission back to [home] by ambulance. Everyone was so kind- I subsequently made a friend on the ward who had been sectioned under S136 two weeks before also on Beachy Head, it sounded such a different experience, I'm so thankful that didn't happen to me'.
Sinita is now in recovery, she has returned to work and is doing advocacy work with MIND.

Likewise, the husband of Lou, a female 'in her fifties' who had long term bipolar and mood instability problems and had not been taking her medication regularly, described how she had become 'very strange and paranoid' and had suddenly disappeared from work and went missing, causing him much distress. Her care team asked Street Triage team for assistance and they found her in a hotel. She was able to access the help she needed immediately and the team also provided vital reassurance for her husband:

> *'An officer and a mental health team member visited me at home… they were helpful and friendly. They made me feel at ease'.*

The only slightly negative feedback was given by Katy aged 35, who had a long-term diagnosis of paranoid schizophrenia. When she had a lapse in taking her medication she began to experience troubling thoughts about harming her ex-partner. She sought help though the police and although she described the support she received from the Triage nurse as very prompt, compassionate and supportive, she felt that she put on what she called her *'show face'* and convinced him that she was now taking the medication again and was fine, whereas in fact she continued to experience the disturbing thoughts for the next two days. She felt that if she had been assessed under S136 and expressed those thoughts that more risk-averse action such as admitting her to hospital until the medication 'kicked in' may have been taken but also reasoned that she might also have put on her 'show face' in that that situation and been released home again.

4.8.2 Brighton and Hove Mental Health Rapid Response Service (MHRRS)

The Care Commissioning Group for Brighton and Hove also trialled Street Triage, but have mainly addressed the high rates of police custody detentions through the enhanced mental health liaison initiative Mental Health Rapid Response Service (MHRRS). Again, Table 8 shows the dramatic improvement in the reduction of S136 detentions, and in particular, a

significant reduction in the use of Brighton police custody from 253 in 2012 to just 60 in 2015.

The service supports people in Brighton and Hove, age 18 years and over, who are in mental health crisis (excluding those diagnosed with dementia) by providing a response within 4 hours for agreed new referrals and enhanced provision by Assessment and Treatment Service through telephone advice and support, as well as face-to-face assessment and support. Referrals can be made by individuals themselves, their carers, health professionals, other concerned parties and the police. The service is available 24 hours, staffed from 8am to 10pm Monday to Friday and 10am to 10pm weekends & bank holidays (outside these times the urgent phone line is responded to by the Mental Health Liaison team based in A&E).

A recent audit of MHRRS (SPFT 2016) found that the service processes around 640 calls and 80 face-to-face assessments a month. The vast majority of calls (55%) are from the person themselves; 15% from family/ carer/friend, 19% from GP or other health professionals and the remainder from the blue light services (A&E, paramedics and police). The team leader for MHRRS and the link officer for the police have reviewed issues as they happened in order to develop the service. Consequently, Sussex Police now regularly call MHRRS and have reported more knowledge, confidence and satisfaction about getting mental health support for people they come into contact with.

There was overwhelming support from frontline response staff from both organisations as regards the street triage and MHRRS initiatives and a consensus that the regular meetings and training sessions help identify concerns between the two organisations and resolve them transparently and quickly, with shared understanding of each other's service and the opportunities to learn from each other.

4.8.3 Community Partnership initiatives across Sussex

Other initiatives during the life of the project have been developed in partnership, which have yielded extremely positive feedback from users. These include the piloting of a Home Office funded Alternative Place of Safety in partnership with Richmond Fellowship in Horsham and the Place of Calm in Eastbourne funded by East Sussex County Council, which provides an alternative to S136 for those at lower risk of immediate harm.

Alison, who took part in the interviews, had a long history of depression, Post Traumatic Stress Disorder (PTSD) and alcohol addiction and had previously been detained under S136 many times to the suite in the Crawley area. More recently, having been released from A&E after an overdose, she had been detained to the Alternative Place of Safety, which was less punitive and more patient centred. She was effusive in her praise for the compassionate care she had received in contrast to previous experiences where she felt she had been seen as '*a complete waste of space'*.

A similar approach is employed the Place of Calm which started as a 12-month pilot project managed by Sussex Oakleaf, working in partnership with Recovery Partners to offer a comfortable, calm setting for up to 24-hours to provide practical and emotional support for people in a suicidal crisis. Recovery Partners is user-led and run; project workers have lived experience of mental health challenges and are trained as Peer Support Specialists. Access is by referral following a mental health assessment by qualified practitioners.

As outlined earlier, support for those with dual diagnosis, especially those using alcohol, was lacking in many of the S136 experiences but more positive feedback about substance misuse services (SMS) was given by those who had been helped by Brighton Housing Trust, Sussex Oakleaf and the Recovery Colleges. The SMS services in all regions play a vital role to ensure swift access to detox programmes and other forms of support for those who are seeking help.

4.9 Children and Young People

Although our study has not included data collection with those aged under 18, we recognise the concerted efforts to ensure the police do not have to resort to taking children into custody under S136. Although the numbers are relatively small (around 50 per year, young people are more likely to have to wait longer than adults for assessments by appropriate experts, and for hospital beds if admission is needed, and there have been many media reports about the harrowing experiences of children in police custody, as well as from some of our participants who had experienced S136 as children:

Sonia aged 21 has had 15 detentions since the age of 16. She has a history of sexual abuse and has had many years of contact with CAMHS and adult mental health services. She has a diagnosis of Borderline Personality Disorder with Post Traumatic Stress Disorder and has dissociative and Bipolar symptoms. She describes how the S136 incidents are triggered by memories of the abuse:

> *'the night before I got sectioned I tried to hang myself and then the police caught me in the middle of the road, I just lost it.*
>
> [talking about being detained in police custody] *When I'm really ill I dress, wear stuff, to cover my whole body up… [but] you get everything taken away… I had to strip off and wear this padded thing… so I was in there… crying and... I start seeing people from the past in the walls… When you are in the suite you feel more normal, human, not so degraded. …when you're in the police cell…. I actually do feel like a criminal. … With mental health you get treated differently from physical. You wouldn't be punished if you were physically ill. You wouldn't put someone with a broken leg in a police cell until you get assessed by a doctor.'*

The proactive approach taken by Sussex Police included a complete ban on the unethical practice of using police custody as a Place of Safety for young people aged under 18 from April 2015, ahead of this becoming national policy. SPFT now prioritise children and young people in all health based Places of Safety across Sussex; and a Place of Safety has been created at the CAMHs unit at Chalkhill.

4.10 Carers and Family Support

The study was not able to speak to many carers and consequently does not claim to present the view point here of those who care for, or are related to a person experiencing mental health crises, however, many of our interviewees did speak about the conflicting messages conveyed to their carers by statutory services and whilst acknowledging this further layer of complexity, felt strongly that *something* needs to change.

This perspective was raised by participants who had only been detained once as well as those who had been detained on many occasions. Interviewees spoke about the pressure

placed on their family by the mental health team's reliance on them to 'pick up the pieces', often despite having other caring responsibilities within the family. *'There was a lot of pressure and stress and responsibility put on Mum, that she should be the one asking for assessments… it put a lot of strain on* [the family] (Nina, 18).'

Katy too described how *'when the crisis team, or anybody's involved, they're reliant on* [her partner] *informing them when I'm not well, and it's an unfair role that they've given her.'* Again, she felt that this had placed considerable strain on both her partner and their relationship.

Sonia described how her parents had risked financial instability to get her private care when services told her she was 'too ill to be an inpatient so to become a day patient.'

The absence of any form of support for family members placed into the carer role was also raised, parents had been told to 'ask the school for counselling' for siblings, whilst others had received assessments for carer support but their need had not been recognised.

Molly described the sense of confusion and dismay her husband relayed when he picked her up from the S136 suite. Her overdose had come as 'a total shock' and she felt it would have been beneficial if he had been informed about what had been concluded in the assessment, *'my husband should have been party to, some stuff… prepped on what to expect or what to do. You know, when you have a baby you have a midwife come round, then you have a health visitor come round… a list of numbers, I don't know but something… He didn't know* [what to do] *he was petrified.'*

Notwithstanding the obligation on statutory services to protect an individual's confidentiality, many participants felt that there were mixed messages sent out about the expectation of whose role it is to keep the person in need safe at different times, which had the potential to create a worrying gap. Many participants also felt that someone should not be discharged from a 136 without knowing who has been informed of their detention.

5. Conclusions

The spectacle of someone being detained from a public place by the police is a large part of what makes the incident so visible and controversial. These circumstances are often heightened by situations being 'blue light' emergencies, which may involve multiple agencies on the cliffs, highways, railway lines, transport hubs, car parks and so forth, with many such incidents being triggered by 999 calls to police by concerned members of the public or carers. There may be more awareness and a faster response in certain 'hotspots' across Sussex, notably Gatwick Airport, which has the highest S136 rates of all; Beachy Head; Brighton station and other parts of that city.

5.1 The 'Appropriate' Use of S136 in Sussex

A key focus of this research has centred around the thorny question of how appropriate are the high rates of S136 in Sussex. The county has been subject to governmental and public scrutiny during the life of the project, not only because of the historically high rates but also for the number of people taken to police custody rather than the specialist suites. Our research has challenged some of the simplistic assumptions around these phenomena and revealed some of the underlying complexity, such as the need to take into consideration idiosyncratic geographical and social factors, namely the high number of out of area detentions, especially in well-known 'hotspots', as well as the need to identify the number of individual people involved, rather than just the number of detentions.

Secondary analysis of the records revealed that in 2012, highly distressed people were detained on 1421 occasions and that 80% of these incidents took place 'out of hours'. In addition, given that 81% of those detentions occurred when people were presenting to police as suicidal, the use of S136 by Sussex police could be interpreted as an appropriate and even compassionate response to vulnerability in the face of no other resource being available. Our qualitative data clearly shows that S136 is almost exclusively experienced by those who have been detained as a 'life-saving', albeit too often also highly traumatic, intervention. We would suggest that whilst S136 rates in Sussex have been some of the highest across the UK, police decision making appears to be an appropriate, risk averse and even compassionate response to extreme emotional distress that has been used mainly for 'out of hours' suicide prevention when no other service is available.

Policy development in Sussex during the life of this research project has been innovative and fast moving, such as the decision by Sussex Police to place a complete ban on allowing children and young people to be taken into police custody from April 2015 and to stop Eastbourne Custody being used as a place of safety in common practice. In addition, extensive training and change of culture around the use of health based suites S136 for suite nurses and police officers, with regard to alcohol and restraint has also drastically reduced the numbers of S136 detentions of adults into police custody. Significant reductions in detentions have also been achieved through the highly successful Street Triage pilot and other alternatives to S136 including the extended 24 hour Mental Health Rapid Response Service in Brighton and Hove and the piloting of respite crisis provision led by voluntary agencies as an alternative to being sectioned. Although S136 may still be the only possible 'intervention' in some cases of threatened suicidal behaviour, harm to self or others, these alternatives have been shown to be effective in improving user experience, ethically more appropriate and may also be financially more cost effective in the long term.

5.2 What is a Mental Health Crisis?

People in extreme emotional distress expect to receive help whether in or out of hours, and whether or not they are known to services. Information and advice through social media and awareness campaigns indicate that help or support should be available through statutory mental health services, but if this is not the case, emergency services will inevitably be accessed. Rejection or inadequate responses to help seeking appears to escalate desperate behaviour and result in increased need for S136.

The definition by a mental health professional of what constitutes mental health crisis or urgent need may differ widely from that of the lay public or the police. Everyone who consented to take part in the qualitative research said their decision was motivated by the hope of improving future experiences for others and to highlight the inadequacies of the provision of emergency mental health care. Most crises happen out of hours and many of S136 detainees interviewed in the study had sought help from other sources before the incident (via GP, statutory mental health services, mental health helplines, 101, 999 or A&E). Furthermore, online sources of help often point those in distress towards emergency services, which elevates expectations of support being available.

Use of alcohol was one the biggest barriers to receiving help, not only for those who had been previously known to substance misuse services and were referred back when they were in crisis (in some cases with a three month wait for an appointment) but also for those with no prior addiction history, who were self-medicating with alcohol to try to cope with their distress. Three of the younger men who consented to take part in this study were wheelchair bound and/or paraplegic as a result of the injuries they had sustained whilst being intoxicated and suicidal. One woman had been rescued by the coastguards from the sea after having taken an overdose of drink and drugs when a psychiatrist had dismissed her attempt to ask for help with her suicidal feelings. Another woman, a mother of three young children, who had waited four months for an ‘emergency’ assessment, was using increasing amounts of alcohol to cope with her anxiety and despair. On being advised to ‘go home and eat chocolate’, she slashed her wrists in front of her children. When she did eventually receive adequate support, she was diagnosed with bipolar disorder.

There was a consensus across all the stakeholders that access to help or support needs to be 24/7, reinforced by the joint review into S136 in 2014 and the Crisis Care Concordat (as well as numerous other policy recommendations) but that the involvement of voluntary and third sector agencies is essential in this process to ease the burden on statutory services as well as to provide different (and at times more effective) kinds of expertise, including peer support. Feedback from our deliberative workshop participants supported ‘out of hours’ options being provided by a range of partners who were not perceived to be mental health professionals, including respite ‘safe’ houses, drop-in cafes, internet and peer support groups.

5.3 Repeated Detentions, a Cycle of Despair

Our study identified significant numbers of ‘repeat detainees’ who accounted for a third of the detentions in a year and over half of those who consented to be interviewed had been detained more than once in 2012. Although the overall figures reveal higher detention rates for men than women, our research identified a group of women who seemed to be trapped in a cycle of despair with several having 50 or more S136 detentions over their life history. In

common, many in this group of women had been diagnosed with a personality disorder, usually as well as having other diagnoses such as Post Traumatic Stress Disorder; most had also briefly alluded to a history of sexual abuse and/or domestic violence, and many experienced recurrent dissociative episodes. These were vividly described in terms of extreme emotional pain and desperation, often triggered by anniversaries or flashbacks of traumatic events and culminating in dramatic rescues, involving police, ambulances, coastguards and fire services, frequently alerted by concerned relatives/friends or other members of the public.

A personality disorder diagnosis had often been acquired in childhood/teenage years, and all of our participants who had received support from CAMHs felt the expertise in this group of 'disorders' was inadequate, and furthermore that as they had progressed into adult services they had been abandoned. Ultimately personality disorder was very much seen by this group as a social, rather than a medical, categorisation which served to exclude and marginalise them from any meaningful support or services. A common view was that (most) mental health professionals ascribe their suicidal behaviour as 'acting out' or 'attention seeking' and therefore not really being 'ill' or at risk. Some of this group emphasised that when they are in extreme distress, only the police know how to 'handle' them, in that that they may need restraint from their self-confessedly destructive, and indeed often aggressive, behaviour. Gratitude was expressed towards the kindness and compassion they have received from the police in particular, for understanding the extent of their distress, and treating them as a 'human being' not a behavioural category. Many were unable to see any alternative to S136 in the way services operated at the time of interview. However, there were examples of women, who despite their long histories of feeling marginalised from services, had received the support they felt they needed in order to escape from this desperate cycle (for example through the Lighthouse, Bluebell House and the Sanctuary in Hastings).

Debates over the delayed publication of the DSM V have resulted in much public and professional scrutiny with regard to the categories of 'borderline', 'emotional' and 'anti-social' personality disorders and the subsequent implications for care. Some of the mental health professionals in our study did express the view that this group in particular were 'not ill' or that they were 'untreatable', despite their very public displays of despair and desperation. More nuanced discussions with both statutory and voluntary sector workers and with participants themselves indicate that whilst hospital admission may not be the best therapeutically effective option, appropriate crisis responses in these situations can be developed, given adequate resources, so that police officers are not always forced into a 'default' use of S136. Hence the continuous review of the legal and social implications, as well as the therapeutic aspects of these and other 'contested' diagnostic mental health categories is an essential aspect of the Parity of Esteem agenda.

5.4 Continuing joint working and using 'lived experience' to inform policy and practice development

During the life of this project, frontline services have been under unprecedented pressure, and the dangers of under-resourcing the teams who work exhausting, long and antisocial hours in highly stressful emotional and physical circumstances cannot be underestimated. Our research highlights the dedication of the multi-agency teams, not only in dealing with highly complex emergency situations, but also working together to develop innovative alternatives to S136. However, there is no standard pathway of an individual who is

distressed to the point of harming themselves or others. The 'lived experience' data from our participants also reveals the complexity of the perceived need for emergency mental healthcare, for which there is no easy solution. Hence, S136 may still be the only option in some cases.

NHS and police protocols do not always work in synchrony and there are many obvious and delicate ethical issues around the need to share information across emergency services regarding highly vulnerable people with complex needs. Addressing the controversial issues of information sharing across agencies and the prioritisation of risk reduction is paramount both between police and mental health professionals, as well as where appropriate in partnership with other local government and voluntary agencies. Moreover, insights from detainees themselves, both in individual interviews and in the deliberative workshop, were equivocal about the need to prioritise safety over confidentiality. Community initiatives with voluntary sector partners providing out of hours support for vulnerable groups were often experienced as less stigmatising, both therapeutic and preventative, and relieve the burden on the statutory emergency services.

In conclusion, it is vital that the good practice in joint working between SPFT and Sussex police is maintained, which includes the partnerships across local authority and voluntary sector workers. Observations and interviews with paramedics, coastguards, Samaritans, Beachy Head chaplains, plus workers from MIND, YMCA, Grassroots Suicide Prevention, Recovery Partners and Richmond Fellowship) has revealed the extent of dedication and unity in their goal to provide compassionate and effective responses for those in severe distress in the community, whether or not they have a medically recognisable mental illness. Even if the moral and ethical aspects are set aside, there is a strong economic argument about the cost of high rates of S136 detentions. As we progressed through 2016, the cuts in funding across all services have presented enormous challenges to the burden on emergency health care and the continuity of innovative good practice, and the strain on front line workers cannot be underestimated.

Finally, our research re-emphasises that alongside the need for adequate resources to support, sustain and increase inter agency policy and practice working, the voices of those with lived experience must be included in developing effective interventions and suicide prevention. This truly integrated approach to avoid the use of S136 as much as possible, as we hope to have shown, is not only morally and therapeutically imperative, but also seems to make sense financially. People in crisis are often perceived, or perceive themselves, at the bottom of the social hierarchy. Whether or not extreme emotional distress is or is not an 'illness', joined up strategies for out of hours help and intervention delivered with compassion and kindness are paramount in de-escalating and preventing the very public desperation displayed by so many in an increasingly divided and unequal society.

6. Further Information and Continuation of Research

Professor Gillian Bendelow
Professor of Sociology of Health and Illness,
School of Applied Social Science, University of Brighton (Falmer Campus)

https://www.brighton.ac.uk/staff/professor-gillian-bendelow.aspx
http://www.brighton.ac.uk/Research/MakingImpactMatter/MentalHealthPolice.pdf

6.1 Continuation of Research

The Section 136 in Sussex Research Study has now become the 'parent project' to a programme of ongoing research around emergency mental healthcare through which we hope to continue to enhance understanding and support developing best practice around access to support for those experiencing emotional and mental health crises.

The following funding has been secured to date:

SPFT Charitable Funds: Pilot Project
PI Claire Warrington: Repeat detentions under Section 136: Views from service users identifying best practice to breaking the cycle
April 2015 - April 2016 (Report in preparation, due Spring 2017)

Wellcome Trust Humanities and Social Science: Doctoral Studentship
Claire Warrington: Frequent detainees under Section 136 of the Mental Health Act: Repeated detention and practitioner responses
October 2015 - September 2018

University of Brighton Scheme A: Doctoral Studentship
Ashley Austin Negotiating identity: women with personality disorders
October 2015 - September 2018

In addition, this project has made a significant contribution to the decision by SPFT to launch a new research theme in 2016 co-directed by Prof Gillian Bendelow and Dr Helen Startup:

Personality, Emergency Care And complex Needs (PECAN)

PECAN has as its vision to develop programs of research that enhance the quality of life of individuals with life-long psychological struggles, individuals in crisis and individuals with needs that are complex (either due to issues of comorbidity, because of the context in which they occur, or because at present psychological treatment outcomes are poor such as those with anorexia nervosa). http://www.sussexpartnership.nhs.uk/research-themes-research

6.2 Further Support:

Stay Alive Suicide Prevention App

Support, signposting and resources for anyone experiencing thoughts of suicide or concerned about someone else who may be at risk.
Free to download from: App Store (apple) or Google Play (android)

App content is also available as a free printable pdf:
http://www.prevent-suicide.org.uk/downloads/StayAliveAppContentPack.pdf

Samaritans

http://www.samaritans.org

24-hour free phone number: 116 123 (free from any phone) or Email: jo@samaritans.org

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