

**FREQUENT DETAINEES UNDER
SECTION 136 OF THE
MENTAL HEALTH ACT (1983):
LIVED EXPERIENCE AND
SERVICE PERSPECTIVES ON
REPEATED DETENTION**

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ABSTRACT

Section 136 of the Mental Health Act (1983) is a highly controversial police power, often used as suicide prevention, which enables the detention of a person who appears mentally disordered and in need of immediate care or control. Legislative change in 2017 appears unlikely to have resolved widespread concerns over the unsustainably high national rates of use. Understanding why some individuals are detained repeatedly is therefore vital if Section 136 numbers are to be lowered.

Mixed-method research combined three data streams:

- Narrative interviews of participants with lived experience of recurrent suicidal crises and multiple detentions, which were jointly analysed with advisors who identified as having complex mental health needs
- A dataset of over 500 repeat detentions in Sussex
- A national police survey and further data from neighbouring areas

A realist-informed approach revealed how recurrent detention is triggered by a chain of interrelated factors. Nationally, the phenomenon is widely recognised and appears to constitute a third of Section 136 use. Most recurrent detentions in Sussex were characterised by slightly more men than women being detained twice, however a small but stark proportion represented the police intervening in the frequent suicide attempts of a few individuals, who were almost exclusively women. Most in this high frequency repeat group had received diagnoses of borderline or emotionally unstable personality disorder. The lived experience accounts described how the impact of unresolved trauma could be exacerbated by the disempowering medicalised approaches employed by mental health services. An unmanageable sense of hopelessness was recurrently provoked by the perception that these circumstances could not be changed. When this despair became overwhelming the police were forced to contain the resulting suicidal crises, fulfilling the position of always-available protector. However for some individuals, a multilateral trauma-informed approach had disrupted the cycle.

Repeated detention can thus be viewed as a lens through which to identify some of the most vulnerable people, who have found themselves experiencing frequent suicidal distress through serial societal disregard. This study makes a direct contribution to understanding this neglected area of research from a psychosocial perspective. The implications for practice and social policy are that consistent and empathetic support structures are necessary to enable individuals to develop stable, trusting relationships and a belief in having a future. This work also contributes to the ongoing debates regarding the limitations of the biomedical model of mental health care.

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DECLARATION

I declare that the research contained in this thesis, unless otherwise formally indicated within the text, is the original work of the author. The thesis has not previously been submitted to this or any other university for a degree, and does not incorporate any material already submitted for a degree.

Signed

Dated

1 INTRODUCTION: SECTION 136, REPEATED

DETENTION AND SUICIDE

1.1 Chapter Overview

The recurrent detention of some people who are subject to Section 136 of the Mental Health Act (1983, as amended 2007) is a highly complex issue into which many further complexities are interwoven. The following two chapters attempt to disaggregate these factors in order to provide an examination of the context in which this research has taken place. The second chapter reviews bodies of literature related to the evolution of the social concept of mental ill health and related English laws; the discourse surrounding 'biomedicine': the dominant model of mental illness, and psychiatric diagnosis; critiques of and alternatives to the biomedical paradigm and the mental health service user/survivor movement. This chapter introduces that discussion by explaining Section 136 and how repeated detention was developed as the topic of focus for this PhD.

These two opening chapters provide a narrative account of the literature. This approach has been selected over a systematic literature review as the context of repeated detention is a deeply complex one, comprised of a multitude of issues. A systematic review would have entailed a predominant focus on one area, but as the following discussions will indicate, there is a dearth of direct research on recurrent detention. Furthermore, as will be demonstrated throughout this thesis and discussed in detail in the methodology chapter, this research has been exploratory in nature and has not sought to test a specific hypothesis, for which a systematic review is typically the first stage. Much of the literature that is highly relevant to this subject would be unlikely to meet the standards for a Cochrane style review nor be amenable to meta-analysis. Likewise, despite the adoption of a realist stance, that is explained in Chapter Three, this work has not focussed on an intervention in the classic realist evaluation conceptualisation. Consequently, the bodies of literature including policy documents and outcomes of monitoring national service data that are

relevant to this topic would not conform to a typical realist review (Berg & Nanavati, 2016; Pawson, Greenhalgh, Harvey, & Walshe, 2005).

The present chapter begins by presenting Section 136 and outlining the key issues related to it. The discussion will examine the poor monitoring and data recording, insufficient provision of suitable places of safety and detention rates. Questions prompted by the police role in judging mental health will also be reviewed, as will the problematic concept of the 'conversion rate': the number of detentions that result in hospital admission and allied concerns over the outcome of detentions. Changes to the recognised sociodemographic profile of those detained will introduce a central focus of this research, namely the importance of this piece of legislation in suicide prevention. The second section will present a short overview of the *Section 136 in Sussex* study from which this research was developed. Consideration will then turn to examples of repeated detention within wider literature, as well as other groups that appear to share similarities with those recurrently detained. Finally, the focus will return to self-harm and suicide, presenting their significance from a public and world health perspective before touching upon the links between these phenomena, gender and trauma, as an introduction to the deeper exploration of these issues that will follow in the second chapter.

1.2 Section 136 of the Mental Health Act

The majority of the Mental Health Act is concerned with governing the interactions between mental health professionals and those deemed to be mentally unwell (Buchanan, 2002). In contrast, the authority to utilise Section 136 rests solely with the police, and their decision to detain someone in this way is based upon the officer's assessment of the risk that person may present and perception of the individual's mental health status. Section 136 provides that:

If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons: remove the person to a place of safety [or] if the person is already at a place of safety... keep the person at that place or remove the person to another place of safety...

A person [at] a place of safety under this section may be detained there for a period not exceeding [24 hours, except under certain extenuating circumstances] for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.

(Mental Health Act 1983)

Section 136 (S136) was first introduced as part of the Mental Health Act (1959). Since its inception, it has exemplified enduring controversies that are reviewed in the next chapter, regarding the role of psychiatry and the tensions between social care and social control in mental illness (Conrad, 2007; Rogers & Pilgrim, 2010). S136 was unaltered in the 1983 revision of the Mental Health Act, and subsequent amendments to the Act in 2007 only made a slight adjustment in permitting a detained person to be transferred between places of safety. Other than a brief mention in the government review into people with mental health problems in the criminal justice system (Bradley, 2009) S136 then escaped further parliamentary scrutiny until 2014, when the government conducted a review into S136 and Section 135(1): police powers of entry to a private dwelling to enable an Approved Mental Health Professional (AMHP) to conduct a Mental Health Act assessment (Department of Health & Home Office, 2014). That review followed the Crisis Care Concordat (Department of Health, 2014) a national agreement by regional public services to improve the care of people experiencing mental health crises. The recommendations of the review were carried forward and resulted in Sections 80 – 83 of the Policing and Crime Act (2017) which amended aspects of S136 and will be discussed herein.

Any topic related to health and illness can provoke strong and divided opinions, so it is unsurprising that this complex element of the Mental Health Act has long been a point of great contestation (Dunn & Fahy, 1987; Lynch, Simpson, Higson, & Grout, 2002; G Riley, Laidlaw, Pugh, & Freeman, 2011; Rogers, 1990; Wright, 2014). Yet even within that context, the anomalous nature of S136 has given rise to specific challenges and addressing those challenges has become an increasingly urgent matter in recent years, as this chapter will now explain.

1.3 ‘The Cinderella Section’: Issues Surrounding S136

The Cinderella metaphor, appositely used by Latham (1997) described S136 having long been neglected by mental health services and the police, despite fulfilling a vital function to both.

1.3.1 Data Recording

Arguably, the most significant problems that have plagued this element of the Mental Health Act from the outset can be linked to the absence of any statutory provision having been made to monitor its use. Docking (2009) cites the Royal College of Psychiatrists observation that S136 was created as the only civil section not requiring statutory documentation. As a consequence of this anomaly, for decades there was no complete recording of detention rates (Bradley, 2009; Keown, 2013). In turn, a detrimental lack of ‘ownership’ of S136 resulted in it being poorly comprehended by the professionals enacting it and overlooked by the bodies overseeing operation of other elements of their professional practice (Docking, Grace, & Bucke, 2008; Latham, 1997; Lynch et al., 2002). With no one agency taking charge of supervising the implementation of the power at a national level, disparate practices became embedded in different areas of the country and even different locations within some regions (Dunn & Fahy, 1987; Kent & Gunasekaran, 2010).

Documented concerns over the poor, frequently absent record keeping in relation to S136 can be found from within ten years of the Mental Health Act 1983 being created (Rogers, 1990; Turner, Ness, & Imison, 1992). Shortly thereafter, Latham (1997) drew attention to the lack of understanding and therefore inconsistency of documentation found nationally, having contacted each police force in England and Wales and found less than half were able to provide information as to how often they detained people in this way.

The genesis of these issues is likely to be attributable to the unique position S136 occupies at the intersection of two traditionally very different parts of public service. The police represent the archetypal agency of the criminal justice system and their involvement in mental health practice may thus appear incongruent. In

the opening to the 2014 governmental review described previously, the Home Secretary stated:

"Most members of the public won't think of the police in relation to people with mental health needs. The police catch criminals, arrest lawbreakers and deal with violent thugs. Unless you have done something wrong, or been a victim of crime, you won't expect to come across a police officer"

(Department of Health & Home Office, 2014a, p.4).

Therefore, people subject to S136 have historically been regarded by the police and mental health services as the responsibility of the other agency. In detaining an individual whom they believe to be in immediate need of care, the police have expected mental health services to take charge of that person (V. Lamb & Tarpey, 2018; Menkes & Bendelow, 2014). Conversely, mental health professionals have frequently accused the police of detaining people inappropriately (Menkes and Bendelow, 2014; Lamb and Tarpey, 2018; Rogers, 1990).

1.3.2 Places of Safety

Allied to the lack of clarity over which agency should be accountable for a person detained under S136, is the longstanding insufficient provision of health based places of safety (HBPoS) to which people could be detained. Ironically, this vivid example of the conflicting views described above may have both partly arisen from and then contributed to perpetuating the misperception of health agencies that S136, and accommodating people thus detained, was a police issue (Lynch et al., 2002). In many parts of the country common practice saw police custody suites being used as places of safety despite multiple Home Office circulars, good practice guidance and codes of practice dating from 1990 onwards all recommending custody be used in this way only on an exceptional basis (Docking, Grace & Bucke, 2008). A national building programme in 2009 created many S136 suites attached to psychiatric hospitals (Pugh & Laidlaw, 2016) but the number of detentions appeared to continue to exceed this provision, with thousands still being detained to custody in the subsequent years. Furthermore, prior to 2015 only detentions to HBPoS were monitored, rendering those detained to police custody invisible to mental health service statistics (NPCC, 2015).

1.3.3 Detention Rates

In 1997, Latham extrapolated an annual figure of 7,900 detentions for England and Wales from the 2,705 detentions recorded annually by the 20 forces who had been able to supply him with this information. That absence of accurate detention data made large scale reviews of the use of S136 at a national level challenging. Eleven years after Latham's work, the Independent Police Complaints Commission reported also having had to infer the total number of 17,400 detentions that they estimated in 2005/6 from partial records (Docking, Grace & Bucke, 2008). Notwithstanding the difficulties in ascertaining reliable national data, various elements of S136 have been subject to academic scrutiny through studies usually based around small, geographically bound samples. Findings from some of this work will be reviewed presently. Various professional bodies also reviewed the operation of S136 during the last two decades. In 2006, the Care Services Improvement Partnership published a report that was highly critical of the excessive rates of people detained to police custody, the report urged a change in the implementation of the legislation (Bather, 2006). Other significant reports and review documents for statutory bodies such as the Independent Police Complaints Commission (Docking, Grace & Bucke, 2008) the Care Quality Commission (Care Quality Commission, 2014) and the joint inspectorates of custody, healthcare and prisons (Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons, Care Quality Commission, & Healthcare Inspectorate Wales, 2013) all highlighted concerns over various aspects of the operation of S136. The main themes that emerged from these reports continually related to concerns around the rates of people detained and the numbers detained to police custody.

Since 2015 annual rates of detention to both police custody and HBPoS have been published. Despite considerable differences having been present on each occasion that rates have been published by separate bodies¹, the numbers detained have predominantly risen, as Table 1.1 indicates below. Figures well in

¹ These discrepancies are attributed by the NHS to differences in how transfers between places of safety are recorded, as well as some issues with inclusion of data from British Transport Police and detentions where jurisdiction crosses the Welsh border (NHS Digital, 2016). Incomplete reporting has also been acknowledged in both the Home Office and NPCC data.

excess of 20,000 detentions a year have been continually reported since 2011 with only occasional small reductions in numbers suggestive of fluctuation rather than any sustained changes having been achieved. It may be of note that the mental health triage schemes (see section 1.3.4 below) began national piloting and subsequent roll out from 2013, coinciding with those reductions.

Table 1.1: Reported Rates of Detention to both Police Custody and Health Based Places of Safety (England and Wales)

Source	Year	Total Detentions Reported
Parliament	2011/12	25,000
	2012/13	22,834
	2013/14	24,489
National Police	2013/14	26,137
Chiefs Council	2014/15	23,602
	2015/16	28,271
Home Office	2016/17	26,328
	2017/18	29,662

As stated above, the Policing and Crime Act (PCA) made the first substantive changes to S136 since its creation. Two of those changes related to the use of police custody as a place of safety. For anyone aged under 18 this was forbidden. For adults, the PCA stated custody was only to be used if someone's behaviour was so extreme as to present an imminent risk of serious injury or death such that no other place of safety would be able to safely manage that person, a decision requiring senior officer authorisation. The intent of this dictate was to ensure the use of police custody as a place of safety was practically eliminated, a desire expressed by the majority of respondents to the 2014 Government Review, as well as having been a near universal theme in the qualitative studies of experiences of detention that will be discussed presently.

The latest statistics reported were from April 2017 to March 2018 (NHS Digital, 2018). This period covered data both before and after the introduction of the PCA amendments, which were enacted in December 2017. The 2017/18 data

indicated a reduction in custody use may have been achieved as nationally, despite a rise in the total number of detentions from the previous year (see Table 1.1 above), detentions to police custody fell from 1,029 in 2016/17 to 471. However, there have also been concerns raised that this has been accompanied by a sharp rise in the reported use of Emergency Departments (M. Brown, 2018). Prior to the PCA changes, multiple concerns had been voiced that A&E would be an unsuitable place of safety (Apakama, 2012; Longhurst, 2017; Warrington, 2017). Recent years have seen increasing demand on hospital emergency departments coupled with shortages of staff which are acknowledged as having resulted in poorer performances on multiple indices of care (The King's Fund, 2018). A further significant factor relating to the use of Emergency Departments as a place of safety for those who have self-harmed or made suicide attempts is negative attitudes of healthcare staff to this group of patients. This issue is examined in further detail in the following chapter.

1.3.4 Police Assessment of Mental Health

Another point of contention that has recurrently arisen in relation to S136 is that it is unique in permitting one individual with no medical training, to deprive a person of their freedom on grounds of their mental health (Durcan, 2014; Latham, 1997); a decision requiring no knowledge of that person or the circumstances of their mental health (S. L. Jones & Mason, 2002). Instead, the assessment that a person should be detained is based solely on a police officer's judgement that the individual appears to be in immediate need of care or control owing to their mental state. The question of whether the police are the appropriate group of professionals to make this decision is highly complex, being tightly interwoven with debates around societal attitudes to the 'management' of mental illness and the medicalisation of distress. So too is the explanation of how the police have arrived at this position of being '*street level psychiatrists*' as Teplin & Pruett (1992) observed. Both issues will be addressed in the next chapter within the context of the legislative history of S136. Within the present discussion however, it is of note that the 2014 government review did not question in great depth the validity of the existence of Section 136. Furthermore, whether the police should remain the body with which the authority to detain rests was only considered in

relation to extending the power to others *as well as* rather than instead of the police (Department of Health & Home Office, 2014a).

Whilst not extensively researched, evidence would support this reliability of police decision making in detention situations. Rogers (1990) examined the accuracy of police assessments of individuals' need to be detained and found that only 5% were deemed not to be mentally ill. She noted this level of accuracy was contrasted the prevailing opinion of the psychiatrists whom she noted on multiple occasions had tried to dissuade officers from making referrals. Rogers' finding that the police were making appropriate judgements when detaining people is also in accordance with a more recent study that found the police hold similar attitudes towards mental illness as the lay public (Bell & Palmer-Conn, 2018). From these studies the inference can be drawn that when called upon by the public, police assessment of the need to intervene is likely to be in line with the expectation of the person alerting them; yet the action that is then taken, namely S136 detention, is far from always welcomed.

Comparatively few studies have explored experiences of S136 from the perspective of those who have been detained, however, where carer and patient views have been reported, many have been negative. Riley, Freeman, Laidlaw, & Pugh (2011) named their paper for one of their most striking quotes from a person who had been detained and said the experience was frightening. Another study gave the account of a man who at the time he was detained had not understood why he was placed in a cell and had reached the conclusion he was in danger and being attacked (Akther et al., 2019). Patients who were not disorientated still described the experience in negative terms; Durcan (2014); Jones & Mason (2002) and Riley et al., (2011) have all reported patients feeling stigmatised and criminalised by police contact when they had not committed a crime. Worse still, others have recalled being treated poorly, with reports of rough handling including patients being pushed into vehicles or physically restrained in handcuffs (Lea et al., 2015). A review by the Independent Police Complaints Commission of 52 cases identified force had been used too often and in which the decision to use physical restraint had not been properly evaluated, moreover that in many cases the decision making around force had been recorded (IPCC,

2016). This is suggestive of officers using restraint as routine rather than any consideration being regularly given as to whether it was appropriate or necessary.

A broad conclusion often directly stated within extant literature is that the police have a poor understanding of the needs of those suffering from mental illness (Livingston et al., 2014; Morgan & Paterson, 2019; Pinfold et al., 2003). Commentators within the police have also raised concerns on multiple occasions that the mental health training input received by new officers is insufficient (Matheson-Monnet & Jennings, 2017; Silverstone, Krameddine, Demarco, & Hassel, 2013). Despite multiple suggestions that the police should receive better training in this area and numerous methods having been developed accordingly (Marzano, Smith, Long, Kisby, & Hawton, 2016; Matheson-Monnet & Jennings, 2017; Scantlebury et al., 2017). Nonetheless, it would appear that in general officers are able to accurately recognise mental health problems sufficiently to know when S136 is necessary.

Mental Health Triage

The PCA also introduced a clause to S136 stating that:

“Before deciding to remove a person to, or to keep a person at, a place of safety... the constable must, if it is practicable to do so, consult [a health professional].”

PCA, 2017; Part 4, Chapter 4, 80(5)(1C)

In part, this phrasing has brought S136 practice into alignment with the mental health triage schemes that have proliferated since 2013 when nine such schemes were piloted with funding from the Department of Health. Often called ‘street triage’, the purpose of these schemes was to reduce the rates of detention by supporting police with a mental health professional who may be paired with an officer, based in a control room or offering telephone support (Reveruzzi & Pilling, 2016).

Triage schemes have now been adopted in all but one of the 43 constabularies covering England and Wales and are generally considered effective in diverting some people from S136 and improving access to mental health support (HM Inspectorate of Constabulary and Fire & Rescue Services, 2018; Kirubarajan et

al., 2018; Puntis et al., 2018). In models that see a police officer and a nurse jointly responding to calls, police officers' confidence in dealing with mental health calls, interagency understanding and cooperation have been reported as improved as well as the service offered to those in need (Horspool, Drabble, & O'Cathain, 2016; Lancaster, 2016). However, the decision as to whether or not to execute a detention remains firmly with the police.

1.3.5 Detention Outcomes

A further factor that has frequently been cited in discussions surrounding whether the police use S136 appropriately has been the low number of detentions that 'convert' to hospital admissions under other parts of the Mental Health Act following assessment by a psychiatrist and an AMHP. Detention outcomes typically comprise voluntary (informal) admission; compulsory admission under Section 2, or less commonly Section 3; or the termination of detention with or without referral to mental health or other services, sometimes referred to as follow up. Both admission and follow up have generally been assumed to be low, for example data from the Health & Social Care Information Centre report on 2012/13 indicated that in each year between 2009 and 2013, fewer than 20% of those detained under S136 were admitted (Health and Social Care Information Centre, 2014). (Borschmann et al., 2010) reported a higher number (57%) of detentions resulting in admission from one hospital place of safety over a period of three years, whilst Sadiq, Moghal and Mahadun (2011) reported just under 38% of their 8 month sample were admitted. As with the other elements of S136 discussed above, obtaining reliable data on this has presented a challenge and whilst helpful, the smaller scale studies that have been conducted into S136 cannot be assumed to extrapolate to the wider population of those detained.

The assumption underlying the conversion rate is that if a person has been appropriately detained by the police, in other words is 'truly' mentally ill, the result should be hospital admission. Some have argued further that involuntary admission is the only genuine indicator of an appropriate detention, as the Mental Health Act principle of applying the least restrictive option means if a person is willing to enter hospital voluntarily, they should not have been subject to a compulsory detention by the police. However, there are several reasons why this

may be an inaccurate assertion and thus the conversion rate may not provide the clear index of appropriateness that it has often been claimed to do. Whilst the full Mental Health Act principles are beyond the scope of this discussion, it may be that as the only police power under the Act, S136 could be considered the least restrictive option available to officers who would be unable to otherwise assist someone who was willing to enter a psychiatric hospital to do so in any other way. Although this question may not as yet have been legally tested in order to establish precedent, the independent review into the Mental Health Act (gov.uk, 2018) recognised the need for reduction in the coercive elements of S136 manifested in the use of police custody and vehicles for transportation.

A more commonplace flaw in the conversion rate argument relates to the subtle but significant difference in purpose of each point of assessment (Department of Health & Home Office, 2014a). The police officer makes an assessment of whether to detain, based upon their perception of the person's immediacy of risk of harm to self or others. The Mental Health Act assessment that is subsequently conducted has the purpose of determining presence of mental illness and likely requirement for treatment. It is in effect assessing whether the person needs to be admitted to hospital, whilst the police are assessing whether the person needs to be prevented from causing immediate harm. Whilst there is a great deal of overlap in these two questions, each may have a different answer. Especially within different contexts and at different points of the same day.

The lack of reliable and publicly available data on detentions discussed above has similarly hindered efforts to obtain a reliable picture of S136 outcomes and the extent to which this may have changed over time. However, within the context of the global financial crisis there have been frequent concerns raised about the reductions to inpatient beds coupled with rising demand (Holloway, 2010, 2011; Keown, Weich, Bhui, & Scott, 2011). Consequently, it is almost certain that the threshold for admission has become markedly higher in recent years and that this in turn would almost inevitably have impacted on S136 outcomes. The 2014 Government Review suggested that a third or fewer admissions resulted from S136. Notably, the accompanying literature review (Department of Health, 2014b) revealed this data was derived solely from detentions to HBPOs.

The data quoted in the review (excerpts of which are presented in Table 1.2 below) also indicates that despite a small shift in the proportion between voluntary and compulsory admissions, the total number of detention outcomes appeared to have remained remarkably consistent. Furthermore, that voluntary admissions increased with the effect that overall more than 90% of detentions consistently resulted in hospital admission. Although this data initially appears strong, it does not include detentions to police custody and so consequently how many of those from custody were admitted. The data presented previously herein suggests that custody detentions may have represented slightly more than half the total detentions in these years, meaning this table presents far from a complete picture of the outcomes.

Table 1.2: S136 detentions to health based places of safety resulting in hospital admission (England only)

Year	Number of detentions	Involuntary admissions (%)	Informal admissions (%)	Total admissions (%)
2003/04	4,106	1,239 (30%)	2,815 (69%)	4,054 (99%)
2006/07	6,004	1,581 (26%)	4,406 (73%)	7,989 (94%)
2010/11	14,111	2,376 (17%)	10,753 (76%)	13,129 (93%)
2011/12	14,902	2,561 (17%)	11,397 (76%)	13,958 (93%)
2012/13	14,053	2,411 (17%)	11,330 (81%)	13,741 (98%)

(Adapted from Annex D: Data sets for S135 and S136: Department of Health & Home Office, 2014b)

1.3.6 Sociodemographic Details of People Detained

Attempting to unravel the issue of admission further raises another key factor related to S136. Early studies reported disproportionately high rates of detention of young black men, often with a diagnosis of schizophrenia who were often detained on grounds of their perceived risk to others (Pipe, Bhat, Matthews, & Hampstead, 1991; Turner et al., 1992). The high-profile issue of the over-representation of minority ethnic groups in mental health services is a key aspect

of the comprehensive independent review into the Mental Health Act, which concluded at the end of 2018 and is anticipated to augur substantial amendments to practice and legislation (gov.uk, 2018). However, data on S136 suggests this bias may not be as great an issue within S136. As further research specific to S136 emerged, it became increasingly apparent that the majority of detentions related to concerns, not of the person's risk to others but of their risk to self.

The vital role the '*Cinderella Section*' has long fulfilled for the police service has been in enabling them to meet one of their primary obligations under the Policing Act 1996: the protection of life, specifically as suicide prevention (Docking, 2009; Docking et al., 2008) especially away from large metropolitan centres (Greenberg et al., 2002; Menkes & Bendelow, 2014). Indeed, an influential report by Her Majesty's Inspectorate of Constabulary stated that when encountering someone apparently suicidal, S136 was frequently a police officer's first (and historically only) line of response (HMIC, 2013). The low rates at which S136 has often been thought to convert to hospital admission may mean that the disproportionate number of Black and Ethnic Minority (BAME) males being subject to compulsory detention in the UK mental health system are not arriving there via S136.

1.3.7 Macroeconomic Context of S136

Macro-economic factors are a further key element of the contextual milieu in which S136 occurs. Penrose (1939) observed that resource availability was one of the main determinants of a societal response to people whose behaviour does not fit within its norms. During the same time that recorded rates of detention appear to have risen sharply, so too have public sector resources significantly diminished. The global economic crisis of 2007/8 led to governments in many countries including the UK instituting austerity measures, as a result of which the budgets of nationally funded frontline health, social care and criminal justice services were all subject to serial cuts (Local Government Association, 2018). Multiple social and systemic factors including fiscal adversity at both individual and institutional levels are acknowledged as being implicated in triggering interactions between the police and people suffering from mental illness (Livingston et al., 2014). From an individual perspective, unemployment and financial hardship in the climate of austerity have been linked to rises in

psychological distress, manifesting among other ways in increased rates of self-harm and suicide (Barr, Taylor-Robinson, Scott-Samuel, McKee, & Stuckler, 2012; Coope et al., 2014; Hawton et al., 2016). Interacting with this are systemic factors such as the reduction in service budgets tightening resources (Holloway, 2011; Loughran, 2018; McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008).

A crisis model of care in which services have become increasingly focussed on cure rather than prevention has proliferated under the increased pressure on services these dwindling budgets have produced. The consensus statement on sustainable funding for public health supported by over 80 national physical and mental health organisations recently observed that the successive policies of diminishing public sector spending had rendered the health and social care system *“locked in a ‘treatment’ approach, which is neither sustainable nor protects the health of the population as it should”* (Centre for Mental Health, 2019; paragraph 4). For example, considering childhood mental health problems, a report by Sainsbury Centre for Mental Health (2009) noted that focussing intervention solely on the higher end of children displaying extreme and clinically significant problems missed the opportunity to assist many more who are in need and hence are likely to later present greater resource demand on public services. Similarly, the mental health charity Rethink stated that the budgets of almost half of early intervention services had been decreased and none had seen an increase. Here too, concern was raised at the false economy of depleting services to the point where pressures on individuals are increased exacerbating problems and crises (Rethink, 2014).

Numerous concerns have been raised that cuts to services have had a detrimental impact on the capacity of existing agencies to care for vulnerable people including those with mental health problems (Heslin et al., 2017; Lea et al., 2015). An investigation into S136 by The College of Emergency Medicine noted its safety and quality monitoring committees had received “many reports of sub-optimal care in the way people with mental health crisis are cared for” (2014; p. 3). As will be reviewed in greater detail in the following chapter, the closure of the large institutions that had previously accommodated those deemed in need of

state care due to mental illness was never adequately resourced, resulting in a dearth of sufficient community care for this population (Laurence, 2003). Coupled with the increased pressures introduced by further restrictions on services through public sector spending cuts in the recent era of austerity, the apparent increase in demand for mental health care has corresponded to psychiatric inpatient capacity being reduced, further escalating pressure on the police to fill the widening gap in crisis response (Cummins, 2012). The lack of inpatient beds has also been documented as having a bearing on S136 detention outcomes, for example health care professionals described their decision to detain in Mental Health Act assessments being partly guided by the availability of beds (Lea et al., 2015). Furthermore, it is recognised that key socioeconomic determinants such as social deprivation, gender and social exclusion mediate the effects of macro level economic downturns, with such groups suffering disproportionately worse impacts and likely increasing the rate at which crises resulting in S136 are precipitated (Keown, 2013). Again, the complexity of these issues is discussed in depth in the subsequent chapter.

1.3.8 Summary

Section 136 is undoubtedly a complex piece of legislation that has been plagued by controversy and questions. Largely as a result of the prolonged period of time in which no consistent or reliable data was gathered or reported, it is not possible to ascertain a true picture of how it was used during the 80's, 90's and early 2000's. Nonetheless, with more consistent data emerging from 2011 onwards, some issues have remained. One curious factor appearing whenever national data were investigated was that Sussex in South East England has consistently been noted as having the greatest rates of use in the country, as well as higher than average uses of police custody as a place of safety. In seeking to gain a better understanding of these trends, the *Section 136 in Sussex* research (Bendelow, Warrington, & Jones, 2016) was broadly welcomed by a range of professionals and those who had been detained under S136. This study was commenced by Professor Bendelow in 2011 through a BA/Leverhulme fellowship and continued between 2012 and 2014 with the support of the Mental Health Research Network and Sussex Partnership NHS Foundation Trust (SPT) Research and Development Department, through which I was recruited as the

project's research assistant. As the study from which this PhD was developed, henceforth referred to as the parent project, some of the key findings of the *S136 in Sussex* work will now be considered.

1.4 S136 in Sussex: Spotlighting Repeated Detention

From the outset, the parent study sought to put the voice of those who had been detained at the centre of the research. With the help of the Mental Health Act monitoring team at the Trust, each person who had been detained in 2012 and for whom an address was recorded, was invited to take part in the project through allowing the study team access to more detail in their records, submitting written information or taking part in an interview. In addition, the anonymised records of each detention in 2012 were analysed and a broad range of professionals from the police, NHS, Local Authorities and third sector organisations took part in interviews, focus groups or observed meetings. One of the most striking aspects of the work was the response with which our approaches were met. Both practitioners and those who had been detained expressed an overwhelming willingness to be involved and an openness to the research. The comprehensive secondary data analysis examined not only how many people were detained but also what happened on each detention; whether people were noted to have been intoxicated when they were detained; which place of safety they were taken to and whether they were transferred between sites; the length of time they were held and the circumstances of detention, including the date and time of detention and whether the person appeared to have been suicidal.

1.4.1 Lived Experience of Detention

Most of those who took part in interviews had been detained more than once and thematic analysis revealed multifaceted issues including histories of trauma, often through experiences of childhood abuse, which marked the narratives from this group. So too did references to dissociative episodes in which interviewees acknowledged that their behaviour could alter dramatically; one young woman related that she became unmanageable and would lash-out violently during these incidents. This group of participants described being plagued by chronic and recurrent suicidal urges that often resulted in extreme attempts to end their lives.

Whilst most interviewees linked these attempts to life events and unresolved trauma, a narrative also emerged relating to mental health diagnoses. Unsurprisingly depression and anxiety were often cited by interviewees as conditions or diagnoses that were implicated in the events leading to their detentions. So too was bipolar affective disorder (a diagnosis that several interviewees had only received after multiple suicide attempts). Many of the female participants who had been recurrently detained had at some stage been diagnosed with borderline or emotionally unstable personality disorder.

A related theme interwoven in interview accounts, was the experience of fractured relationships with mental health care providers. Within this group several participants considered that being detained was often the only way in which they could be kept alive and indeed one interviewee speaking about her Community Mental Health Team stated: *"[they] 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!"* (Bendelow, Warrington and Jones, 2016, p. 15). There was a sense among these interviewees that the Mental Health Act assessments which they had frequently received neither took into account the significance of triggers to their distress nor adequately acknowledged the entrenched nature of their underlying issues.

Almost all in this group expressed a desperate desire for therapy to address the issues which fuelled their behaviour, yet almost all had been unable to access such therapy. Some interviewees had been referred for psychotherapy in the past, which they had begun to find beneficial, but that had subsequently been terminated when funding had been reallocated, whereas others had been told that funding was not available for the specialist therapy they required. One participant had been referred to a specialist personality disorder unit out of the county where she had been undergoing a period of assessment in a supportive environment shortly before attending the interview, however she reported that although they were continuing to work with her for the time being, they had told her that she would not be able to remain under their care long-term as her chronic depression and post-traumatic stress disorder (PTSD) had been misdiagnosed as a personality disorder. Thus, for the participants in our study

who had been repeatedly detained, desperate attempts to end their lives had seen the police cast into the invidious position of proxy carers. Referring to her chronic depression and suicide attempts, one woman who was in her early twenties told us *“I’m no fan of the police but it’s the police who’ve saved my life 21 times”* (ibid).

1.4.2 Detention Data

The data analysis revealed that in one year, although almost one thousand people were detained only once, the remaining 143 individuals were each detained more than once. This equated to 13% of all people detained accounting for 30% of the total number of the 1,421 detentions that year, with one person detained 24 times and another on 20 occasions. As the analysis was revealing the repeated detention of some individuals to be significantly swelling the overall detention rates in Sussex, we also began to make contact with a number of police and mental health professionals from elsewhere in the country through dissemination events. Discussing repeated detention was met with a strong sense of recognition that not only S136 rates and place of safety access but also recurrent detention were familiar issues with which other areas had long been beset. Surprisingly, the extant literature around Section 136 contained comparatively few references to this phenomenon and only one study appeared to have directly investigated the issue.

1.4.3 Repeated Detention in Other Research: Hidden in Plain Sight

Multiple studies have reported that individuals were noted to have been detained more than once within their data, however, the majority of studies have only alluded to repeated detention indirectly. For example, in the description of their sample, Riley et al. (2011) stated one county had 250 detentions of 204 individuals over a period of 18 months and that some individuals were detained on more than one occasion. Another report published the same year examined the S136 assessments conducted during eight months in the city of Manchester (Sadiq et al., 2011). The description given of this sample states that “A total of 41 patients were assessed in 45 assessments” (ibid, p.31) from which the implication is that at least one person was detained more than once. Prior to

these studies, Pipe et al. (1991) reported that the records of 34% of their sample of 99 people in a London HBPOS indicated they had previously been detained under S136.

The clearest published accounts of multiple detention have been contained in three studies. Turner, Ness and Imison (1992) referred to a “*core group of repeat referrals* [people detained under S136]” (ibid, p. 765). These were 22 individuals: eight females and 14 males, who were detained 73 times. This study provided a breakdown of the age and ethnicity, number of detentions and outcomes of the people who were repeatedly detained. Turner and colleagues’ data indicated that it was an Afro-Caribbean man who was detained on nine occasions who had the highest number of detentions for an individual within their data. Borschmann et al. (2010) published several articles following an extensive review of detentions over three years in one borough of London. They reported that from the 887 detentions that comprised their study, seventy people who were detained more than once accounted for 19.4% of all detentions in the period. Furthermore, they gave the information that one man was detained seven times, which suggests this was the highest number of repeated detentions for an individual in their dataset.

Finally, Spence and McPhillips (1995) reviewed the records of the assessments conducted on people detained in Westminster over a period of six months. From the 65 assessments of 57 individuals they found that with the exception of one person who was detained twice and had a primary diagnosis of schizophrenia, the remaining seven multiple detentions in their dataset were linked to individuals with a primary diagnosis of personality disorder. Unfortunately, this study did not report how many individuals were detained more than once and was based on low numbers of assessments. Nonetheless, the relevance of this work is twofold, firstly in giving a clearer identification that the occurrence of repeated detention had been noted as an issue and secondly by suggesting a link between personality disorder and recurrent detention.

1.4.4 Policy Acknowledgement

Despite the scarcity of direct empirical evidence detailing the phenomenon, the occurrence of repeated detention has been noted in policy guidance. The Good

Practice Guidance on Sections 135 and 136 published by the Welsh Government (2012) stated that:

"Local monitoring of the use of section 136 should enable the identification of the repeated use of section 136 for the same person. Repeated use of the powers for the same individual should prompt a multi-agency review to enable support and other arrangements to be considered for that person" (ibid, p28).

Similarly, the both Codes of Practice published by the Welsh and English Governments state local policies should define responsibility for creating multi-agency care plans for people who are detained repeatedly (Department of Health, 2015; Welsh Government, 2016).

The 2014 joint Department of Health and Home Office review referred to above, stated that 955 individuals from a sample of 8,072 people who were subject to S136 in the year 2012/13 were detained more than once, with 7% being detained on four or more occasions (Department of Health and Home Office, 2014b). Nonetheless, repeated detention remains unreported in annual monitoring figures and so there is currently no national trend data available, nor is it possible to gauge the extent to which repeated detention was occurring from any other publicly available data.

The studies described above provide empirical evidence that repeated detention has long been a phenomenon recognised at least at the practitioner level, however prior to the *S136 in Sussex* research, only two studies, both over twenty years old, had provided descriptive accounts of repeated detention. Our Sussex research had provided greater detail on this phenomenon, but questions related to causal factors and options to reduce repeats remained unanswered. Of greater still significance, multiple stakeholders, including those who had been recurrently detained, felt the subject warranted focussed empirical scrutiny. Furthermore, the absence of reliable data on repeated detention may hinder progression in practice and policy support. Notwithstanding the paucity of evidence on this topic, the parent Sussex project had indicated some areas that were likely to be relevant to this research.

Although not specifically examining S136, another study has a significant bearing on this element of the discussion. Pakes, Shalev-Greene and Marsh (2014) used the National Crime Agency's 'Come to Notice' database to conduct a thematic analysis of fifteen individuals who each had recurrent contact with the police at times of crisis, but who also routinely absconded prior to conclusion of contact episodes. This research will now be considered.

1.4.5 People who Repeatedly Come to Police Notice

An immediate limitation to the study of Pakes, Shalev-Greene and Marsh (2014) was that only records from one source were used, namely police reports. Additionally, as details of case histories were altered to protect identities, a full picture of the individuals and their care histories could not be established. For example, several of those described would certainly have been detained under Section 136 on multiple occasions given the circumstances detailed, but this is not made explicit in every case. One example was a woman who was described as frequently calling the police from bridges, edges of rivers and railway stations to say she was about to end her life. The paper stated that she had been subject to various Sections of the Mental Health Act on at least 35 occasions, including S136. Absconding from a police mental health detention is possible but it is unlikely that an individual would be able to do so repeatedly. The woman was however also described as having a pattern of presenting at hospitals saying she had taken an overdose or was having chest pains but leaving before treatment could be given. Nonetheless, this research offers some critical insights into a small group of people who were involved in multiple police-related contacts and about whom little appeared to be understood.

Pakes and colleagues reviewed some of the conclusions drawn from previous research into people who abscond from hospitals but emphasised that there were two key differences between their 'come to notice' group and classic hospital absconders. Firstly, the authors noted that those described in their paper had initially engaged attention, often through contacting the police directly or presenting to hospitals; and secondly that they had recurrently left situations when they had not been admitted to hospital. In contrast, the previous research they reviewed that had focussed on 'absconders' had dealt exclusively with

people who have left in-patient settings. Although in-patient admission under the Mental Health Act was not categorically listed for all of those in their sample, it seems likely that most if not all would have had previous voluntary or involuntary periods in hospital, thus, by extension, it seems possible that some may have absconded as a pre-emptive attempt to avoid admission.

The authors acknowledged without first-hand input from the individuals it is not possible to ascertain their reasons for this striking behavioural pattern. However, they observed that further differences also existed between their sample and the profile recognised as most likely to abscond from in-patient wards; the latter being young males with schizophrenia, who generally try to get back to their own home or to relatives or friends. In comparing this to their sample, they observed that the 'come to notice' group appeared to seek anonymity. Furthermore, homelessness and detachment from social ties also featured prominently in their records. They concluded that

“crises however frequent are not business as usual. The vast majority of our individuals do not seem to be habitually attention-seeking (ibid, p.305)”.

Rather, they noted the connected themes of crisis, trauma and loss appeared to be the most central characteristics within the reports comprising their sample.

A final element of the Pakes, Shalev-Greene and Marsh study that is pertinent to this discussion is their identified theme of 'mobility'. Their sample of cases included five people who, each with a range of 14 to 28 documented episodes on the UK Missing Persons Bureau Database, had been noted to have 'come to notice' with the greatest frequency. The authors reported that their analysis showed a lack of personal ties and that being of no fixed abode or frequently mobile, many have had contact with *“a large number of police forces (ibid p.303)”*. Others were noted to have had multiple contacts with the British Transport Police through frequently being found or attempting suicide on or near rail routes. This is analogous to our research, in which it was observed that several of those who were repeatedly detained in Sussex lived outside the county.

Additionally, the relevance of this paper is the indication of the importance of social factors such as a lack of close community ties that set those in the Pakes, Shalev-Greene and Marsh sample apart from other groups that may have been more extensively researched, such as absconders from in-patient hospital settings. Taking a similar approach to Pakes and colleagues' consideration of similar groups, an area of potential relevance to repeat detainees under S136 that has received much greater academic attention is frequent attendance in physical healthcare settings, such as General Practice surgeries and hospital emergency departments. Given the possible analogous features of these two groups, elements of this field of research literature will now be briefly considered.

1.4.6 Frequent Attenders to Healthcare

Strong connections have been made between mental health and high frequency attendance at both A&E and GP facilities. Vedsted and Christensen (2005) considered 61 articles relating to 54 studies of frequent attendance in primary care settings published between 1966 and 2004. They reported that although there was no widely agreed definition of the number of contacts that could be considered 'frequent', there were factors that appeared consistent across the various studies. Mental health conditions had the strongest association with highly recurrent attendance in primary care, such that this aspect had a greater influence than physical health including chronic diseases. Females appeared more often as frequent attenders and the authors also observed that the top 10% accounted for 30 – 50% of all contacts. Here again, similarities to the 30% of recurrent detentions we found in our Sussex research as well as the overrepresentation of females in the most frequent detention and attendance groups. Specific diagnoses for mental health were not described by the authors, however they reported that combined musculoskeletal, social and psychological problems were observed in close to 40% of frequent attenders.

Whilst almost half of the studies reviewed by Vedsted and Christensen were drawn from the UK, a wide range of other nations were also included. In a more geographically focussed study, Keene and Rodriguez (2007) also identified secondary care mental health service use to be a major factor for both males and females who, over a period of three years, frequently attended the A&E

departments in a South East England Health Authority. Providing more specific detail of the reasons for A&E presentations, they found frequent attenders could be divided into four distinct typologies. Two of these groups comprised older patients having multiple physical conditions or requiring treatment for fractures and cardiac conditions. However, two groups of younger people for whom self-harm was an issue accounted for the largest proportion of frequent attendances. The authors noted that one of these cohorts was young men who also attended with other types of traumatic injuries, for example resulting from being the victim of assault, whilst the other group comprised young females with self-inflicted injuries. Keene and Rodriguez also examined the common outcomes of mental health care for those frequently attending A&E and identified that whilst young females presenting with self-harm were likely to be on the community care caseloads, disproportionately more of the young men were shown to have been treated through psychiatric hospital attendance (as out-patients or inpatients). The authors noted that the frequent attendance of both gender groups for recurrent episodes of self-harm indicated a high level of unmet need.

Finally, taking a different approach, Vedsted et al. (2001) studied 185 patients who attended participating GP practices in their index year of 1990 and tracked their further appointments over the following six years. Patients were screened on two psychometric scales at their initial appointment. Vedsted and colleagues found psychological distress significantly increased the probability of a patient frequently attending their GP. Furthermore, this study indicated the more severe a patient's level of psychological distress appeared from their initial self-report questionnaires, the higher frequency of their subsequent attendance was likely to be.

1.4.7 Summary

The existence of small numbers of people who present to frontline services frequently enough to represent a considerable proportion of the total number of contacts has been repeatedly documented. However, as this discussion has so far considered, the predominant policy and public concerns that have surrounded S136 have centred around the poor documentation, overall rates of detention and the high use of police custody. These and other issues, such as the

disproportionate detention of some ethnic groups have similarly received greater focus within research on S136, although many of these studies have alluded to the recurrent detention of individuals. Studies investigating patterns of behaviour similar to repeated detention have signalled problematic and complicated unmet needs relating to psychological distress and trauma are likely to be implicated in these groups.

Gender has also been indicated as a potential factor. Within the parent *S136 in Sussex* study, 60% of all who were detained in the year were male but examination solely of those repeatedly detained revealed that the gender gap closed with only slightly more men appearing in this cohort (74 males, 69 females). More men were detained two, three and four times in the year and an equal number of males and females were detained on five occasions. However, the gender difference became far greater within those who were detained with the greatest frequencies. One male was detained six times in the year, whilst the remaining 8 individuals who were detained on six or more occasions were female. Information on psychiatric diagnoses was not contained within our quantitative dataset, but in line with the frequent attendance literature discussed above, our interview accounts indicated psychological distress was clearly a major issue. The debates surrounding the development of mental health diagnosis are examined in more depth in the following chapter. However, the tightly interlinked issues of gender and mental health and that of Borderline or Emotionally Unstable Personality Diagnosis and suicide are inescapable aspects of this topic that bear some scrutiny at this stage.

1.5 Suicide and Self-Harm

1.5.1 Suicide: International and Domestic Concerns

A report by the World Health Organization (WHO) labelled suicide prevention as a “Global Imperative” for public health (Saxena & Krug, 2014) identifying that worldwide, there are an estimated 804,000 such deaths each year, equating to someone dying by suicide every 40 seconds. Within the UK and Ireland, it has been recently reported that there are over 6,000 suicides annually (Mental Health Foundation, 2016). More males than females die this way in almost all parts of

the world. Joiner (2005) points out that China is a notable exception in having equal numbers of self-inflicted deaths amongst women as men and WHO (2002) observes parts of India also contradict the typical gender difference in suicide mortality. According to the most recent independent national figures close to three quarters of those dying by suicide in the UK were male (ONS, 2017). Although the rate of such deaths in both genders has fallen recently, suicide remains the leading cause of death in males aged up to 49 and females aged under 34 (Public Health England, 2017).

Cox et al. (2013) have defined 'suicide hotspots' as places known to have a high likelihood of a fatal outcome if suicide is attempted there and where multiple such deaths have been recorded. Two such internationally infamous suicide hotspots are located in England. Fatal falls and drowning account for less than 6% of completed suicides in each area (significantly fewer than deaths by poisoning and hanging, which are replicated in other parts of the country where there are not such 'hotspots'). Furthermore, multiple non-fatal 'falls' are documented in both locations, which whilst not recorded as such, are often likely to be suicide attempts. Nonetheless, the notoriety of these two high points located in East Sussex and Bristol pose considerable issues for those attempting to lower suicide rates. Certainly, Beachy Head and the surrounding area contributed the second highest proportion of S136 detentions within our Sussex study data, which reinforced our finding in relation to the link between detentions and suicide prevention. Similarly, this was the reason the Department of Health funded 'street triage' scheme (referred to previously, see *Mental Health Triage in section 1.3.4*) was piloted in this part of the county first.

It is estimated that for every completed suicide there have been many further unsuccessful attempts. The WHO website suggests this number is over 20 (WHO, 2017), whilst others have put the range of prior attempts per completion as ranging from 10 to 40 (Witkowski, 2017). On the micro level, despite some evidence to suggest those who receive intervention or follow up are not likely to go on to make further attempts (Kapur, House, May, & Creed, 2003) a previous suicide attempt is considered a principle risk factor for future attempts and has been reported to be the most significant predictor for both further attempts and

subsequent completion (Beghi, Rosenbaum, Cerri, & Cornaggia, 2013). Many issues hinder gaining accurate data to truly assess the scope of the issue. As some have pointed out, it is a complicated matter to both clearly define and to attempt to delineate between the acts that are frequently considered related that may be variously termed as attempted suicide, parasuicide, and pseudo-suicide (C. Hart, 2013). Furthermore, this complexity is of course heightened in the case of completed suicide, where the person is no longer alive to corroborate their prior intent so that it can only be inferred. It is thus probable that many more suicides are recorded by coroners as open or narrative verdicts or as having been accidental or due to misadventure (Scourfield, Fincham, Langer, & Shiner, 2012; Shiner, Scourfield, Fincham, & Langer, 2009).

1.5.2 Self-Harm

A matter that similarly provokes great concern and contestation is self-harm. This topic has long been plagued by a lack of concordance around definitions and divided opinion on whether self-harm and suicide attempts exist as discrete phenomena or as parts of the same continuum (O'Connor & Portzky, 2018). Whilst often placed in the same category as suicidal behaviour and certainly receiving a comparable response in practice, focused examinations have contended that non-suicidal deliberate self-harm or self-injury is distinct from attempted suicide due to the significant differences that exist in the intent and purpose (Chandler, 2014, 2016; Chaney, 2017). For example, Nathan identifies various functions of self-harm as including communication, punishment of self and others, a way to dissociate or to feel 'real', a way to stay alive, a safe and therefore containing relationship (Nathan, 2006). Almost unarguably, self-harm appears to be a sign of significant emotional distress that is often used as a means of regulating strong, unwanted and otherwise intolerable feelings (Brooks, Chester, Klemra, & Magnusson, 2017). Self-harm is widely considered to be a "significant" mental health issue due to a rise in recorded rates during the twenty-first century (Millard, 2015). Additionally, Public Health England have been among many to have raised concerns over the increasing prevalence of self-harming among adolescents (Brooks et al., 2017).

Self-harm and suicide may not form a neat or simple continuum, yet evidence clearly indicates that those who self-harm do have a significantly greater likelihood of dying by suicide than the general population (Bywaters & Rolfe, 2002; Horrocks, Price, House, & Owens, 2003). Indeed, the risk of completing suicide has been said to increase as much a hundredfold for people who have self-harmed within the last 12 months and that 7% of those known to have self-harmed will have completed suicide within ten years (C. Hart, 2013). Other studies have differed in the rates given but appear to agree that the risks of both subsequent self-harm and suicide completion or further attempts are both greatly elevated by the presence of previous suicide attempts or self-harming.

1.5.3 Suicide, Self-Harm and Mental Health

Feeling or being suicidal and self-harming are not of themselves considered to be mental illnesses, although both appear in the symptomology of multiple 'recognised' conditions. As previously alluded to, herein lies the crux of an issue that has long plagued S136 and that will be more fully demonstrated in the next chapter: the police and general public who call upon them, having a lay perception of mental illness which encompasses acute distress, adjudge whether a response to such distress is appropriate in a different way to mental health professionals, who are trained to seek signs of diagnosable and treatable mental illness. The related issues of stigma and negative reactions to suicidal distress and self-harm, which further compound the complexities of both are also considered in the following chapter, as interwoven elements of the social contexts in which they occur and from which they cannot be separated (Chaney, 2017).

Returning to the present consideration of studies that have attempted to discern risk factors for suicide, including the presence of mental illness, modern sociological autopsies (Fincham, Langer, Scourfield, & Shiner, 2011) have proliferated in the tradition pioneered by (Durkheim, 2002 [1952]). Many such studies have frequently identified mental disorder being most commonly linked to deaths by suicide (Cavanagh, Carson, Sharpe, & Lawrie, 2003). Whilst this may be argued to be a more likely finding when working back from the point at which someone has taken their own life (Rogers & Pilgrim, 2010) it is unquestionably recognised that diagnoses such as depression carry an increased risk of suicidal

behaviour (Angst, Angst, & Stassen, 1999). Indeed, any psychological or physical dis-ease that is experienced as chronic or long term or perceived to be life-limiting can provoke suicidal despair (Joiner, 2005; Rajkumar, Brinda, Duba, Thangadurai, & Jacob, 2013). Furthermore, the link is strengthened by the data that between 2000 and 2014 over half of the 8,129 deaths in UK custodial settings (including prisons, immigration removal centres and police custody) were people detained under the Mental Health Act (IAP, 2015). Large and Kapur (2018) have suggested in addition to the probability of suicide risk being a factor in many psychiatric admissions, features of the hospital environment and process of detention may also be pertinent in the association between hospitalisation and suicide completion.

1.5.4 Social Factors, Trauma and Diagnosis

Critically, focussing away from immediate circumstances that may be considered as potential triggers for suicide, a broader stance was put forward in Durkheim's classic work, in which a structural account was proposed that held social ties as of pivotal importance. Whilst weak social bonds and isolation have come to be accepted as key risk factors, Mueller and Abrutyn (2016) drew upon Durkheim's work to propose that in a cohesive, contemporary small community with an enduring adolescent suicide problem, very strong social bonds may have elevated the risk to highly integrated individuals through a combination of factors including limited access to alternative groups and the rapid spread of information and perceived pressure to meet high expectations.

Other environmental factors that have been shown to have a significant impact on later development of both mental health problems and suicide risk are traumatic events occurring in childhood and adolescence (Dube et al., 2001; Felitti, 2009; Séguin, Beauchamp, Robert, DiMambro, & Turecki, 2014). The negative impact of Adverse Childhood Experiences (ACEs) can be mitigated by the presence of social support (Cheong, Sinnott, Dahly, & Kearney, 2017) a finding which provides significant further support for the vital role social relationships can play in development of 'psychopathology'. Critically, all the factors discussed so far are frequently seen to converge in one psychiatric condition that is notably marked by a history of traumatic experiences or multiple

ACEs and a greatly elevated risk of self-harming and repeated suicide attempt as well as feelings of isolation or abandonment and social relationships that are frequently fractured or tumultuous: that of borderline or emotionally unstable personality disorder (B/EUPD)².

The National Institute for Clinical Excellence (NICE) guidelines compiled by the professional bodies for psychology and psychiatry assert that there is an approximately equal gender distribution in the community and that it is the disproportionate number of women receiving secondary care mental health services that generate the impression only women are diagnosed with BPD (NICE, 2009). Nonetheless, outside forensic populations, this diagnosis is considered to be predominantly received by women, and many have identified the diagnosis of BPD as the epitome of psychiatric oppression of women (C. Shaw & Proctor, 2005).

As with the other areas hitherto discussed, gender and mental illness is a highly vexed topic and similarly to suicide and self-harm, it is not possible to provide a comprehensive account of the issues relating to diagnosis without incorporating the impact of context, including historic and cultural factors. Again, this area is worthy of much deeper exploration than is within the scope of this discussion, nonetheless several points should be acknowledged. Of critical importance is the uneven distribution of gender throughout almost all parts of the mental health system. More females than males receive psychiatric diagnoses, in particular common mental health problems such as depression and anxiety, yet many more males are detained in medium and high secure hospitals (Rogers & Pilgrim, 2010)

Allied to this trend is the 'gender paradox of suicidal behaviour' (Canetto & Sakinofsky, 1998) by which it is recognised that much higher numbers of males constitute the statistics on suicide mortality, whilst far more females make non-fatal suicide attempts. It has been contended that factors such as measurement

² Each of the two primary diagnostic manuals discussed in depth in the following chapter use different terminology, DSM using borderline and ICD having used emotionally unstable. Whilst subtle differences are said to exist between these two 'conditions' (Rethink, 2017) the terms are used interchangeably throughout this thesis.

artefact may exert an influence, for example the renowned study on depression by Brown and Harris (1978) which brought significant advances in the understanding of how stressful life events impact the development of depression in women. The original intent of this research having been to examine the impact of class on both genders (Busfield, 1988).

The gender paradox in suicide has been attributed by some to being predominantly an artefact of gendered differences in methods of suicide attempt, with males more likely to take more violent actions that have a higher likelihood of fatality and are coupled with reduced scope for intervention (Callanan & Davis, 2012). Partly as a result of this difference however, female suicide attempts, especially when repeated, are at times dismissed as not having been made with serious intent to end life. However, in both cases, a multitude of other factors including socialisation, life events and how these are perceived also play significant roles (Gooding et al., 2015; Nazroo, Edwards, & Brown, 1998; Schrijvers, Bollen, & Sabbe, 2012; Taylor, Gooding, Wood, & Tarrier, 2011). An integrated account for the interaction of the near-innumerable range of complex social and psychological risk or protective factors has been proposed by Haigh (2009). The Personality Development Pathways model is presented in the style of a tube map that has a range of stops and interchanges signifying a comprehensive set of childhood and adult experiences between starting points of being born strong or vulnerable and termination points including 'life' as well as mood disorder, life-long personality disorder and suicide. Although not incorporated in Haigh's model, the impact of gender as related to fundamental philosophical issues that exist within the mental health system and particularly surrounding diagnosis cannot be overlooked (Bentley, 2005). These points are of central importance to this work and so will be examined in greater depth in the following chapter.

1.6 Chapter Summary

The authority to detain a member of the public under the Mental Health Act may be one of the most controversial of all police powers. Section 136 occupies a unique position at the intersection of the criminal justice and health

systems. This factor has long rendered overall responsibility for monitoring and managing its use neglected. Whilst the police have considered it a mental health matter, mental health organisations have taken the view that 'ownership' should rest with the police. Disparate procedures around both implementation and data recording arose as a result of this disjuncture, in turn generating further problems.

People who were detained under S136, especially those taken to police custody, have long seemed invisible and patterns in the outcomes of detention have been unclear. Mental health triage schemes have brought closer partnership working, enabling the police to be better supported by mental health services. The use of police custody as a place of safety has been reduced with improved access to health-based suites. Similarly, the new Policing and Crime Act, which has made the first major amendments to S136 since its inception, may at last be bringing an end to the use of custody for this purpose. Nonetheless, our study of *S136 in Sussex* highlighted a number of issues that seem unlikely to have been entirely addressed by the implementation of triage or legislative developments. Not least among these concerns was the recurrent detention of some individuals, sometimes with very high frequencies.

Narrative interviews with people who had been detained suggested histories of trauma and poor relationships with mental health services compounded the difficulties faced by some participants, for whom suicide attempts resulting in police detention had become recurrent experiences. The scarce literature on this subject points to repeated detention being a small but commonplace phenomenon, further complicated by the diagnosis of personality disorder. Research into groups who may share similarities with those who are repeatedly detained points to a complex mix of social and psychological adversities having a significant bearing on recurrent problematic presentation to front line public services.

Section 136 is commonly used as suicide prevention. Suicide and self-harm are recognised as major public health concerns that present a thorny issue and the relationship between self-injurious intent and mental illness is far from clear.

Gender adds a further dimension; more men than women complete suicide yet more commonly women appear to attempt suicide and self-harm. More women than men may be detained with high frequency and the deeply vexed diagnosis of borderline or emotionally unstable personality disorder appears to be implicated. Hence it is clear the study of repeated detention will necessitate an approach that incorporates the contexts in which it arises as well as uncovering the relationships between the complex multifactorial elements.

1.6.1 A Psychosocial Approach

This chapter has introduced the key aspects of the theoretical framework on which this PhD is founded. Recurrent detention appears closely linked to suicide and self-harm, which arise as the result of interactions between acute emotional distress and sociocultural factors. Accordingly, the triggers to repeated detention cannot be understood or addressed without accounting for the influence of context. Kobler and Stotland (1964) introduced their detailed examination of a series of inpatient suicides as informed by a psychosocial approach, which they explained with these words:

“We believe that one cannot understand an individual, his behaviour, or what has happened to him, without knowing the setting, the significant aspects of the environment. To understand a person in psychology, one must look at the ‘life-space’; i.e. the person and the psychological environment as it exists for him. Moreover, there are constant, shifting interactions within the life space... research must be concerned with ‘organized complexities’” (ibid, p. vii).

Howe (2009) has defined ‘psychosocial’ as relating to the: *“area of human experience which is created by the interplay between the individual’s psychological condition and the social environment”* (ibid, p.137). This review has underscored the need for a psychosocial framework by indicating the multiple and complicated social and cultural facets of the context in which repeated detention occurs.

The following chapter will develop these themes further, outlining the evolution of societal attitudes and responses to mental illness, as well as illustrating that the police role in responding to mental illness and suicidal behaviour predates the inception of the Mental Health Act and even the health service by centuries.

The dominant biomedical approach to mental illness will be considered, as will alternatives to this paradigm and the mental health 'service user' movement.

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2 CARE OR CONTROL?

SHIFTING ATTITUDES TO MENTAL ILLNESS

2.1 Chapter Overview

Having discussed some of the extant work on Section 136 (S136) and identified the key practice issues in the previous chapter, this review draws from wider bodies of literature to examine some of the debates that form the broader context in which this topic is situated. The previous chapter revealed that many of the problems of S136 originated from the mutual reluctance of mental health services and the police to take 'ownership' of it. The question of where a person should be detained to, manifested in the insufficient provision of health based places of safety and consequent over-reliance on the use of police custody, has long presented a seemingly intractable problem. These concerns form the central matter of consideration at the heart of this review: how society conceives or defines a mental health crisis and relatedly, what an appropriate response should be. In particular, the complex issues surrounding suicide and self-harm are critical to S136.

This chapter will begin by demonstrating how changing social policies and the evolution of treatment of people considered mentally ill have reflected societal attitudes to these questions of responsibility. The notion of 'madness' has evolved into 'mental illness' and latterly 'mental health problems', yet the progression in language has belied changes in attitude. Control has remained a near-constant core element of the societal response to those deemed to be mentally ill. Attempting suicide has long been considered self-evident indication of mental disturbance and has traditionally received a response dominated by state-exercised control; latterly, so too has self-harming. Examination of the treatment of those deemed mentally ill will provide a foundation to chart the socio-political determinants of care, as well as the rise to dominance of biomedicine. Criticisms of the concept of medicalisation put forward by commentators who are cautious of the biomedical approach, alongside the

arguments of its proponents will be used to advance the review to the second part, in which the challenges to psychiatry and biomedicine will be considered. The review will draw upon critiques of psychiatric diagnosis with particular reference to the contested 'conditions' labelled personality disorders, to argue the greatest failing of categorical systems of diagnosis is their disregard for the crucial role of contextual factors in the development of these disorders. This discussion will foreground presentation of important advances including critical psychiatry and the recovery movement, leading to the final area of focus, that of the so-called mental health 'service user movement' and patient involvement. Historic and newer attempts to privilege narrative and meaning in understanding and addressing the problems of mental ill health will be examined to conclude the review.

2.2 The Evolving Societal Response to Mental Illness

Madness, mental disturbance and emotional distress can be identified as being present to some extent in all cultures. However, the approach to such phenomena differs markedly throughout the world, indicating that conception, definition and the notion of appropriate response are very much matters that are socially determined and dependent upon the context in which they occur (Bendelow, 2010a; Porter, 1997). A review of the history of mental health care prepared for the mental health charity, Mind (Darton, 1999) suggests this was the case even in the prehistoric period when such disturbance was considered the domain of gods and magic, with Stone Age psychosurgery in the form of trepanning: creating a bore hole in the skull to let evil spirits escape (Porter, 2002). This approach located the problem within the body, in this case the brain, even though ascribing the cause to the work of demons. As history advanced, the 'western' approach was assumed to have oscillated between predominantly social and biological; considering madness as arising from the whole person in their context or isolating the problem to a specific physical site (Sedgwick, 1982). Several more recent reviews of elements of historic psychiatric practice have asserted that this notion of the pendulum swinging between the dominant approaches of psyche and soma is an over-simplification (M. Pickersgill, 2010; Rasmussen, 2006; Sadowsky, 2006). However, the biomedical model, which has

been tightly interwoven with notions of reason and rationality, has unarguably gained dominance among approaches to mental health during the era of Enlightenment. How madness has been viewed and what has been considered to constitute an appropriate response to mental disturbance has ostensibly undergone significant change during the last two centuries. Yet over time the concepts of control and care have become ever more tightly interwoven to the point where the former appears to have subsumed the latter.

2.2.1 The Rise of the Asylums

As the previous chapter illustrated, recent decades have seen increasing concern at the number of mentally ill people 'locked up' by the police, as the narrative around Section 136 has frequently been presented. Yet the police role in detaining the mentally ill is far from a new phenomenon. The 1744 Vagrancy Act made provision for a constable (or churchwarden) to be ordered by justices of the peace to escort to a secure place, and if deemed necessary to shackle there:

"persons, who by Lunacy, or otherwise, are furiously mad or are so far disordered in their senses that they may be dangerous to be permitted to go abroad"

(S20 of the Act, as quoted in Glover-Thomas, 2002, p.4).

Arguably, removing the capacity of a churchwarden to fulfil this function was the only significant difference between this element of the 1744 Act and the wording of S136 permitting a constable to remove a person who appears to be suffering from mental disorder and to be in immediate need of care or control from a public place and to detain them at a place of safety.

The process of segregating and incarcerating the insane was typified by the creation and population of the asylums; linked by some to the rise of the industrial revolution (A. Scull, 2016; A. T. Scull, 1975). Previously, the church had often taken responsibility for helping to feed and shelter the vulnerable members of society, which remained the case initially; many of the places that would later become asylums were originally created as places of hospitality for travellers and indigents (Porter, 2002). Over time, the purposes of these places progressively became the care of the sick, including those who were sick of mind (Strathern, 2012).

The precise timings and reasons for the rise of the asylums may remain elusive (Rogers & Pilgrim, 2010) but the eighteenth century saw the creation of many new workhouses and madhouses alongside the significant expansion of existing hospitals. Among the best-known examples of these madhouses were St Thomas', St Bartholomew's and the Bethlem Hospital, the latter having been founded five centuries earlier by the Priory of the Order of St Mary of Bethlehem. Similar institutions were to be found at this time throughout Europe (Foucault, 1971; A. Scull, 2016; Showalter, 1987). Large-scale population of asylums was favoured over the previous, somewhat ad-hoc approaches to the care of the mentally ill. Commentators have indicated that the demand for productivity may have been a key influence forcing differentiation between those without work and those unable to work (Glover-Thomas, 2002). This disaggregation of the indolent and incapable meant that the former could be put to work whilst housing the latter simultaneously began to transform lunacy into a lucrative area of commerce. Industrialisation was also driven by capitalist ideals, which meant alongside the by now long-favoured characteristic of reason, efficiency and organisation also became revered (A. T. Scull, 1975).

The Madhouses Act (1774) was claimed to have stood testament to the number of wealthy patrons who commonly found themselves incarcerated by relatives seeking to acquire inheritances during this time (Glover-Thomas, 2002). However, the Act itself did little to secure better conditions as it conferred neither power of sanctions for inadequate institutions nor veto of licence applications. As well as providing an early indication of societal concern over the tensions between care and control, this sadly hints at an unfortunate traditional propensity of some working in the 'Lunacy Trade' to be motivated more by profit than the treatment of the sick (A. T. Scull, 1981).

During the 18th century, medical practitioners treated sickness of the mind through accepted physical interventions. Practices that today are considered acts of self-harm indicating extreme emotional distress or indeed mental illness, such as opening veins and inflicting scars and burning, were expected to cure sicknesses of the mind as well as the body. Documentation from the Bethlem Hospital indicates that current attitudes to self-harm were certainly not formed

until considerably later; patients were described as managing their distress by engaging in therapeutic blood-letting when they were unable to obtain this service from physicians, something which clinicians recorded as an understandable course of action (Chaney, 2017). But during this period some sceptics of the curative qualities of what may today be labelled physical abuse developed 'moral therapy'. The Quaker William Tuke who opened the York Retreat in 1796 was among the pioneers of an approach that favoured treating lunatics with kindness; replacing the accepted forms of brutal treatment with a more humane approach that resembled an early form of occupational therapy, for example by structuring days to include simple tasks and walking in the countryside (Busfield, 1988). For years, the York Retreat was noted as achieving more success than its counterparts in 'healing' the madness of many who passed through its doors in spite of restricting medical input solely to treating physical illnesses, as a succession of doctors themselves became disillusioned watching their prior ministrations failing to achieve notable benefit to the minds of patients (Digby, 1984; A. T. Scull, 1975).

The achievements of moral therapy were broadcast by various publications issued by Tuke and others visiting or engaged with the York Retreat, fuelling arguments for widespread reform. Whilst popular opinion still favoured the incarceration of the deranged (Glover-Thomas, 2002) concerns mounted over the deprivations endured by those who were consigned to the asylums.

Notwithstanding the calls of reformists during the latter part of the Victorian era to abandon the asylum system altogether, segregation of the mentally ill remained at the heart of nineteenth century societal response to madness. Even in the early times of the Victorian asylums, demand quickly exceeded supply. Whilst the many people absent of what may today be defined as mental health problems but nonetheless deemed at the time to be social deviants, such as unmarried mothers are likely to have contributed significantly to this trend, the over-population of the asylums also hinted to the advancing process medicalisation: the colonisation of medicine into areas of life not previously considered to fall within its jurisdiction (Conrad, 1975, 1992; Illich, 1975). Stark imbalances in the numbers predicted when establishments were built and those admitted once they opened, meant that although many alienists, as the owners of madhouses were

then known, increasingly claimed to offer moral therapy, the reality remained that inspections frequently found inmates of asylums being chained, naked and neglected in conditions diametrically opposed to the system of restoring dignity and self-respect pioneered in the early days of the York Retreat (Glover-Thomas, 2002; A. T. Scull, 1975).

2.2.2 Progression in Language, Laws and Practice

Attitudinal shift in the social concept of mental illness can be inferred from the changing nomenclature over time. Madhouses were rebranded as asylums and would later become mental hospitals (A. T. Scull, 1981). The change in the concept of insanity with the dawning of the Enlightenment had been to reconsider the madman, not absent of morals or afflicted by demons but rather one who had lost his reason and was therefore deserving of pity, especially given the status to which reason had been elevated in this era as humanity's most prized quality. Thus, the purpose of the establishments into which the madmen and women continued to flow was increasingly intended to be care as well as mere confinement. As 'understanding' progressed, the lunatics too were rebranded and became mental patients. Still not deemed acceptable to be abroad, their basic needs were addressed with progressive institutions designed to provide pleasant environments with curative properties: spacious with access to fresh air and sunlight, as endorsed by the Victorian view of health care (Laurance, 2003). Again, the reformist ideals with which many of these institutions had been designed became marginalised and the primary purpose of the asylums reverted to confinement of "*the odd, the disturbed and the 'morally degenerate'*" (ibid, p.20).

This process of evolution saw treatment becoming favoured over mere confinement. The mad-doctors, who would later become psychiatrists, located the asylums as their stronghold (N. Crossley, 2006; A. Scull, 2016). From this foundation, psychiatry was to succeed in defining and fulfilling a role for itself as medicine was evolving away from the informal model previously comprising separate groups of surgeons, apothecaries and physicians. Passed in 1858, the Medical Registration Act formalised the progression that had begun to merge these distinct forms and established standards for entrance into the medical

profession (Glover-Thomas, 2002). The prevailing medical orthodoxy at this time maintained physical defects caused illnesses, thus the developing profession of psychiatry sited mental disturbance as anchored to a defect of the brain.

In the ensuing time of change, those doctors who chose to specialise in treating the sick mind persisted in pressing the view that madness necessitated medical intervention and over successive years the developing practice of psychiatry rose to dominate the branch of medicine 'dealing' with mental illness. Pressure from outside the medical profession encouraged this emergent branch of psychiatry to continue to try to treat and cure insanity (Glover-Thomas, 2002; A. T. Scull, 1975). No longer were the mentally ill to be simply warehoused for public amusement in the asylums, now medicine would seek to cure the sick brain and thereby to bring about a return to a state defined as 'normal' functioning (Strathern, 2012).

The view persisted that the asylum fulfilled a key function in the field of mental health care but the influence of the some of the principles upon which moral therapy had been founded could be seen to have taken hold. The famed psychiatrist Henry Maudsley was among many who felt that it was of therapeutic benefit to remove the insane patient from the environment in which their insanity had been produced (Busfield, 1986). Legislation could again be seen as playing a key role in cementing some of these progressions, particularly in relation to strengthening the authority of the burgeoning psychiatric profession. The Lunatics Act (1845) ensured every asylum had a registered medical practitioner and introduced the Lunacy Commission, which was comprised of mostly medical practitioners to inspect and maintain standards in the asylums. The confidence with which these assertions of expertise were made may have contributed significantly to psychiatry becoming firmly anchored at the vanguard of medicine's war on the diseased brain and too in assuring the profession excluded laymen from any significant control in dictating the care of the mentally ill (Glover-Thomas, 2002; Porter, 1987). Subsequent amendments and variations to the laws governing the conditions under which the insane were to be housed, and crucially also treated, saw the some of this sovereignty being revoked. However, the introduction of the Mental Treatment Act in 1930 re-established medical

discretion as dominant in determining what constituted appropriate care of the mentally ill.

Other disciplines dealing with the mind such as psychoanalysis and psychology also expanded greatly during the early part of the 20th century (N. Crossley, 2006; A. Scull, 2011). The world wars were implicated in this growth phase influencing the 'psy' disciplines in two key ways. Firstly, the effects of war on the mental health of the veterans who returned from the wars forced a realisation that mental illness could no longer be attributed solely to biological defect, as had been the prevailing wisdom up to that point; environmental influences therefore had to be incorporated into models of aetiology. Increasingly during this time, psychiatry moved to incorporate notions of psychic pain that were heavily shaped by the influences of psychology and psychoanalysis and treatment too became oriented towards social approaches (M. Pickersgill, 2010). Importantly this time also saw cross-disciplinary work being formalised with the inception in 1922 of the National Council for Mental Hygiene, which included not only psychiatrists but also social workers and psychologists (Darton, 1999). Secondly, as the demand for treatment of the psychic as well as physical wounds of war was greatly magnified in the aftermath of both wars, the solely institutionalised model of care became untenable and so despite the creation of multiple military hospitals, practice also began to extend increasingly beyond the mental hospital setting (A. Scull, 2011).

2.2.3 Beyond the Asylums

The move to treat more mental health problems outside the confines of the institutional setting had begun decades earlier with reformists arguing that incarcerating the mentally disturbed was inhumane. But it was the number of people needing care following World War II that triggered a period of significant social change, the influence of which would extend to impact the mental hospitals as well as many other aspects of society. Here again, legislative changes can provide an insight into social change and attitudes to mental illness. A notable first step was the creation of the National Health Service in 1948. This was to be followed in 1959 by the first Mental Health Act. However, the critical turning point in the structure of mental health care followed almost twenty years later as the era of the asylums was ended. Government policy in the form of the Hospital

Plan announced that communities and district hospitals would instead become the appropriate locations for treatment of the mentally ill.

Pharmaceutical advances also made a significant contribution to changing attitudes towards mental health treatment and social policy. New psychiatric medicines promised the viable prospect of treatment outside the institutional setting (Busfield, 1986). The 'Water Tower' speech to the National Association for Mental Health, frequently credited as the seminal turning point at which the decision to close the asylums was announced, referred to the reductions in admissions and asserted an apparently sound financial basis to abandon asylums in favour of community treatment for all but the most severe, who were said to be a small minority. Despite vociferous and sustained criticism of the premises on which this decision was based (e.g. Jones, 1960) the Hospital Plan was enacted and large district general hospitals were built around the country. The stated intention was that mental health would be treated in the community alongside physical health in the psychiatric units that would be built as part of these estates. Local Authorities were envisioned as being able to provide services in partnership with these new hospitals in order to meet the full range needs regardless of severity.

Initially, the move to empty the mental hospitals appeared to have been a success. Many hundreds of people had been institutionalised and once admitted had lived their entire lives inside the mental hospital, even absent of any ongoing sign of psychiatric illness (Toms, 1987). Some attributed the early relatively unproblematic transition to the new modes of care to the capacity of many previous long-term residents to live independently, having minimal support requirements beyond regaining the motivation to attend to their own needs after being institutionalised (ibid). Others felt this element likely paled in comparison to patients being:

“so intoxicated by their new found freedom that they did not mind the physical privation of the dingy bedsits and dilapidated boarding houses in which many of them found themselves”

Laurance, 2003, p.23).

As this quote suggests, the large sums of money expected to be unlocked by disbanding the mental hospitals did not materialise as adequate provision in the

community. Whilst many patients released from the confines of the hospital were reported as being satisfied with the community settings to which they were relocated (Leff, Thornicroft, Coxhead, & Crawford, 1994) concerns mounted that the services available were inadequate to meet the needs of both those with more severe needs and new patients who had not previously known the institutional system. In addition to her prescient questioning of whether sufficient community resources could or would be funded to meet the demand, Jones also criticised the vision painted by Powell's speech, warning that although public tolerance had improved, if mentally ill people became a nuisance those attitudes could easily change again.

2.2.4 Policing 'Insanity': The Case of Suicide

Whilst changes in the circumstances of most deemed mentally ill over the preceding centuries have been subject to extensive commentary, attitudes to suicide and self-harm have received comparatively little focussed attention (Healy, 2006). However, the small body of extant literature in this area reveals critical insights into the evolution of the contemporary stance on both. From this work it is also possible to approximate how societal attitudes shaped the approaches of the medical profession to those who attempted suicide or engaged in self-harm. Anderson's important work on suicide in the 19th century drew on multiple historical records, which she presented alongside extensive contextual detail, thereby providing a comprehensive social history of attitudes and responses of the period (Anderson, 1980, 1987, 1989). Being suicidal was one of the most common criteria upon which assessments of insanity and decisions as to admission into Victorian asylums were based (Anne Shepherd & Wright, 2002). The belief that those who are mentally ill are customarily prone to present a risk of harm to self or to others, as considered by the Vagrancy Act persisted a century later.

The early to mid- Victorian period also covered substantial social change, including the formation of the modern police force that began in London in 1829 and was extended to the rest of the country in 1835 (Joyce, 2011). It would be another ten years before the remit of the police began to extend to investigating crime; the initial purpose of the newly created force was maintaining public order

(ibid). To which end the police at that time concerned themselves with arresting deviants who were causing public disturbance; primarily drunks, prostitutes and suicide attempters. Thus, in relation to the latter offence Anderson (1987) states that:

"variations in these rates of arrest are as much a part of the history of the police as of the history of attempted suicide"
(ibid, p.283).

It can therefore be argued that the modern situation that sees suicide prevention as a police activity originated with the creation of the police. However, whilst the act of attempting suicide was a crime when the police force was being established, this is no longer the case. Yet Section 136 detention for suicide prevention is still effectively a criminal arrest. As highlighted in the previous chapter, many detained by the police report feeling criminalised by the experience (Bendelow et al., 2016; Durcan, 2014; Riley et al., 2011).

The decriminalisation of suicide provides a critical insight into how this position was derived. The Suicide Act (1961) overturned the 13th century offence of self-murder (*felo de se*); a development that is generally held as an indicator the increasingly secular attitudes of the twentieth century (Holt, 2011; Weaver & Wright, 2010). However, whilst acknowledging this critical legislative change may have coincided with a social turn away from the ecclesiastical values that condemned attempting or committing self-murder as moral outrages, Moore (2000) contends that there was little evidence of the sort of widespread public appetite for a change in practice that typically drives legislation. Instead, she asserts that the principal underpinning the Act was that state control could be more effectively exercised to prevent suicide by transferring this jurisdiction from the criminal justice system to the medical profession. Whilst many people who came to police notice for attempting suicide were held on remand in prison, very few went on to be convicted. Hence, Moore states that the Home Secretary who engineered the passing of the Act was seemingly motivated less by a desire to enact a more compassionate response to people in a suicidal crisis as much as by discrepancies in the rates of the common law offence of attempted suicide and those who were ultimately subject to legal sanctions.

A further central tenet of Moore's thesis is that the Suicide Act would have neither been proposed nor passed had legal coercion of those attempting suicide but unwilling to receive assistance not already been introduced. With the asylums being disbanded, the need for a legislative means to enforce care on the mentally ill was satisfied by the replacement for the Lunacy, Mental Treatment and Mental Deficiency Acts. The conflation of mental illness and the propensity to cause harm to self or others underwrote the new Mental Health Act (1959). The powers this legislation conferred were thus predicated on the certainty that apparent mental illness was a sufficient condition to entitle professional intervention and coercion. Reviewing the scant parliamentary debate and correspondence that accompanied the passing of the Suicide Act, Moore reports the prospect that a person who attempted suicide may not be mentally ill was never considered. Crucially, using wording markedly reminiscent of that of the 1744 Vagrancy Act, the new Mental Health Act had introduced Section 136 which conferred upon a constable the power to detain a person who appeared to be mentally disordered, for protection of the person or public.

Substantive changes to the field of mental health followed the closure of the asylums and the Mental Health Act was replaced in 1983, having undergone extensive alteration. However as explained in the previous chapter, the wording of S136 was unchanged. This was in spite of one of the predominant aims of the 1983 revisions being to reduce the potential for wrongful detention and appease civil rights campaigners who had criticised the excess of power woven throughout the 1959 Act (J. M. Laing, 2000). In light of many of the recommendations of the review conducted by Lord Butler (who had ushered the Suicide Act through during his tenure as Home Secretary) the 1983 Act was broadly considered to be "*humane, progressive and liberal*" (Pickersgill, 2012, p. 33). In contrast, the further amendments to the Mental Health Act which followed in 2007 spoke to a desire to tighten controls of mentally disordered persons.

The definition of mental disorders was broadened, as was the range of professions who were eligible to become Approved Mental Health Professionals, subsuming the Approved Social Worker role, alongside the same process being introduced for the responsible medical officer (I. Harvey, 2010). In addition,

supervised Community Treatment and Community Treatment Orders to mandate receipt of care to patients in the community were introduced; and the previous 'treatability test', which had meant patients could only be detained if their condition was deemed to be amenable to treatment was replaced with an 'appropriate treatment test' (Dow, 2008) which enabled alignment with the fiercely contested legal categorisation of Dangerous and Severe Personality Disorder, discussed subsequently herein. Once again, other than permitting transfers between places of safety under the same detention, S136 remained unchanged in 2007.

The successive amendments to the Mental Health Act signified a revived sense of the need to protect the general public from the mentally ill; once more the concern was that those suffering from disordered minds were too 'dangerous to be permitted to go abroad'. As well as establishing police powers in relation to mentally disordered persons³ the changes in practice and legislation over the following forty years enshrined coercive practice in mental health practice, prompting critics to voice the now classic Foucauldian questions as to whose interests psychiatry serves (Rogers & Pilgrim, 2010). Conversely, patients' entitlement to treatment has not appeared to concern either of the Acts (J. M. Laing, 2000). Goffman asserted that the asylums did not exist to provide employment to the professionals who worked therein but rather to satisfy the demands of the criminal justice agencies and relatives of patients, who he claimed were the real clients of the institutions (Goffman, 1961). Either by legal mandate or subtler but no less coercive means, Goffman's contestation, echoed by others such as Szasz (Szasz, 2004) and Foucault (Foucault, 1971) was that patients entered these establishments at the bidding of others. Indeed, the impact of familial persuasion has been noted to result in perception of coercion being greater among patients admitted to hospitals on a voluntary basis than their compulsorily admitted counterparts (Monahan et al., 1995). Thus, interrogating the function of the psychiatric system and the role played by psychiatry's use of coercion continues to be both a contemporary and necessary concern.

³ In addition to Section 136 and disregarding the definitions of identified authorities, the Mental Health Act (1959) made a further 18 provisions for police powers, often granting powers to a mental welfare officer, constable, or any person authorised.

2.2.5 Psychiatric Coercion: Control as Care?

As intimated above, the most obvious manifestation of power in the profession of psychiatry is in the ability of practitioners to deprive a person of their liberty. As the previous sections have indicated, social control of those deemed mentally ill has remained a constant feature of the English legal system for more than two centuries since the 1774 Madhouses Act introduced the power of admission via certification (Glover-Thomas, 2002). Szasz (2002) argued that there was in effect no difference between using the law to imprison criminals and using psychiatry to imprison those deemed mentally ill. Pilgrim (2016) has also highlighted that only terrorists and psychiatric patients face the prospect of detention without trial in modern developed societies. The particular salience of this area for the present work is highlighted by the finding that those who have previously been compulsorily detained are at increased risk of undergoing coercion on subsequent admission (Fiorillo et al., 2012). Moreover, when police detention results in psychiatric admission, patients have been found to be significantly more likely to experience coercion if self-harm had been noted as a concern (Al-Khafaji, Loy, & Kelly, 2014). Beyond forced detention other, arguably more nuanced examples of psychiatric power also bear scrutiny. The concerns around the privations of the mental hospital were not altogether made obsolete with the closure of these establishments. Community treatment was hoped to offer a more acceptable location more conducive to improved outcomes, however a number of the dynamics described by Goffman (1961) as having operated within the asylums were simply transposed into the new setting in which psychiatry was to be practiced.

Goffman criticised the medical model because of the power which he observed having been bestowed upon the psychiatric profession by virtue of their expert role in the period following the end of World War II. However, this dynamic has been found to persist in contemporary psychiatry and caution has been raised against dismissing Goffman's text as obsolete given the capacity for psychiatry to remain one of the social systems capable of dehumanising people who are subject to objectification or reduction to a role, such as that of 'patient' (Mac Suibhne, 2011). This reference to the conceptual role of the patient echoes Parson's seminal writings on the sick role (Parsons, 1951, 1975): the mechanism

by which responsibilities are conveyed upon actors in the healthcare system. Parsons described the medical system is structured such that it is incumbent upon both patients and physicians to recognise and fulfil the functions assigned to them. Through meeting the demand that they firstly recognise their incapacity to fulfil normal functioning and secondly show willingness to improve the situation through seeking expert input to rectify this position, the patient can regain a level of social legitimacy in spite of the deviant status inherent in their illness (Williams, 2005).

The idealised notion or expectation of a good patient was not uniquely observed by Parsons during this time but also concords with the observations of Jeffery (1979) in his key paper entitled '*Normal Rubbish*'; so named after his observation of a Casualty Officer in an emergency department referring to the majority of patients as "*the usual rubbish*" (ibid, p.92). Jeffery found that medical professionals regarded certain types of patients as especially deviant. Most often this label was applied to those admitted due to substance misuse or self-harm, including suicide attempters. Drawing on this work more recently, it has been reported that although not universally supported, similar trends could be found in the perceptions of medical nursing staff about patients who did not obey conventions related both to social norms (rudeness, courtesy towards other patients) and the sick role (Conway, 2000). The latter included the expectation that patients engage with their own recovery; 'doesn't try' and 'defeatist' were both labels conferred on patients in the 'difficult' category.

As indicated by Jeffery's work, deliberate self-harm and attempting suicide are distinct among expressions of psychic dis-ease. As stated earlier, self-injurious behaviour was not always considered abnormal during the time when such harms were inflicted for curative purposes by medical practitioners. However, the last century self-harm has been located within. In contrast, social attitudes to suicidal behaviour have not altered significantly. Attempting suicide has consistently attracted a response that prioritises control over care (Rogers & Pilgrim, 2010). Indeed, as the earlier discussion illustrated, it is unlikely suicidal behaviour would have been decriminalised without robust provision having already been made to permit state intervention in suicide attempts.

A further issue that complicates responses to suicide is that suicidal intent is interpreted differently dependent on the status of the suicidal person. As the previous section showed, being suicidal has historically been taken as *ipso facto* evidence of mental illness. The contemporary view generally considers mental health patients to be suicidal as an artefact of their primary condition, conversely those without a diagnosed mental illness are notionally 'permitted' the option of contemplating rational suicide (Allen, 2013; Rogers & Pilgrim, 2010). Despite the evolutions in understanding mental illness, lacking a diagnosed mental health condition still confers a greater level of assumed reason. Terminal illness, bereavement and other devastating circumstances to which people with a mental health problem are no less immune, are considered to be factors that may prompt an 'understandable consideration of suicide' only where a pre-existing mental illness is not present.

As Rogers & Pilgrim (2010) highlight, social factors such as the levels of discrimination; impaired future work, housing and relationship prospects; and unsatisfactory or inadequate treatment options, now extending to increasing reports of cases of abuse, are all seemingly too easily discounted issues that can be implicated in a person becoming suicidal. There is also a notable tendency among professionals to make post-hoc ascriptions of mental abnormality where suicide has been completed, both by people from psychiatric and non-psychiatric populations (Pridmore, 2011). Black et al. (2004) note that nearly all psychological autopsies of people who die by suicide conclude that the person was mentally ill at the time of their death.

Whilst suicidal thoughts or related behaviours have not historically been considered psychiatric diagnoses⁴, the concept of loss of reason dominates reactions to both, certainly outside the field of professional mental health. It is likely that this reaction is not solely due to suicidal behaviour being considered as 'symptomatic' of many psychiatric conditions. Both suicide and self-harm are thus inherently socially embedded acts which cannot be truly understood in absence of the contexts in which they occur.

⁴ Non-suicidal self-injury has now been added to both diagnostic manuals, see section 2.3 which follows.

The stark differences in gender seen in this area present a further thorny aspect of the discourse on power in psychiatry. As highlighted in the previous chapter, in almost all parts of the world the majority of people completing suicide are male, yet in contrast suicide attempts and self-harm are commonly considered more prevalent in females (Brooks et al., 2017; Millard, 2015; Nicoletti, 2004; Victor & David Klonsky, 2014). Similarly, whilst the majority of people detained in western psychiatric facilities are male, females have been reported to face greater likelihood of experiencing coercion during involuntary admission in European settings (Fiorillo et al., 2012).

During the time in which the asylums were being disbanded, feminists began to interrogate the gender imbalances apparent in the mental health system. The influential study of Brown and Harris (1978) discussed above, has been cited alongside works such as Chesler (1972; 2005); Gove and Howell (1974); Gove (1978); Oakley (1981); Kessler and McLeod (1984) and Showalter (1987) among others who have contended that societal oppression of women results in greater incidence of female mental illness and that the male dominated field of professional psychiatry further entrenches these issues by labelling women ill (Busfield, 1988). At the extreme end of this critique is the view that mental illness as a social construct is fundamentally sexist being based not around deviance from societal norms but specifically around the archetypal constructs of femininity (Chesler, 1972). Others have argued convincingly that such a stance hinders feminism from being able to contribute to redressing the imbalances that exist within the mental health system by excluding feminists through an obligation to oppose a patriarchal system that fundamentally oppresses women (Busfield, 1989). That a feminist perspective could prove invaluable in mental health and suicidology is however beyond question (Lester, 1990).

2.2.6 Summary: The Tensions Between Care and Control

The preceding discussion has reviewed historical developments in attitudes to the mental health as demonstrated by changing language, laws, responsibilities and means of caring for those deemed mentally ill. Changes to the delivery of care in recent centuries, whilst often driven by 'good' motives, have at times risked being undermined by the use of power. Closing the asylums was at least

partly a humanitarian move that addressed some of the more barbaric practices of warehousing and disregarding the insane. But inadequate provision of resources meant that effectively the 'problem' of mental illness was merely dispersed by deinstitutionalisation, shifting the primary societal concerns from welfare of ill people to protection of the public from them. Neglect has been a recurrent issue, with the privations of madhouses, asylums and later mental hospitals following into communities. Coercion too, has been an ever-present influence. The shifting (or not) attitudes of society to its mentally unwell or disturbed members can be viewed through changing policies, the wording of S136 of the Mental Health Act 1959 mirrored that of S20 of the Vagrancy Act 1744 in such stark terms as to leave little room to question whether attitudes have indeed changed at all. Certainly, the question as to whether care or control is the more appropriate course of action, remains as yet unresolved.

The responses to suicidal behaviour in particular have changed little, in the 1800's a person attempting to end their life was possibly only likely to receive a caring reaction from a police officer who was prepared to travel miles to try to bring that person into receipt of medical care for their wounds. It has taken two centuries for the decision to be made in the Crisis Care Concordat people experiencing mental health crises should not be transported by police because it is stigmatising and for the Policing and Crime Act to mandate that a healthcare facility and not police custody must be the place to which a person attempting to end their life should be taken. At the heart of this a deeper question remains unaddressed. If it is not possible to easily define *who* should respond or indeed *how*, perhaps it is because the question of *what* should be tackled remains unanswered. It is this related issue of how mental illness may be defined, or diagnosed, that this review now turns.

2.3 Diagnosing Difficulties: The Controversial

Dominance of Biomedicine

2.3.1 Biomedical Psychiatry

As the Classical Era began to draw to a close the form of medicine practiced underwent a parallel evolution. Previously, patients' descriptions of their illnesses

had been privileged and medicine had sought to bring about a more holistic notion of health, conceived of as restoring a form of balance. This arguably vaguer concept of wellness now began to be replaced by a more 'clinical' form, which increasingly viewed the patient less as a whole person, focussing instead on illness as caused by defects or abnormalities of precise sites in the body (Foucault, 1964; Jewson, 1974). Foucault (1973) described this as the clinical gaze: the detached consideration of a patients' pathology by clinicians by which means the patients' perception of their own illness became secondary to the judgement of their doctor. Advances in scientific medicine made during the late 19th century were partly credited with facilitating this shift of focus to the cellular level (Bendelow, 2009). New technologies such as the stethoscope meant physicians were now liberated from the need to rely on patients' accounts of their symptoms and could thus focus on accurate measurement, diagnosis and treatment (Stanworth, 1992; Strathern, 2012).

The era of Enlightenment had been marked by the turn to 'reason' and with this came the intensified search for knowledge and understanding. The rise of prominence of the disease model driving medical practice marked the turning of medicine towards allying with other newly developing fields of science such as biology, anatomy and physiology. As with the other sciences, medicine sought to problematise illness and to understand how the body functioned and so malfunctioned in the case of disease. This focus on the disease as a separate entity that could be identified, understood and thus treated through the application of sufficient biological and physiological knowledge has now come to be synonymous with biomedicine (Bendelow, 2009, 2010a; Pilgrim, 2014a; Wade & Halligan, 2004). Allied to this progression, psychiatry began to reason that a defect of the brain was likely to produce mental sickness just as a defect elsewhere in the body could produce physical illnesses. By extension, this argument pursued a course that as physical diseases could be treated or cured by medicine, so too should diseases of the mind be amenable to medical cure.

The principles underlying the alignment of psychiatry and medicine were summarised by one of the most influential early psychiatrists, Emil Kraepelin.

During his inaugural address in 1886, he is quoted by Jablensky as articulating key themes that would become the central points of focus to his future work:

"psychiatry needs a profound and deep union with general medicine; it is above all the medical, somatic side of our science that provides the point of departure for psychiatric research; the task of psychiatry is the clinical study of mental disorders, i.e. the empirical determination of individual forms of illness according to their cause, course and outcome ...as long as it is impossible to relate a simple and unequivocal patho-anatomic observation to an equally simple and unequivocal psychopathological observation, scientific psychiatry will not have reached the goal it should be capable of reaching" (2007, p. 382).

Kraepelin is credited with making a substantial contribution to pharmacology and experimental psychology, as well as being a proponent of multidisciplinary working; he embraced the emerging field of psychology as introducing the capacity for shared learning to improve understanding of psychopathology and thereby advancing treatment (ibid). However, the Foucauldian critique asserted that the alignment of psychiatry to the sciences of physiology, biology, chemistry and medicine facilitated a closer association between medicine and socio-political discourse, which was not an apolitical shift. Extending the discourses around power that had been started by Nietzsche, Foucault's interest focussed on how madness had come to be synonymous with unreason and the parallel evolution of incarceration as care. He was critical of the use of power inherent in this form of medicine, seeing its purpose not as nurture but rather as a method to achieve political aims such as the segregation of non-productive members of society (Foucault, 1964; Rogers & Pilgrim, 2010).

Power dynamics are today widely acknowledged as being an undeniable component of medical practice (Druehl & Sporrang, 2017; Elston, 2002; Goodyear-Smith & Buetow, 2001; Kaufman, 2016; Saks, 1994; Zola, 1972). Relatedly, so too is the paternalism of medicine a factor that cannot escape consideration (Busfield, 1989, 2017; Coyle, 2008; Hoy & Hallman, 2012; Peltopiri, Engström, & Engström, 2013). The profession's unique ability to define people and behaviours exemplifies the social control inherent to medicine (Conrad, 1992). A further issue at the heart of the critique of modern psychiatry is

its failure to realise Kraepelin's predictions of a scientifically derived linear trajectory of identification and treatment of mental illness.

2.3.2 Psychiatric Diagnosis and the March of Medicalisation

Psychiatry continued to pursue the medical model as the twentieth century progressed. The Diagnostic and Statistical Manual of Mental Disorders (DSM) was first published by the American Psychiatric Association (APA) in 1952 and an older system of nosology, now recognised as the World Health Organization's International Classification of Diseases and Related Health Problems (ICD) had emerged sixty years earlier⁵. The notion of identifying and classifying types of mental illness was not new, in addition to Kraepelin's work towards delineating mental disorders, one of the first widely used reference texts '*A manual of psychological medicine*' published in 1858 had included portraits depicting types of insanity, which could be recognised by the different physical features of a patient (Scull, 2016). Similarly, phrenology for a time purported to be able to distinguish different characteristics by feeling the head of a patient, as it was 'known' that that the brain development shaped the skull, thereby revealing over or under-developed areas which corresponded to personality traits (Adler, 2004).

The renewed move to categorise psychiatric conditions, and the associated proliferation of chemical approaches to treating the brain which marked the evolution of psychiatry at this time were eschewed by psychoanalysis, which sought to understand individual psychic conflict, thus guiding the patient to reach a resolution to their inner turmoil rather than cure of specific symptoms (Busfield, 1986; Craib, 1997). Scull's (2011) narration of the 'contested jurisdictions' of mental health contends that the turf war between the 'psy' professions had reached a form of truce by the middle of the twentieth century. According to Scull, it was at this point that psychology aligned itself with research and acceded to academia, a succession from the psychoanalytically trained psychiatrists who had held the majority of these roles previously (Hale, 1997). Scull credits this transition as having been aided by the symbiotic relationship developed with the

⁵ The focus of DSM remains purely psychiatric conditions, however ICD began under the auspices of the International Statistical Institute as the International Classification of Causes of Death and did not incorporate a section on 'mental disorders' until its 6th iteration, published by WHO in 1952 (APA, 2017). ICD-11 retains a chapter on Mental and Behavioural Disorders (Gureje, 2018).

bourgeoning psycho-pharmaceutical industry. Psychiatry remained sovereign over the domain of diagnosis and so too administration of those drugs, thereby maintaining the discipline's position of dominance in the mental health hierarchies that had first been established in the pre-war period.

It should be noted that whilst medicalisation is generally couched as having negative connotations, one of the most renowned authors on the topic, Peter Conrad, is among few to have pointed out the term and process are correctly used neutrally. Notwithstanding the cautions of those noting medicalisation can equate to social control (see for example Parsons, 1951; 1975; Pitts, 1968), it can also work to improve the circumstances of those whose problems become medicalised (Conrad, 2013). So too is an argument commonly overlooked that those who seek medical assistance to manage their distress may be empowered by the medicalisation of distress in providing means to control their experience (Sedgwick, 1982). Indeed, much of the early work on medicalisation sought to analyse not judge the increasing scope of medicine into domains hitherto considered outside medical jurisprudence (Busfield, 2017). In many cases medicalisation brought benefits, such as reconceptualising experience from deviance to illness, generally removing implications of blame (with some notable exceptions, see section 2.4 in this chapter). So too has medicalisation spurred a wealth of research and new treatments.

During the 1950s and 1960s, psychologists such as Albert Ellis and Aaron Beck began to focus on merging cognitive and functional therapeutic skills to develop Rational Emotive Behaviour Therapy and subsequently Cognitive Behavioural Therapy (CBT; Beck, 2005). This signalled a new era of mental health treatments that were amenable to experimentation and replication and a solid evidence base for these treatment modalities was thereby steadily amassed, enabling cognitive orientated therapies to overcome the initial scepticism with which they had been greeted (Rachman, 2015). The strengthening of CBT coincided with the appetite for psychodynamic approaches beginning to dissipate, and so the latter became increasingly marginalised. As the movement pressing for patient rights and choice began to gain prominence (discussed further into this review, section 2.4.3) evidence backed treatments rose to the fore. Psychiatric diagnosis rapidly

became the central delineating factor upon which these growing fields of research were founded. Such was the power of the disease model that the diagnostic manuals remain today the guiding authorities by which care is determined in most arenas. So too has the ascendancy of CBT seen this modality become cemented in English primary mental health care as the lynchpin of the Improving Access to Psychological Therapy programme (see section 3.2 of Methodology Chapter for further consideration of this matter). However, the dominion of biomedicine has not gone uncontested and the validity of diagnosis has been heavily critiqued from all sides, as this discussion now moves to consider.

2.3.3 Diagnosis: Controversies and Debates

Since their initial publications, the DSM and ICD have both undergone multiple revisions. The first edition of the DSM was a modest 130 pages long whereas the most recent iteration DSM-5 ran to 947 pages (Davies, 2013). Proponents of the Manual claim that the increasing size of successive updates reflects the natural progression of scientific understanding (APA, 2017). Meanwhile critics have argued that the unquestioning acceptance of the disease model has become outdated and counter-productive, focussing practitioners on accurate diagnosis to the extent they become paralysed and de-skilled (van Bilsen, 2013).

Nonetheless, diagnosis has remained the keystone of biomedicine, even in spite of acknowledgement from some that the atheoretical basis of these categorical systems means that disorders can be defined only on a symptomatic basis, which in turn permits the manual's use absent narrative or "*other important non-symptom clinical features such as family history*" (Ketter and Citrome, 2012, p.393). Although the DSM has been the subject of more apparent commentary, it should be noted that the ICD has not been immune to criticism (R. Kendell & Jablensky, 2003; Maier et al., 2000; Vieta & Phillips, 2007).

The first editions of the DSM had been more heavily based on the psychodynamic concepts that had prevailed for a comparatively brief time around the 1960's resulting in more ambiguously defined diagnostic criteria; the aim of DSM III was to introduce categorisation based on empirical evidence, thereby to further scientific diagnosis and so to advance treatment (Galatzer-Levy &

Galatzer-Levy, 2007). Published in 1980, this third edition was widely accepted to have marked a turning point with the dawning of the neo-Kraepelinian revolution in psychiatry (APA, 2017; Compton & Guze, 1995; de Leon, 2015). Many have asserted that the further layers of complexity emerging with each revision indicate that the very notion of psychiatric diagnosis is not fit for purpose. Not only has the validity of these classification systems been seriously challenged (Sartorius, 2017; Timimi, 2014) but the dispute has further extended to the British Psychological Society's Division of Clinical Psychology issuing a Position Statement calling for an end to the disease model of mental health (British Psychological Society, 2013). Even prior to the publication of DSM-5, seemingly the most controversial iteration to date, questions were being raised as to the utility of the DSM criteria, with some remarking that clinical psychology practice had long come to favour formulation over diagnosis. Noting the residual application of DSM to psychological research, (Gill, Mullin, & Simpson, 2013) observed that even in this context it was unclear whether this was now:

“simply due to the constraints of orthodoxy; to aid communication; to aid publication in higher impact medical journals; or to facilitate the generalisation of findings to similar client groups” (ibid, p.28).

Falmer (1997) noted that some psychiatrists had argued that the concept of classification should be discarded as early as the 1960's. Early calls to abandon the diagnostic system coincided with the anti-psychiatry movement engaging biomedicine in a critical push back of the coercive manner by which psychiatry was perceived as attempting to impose 'normality' (Cooper, 1968; R. D. Laing, 1960, 1976) and through the use of a *“medical rhetoric of illness and treatment”* (Szasz, 2004; p.333). Rosenhan's (1973) seminal experiment also strengthened this argument. Over the course of three years he and seven colleagues gained admissions to twelve psychiatric hospitals by claiming to hear a voice. Each received a diagnosis, and at no time did a professional suggest they were 'sane'. Rosenhan did not argue against the existence of psychiatric illness, but rather that diagnoses were too liable to inaccuracy and that once labelled mentally ill, normal behaviour was too readily adjudged symptomatic by professionals on the strength of nothing more than the label itself. Rosenhan stated that psychiatric diagnoses offer a greater insight to the context in which they are generated than the condition of the patient thus diagnosed. Although critics such as Spitzer

(1975) labelled Rosenhan's study 'pseudoscience' claiming it demonstrated nothing more than psychiatrists' inability to detect fabricated symptoms, for which they understandably would not be looking. The experiment has nonetheless remained of great importance within critiques of the validity of psychiatric diagnosis.

At the same time, others were looking away from the issues surrounding diagnosis, locating mental dis-ease as arising from environmental circumstances and claiming that it was merely compounded by the psychiatric system. R. D. Laing gained prominence for his rejection of the biomedical model and the concept of diagnosis (1960). Laing asserted that experiences which were labelled as schizophrenia were not biologically caused but rather an understandable reaction to environmental factors such as dysfunctional families. Whilst not denying that the notion of mental illness fitted the reality of some people's experiences in a metaphorical sense, he promoted treatment more reminiscent of the York Retreat: arguing that the best approach was to consider the patient as rational rather than to oppress them with medication or coercion. Similarly, the importance of environmental factors was highlighted by the work of Brown & Harris (1978) examining how social factors impacted upon the subsequent development of psychiatric illness in women.

Challenges to the concept of diagnosis within mental health have always existed, with feminist and Foucauldian critics prominent among those contesting the practice and validity of labelling certain people as mentally ill (Bullough & Bullough, 1978; Foucault, 1971; Mendelson, 2003; Showalter, 1987). It has even been argued that striking parallels to the Rosenhan experiment can be found in literature from 200 BC (Fontaine, 2013).

Annemarie Jutel has summarised that:

"[d]iagnosis is always a social creation. That doesn't mean that the diseases it labels aren't 'real', but it does mean that before a diagnosis can exist, it has to be visible, problematic, and perceived to be related to the field of medicine" (2011, p. 3).

Yet even where clear indications of a visible problem exist, the medical profession has historically struggled to reach the sort of consensus that would be demonstrated by consistency in labelling psychiatric phenomena.

Whilst not focussing on diagnosis, Shepherd and Wright (2002) report the case of a woman who made multiple suicide attempts whilst confined in several Victorian asylums over more than four years; her recorded diagnoses changed multiple times. Differing approaches to preventing the woman from taking her own life are noted to have included full restraint in an ankle-length locked garment and sedation with morphine but she ultimately completed suicide. This case indicates the dilemmas that remain unaltered in contemporary discourse, namely the criticism that diagnosis does not map to a treatment that provides recovery from the illness that biomedicine purports to have identified.

As discussed in the previous section, the two world wars had a critical influence on how mental health was judged, progressing understanding from considering some soldiers cowards or deserters to developing the concept of shell-shock which would later be subsumed in the notion of post-traumatic stress disorder. This evolution of appreciating the impact of war on survivors provides an example of the benefits that the mental health profession hoped to provide on a widespread basis in developing and refining diagnoses. Finding a name to put to certain phenomena that 'explains' and helps to normalise those experiences, can be seen by some as a welcome validation (Wade and Halligan, 2004; Wykes and Callard, 2010). However, in other cases this process of being diagnosed or entering the psychiatric system can be felt as frightening and stigmatising (Nyttingnes, Ruud, & Rugkasa, 2016).

Commenting on his experiment in a later interview, Rosenhan said he and his colleagues found admission a dehumanising experience. He stated:

"Psychiatric hospitals are storehouses for people in society whom you really don't want, whom you really don't understand, and for whom you've lost a great deal of sympathy"

(David Rosenhan: *Being Sane in Insane Places* - YouTube, 2011, 00.01.43).

This observation echoed the point made by Szasz (2002) that psychiatric hospitals merely function to legitimise the incarceration of those deemed to be

mentally ill. During the largely negative media focus on care in the community that followed deinstitutionalisation, patients spoke of their horror at receiving certain diagnoses such as schizophrenia, because of the way these had been portrayed in the media (Rogers et al., 1998). Some described believing that not only would others be likely to perceive them as violent and unpredictable, but worse, that this may indeed be the case. Rather than considering the possibility of questioning the validity or rejecting the label, diagnosis was therefore seen by some participants as an inescapable life sentence.

The issue of labelling and the pursuant stigmatisation it can confer are inextricably linked elements of the diagnosis discourse and to the notions of dangerousness to self and others (Szasz, 2002). Perhaps the clearest demonstration of this is provided by the deeply vexed diagnoses of personality disorders. The validity and ethics of the diagnoses grouped under this nomenclature have been challenged from academia, mental health professionals, politicians and those said to have such conditions (Bendelow, 2010b; Lamb, Sibbald, & Stirzaker, 2018; Manning, 2000; Nehls, 1999; Robles et al., 2014) as will now be considered.

2.3.4 The Contentious Field of Personality Disorders

The two forms of personality disorder about which most has been written both entered the discourse around mental illnesses at an early stage. Jones (2009) relates that the contemporary concepts of psychopathy and antisocial personality disorder evolved from Kraepelin's grouping of behaviours entitled psychopathic personality, the origins of which can be traced to early 19th century writings in terms such as moral insanity. Meanwhile, Chaney (2017) charts how the roots of borderline personality disorder (BPD) are also linked to an earlier notion, that of hysteria, which was a prevalent account given for a wide range of usually otherwise unexplainable symptoms. She describes that towards the end of the 19th century, hysteria began to evolve into the concept of the hysteric personality; by the early part of the following century, hysteric personality had become an accepted classification of usually female patients, particularly those noted to be prone to 'hysterical self-mutilation' as a means of emotional manipulation. The early editions of the DSM included a syndrome known as delicate self-cutting; the

term 'delicate' referring to the disposition of the patient rather than the extent of their self-injury.

By the time the DSM entered the field of mental health, the conventional wisdom was that BPD was a female diagnosis. Millard (2015) has highlighted how this classification came about based on very small-scale studies that were predominantly based in private psychoanalytic settings in the US, in which women were at that time frequently disproportionately over-represented. Moreover, he notes these studies generally excluded patients who did not fit the 'typical' delicate self-cutter profile, resulting in some excluding up to a third of patients who were male.

Although BPD is still considered to be disproportionately diagnosed among females (National Institute for Mental Health in England, 2003) equal numbers of males and females in the general population are said to meet the criteria for the diagnosis (BPS & RCP, 2009; Grant et al., 2008). It has been suggested that the proportionately lower rate of men so diagnosed is due to a combination of societal gender driven factors rendering males less likely to recognise a problem and seek help (Busfield, 1988; Howerton et al., 2007) and health professionals less likely to recognise how males who could be diagnosed with BPD would present (Evans, 2016). Additionally, issues around transference in males with difficulties in emotional regulation have been suggested as inhibiting diagnosticians (ibid). A further aspect linked to social influence can be inferred from the high numbers of males seen in the criminal justice system with BPD diagnoses or 'traits' (Dutton & Starzomski, 1993; Fazel & Danesh, 2002; Hart, Dutton, & Newlove, 1993; Singleton, Meltzer, Gatward, Coid, & Deasy, 1998).

Although personality disorders were noted in the earliest editions of DSM, it was the publication of DSM III that saw these diagnoses being distinguished from other psychiatric phenomena as they were grouped into '*Axis II: Mental retardation and personality disorder*', thereby providing a point of differentiation from all other psychiatric disorders placed in Axis I (Manning, 2000). Proponents of this differentiation have asserted that the division yielded greater research interest and so better developed treatments for personality disorders (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Newton-Howes, Mulder, & Tyrer, 2015) but it may

also have contributed to proliferation of the belief that personality disorders were untreatable. The focus on treatability was heightened with the creation of the concept of dangerous and severe personality disorder (Department of Health & Home Office, 1999). Despite having no medical basis and in the face of ardent appeals that the proposed programme was unethical and “*glaringly wrong*” (Mullen, 1999, p.1146) the legal categorisation of some people as being severely personality disordered went ahead.

How amenable to treatment an individual with personality disorder may be remains a highly contested and heavily value based judgement (Scott, Jones, Ballinger, Bendelow, & Fulford, 2011). Mainstream mental health services are acknowledged as still marginalising those considered to have this diagnosis (Adebowale, 2010). Despite a Department of Health policy guidance asserting personality disorder is ‘*no longer a diagnosis of exclusion*’ (National Institute for Mental Health in England, 2003), the year prior to this a paper was published in the British Journal of Psychiatry considering *the ‘distinction between personality disorder and mental illness’* (Kendell, 2002). Others have observed that the response of mental health services to those being so diagnosed is tantamount to demedicalisation (Sulzer, 2015).

Notwithstanding the enduring nature of the difficulties faced by those receiving this diagnosis, remission is recognised, albeit this is often less immediately apparent in the discourse surrounding personality disorder. Zanarini et al. (2003) found over 70% of patients reassessed at intervals up to six years after psychiatric hospital admission met remission criteria and that recurrence of symptoms post-remission was rare (5.9%). Furthermore, multiple psychotherapeutic treatments have been developed and shown to be effective for this group.

It is widely acknowledged that those considered to have personality disorders are subject to great stigma (Parsonage, Hard, & Rock, 2014; Pickard, 2011; Sheehan, Nieweglowski, & Corrigan, 2016). Specifically, B/EUPD being ineluctably tied to the ‘difficult patient’ concept throughout the medical and social science literature (Sulzer, 2015) is one of, if not the most stigmatising diagnoses a patient can (Bodner et al., 2015; Nehls, 1999). Indeed, Manning (2000) has

contended that a primary function of the label was to provide a grouping for patients perceived by the medical profession as difficult. Lewis & Appleby's (1988) renowned paper entitled, '*Personality disorder: the patients psychiatrists dislike*' reported that psychiatrists reading case vignettes considered the patients they were told had been diagnosed with personality disorder to be less deserving of treatment. A similar perception seemingly also exists in the general public, with non-experts less likely to consider the subjects of vignettes that described people with BPD as being in need of psychological help than those suffering issues more recognisable as depression or schizophrenia (Furnham, Lee, & Kolzeev, 2015).

Resonating with the evolution of BPD described above, one of the elements that so often renders this group of patients consigned to the category of 'difficult' is the tendency to engage in repeated self-harming behaviour and suicide attempts. Horrocks et al. (2003) reported as many as 80% of those attending hospital emergency departments for serious self-harm met the criteria for BPD diagnosis. Rates vary between studies but there is little disputing the elevated risk of death by suicide amongst those with a diagnosis of personality disorder.

The research team involved in the influential National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH) reported a rise in self-inflicted deaths of patients with a primary diagnosis of personality disorder over the ten years to 2013 (NCISH, 2013). Furthermore, the same group reported that patients with a primary personality disorder diagnosis were the third largest group of all patients with mental illness to die by suicide over ten years (8% of a total 11,536 suicides between 2004 and 2014 (Burns et al., 2017). A complex range of social and psychological issues are tightly interwoven elements of the lives of those so diagnosed (Pidd, Benefield, & Duggan, 2005) and suicide is not the only factor involved in the severely shortened life expectancy faced by people said to have a personality disorder (NIMHE, 2003). Other research has stated that the risk of dying by suicide is 13 times greater for those diagnosed with BPD than the general population (Paris & Zweig-Frank, 2001).

Alongside the issues such as homelessness, poor physical health, substance misuse and stigma that often compound the difficulties experienced by those said to have a personality disorder, extensive research has also indicated that other

mental health problems commonly contribute further complications. People meeting the criteria for diagnosis of a personality disorder frequently experience sufficient symptoms of other personality disorders (Coid et al., 2006) and these often co-occur with other mental illnesses. Although the division between Axes I and II remained unaltered in DSM IV, the latest edition of the Manual removed the multi-axial system, appearing to have bowed to assertions such as that of Stevenson, Boyce and Brodaty (2008)

“Psychiatry is gradually coming to realize that the DSM’s Axis I disorders are more often than not ‘comorbid’ with Axis II disorders (ibid, p. 280)”.

Going further still, the most recent revision to the ICD radically overhauled personality disorder diagnoses, replacing the previous categories with six *“prominent personality traits or patterns”* including a *“borderline pattern”* and grading the level of severity as mild, moderate or severe.

Far from unrelated to the multifaceted range of psychological and social issues that plague the lives and likely also contribute to the early morbidity of those considered to have BPD, one of the objections repeatedly raised to the diagnosis is that it is relabelling victims of trauma, frequently childhood sexual abuse. Soloff et al. (2002) found that 84% of patients diagnosed with borderline personality disorder had attempted suicide previously and that 96% of that majority had been abused as children. Yen et al. (2002) similarly found that both abuse and neglect in childhood were reported by more than 90% of 358 patients with BPD. Hence, it has been said that diagnosing personality disorder equates to societal level victim blaming; negating the injustices that have led a person to develop such a troubled pattern of thoughts and behaviour and then attaching a pejorative label to that person which censures them for their deviance (Sisti, Segal, Siegel, Johnson, & Gunderson, 2016). The recently published ‘Consensus Statement for People with Complex Mental Health Difficulties who are diagnosed with a Personality Disorder’ (N. Lamb et al., 2018) was the result of work by leading academics, practitioners and policy makers, compiled by a working group that included people with lived experience of the diagnosis, as well as a range of leading mental health advocacy organisations and professional bodies. The Statement was critical of the term personality disorder and called for it to be

abandoned altogether, asserting that it obscures the problem it should be addressing and exacerbates the difficulties those gaining this diagnosis are likely to face in future. This issue of the aetiology of pathological behaviours (if not pathologies *per se*) speaks to a further area of contestation of diagnosis within the biomedical model.

2.3.5 Social Causation of Mental Illness

A further critique of the biomedical model being applied to mental health is that by largely disregarding cause or addressing it in an overly simplistic manner, it hinders acknowledgement of multicausality, as well as the complexity that is often present in chronic illness and which may not be amenable to treatment or indeed cure (Bendelow, 2009). One of the primary objections to medicalisation is that the process individualises social problems and transfers resources away from social or political to the medical interventions (Busfield, 2017; Clark, 2014a, 2014b). Biomedicine has shifted the focus of healthcare professionals from the embodied patient to the biological cell, yet mental health conditions are not solely an artefact of physiology (Jewson, 1974). Numerous studies of most mental health diagnoses that have been based upon multiple populations have shown the incidence and trajectory of mental illnesses are linked to social factors such as deprivation and migration (Birley & Brown, 1970; Sharpley et al, 2001; (Brown, Birley, & Wing, 1972; Murray, 2017; Sharpley, Hutchinson, Murray, & McKenzie, 2001; Webber & Huxley, 2004). It has been suggested that social capital: participation, integration and cohesion with others, is also related to mental illness, in particular at the level of individual's appraisals (De Silva, McKenzie, Harpham, & Huttly, 2005). Similarly, social networks have been shown to provide important differentials between access to social capital for people with mental illness (Sweet et al., 2018).

Fox (2000) argued epistemological uncertainty conferred a further flaw of diagnosis. Being based upon population or large sample evidence the biomedical account can offer physicians little by way of heuristic value when formulating the likely path ahead for an individual patient. Unlike many (although certainly not all) diagnosable physical health conditions, mental health diagnoses do not necessarily map to treatment in a linear fashion. Many physiological imbalances

once diagnosed can be corrected with a treatment that either works immediately, for example by the administration of insulin or epinephrine, or in the longer term, such as high cholesterol being reduced with statins. Conversely, the chemical imbalances that have been said to be implicated in some mental illnesses are far more complex in interaction; even with medicines that do appear to be effective in many cases, the varied responses and lengths of time for individuals to respond, indicates that the 'true' nature of how these drugs produce an effect is still unclear.

The case of lithium being used for bipolar affective disorder illustrates this point. Despite being considered the primary pharmaceutical treatment for bipolar disorder (Machado-Vieira, Manji, Zarate, & Jr, 2009) lithium is only effective for around a third of patients and its precise biochemical actions remain uncertain (Tobe et al., 2017). The use of Selective Serotonin Reuptake Inhibitors as both antidepressants and to treat anxiety provides a further example; increasing anxiety, worsening depression and alarmingly, triggering suicidal ideation and suicide attempts are recognised side effects experienced by some patients (Gunnell & Ashby, 2004; Perlis et al., 2007).

Whilst the negative side effects of SSRIs exacerbating the symptoms they are supposed to be treating are relatively uncommon, some psychotropic medication reliably produces severe symptoms that can significantly limit patient's quality of life. Antipsychotic medications in particular are known to trigger seizures, extreme weight gain, tardive dyskinesia (a neurological disorder producing uncontrollable repetitive physical tics and tremors) hormone changes and increased risk of diabetes are among the range of iatrogenic effects, which in themselves commonly necessitate secondary medications (Pilgrim, 2014b). Indeed, some have stated these side effects have become inextricably linked to perceptions of the original illness. Referring to the antipsychotics prescribed for schizophrenia, it has been stated that:

"due to the pervasive and crippling effects of long-term drug use, the idea of psychosis as a chronic and irreversible brain disease becomes a self-fulfilling prophecy" (Leader, 2011, p. 329).

Despite occasional ‘false alarms’ from the field of neuroscience, for example the discovery from twin studies of that non-affected siblings did not show the same increased ventricular volume (Reveley, Clifford, Reveley, & Murray, 1982) biological substrates for mental illness, psychic distress or any other name this group of phenomena may be recognised by, have continually evaded identification. Related to this is the failure of biomedicine to advance a physical test to conclusively identify psychiatric illness in the same way as a high temperature or irregular heart rhythm can be identified. Critics have argued that without being able to differentiate between disorders, taking a symptom-based approach to the diagnosis of mental illness becomes meaningless, given the same symptoms can be linked to very different issues (Everitt, 1993; Leader, 2011). In a statement, somewhat reminiscent of the early physicians who developed a cynicism towards their craft when they failed to cure patients at the York Retreat, the eminent psychiatrist Professor Sir Robin Murray ended a recent reflective piece on his career thus:

“I expect to see the end of the concept of schizophrenia soon. Already the evidence that it is a discrete entity rather than just the severe end of psychosis has been fatally undermined... Presumably... the term schizophrenia will be confined to history, like “dropsy” (2016, pp. 3-4).”

2.3.6 Summary: The Present State of Controversies in Biomedical Psychiatry

Regardless of scant success to date, the search for biological substrates of the ‘diseases’ of the mind remains a quest to which end gargantuan resources of time and money continue to be invested (Leader, 2011). Meanwhile, DSM-5 brought a tidal wave of criticism, not only from user groups and academics but critically also from several of those charged with its creation. One of a multitude of now near infamous quotes describes the process as no more scientific than a group of people deciding where to go for a meal (Davies, 2013). Issues with the validity of the latest Manual have been enumerated and multiple sources have cautioned against the potentially deleterious consequences of continuing in a ‘business as usual’ fashion with diagnosis of mental illness (Johnstone, 2017; M. D. Pickersgill, 2014).

Psychiatrists have acknowledged more personalised psychotherapeutic care is currently an unmet need for conditions such as bipolar disorder (Bauer et al., 2018). Key policy shifts also followed in the wake of these concerns, with the highly influential National Institute for Mental Health announcing a commitment to a new direction through its Research Domain Criteria programme turning away from categorical diagnoses to dimensions of pathology and functioning (Cuthbert & Insel, 2013). The organisation's lead has been vocal in condemning the lack of progress made in the last half century in both drugs and therapies having failed to bring about demonstrable progress in prevention or mortality from psychiatric disorders and stating complex conditions are unsurprisingly unlikely to be amenable to unimodal treatment approaches (Vieta & Torrent, 2016). Nonetheless, dominant publications expect new approaches seeking legitimisation to be amenable to developing a traditional evidence base and for non-pharmaceutical treatments to be manualised (Insel, 2015). Following this direction of travel, the revised ICD chapter on Mental and Behavioural Disorders released in 2018 has also taken a more domain-led approach (Gureje, 2018). Whether the turn from diagnosis will prove to mark a sustained shift in attitudes to how mental ill/health is conceived and thus treated remains to be seen. There has at least been an indication of a willingness to challenge the status quo from some within the field.

In the meantime, whilst diagnosis and the biomedical model continue to dominate, further evidence of psychiatry's capacity to evolve comes from those who rather than challenge or reject the model have offered ways to enhance it through shifting priorities and attempting to readdress power imbalance. Three such examples will now be considered: Postpsychiatry, Values Based Medicine and the Recovery Movement, before the discussion concludes with the alternative model of distress suggested by the Power Threat Meaning Framework (Johnstone et al., 2018).

2.4 Progressing from the Biomedical Model

2.4.1 Critical Psychiatry: Postpsychiatry and Values Based Medicine

Criticisms of the dominance of the biomedical approach have come not only from commentators outside the medical profession but powerfully also from 'within' as have been reviewed. Recently, two key approaches have been of particular prominence in suggesting a direction into which psychiatry may productively evolve. The work of Fulford and Bracken and Thomas (Bracken & Thomas, 2004; Bracken et al., 2012; Bracken & Thomas, 2001; Fulford, Peile, & Carroll, 2012; Woodbridge, Fulford, & Sainsbury Centre for Mental Health, 2004) have placed them in the vanguard of critical psychiatrists pressing for a move from the traditional hierarchy. Rather than rejecting the advances of science and traditional teachings of their discipline in the manner of anti-psychiatry, the contemporary critical psychiatrists have argued that their discipline should not be devalued by historic power imbalances but that progression is necessary to enable the profession to advance and ease real suffering (Wade and Halligan, 2004). Fulford, Bracken and Thomas have proposed newer forms of practice, which situate the patient's expertise and values as an integral part of their own care (Colombo, Bendelow, Fulford, & Williams, 2003). Drawing from the anti-psychiatry critique outlined earlier, postpsychiatry acknowledges the potential dehumanising impact of the 'clinical gaze' but rather than reject the discipline outright, pushes for reform for the benefit of both patients and clinicians. Thus, instead of objectifying the patient and their symptoms, the newer approaches have encouraged moves towards more personalised care (Fulford, Peile and Carroll, 2012).

Bracken and Thomas (2004) have suggested that whilst not being 'another model' for mental health practice, postpsychiatry offers a progressive way to repair some of the harm done by professional services' preoccupation with models. Acknowledging that user-led research consistently reports paradigms to be unimportant, especially in relation to individual practitioners' engagement and interpersonal skills, Bracken and Thomas have asserted that postpsychiatry thus focusses more on promoting citizenship by moving beyond the divisive agendas

that have previously pursued this field. Postpsychiatry arose to a large extent, from a concern that the discipline was becoming too heavily influenced by neuroscience and in doing so disregarding the importance of context, in turn discouraging collaborative relationships with patients and placing concern for relational factors, patients' values, and meanings into secondary consideration (Bracken et al, 2012). Consequently, it offers an approach that naturally compliments recovery principles, which will shortly be considered, in primarily attending to the individual in their social context and seeking to address relational factors. Crucially, this means not only how professional and 'patient' relate to one another but also supporting the individual to define and determine how they wish to relate to their own symptoms, accepting that the medical model is neither the only option, nor always necessarily the best.

Fulford's model of Values Based Medicine (VBM) acknowledges that for the individual, all aspects of the notion of care and how it is evaluated are subjective; the very concept of what constitutes 'treatment' and thus the desired outcome thereof varies from person to person. The similarity in these movements has been their turn (or return) to seeing the 'patient' in a more holistic way, shifting from pathology-first to patient-first. A further key point of values-based practice is that it also takes into account the values: desires and needs, of the others involved in the system, not only the clinician but also carers and policy-makers. In doing so VBM is rare in explicitly acknowledging the differing, and at times, inharmonious values that may provoke tension between involved parties. Values Based work therefore considers a dialogue and negotiation between those involved as an imperative. This dialogue must be open in nature, with each being able to make their values explicit and so to build seeking concordance into care. This focus on the importance of authentic dialogue resonates with bodies of work relating to ethic of care (Barnes & Cotterell, 2012; Tronto, 1993; Ward, 2014; Ward & Gahagan, 2010). It is also echoed as a key organisational element to supporting the recovery model (G. Shepherd, Boardman, & Slade, 2008) to which focus now turns.

2.4.2 The Recovery Movement

Values based work seeks to enhance psychiatric practice *within* the existing medicalised framework, whereas postpsychiatry's focus on progressing beyond the current models may represent more of a shift from medicalisation. Another progression in psychiatric practice has been encouraged by the recovery movement (Boardman & Friedli, 2012; Perkins & Slade, 2012; Rose, 2014; Andrew Shepherd, 2016; G. Shepherd, Boardman, & Burns, 2010). Recovery in this context is commonly defined with the words of William Anthony (1993) as:

“a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness, recovery involves the development of a new meaning and purpose in life as one grows beyond the catastrophic effects of mental illness” (ibid, p.17).

Recovery shares features with both VBM and postpsychiatry but originated with survivors seeking not to be defined as 'mental patients' (Davidson & Roe, 2007). In common with Postpsychiatry, recovery has sought to promote a broader view of mental health focussing on attaining a meaningful life beyond biomedical illness. The recovery way of working has thus been presented as having the potential to deliver less of a progression in community care and more a remedy to institutionalism, in many ways reminiscent of the moral therapy approach discussed earlier in this review (Perkins & Slade, 2012).

Recovery also shares with VBM a more holistic ethos, which incorporates workers building capacity for hope and emphasises compassion and well-being (Strand, Gammon, & Ruland, 2017). Key proponents of the recovery movement describe it as founded on three key principles (see Figure 2.1 below). The recovery movement has been considered by many to have brought welcome changes, both through broadening the interpretation of 'meaningful recovery' and in practical developments such as the birth of recovery colleges: collaborative organisations that engage people in a range of less conventional therapeutic work (e.g. activities such as gardening, life-skills, alongside psycho-educational courses, that are often delivered as partnerships between service users and 'professionals' (Perkins, Repper, Rinaldi, & Brown, 2012). These colleges have built on the expert patient philosophy in esteeming lived experience. However, some have expressed disquiet, feeling that the turn towards devolving power

from being considered the sole province of professionals to a more democratic model is often only a token gesture (Hunt & Resnick, 2015; Rose, 2014).

Figure 2.1: Principles of the Recovery Movement

Gaining a sense of agency and control over one's life and illness;
Drawing on the support of community (not necessarily statutory services) to achieve integration and inclusion; and
Not letting continuing illness equate to settling for reduced expectations, instead maintaining hope and pursuing aspirations

(Adapted from 'Implementing Recovery' Sainsbury Centre for Mental Health, 2010)

The concept of recovery rapidly gained favour in the UK with policymakers and practitioners alike. Governmental backing for the approach was indicated in a document published by the Department of Health outlining the intent for the then existing National Service Framework to align with recovery principles (Department of Health, 2001b). Two major national studies commenced in the following years that between them sought to transform mainstream statutory mental health services (Holttum, 2012). Alongside this, a position paper entitled 'Recovery is for All', was published by a group of leading psychiatrists at two of London's key NHS Trusts and supported by the Royal College of Psychiatrists (SLAM/SWLSTG, 2010).

Although the widespread commitment to implementing recovery principles evinced potential for progression, the broad endorsement from psychiatry and policymakers also fuelled concerns that the asymmetrical power relations in mental health services would not be altered whilst, as Russo and Beresford put it: "*a psychiatric monologue*" remains the predominant determinant of the future direction of mental health care Russo and Beresford, 2017, p.189). Some survivor groups, such as Recovery in the Bin have voiced scepticism about the recovery movement on the basis that its widespread adoption into mainstream services is firmly grounded in neoliberal ideals (www.recoveryinthebin.org). Whilst supportive of recovery principles, the first tenet of the 18 on which the group are based states they consider recovery to have been 'colonised' by policy makers, commissioners and services. These critiques have also highlighted the

inherently limited capacity of recovery to address the issues raised by traditional biomedicine given the model still takes its starting point from a 'diagnosed' mental illness that may be a life-long condition (Strand et al., 2017).

Reviewing the implementation of the approach, Slade et al. (2014) identified multiple 'abuses' that could be detrimental to patients and countermand the recovery concept. Issues have been raised that the messages inherent to the movement can be experienced as pressure to eschew formal support and thereby become conflated with an expectation that 'recovery' means attaining full mental health (Rogers & Pilgrim, 2014). Further criticism has come from some feeling that echoes of the coercive judgement of the sick role can be observed in the adoption of recovery principles by some organisations that have missed the open dialogue and authentic approach of seeking to understand the patients' values and to support them in progressing towards their goals (Barnes & Cotterell, 2012; Fulford et al., 2012). The broad support for the recovery movement from leadership level was also felt to have been hindered in practice by some professionals who were concerned that organisational concerns around risk had to override a desire to work in a way that honoured the principles of recovery (Tickle, Brown, & Hayward, 2014).

Despite these attempts to progress both psychiatry and mental health services more broadly beyond the traditional unidirectional power structure by giving greater prominence to the patient's perspective, psychiatry trainees continue to be taught to prioritise making accurate diagnoses in patient interactions as a route to prescribing the 'correct' treatment (Blackman, 2007). Under this paradigm, the options for a comprehensive recovery, or even determining what such a recovery might be, may be unavoidably restricted. As Bracken and Thomas (2004) have observed, once a person comes to regard aspects of their being as disordered, the inference that they are of diminished value to their society is almost inevitable.

Those subject to the ministrations of the mental health system have expressed mounting dissatisfaction with the biomedical view. Biomedicine's operationalisation of "*a deficit deviant model*" (Beresford, Nettle and Perring, 2010; p.14) is felt to place blame for illness upon the individual, discounting social

causes and legitimising hegemonic medical practice that does not permit negotiation or power-sharing. Paradoxically, the refusal to accept this paradigm has driven some former patients of the mental health system to demonstrate that alternative modes of attaining recovery are entirely possible and that the concept of severe mental illness being a lifelong condition may be a fallacy. Some of these patient movements will now be considered.

2.4.3 Patient Involvement Movements

As has thus far been examined, the vexed issue of agency within mental illness has long troubled many commentators. Unsurprisingly, many of the recipients of mental health care have also complained that whilst living in the community may arguably afford more freedom than was available to those who lived through the institution era, treatment has frequently been experienced as no less coercive and has at times more closely resembled neglect than care. Mental health legislation remains heavily weighted towards management through control and compulsion rather than having a focus on the provision a person should be able to expect. The Mental Health Act retains the capacity to remove a person from the community for lengths of time that can vary between 24 hours in the case of S136, to an indefinite number of years.

Decisions about people's care and treatment, often even how this is assessed, have been unilaterally made by others *about* them, even in spite of policy declaring the reverse, as will momentarily be considered. Thereby the sick role and long held societal doctrines of the 'good patient' are very much still enforced; the expectation persists that entitlement to care is contingent on complying with the dictates of medical experts (Rogers & Pilgrim, 2014). Consequently, it is perhaps unsurprising that recent decades have seen a ground swell of opposition, which has manifested in a number of different groupings, often collectively referred to as the service user movement (Wallcraft & Bryant, 2003).

Any discussion of this area should start with careful consideration of terminology as this too has been a point of significant controversy with no universally acceptable term for recipients of mental health care or services as yet emerging. The most traditional terminology of 'patient' is rejected by some who desire an end to the historic hierarchic practices that can dehumanise people into

pathologies to be done to as the medical experts see fit. Patient is also disliked by some who reject its connotation of a passive recipient. Terminology such as 'clients' and 'service users' is proffered by some preferring the choice and focus on service inferred by this nomenclature. Naturally, one objection raised is that the notion of mental health care recipients having the customer freedoms these terms tend to infer is belied by the reality of compulsory treatment, deprivation of liberty and lack of autonomy operationalised in vastly different ways to anything that would be accepted within physical healthcare, let alone in business. Furthermore, the very commercial connotations have also been roundly rejected by many in the UK, owing to an attitude of fierce loyalty to the not-for-profit, free and universal service that the NHS was created to provide (Speed, 2006).

It must also be acknowledged that the term 'user' is also considered highly pejorative by many owing to links to both substance misuse and deviant, or manipulative behaviour. Nonetheless, the term has been widely adopted in American and UK discourses. Going further, some of those raising objections to the dominant biomedical approach in mental health have favoured the term 'survivor', feeling it more accurately reflects their experiences of adversarial, sometimes even abusive relationships with treatment providers (Beresford, 2000; M. L. Crossley & Crossley, 2001). This in part reflects the transformation in how some people have chosen to relate to their symptoms and advance their own approach, which will be discussed presently.

In attempting to stratify nomenclature within patient movements, Speed (2006) proposed the variation in discourses and activities could be used to delineate between types of patients who were actively involved in the mental health system. His research was based in the Republic of Ireland, where he acknowledged a different healthcare system exists, thus negating many of the partisan issues evoked by consideration of consumerism in the NHS, nonetheless his findings remain relevant to the UK healthcare system. Speed broadly identified three groups of mental health service recipients. With the first subset identified as 'patient groups', Speed alludes to the sick role in describing members as those who accede to the legitimacy of psychiatric practice with passivity and accept the attendant codification of patient. He suggests rather than

being motivated by activism, patient groups are more likely to be concerned with seeking to improve specific aspects of care, such as a group that may form to improve a waiting room. In contrast, he contends 'survivors' identify with anti-psychiatry and reject the term 'patient' along with any diagnostic labelling. Speed then situates 'consumers' between these two groups, identifying more ambivalence as consumers ultimately accept the legitimacy of psychiatry but are prepared to challenge the system where they feel reform is needed. Identifying that temporal factors may be among a range of influences resulting in people vacillating between membership of these groups, Speed nonetheless confirms that the three types are supported in empirical work as well as sociological theory.

Speed's work demonstrates that attempting to apply the notion of a social movement as it is typically conceived, to the area of mental ill health is a complex matter. Traditionally the concept of a social movement is of a unified progression towards a mutually agreed goal. In contrast, the various different groups that have begun to demand to be heard during the last half a century are perhaps more accurately defined as constituents of a 'field of contention' (N. Crossley, 2006). This term describes how actors or parties within the field have complex interrelations to one another that impact power but importantly occupy shifting roles, such that:

"They sometimes exchange resources; sometimes compete for resources; sometimes co-operate, other times come into conflict. In some cases we will find overlap in membership but in other cases they form into polarized and juxtaposed camps. In all cases, however, these groups and individuals take up positions relative to one another, defining their selves in terms of one another and thereby constructing a complex and internally differentiated internally-meaning complex. (ibid, p. 553)."

Crossley's notion of the service user movement as a field of contention takes account of the emergence of new roles such as mental health service users beginning to deliver services. As hitherto described, recovery colleges are one example that have facilitated a blurring of the boundaries between user, professional and provider, with new partnerships being created with mainstream services, in which peer support schemes and coaching networks have been

developed. Other groups of former patients have gone further, rejecting the biomedical model and with it the notion of boundaries determining who has the authority to provide services, putting forward alternative care choices (Mclean, 2000). The concept of an 'expert patient' has also emerged in recent years, acknowledging that the lived experience of a condition or set of symptoms conveys more in experiential learning than can be taught in conventional ways (Donaldson, 2003). The term 'expert by experience' has been adopted by some to convey this sense that expertise in a subject is no longer to be considered the exclusive domain of those medically trained, but that lived experience should be given equal credence in consideration of one's own life and health (M. L. Crossley & Crossley, 2001).

2.4.4 Reclaiming the Prerogative of 'Expertise'

The shifting stance of those in authority towards the expert patient became increasingly clear during the last decade. Governmental support for drawing upon patients' lived experience emerged with the establishment of an 'Expert Patients Taskforce' by the Department of Health in 1999 (Tyreman, 2005). The remit of this group was described as to deliver better outcomes for patients suffering chronic diseases by integrating patient and clinical self-management initiatives (Department of Health, 2001a). The vision set out in this document was that people with chronic conditions would be supported to influence improvements in future care and to advocate for others as one of the anticipated indicators of success. Patients delivering self-management training to others with the same conditions and contributing to education of future clinicians were suggested mechanisms to draw on lived experience. Inevitably, some clinicians resisted this perceived slight to their expertise fearing more vocal patients making unreasonable demands (J. Shaw & Baker, 2004; Tattersall, 2002) and tensions arising for patients in attempting dual roles within the biomedical framework were acknowledged as likely to inhibit attainment of the programme's aims (Kennedy, Rogers, & Gately, 2005).

During the same period of time further policy initiatives looked to be disrupting the traditional organisation of the health system. Despite objections to aspects of consumerism, the field mental health service provision began to move in line with

other elements of the NHS in 'opening up' to present a more choice-based service (Coyle, 2008). In July 2010 the then government issued a White Paper entitled 'Liberating the NHS' (Department of Health, 2010). This policy document purported to transfer financial responsibility and therefore decision making on how care health services were delivered from central government to a closer level to the patient, namely GP led Clinical Commissioning Groups (N. Black, 2010). The subsequent publication of a second policy document set forth proposals to give patients greater choice by promoting shared decision making. The title '*No decision about me, without me*' (Department of Health, 2012) has since become a strategy slogan for this movement in the NHS. Alongside the introduction of choice of treatment providers by separating purchasing decisions from service delivery, greater patient autonomy was promoted through encouraging the provision of more information on research studies and the choice to participate therein. Whereas for many years NHS research had been predominantly focussed on increasing patient participation in studies, an initially gradual increase in involving patients in other aspects of research gained momentum over the ensuing years. As with the wider survivor movement, impetus for this shift can be seen to have been closely tied to similar developments in other areas of social work and social policy (Kemshall & Littlechild, 2000) where from the late 1990's onwards an increasing awareness developed of the importance of engaging 'users' in the research process.

The motivation for the shift towards supporting greater patient autonomy through encouraging health care recipients to become better informed and take an increasingly more proactive role in determining aspects of their care has not gone uncriticised. Multiple commentators have observed that much of the material espousing the informed patient and shared decision making, whilst drawing on the language of citizenship was firmly rooted in biomedicine and could also be considered as another means of ensuring compliance rather than encouraging alternatives (Dixon-Woods, 2001). Furthermore, it has been observed that the increasing pressures faced by health services have meant that even where practitioners may wish to support patients to gain greater autonomy, the reverse is in practice necessitated as diminishing resources demand shortening the time allocated to each patient contact (Henwood, Wyatt, Hart, & Smith, 2003).

However, as Braye (2000) stresses, notwithstanding the inherent complexities which must be addressed in order to ensure participation is experienced as egalitarian and not exploitative, there is now a consensus that user involvement in research is good practice.

What constitutes 'involvement' has also evolved over time. Lived experience has become increasingly valued with an ever-growing awareness in academia of the importance of conducting research into user-defined priorities (Thornicroft, Rose, Huxley, Dale, & Wykes, 2002). Participatory research involving those with lived experience as co- or peer-researchers in a range of activities across the life of a study has become more commonplace. Whilst in some instances this has mainly comprised discrete activities such as interviewing or organising and running focus groups (Byng et al, 2012) more co-produced studies developed collaborative work in which the peer research team are involved from the outset in the design, conduct, data analysis and dissemination of a study (Ward & Gahagan, 2010). Similarly, many research councils now require an account of the public engagement, sometimes referred to as Patient and Public Involvement (PPI) activities that will be undertaken as part of a funding application, demonstrating the prevalent appreciation for the importance of valuing life experience and engaging those more traditionally thought of as 'subjects' throughout the research cycle. Such progression in attitudes in some ways reflects developments in service provision, as will now be considered.

2.4.5 From Survivors to Providers: Changing Perspectives and Expanding Choices

As described earlier, how each of Speed's groups were positioned relative to the biomedical model was a defining criterion of his nosology. Accordingly, both patient and consumer groups were situated within the classical operational remit of psychiatry, whereas survivor groups were partially defined by their rejection of the biomedical doctrine. Speed noted that the latter may have gone further and extend alternatives to biomedicine. An early example of such a group was the Manic Depression Fellowship who created a self-management training programme in 1998, which was described as being fully devised and led by people with a manic depression diagnosis (Department of Health, 2001a)

Similarly, the Hearing Voices Network (HVN) also gained prominence in the 1990's and is now arguably one of the most successful survivor groups to operate outside the biomedical framework (Corstens, Longden, McCarthy-Jones, Waddingham, & Thomas, 2014; Oakland & Berry, 2015). The groups' website (www.hearing-voices.org) identifies their origin as being a support group who formed having been inspired by a pioneering approach to voice hearing in the Netherlands (M. A. J. Romme & Escher, 1989; M. A. J. Romme, Honig, Noorthoorn, & Escher, 1992; M. Romme & Escher, 1996). Rather than adopting an adversarial stance that attempted to use medication or other means to silence or overcome voices and other phenomena generally deemed hallucinatory, this work started with the premise that these experiences are purposive. Positioning these phenomena as allies and engaging in communicative practices has given the HVN advocates a new way of relating to their voices. In turn, relating to these phenomena has been reported to have alleviated the distress that had plagued many HVN members for decades. Not only have these individuals reported the persecutory nature of their hallucinatory phenomena being ameliorated by the cessation of attempts to suppress them, but many have gone on to eschew the mental health system entirely. Living without medication, advocates have thereby celebrated their liberation from both the raft of iatrogenic effects of psychiatric drugs as well as the Parsonian sick role dynamics. Consequently, the approach advocated by this Network is considered by many to be "*far more effective than any biomedical approaches*" (Baker, 2003, p. 28).

It is not only survivors who have contributed to the evolution of alternatives to the biomedical discourse. Indeed, the extensive and vehement criticism voiced by so many over the most recent edition of the DSM may have provoked something of a watershed. Working together, a group of people with lived experience and carers, psychologists and academics have recently developed an alternative approach to conceptualising mental distress. Johnstone et al.'s (2018) Power Threat Meaning Framework (PTMF) drew upon the work of multiple survivor led organisations including HVN, as well as a range of other existing models and alternative methods of understanding to addressing distress, including formulation and trauma informed approaches. In line with the HVN philosophy, the central premise of the PTMF is that mental distress is an understandable

reaction, usually triggered by experiences of power. The contention upon which the Framework has been developed is that the biomedical diagnosis approach offers little in terms of an account for psychological distress and so can inhibit a process of seeking meaning and understanding in the rush to cure the 'symptoms' that emerge as a result. Rather than start by questioning 'what's wrong with you?' the PTMF thus suggests exploring the elements of power, threat and meaning through open dialogue, as presented in Figure 2.2 below.

Figure 2.2: Components of the Power Threat Meaning Framework

How has **Power** operated in your life (*What has happened to you*)?
What kind of **Threat** has this posed to you (*How did it affect you*)?
What is the **Meaning** of these situations/ experiences to you (*What sense did you make of it*)?
What kinds of **Threat Responses** are you using (*What did you have to do to survive*)?

(Adapted from 'Johnstone et al, 2018)

Although supported by the British Psychological Society's Division of Clinical Psychology, in speaking about the PTMF, the lead author has sought to impress that the framework is intended to be independent of a 'disciplinary home' aiming to negate the criticism of partisanship that the authors feel has the potential to undermine its utility (Johnstone, 2018). Whilst acknowledging that the current dominance of psychiatric diagnosis means it is likely to remain central at this point in time, not only in accessing mental health services but also in broader social contexts, for example to gain access to benefits, the authors have however proposed that in time the PTMF could facilitate a shift from pathologizing individuals towards supporting people to engage in dialogue, that move beyond diagnostic labels to narratives that encompass experience.

2.5 Chapter Summary

This literature review has examined how tensions between the care and control of people experiencing mental health crises have dogged each phase of the evolution of the concept of mental illness; a concept that is very much determined

by the social context in which it is formed. Beginning by describing changes in nomenclature and treatment followed by the rise to prominence of biomedical psychiatry, an account has been provided as to how legislation and changing practice have demonstrated the complex historical and conceptual dimensions involved. Critical discourses from a wide range of disciplines including medicine, psychology, medical sociology and psychoanalysis have been used to demonstrate the vexed and non-linear shift from constituting 'madness' as a social phenomenon, via mental illness as a biological problem, to mental distress as an embodied experience.

This discussion has described how over time, the issue of mental illness has continually been highly political, further testament to the inherent complexities revealed herein. Disputes have persisted as to how best to respond to distress and the struggles between different discourses framing mental dis-ease have manifested these controversies on an ongoing basis. Having outlined the historical circumstances, the review has demonstrated that the dominance of the biomedical model has been continually challenged as social causation, social constructionist and realist approaches have also been variously interwoven to the methods and models adopted during the last two centuries.

The review has ended with a consideration of current advances to and from the biomedical model. These frameworks are not mutually exclusive and all aim to improve the care of those in distress. Although language is another thorny issue, there is a growing appreciation that progress will only be achieved by giving greater prominence to lived experience. Whilst there has been some resistance to 'service user involvement', this field of movement has grown in strength and is now broadly recognised as a vital component in shaping care. The review has ended with a focus on the importance of valuing the voice of the person in need of care, both in understanding how they perceive their experiences and how they wish to be supported.

The following chapter will describe how this framework has been used to devise the research questions and aims, as well as critically incorporating elements discussed herein relating to lived experience.

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3 METHODOLOGY & METHODS:

A REALIST-INFORMED INQUIRY

3.1 Chapter Overview

The bodies of literature reviewed in the previous two chapters have illustrated the foundation for this research by demonstrating the complexly interwoven nature of the questions ‘what constitutes a mental health crisis?’ and ‘whose responsibility is it to respond?’ This chapter sets out the research aims and questions that guided my inquiry and provides the rationale for the approach I employed. It will begin with a reflexive account of how I have derived my epistemological and ontological perspective. This will prefix a description of realism as the methodological framework in my study. The subsequent methods section of this chapter will begin by presenting the research aims and stating the specific research questions that I have sought to answer in this work. The chapter will then progress to describing the study design, analyses and finally the ethical considerations, detailing the processes by which these were addressed.

3.2 Epistemological and Ontological Perspective

3.2.1 My Context

My epistemological position is informed by a combination of my academic background; in psychology at undergraduate level and in a forensic psychology MSc, and practice experience gained firstly in the probation service delivering cognitive behavioural based offending behaviour interventions in the community and latterly within a prison setting working in primary care mental health. Additionally, I held an eighteen-month research post in a nationally influential mental health research charity, working on a study exploring continuity of physical and mental health care for people as they moved through the criminal justice system. As well as the directly relevant learning I gained about how a large study is conducted, this role gave me first-hand experience of how

influential research could be as the charity occupied a 'critical friend' role to government through which they gave opinion that contributed to shaping policy.

I have gained an understanding of both theory and practice through these experiences which fuelled my desire to contribute to the integration of the two, by undertaking this PhD. I have a firm belief that research presents the opportunity to bridge policy and practice. As a frontline worker, I found that there frequently seemed to be a disconnection between the needs of those with whom I was working and the theories upon which my evidence based practice was constructed. In the probation service, especially during the late 1990's and early 2000's, practice was driven by the 'What Works' Agenda (McGuire, 1995, 2005). The research on which this was based largely consisted of correlational studies, which gave rise to a raft of 'treatment' programmes that were designed to address specific elements of offending behaviour using rigidly structured sessions written into manuals. Multiple experimental trials claimed to have demonstrated effective reductions in reoffending (Farrall, 2002). Yet despite a substantial body of evidence that was accumulated for this manualised way of working, critics countered that insufficient attention was paid to how these approaches produced reductions in offending and what made a difference at the individual level (Maruna, 2001; McNeill, Farrall, Lightowler, & Maruna, 2012). When removed from the research trial context in which they were developed, working to manuals provided what felt like a framework for the 'real work' that was undertaken, at times despite rather than because of the guidance.

As early as 1994, arguments were being made for evaluations of interventions to consider 'why' more than 'what'; to examine in closer detail the different outcomes observed and emphasise how these outcomes were achieved (or not) and the impact of relationships within these settings more than simply the extent to which the desired reduction in offending could be demonstrated (Pawson & Tilley, 1994). I found myself drawn in a similar direction as a practitioner, curious about the differences between the people who didn't come back through the court system to those I saw time and again. This guided me in developing my MSc research project, in which I explored factors that may have mediated completion or drop-out from one of the core programmes. I sought to know more about how

some people were able to make changes and how I could work more effectively with those who seemed willing but unable to change.

Working in the probation service was excellent preparation for the later NHS role, using the cognitive behavioural principles on which the groups I had facilitated had been based to help prisoners manage a raft of psychological problems related to depression and anxiety. Perhaps ironically, in this post I found myself frustrated at the lack of an evidence base. The Improving Access to Psychological Therapies (IAPT) programme, of which my service was part, had been implemented nationally to combat long term unemployment through depression in the general population and was at that time untested in a prison population. It had long been well established that among many other mental health problems there was a very high incidence of personality disorder diagnoses within the prison population (Singleton et al. 1999). The study on which I had previously worked (Byng et al., 2012) had confirmed very high incidence of offenders who disclosed having received such diagnoses and the rates were particularly high among our male participants. Originally any personality disorder diagnosis was an exclusionary factor from community IAPT, on the assumption that such patients would be difficult to manage in a primary care therapy service and would have poorer outcomes (Goddard, Wingrove, & Moran, 2015). Our service therefore began as a discrete local pilot, allowing us greater flexibility than the strictly controlled community services. In subsequent years IAPT would be formally piloted and then rolled out as a therapeutic option for personality disorder (Department of Health, 2011; Hann et al., 2015).

Under close supervision from a very experienced psychologist, my colleagues and I found ourselves continually adapting evidence-based community practice in order to make the work viable within a prison context with the associated constraints of the environment. However, this was contrary to the approved models, and technically therefore the work that we were commissioned to undertake. The response we saw in our patients was enormous and led me again to consider the validity of the tenets upon which the evidence base was being compiled. In particular, one of the accepted maxims of personality disorder driving the exclusion was that someone with this diagnosis would overwhelm a

primary care therapy service's resources, demanding more input than the permitted six to eight sessions, and once discharged, would likely want to be re-referred, due to the nature of their entrenched issues. On the contrary, we experienced patients achieving more significant recovery than our community counterparts, frequently in fewer sessions (CPFT, 2012). Furthermore, on the few occasions that patients sought re-referral, a brief conversation or one to two sessions were generally felt by those patients to be sufficient to support them to adapt the skills previously enacted in the original therapy sessions to address the new issues that had presented.

Elements of the practitioner concerns around personality disorder were mentioned in the description of the parent *Section 136 in Sussex* research, referred to in the previous chapter, which attracted me to become engaged in that study. Whilst working on that project, the repeated detention of certain individuals became apparent as an aspect that had not yet been well researched, in which I saw a mirroring of many of the issues I had previously encountered. As a result of my prior experience, I wanted my PhD to draw as much as possible on the perspectives of those with direct 'lived' experience of repeated detention and being a recipient of mental health services. I was also certain that I needed a methodological approach that would not be confounded by the complexity I anticipated encountering. The methodological basis for this study has been specifically led by the principles of realistic evaluation (Pawson & Tilley, 1997). This approach provides away in which to examine how elements of individuals' environments are involved in the interactions that can trigger certain outcomes. As an exploratory study, rather than seeking to test a hypothesis the purpose of my research can be more closely conceived of as having been to develop a hypothesis, deemed in realist terms as a 'programme theory' that accounts for how repeated detention under Section 136 occurs, for whom, under what circumstances and why. The following section explains this concept by providing an overview of realist evaluation.

3.2.2 Realistic Evaluation as Methodology

Realistic Evaluation (Pawson and Tilley, 1997) was developed by a sociologist and a criminologist who felt that much research within the field of evaluation was

flawed in frequently attempting to control, rule out or disregard factors which were not considered as part of the focus of study, such as the social setting. Rather than consider contextual factors as extraneous background noise, Pawson and Tilley argued that the setting in which research takes place exerts a critical influence on the subject and thus in determining the outcome. As a theory-driven approach, the paradigm shares some roots with critical realism, but it can be seen as situated between positivism and constructivism (ibid). During the twenty years since the original publication realistic evaluation has come to be known more commonly as realist evaluation (Wong, 2018) and the terms realist and realist research or evaluation are used interchangeably herein. The epistemological position of realist research is that there is a 'real world' which exists independently of human perception, elements of which can be observed and measured but also that social processes and interactions are greatly influenced by individuals' constructs of the world, which cannot be seen (Pawson, 2003, 2016; Pawson & Tilley, 1997). As such it concurs with my own view described above and has become popular with practitioner-researchers, especially in health fields (Emmel, Greenhalgh, Manzano, Monaghan, & Dalkin, 2018; Wilson & McCormack, 2006).

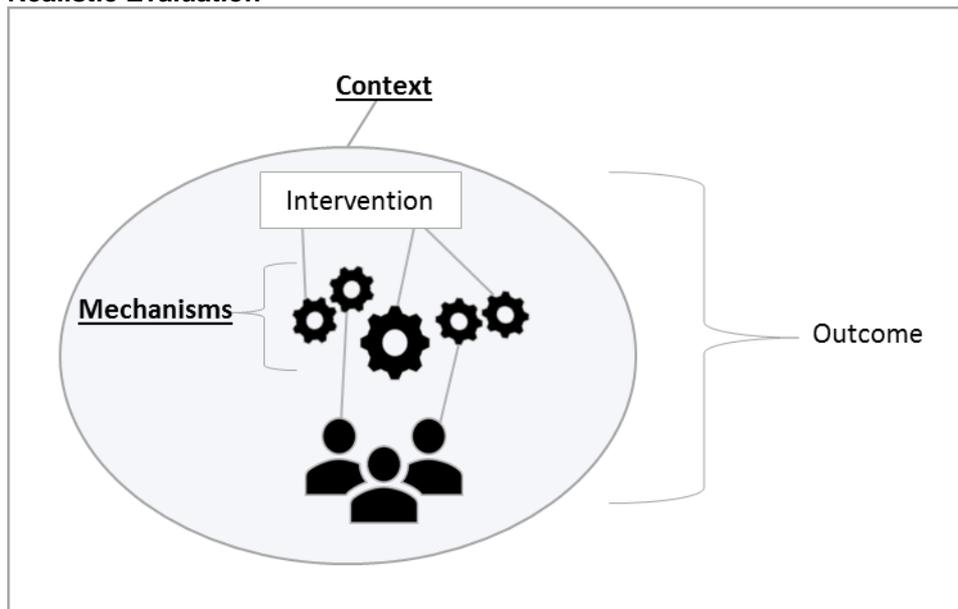
The central tenet of Pawson and Tilley's realism is that outcomes are produced by the interaction of contexts with mechanisms (the resources and reasoning added to a situation by those involved). Mechanisms draw on the concept of ontological depth proposed in critical realism; that reality can be thought of as having layers, few of which are observable, but epistemologically realist approaches also draw from constructivism in asserting that discernible social processes occur, not as the result of programmes or interventions (e.g. policies or schemes) but because of the way people perceive and react to those interventions (Pawson and Tilley, 1997). Aspects such as people's motivation or capacity to change are not easily captured and even if 'measured', for example through the use of psychometric scales, are likely to fluctuate depending on subtle and continual variations specific to any given situation (Liu, Bangerter, Rovine, Zarit, & Almeida, 2016). Nonetheless, these frequently intangible aspects are regarded as vital elements to understanding social processes within the realist paradigm. Mechanisms are thus considered to be constructions of the

resources (for example the provision of a property in an intervention) and the reasoning of individuals (for example their self-confidence or willingness to change a behaviour; Dalkin et al., 2015).

Acknowledging further elements of the constructivist argument, Pawson has stated that one can never fully see another's perspective but in being mindful of this limitation and seeking to gain as full an understanding as possible of the factors acting within the context under study, the ethos of realism is that a more authentic research product may be achieved (Pawson, 2002). The object of study in realist research is recognised as being embedded in the social structures in which it is situated. Rather than attempting to control or disaggregate these aspects as other methods may purport to do, realism considers the setting to be an innate element of the model and seeks to understand how these contextual factors interact with the mechanisms to produce observable outcomes. Hence, realism is concerned with making context-related factors explicit in order to understand these relationships, which are then articulated through 'Programme Theory'; an explanation of how the contexts, mechanisms and outcomes that have been studied may be configured (Pawson and Tilley, 1997). Figure 3.1 below provides a visual representation of such a relationship. It is of note that the mechanisms are not conceived of as solely deriving from an intervention. Realist evaluation thereby acknowledges the constantly evolving nature of contexts and research subjects, in which nothing arises in a vacuum. The way in which realist research embraces the complexity that occurs in real-world interactions has made it an ideally suited methodology in arenas such as public health and criminal justice (Wong, 2018). Realist methods have consequently become well-established in such research (for example (Brennan et al., 2016; Dalkin, Jones, Lhussier, & Cunningham, 2012; Greenhalgh et al., 2009; Mehdipanah et al., 2015). This popularity of realist approaches may reflect the acceptance in some health services research that it is neither possible nor practical to attempt to control multiple variables in such a way as to simulate the experimental paradigms of 'pure science'⁶.

⁶ See Pawson (2018) for a compelling argument that 'pure science' evidence based medicine more closely resembles realist inquiry than is traditionally conceived.

Figure 3.1: Visual Representation of Context, Mechanisms and Outcome in Realistic Evaluation



(Adapted from Pawson & Tilley, 1997)

Programme theories are initially developed using retroductive theorizing (Lewis-Beck, Bryman, & Liao, 2004). Retroduction has been described by Zachariadis, Scott and Barrett (2013) as a process that:

“allows researchers to move between the knowledge of empirical phenomena as expressed through events to the creation of explanations (or hypothesising) in ways that hold ‘ontological depth’ and can potentially give some indications on the existence of the unobservable entities (ibid, p. 858)”.

The following sections describes in more detail the approach taken within the current study to develop the programme theory of repeated detention.

A final important aspect of realism is the expectation that regardless of how thoroughly a phenomenon has been scrutinised and understood, a realist evaluation will only ever reveal semi-predictable truths, named demi-regularities (Lawson, 1997, 2003). This is owing to the inherent variability introduced by the constantly changing nature of contexts and people. Rather than render investigation futile, this has been described by the realist evaluation training manual (Wong et al., 2017) as strengthening the approach because it liberates the paradigm from a search for generalisability, which other methodologies may seek, instead, the realist researcher is encouraged to attempt to discern broad

patterns that may be transferable to similar situations if contextual factors are well understood.

Contexts, Mechanisms and Outcomes

Programme theory in realist research is the name for an explanatory account for the way contexts (C) exert influence by activating or inhibiting mechanisms (M) and how these in turn produce outcomes (O). This relationship is often articulated as $C + M = O$ or referred to as CMO configurations (CMOc). Mechanisms, and often elements of contexts, are not directly observable but are the drivers for observable phenomena, such as a person's reasoning and their abilities, which Pawson and Tilley originally referred to as a combination of the reactions and resources (1997). However, it is widely acknowledged within realist literature and guidance that it can often be difficult to identify mechanisms and contexts. The researcher is therefore encouraged to remain cognisant that mechanisms are causal processes and not 'factors' as conceived in the traditional sense of experimental research paradigms that may, for example, typically be labelled as 'independent' and 'dependent' variables (Wong, 2013, 2018).

A useful strategy for identifying CMOc within realist research is the VICTORE checklist proposed by Pawson (Pawson, 2002, 2006). Whilst acknowledging that not all evaluations will be able to identify all elements, Pawson suggests that the VICTORE mnemonic can significantly assist the process of mapping the complexity of an evaluation into programme theory. Pawson contends this is because all seven elements of the mnemonic are likely to be present, although in some cases may be discernible to greater or lesser degrees. The checklist is compiled as follows (please also see the later section under Analysis in this chapter for an account of how VICTORE has been applied in the present study):

Volitions

Throughout his work, Pawson has continually maintained that "*interventions do not work, it is the interpretations of their subjects that produce results* (2006, p. 34)." Consequently, his checklist prompts the researcher to seek an understanding of subjects' rationales and drives at the outset and throughout a study.

Implementation

This is the chain of events that have brought an intervention into being, it will depend on the scope of the research to determine how far into the history of any given implementation chain an inquiry can extend. One example may be media and public concern prompts a governmental review, ministerial briefing, allocation of pilot funding, selection of pilot sites and so forth. However, a tighter focus could be directed at a more proximal level. Broadly speaking then, implementation here refers to the preceding decisions and steps that have foregrounded the object of study.

Contexts

As previously described, contexts are the situations in which the object of study takes place. Pawson proposed a further aide-mémoire at this stage in the form of the four I's:

Individuals – The characteristics and capacities of the various stakeholders

Interpersonal Relations – Stakeholder relationships

Institutional Settings – Local rules, norms and customs

Infrastructure – The wider social, economic and cultural setting

In addition, the following three elements of VICTORE refer to further contextual elements.

Time

This relates to the impact of history and sequencing. It is here that Pawson cautions the researcher to be mindful of broader influences. These include the 'showcasing effect', which increases the likelihood of many pilot initiatives being successful as much effort, goodwill and focus is applied to their launch that may not be sustained over time, and the seemingly opposite 'intervention fatigue', which accumulates with experiences of successive failed interventions. The purpose of inclusion of this element in the model is that social interactions do not occur in a vacuum but are interrelated to events and experiences that have happened, often many years prior to the point at which research takes place.

Outcomes

Although predominantly concerned with how the outcome measurement of an intervention is determined, this is again particularly relevant within health and social care research as this area has seen a variety of outcome indicators implemented over recent decades. Here again, it will be of relevance to consider how this has impacted upon research participants.

Rivalry

The purpose of inclusion of this element is to draw the researcher's attention to factors outside the focus of study that may in other methodologies be disregarded as extraneous factors or overlooked entirely. Specifically, within classic intervention evaluations this refers to other interventions, schemes or programmes that are beyond the control of the research team to which participants may also be subject and of course the impact these in turn may have upon their response to the intervention of study. An example given of this could be a study examining food vouchers as a healthy eating incentive, but that recipients may also be using a food bank or engaged in schemes run by other agencies that will also impact their food choices.

Emergence

Finally, Pawson highlights the unpredictability inherent in complexity by emphasising the point that even when contexts and mechanisms have been diligently mapped and the interactions therein understood, replication of outcomes can never be guaranteed. Emergence encapsulates the possibility that an intervention may result in some change, no change, whole change or unintended change. A comprehensive programme theory should therefore aim not only to provide an adequate account of CMO configurations but should also consider how the programme may interact with its context in future iterations.

3.2.3 Summary: A Realist-Informed Study of Repeated Detention

The overarching aim of the present piece of work was not to evaluate a programme in the classic sense of a realistic evaluation, rather, in realist terms, this study sought to develop and begin to refine a programme theory of repeated detention. Whilst it may be questioned whether the absence of a conventionally

conceived 'intervention' as the central made this approach suitable for the current study, it is my contention that because the core purpose was to understand the factors implicated in triggering people to be detained recurrently, termed by realists as the generative causation, this work remained intrinsically realist in intention.

Put simply, this PhD aimed to develop a programme theory of repeated detention by identifying the mechanisms underlying this outcome and the contexts in which these mechanisms are activated. The aim can be articulated through the typical realist principle taking repeated detention as the 'what', this research sought to enhance the understanding of who is repeatedly detained, in which circumstances and why. A further reason for applying a realist approach within this PhD was that the utilisation of a range of sources of evidence is encouraged in realist research (Pawson, 2002, 2013). Given the paucity of academic work directly addressing this topic, it was anticipated that service audits and reports will be the most available documentary data. Therefore, an approach that embraces grey literature as data, such as service reports was appropriate.

Applying the principles of realistic evaluation in research inquiry rather than the original purpose of programme evaluation has previously been demonstrated as viable by (Clarke, 1997). This study, which was used to identify the contexts and mechanisms involved in thefts from construction sites was labelled a "*formative realist evaluation*" by Pawson and Tilley (2004, p. 29). Similarly, in my earlier research role we employed a realist approach to our investigation of continuity of physical and mental health care for people as they transitioned through the criminal justice system in England (Byng et al. 2012). In both studies, realist methodology was adopted because the purpose of the research was to maintain a focus on the causal factors, namely the contexts and potential mechanisms operating in the area of study; the primary aim being to provide a comprehensive account (programme theory) that theorises the dynamic interactions of the objects of study with their settings, as is the case in the present research.

More recently, Pawson (2017) commented that more research applying realist evaluation principles in this way to understand issues about which little is known would be beneficial. He commented on a realist study that was aiming to identify

when and why healthcare professionals develop mental illness, which methods are effective in reducing this mental ill-health and in what circumstances those strategies can succeed. Pawson observed that in the case of such a project, as opposed to a traditional realist evaluation that started with the study of an intervention, it made sense to use realist research in this way:

“to begin with a thorough study of the problem. This is all within the technical scope of [Realist research] - basically one is asking for whom, in what circumstances, in what respects and why does the PROBLEM occur” (RAMESES JISMAIL, 29th June 2017, emphasis in the original).

Pawson termed this a “*realist diagnostic evaluation*”. Pursuant to this proposition, my PhD has employed a theoretical framework shaped by the realist approach to understand repeated detention. This work has been underpinned by the conclusions drawn from the previous two chapters, that neither psychological nor social factors in isolation would be able to provide a comprehensive account for this phenomenon. Instead, the aim of the research is to advance a psychosocial understanding of how key mechanisms interact with context to trigger recurrent detention.

Having described my methodology and provided a justification for the use of this approach, the second part of this chapter will begin by reviewing the aim of the PhD and stating the research questions, before detailing the methods that were employed and the ethical considerations.

3.3 Methods

3.3.1 Research Aims

The predominant aim of this research has been:

To develop a deeper conceptual understanding of the psychosocial factors involved in repeated detention.

Two further aims can be articulated thus:

To explore what data on people repeatedly detained under Section 136 is being collated by NHS Trusts and police in England and Wales and to

conduct a secondary analysis of this data in order to identify characteristics of this group.

To conduct qualitative research that foregrounds the voice of people who have lived experience in examining the factors implicated in repeated detention.

These overarching aims were enacted through three research questions, which in turn can be summarised in realist terms as what is repeated detention, and for whom, under what circumstances and why does it occur? A final question examined what practice may specifically address repeated detention. The research questions were expressed as follows:

3.3.2 Research Questions

1. To what extent is repeated detention a recognisable phenomenon in differing parts of England and Wales?
(What is repeated detention?)
2. Are people who are repeatedly detained a single heterogeneous group or are there any distinct characteristics within a sample of people who have been detained on multiple occasions?
(Who is repeatedly detained and under what circumstances?)
3. What can be learned about the care needs of this group and why repeated detention occurs from their accounts of their own experiences?
(Why are people repeatedly detained?)

In developing the study, I divided data collection into three parts. Figure 3.2 below details the purpose of these data streams and which research questions were addressed by each. That is followed by a more detailed explanation of the research methods utilised within each data stream.

Figure 3.2: Data Streams of Study

<p>Stream 1: Exploration of Local, Regional and National Practice Survey of England and Wales police forces and data collection from Sussex and neighbouring counties including audit data and ethnographic observations</p>

Figure 3.2: Data Streams of Study (continued)

<p><i>Purpose: To build national picture of data recording practices and the level of concern around repeated detention, as well as to understand any practice developments specifically targeted to repeated detention</i></p> <p><i>Addresses Research Question 1</i></p>
<p>Stream 2: Regional Detailed Breakdown of Repeat Detainee Characteristics</p> <p>Anonymised data set of individuals recurrently detained in Sussex</p> <p><i>Purpose: To conduct comprehensive analyses that examine the psychosocial factors recorded at the time people are detained</i></p> <p><i>Addresses Research Question 2</i></p>
<p>Stream 3: Lived Experience Perspective</p> <p>Qualitative interviews with people who had been repeatedly detained and those who had been diagnosed with personality disorder</p> <p><i>Purpose: To understand the how those experiencing multiple crises view their care needs and how Section 136 detentions can become recurrent and therefore how repeat detentions may be reduced</i></p> <p><i>Addresses Research Question 3</i></p>

3.3.3 Explanation of Research Streams

Stream 1: Exploration of Local, Regional and National Practice

The purpose of this first phase of the research was to explore the broader context of repeated detention in an attempt to establish whether the phenomenon was recognised beyond the local area in which the detailed research was to be based. Additionally, I sought to learn what practice had been developed and latterly to evaluate the extent to which these approaches met the needs expressed by those who were subject to recurrent detention. This data stream thus comprised three elements:

National Police Survey

My hope was that by examining the national level of concern expressed by police around repeated detention my research would be able to make an assertion that the phenomenon was recognised as an issue beyond solely the immediate area of Sussex. In addition, I hoped that the responses would provide some insight to how the issues related to repeated detention were perceived; effectively seeking

to understand what 'programme theories' of the mechanisms that drive frequent detention were held by practitioners.

The original intention had been to contact the police mental health leads for each of the 43 constabularies covering England and Wales individually. During the first year of the PhD it emerged that this approach would no longer be viable as local police collaborators advised that their colleagues were facing considerable pressure increased by the Policing and Crime Act progressing through parliament prior to receiving royal assent in February 2017. As detailed in the previous chapter, the Act brought in a range of changes to police procedures, some such as the alterations to Sections 135 and 136 of the Mental Health Act, required partner agencies to make changes in collaboration with police. Indications were that preparation for these changes were placing considerable pressure on already stretched constabularies (Brown, 2017).

My local police collaborators suggested that rather than 'cold calling' the individuals I may have more success through the Mental Health Lead for the College of Policing, an influential and widely respected senior police officer with whom I had already had an informal conversation regarding my PhD. The College of Policing is the professional body that oversees standards and education for all police in England and Wales. In order to try to maximise responses, a simplified questionnaire was cascaded by this contact (see Appendix A). The questionnaire asked what view the area took on repeated detention and what would be considered problematic. Again, mindful that the prospect of being followed up may be a concern for some, I indicated that I would not contact respondents further. The limitation of this approach was that it provided only a single opportunity to engage potential respondents in the research and thus also meant further clarification or dialogue could not be sought unless individual respondents chose to initiate such contact. Whilst it would have been preferential to have a greater level of interaction with representatives of police forces from around the country, the option to gain limited information from a larger number of respondents was a pragmatic choice that I felt was justified by adopting this approach.

Local and Regional Practice

The further intention for this first data stream was to reveal any unique or innovative practice that had been developed to address repeated detention, thus a number of ethnographic observations of practice and policy meetings were included to form a more comprehensive understanding of how repeated detention was considered, or at times not, within a variety of contexts. There were a number of pragmatically-driven reasons for selecting this approach, and I was strongly guided by experiences with such observations as part of the prior *Section 136 in Sussex* study. Ethnographic practice observations had been used alongside individual interviews and in total 239 people had been involved in this element of the previous study. It was felt that attempting further interviews for the present study would run the risk of participant fatigue and would yield relatively little new data given the overlapping areas of focus. Additionally, as an extension to my role in the parent study, I had already become partially embedded in some of the relevant contexts, for example, I had been invited to attend several local practice and policy meetings within the local area. Furthermore, I felt that rather than using formal individual interviews, “*conversational interviews*” (Reeves, Kuper and Hodges, 2008, p. 337) taking place during the more naturalistic setting of a meeting observation would yield more information from more informants than through interviewing alone. Using ethnography in this way is considered an entirely legitimate component of realist research and is often employed in such studies (Greenhalgh et al., 2009; Mehdipanah et al., 2015; Willis et al., 2018).

My attendance at all practice observations was by invitational consent of the Chair and my presence was explained on each occasion at the start of the meetings. I also took the opportunity to build early collaborations with the police mental health leads in the three neighbouring counties, which provided opportunities to gain a more detailed understanding of approaches to recurrent detention outside the immediate focal area of Sussex, as well as a channel through which I was able to access secondary data such as service audits and reports. These contacts also enabled me to meet a range of practitioners through being invited to attend relevant meetings and training days. This too contributed to building an understanding of existing practice and policy approaches to address repeated detention, in turn further revealing the key factors felt by

practitioners to be involved in recurrent detention. These collaborations yielded a further layer of wider contextual data that was more detailed than that gained through the national police survey. I was given access to secondary data in the form of local reports on Section 136 activity.

Importantly, my collaboration with Hampshire, led to a number of meetings with a police sergeant who had worked with his local secondary care mental health trust to develop a method of mentoring to specifically address repeated detention. Initially named the Integrated Recovery Programme and subsequently evolving into Serenity Integrated Mentoring (SIM), this programme had been initially piloted just prior to the start of my PhD (Jennings and Matheson-Monnet, 2017). The SIM model brings the person experiencing repeated crises and a key worker from their mental health trust together with a dedicated police officer. Boundaries and targets are then agreed jointly, and ongoing meetings are used to monitor progress. Although delays and other issues encountered in the ethics process meant that I was unable to interview any of the people who had engaged in SIM, as had been the original intent, I was able to attend a professionals' review meeting by invitation of the lead police officer at which the details of those who had taken part in SIM were anonymised. This meeting yielded a very rich source of contextual information about the intervention and the thoughts, or in realist terms, programme theories, of the professionals who had a wealth of experience working in the field of mental health.

Stream 2: Detailed Breakdown of Repeat Detainee Characteristics

Nationally, monitoring of S136 detentions including the age categorisation of people who are detained and whether those detentions are to police custody or health based places of safety have been collated and publicly reported, initially by the National Police Chief's Council between 2013 and 2015 and latterly by the Home Office. Similar data has been collated and reported annually by the Health and Social Care Information Centre for many years however, as previously noted herein, this report had only recently begun to include detentions to police custody and some discrepancies persist between the sets of figures released (see Chapter One, section 1.3.3). Furthermore, no agency currently identifies the rates at which individuals are repeatedly detained.

Within the parent *S136 in Sussex* study, the analysis of a twelve-month period of data yielded valuable information about the complexity of issues involved in S136. Numerous changes to practice in the county have taken place in the intervening time and it was not known whether or how these may have impacted repeated detention. The length of time for which detention data was collated for analysis was extended to 28 months for this research and focussed solely on those detained more than once during that time. Although anonymised to prevent individuals being identified, it was hoped that a more detailed indication of the psychosocial demographic characteristics of individuals detained repeatedly in Sussex would be obtained in this way.

Stream 3: Lived Experience Perspectives

People who had experienced multiple detentions and those engaged in a support service for patients of Sussex Partnership NHS Foundation Trust (SPT) who were diagnosed with borderline or emotionally unstable personality disorder were invited to participate in semi-structured interviews. The focus was less on experiences of detention and more on how participants perceived crises and the role of Section 136 within the wider context of their life, including what factors participants believed precipitate their recurrent detentions. Interviews sought to investigate participants' networks of support, by examining how their needs were met through either formal services or social contexts.

3.3.4 Recruitment

Lighthouse Recovery Support Service

Based in Hove in East Sussex, the Lighthouse is a holistic psychosocial support service run jointly by (SPT) and a third sector provider, which offers 'membership' to patients of SPT who have a diagnosis of borderline or emotionally unstable personality disorder. Other than closing on Christmas day, the Lighthouse is open into mid evening every day of the year and offers a range of psychotherapeutic options as well as providing a social space, catering and group activities such as knitting, yoga and quizzes. The service also offers telephone support during opening hours, meaning that members who are unable to attend in person can call to speak to someone who knows them if they are in crisis. The service was created to provide a 'psychologically informed environment' which is grounded in

trauma-informed principles (see section 2.4). Critically, the ethos of is that rather than 'patients in treatment' individuals are considered to be members, the term denoting that the traditional hierarchies seen in mental health services are set aside and members are able to access support for as long as they need.

I was invited to attend a community meeting, which are regular meetings attended by all staff and as many members as are able to attend. At the meeting I introduced myself and my study, discussing the reasons for the PhD in light of the previous *S136 in Sussex* project. Following this meeting the members suggested as well as information sheets that I leave a sign-up sheet with their receptionist so that anyone interested in a further conversation with me could ask to be contacted. In addition to this I spent some time before interviews in the common area where I was accessible to anyone who wished to speak to me. This led to a number of conversations being initiated by members interested in the study, some of whom were considering taking part. As well as trying to ensure members were comfortable to interact with me as a person they could identify, rather than a name discussed by others, spending time at the centre and having attended the community meeting helped me gain a better sense of how the Lighthouse operated, enhancing my appreciation of that context.

Other People Detained with High Frequencies

A further two participants were purposively recruited via the East Sussex S136 Monitoring Board, who sent invite letters to several people identified by the board as having been detained with very high frequencies in Sussex during the previous three years. Each of these two participants lived outside Sussex and therefore chose to take part in telephone interviews.

3.3.5 Justification of Approach

The decisions taken in designing my study were prompted by the view presented in the previous chapter that it is imperative for research to seek to understand a phenomenon from the perspectives of those to whom it pertains, in this case those with lived experience of repeated detention. Furthermore, I was influenced by my concern that research with vulnerable populations viewed by feminist traditions as oppressed (Harding, 1987) has a duty to be emancipatory. In so doing to be mindful of the need to examine the influence of power and that, as

Harding, observed: “the questions an oppressed group wants answered are rarely requests for so-called pure truth” *ibid*; p. 8). Consequently, the streams described above yielded a pyramidal configuration of data that is reported in the following two chapters. Although the national police survey responses were not greatly detailed, this stream gave a valuable macro level orientation. The Sussex repeated detention data set provided a substantial amount of information on the mental health service documentation and showed interesting meso-level contextual detail, such as how the police had been alerted. Finally, the in-depth interviews revealed a wealth of material at the micro level, through which an understanding of how recurrent suicidality and repeated detention came about for those was constructed.

Notwithstanding my choice to privilege the perspective of those with lived experience, it was important to me to retain the broader contextual data that would not have been incorporated had I selected a purely phenomenological or interpretivist approach (Bryman, 2006). Similarly, I considered adopting alternative stances such as ethnomethodology (Ormston, Spencer, Barnard, & Snape, 2003) or employing grounded theory (Charmaz, 2014; Glaser & Strauss, 1967) before opting to retain Pawson & Tilley’s realism. In part, this was a pragmatic choice, based on realist evaluation’s compatibility with my epistemological perspective described previously. However, it was also utilitarian, enabling me to focus on generative causation and to structure an account that examined the meso-influences whilst still encompassing micro level elements of individual interpretivism that I felt were both necessary components in constructing a comprehensive model of repeated detention.

3.3.6 Managing Interview Data

The four face-to-face interviews from the Lighthouse were audio recorded with the consent of each participant. I made some notes during the interviews relating to points such as demeanour or highlighting key comments. Subsequently, interviews were each transcribed verbatim by myself. Audio recording was not available when the two telephone interviews were conducted and so transcription was not possible, however I made detailed notes (both exceeding ten pages) during each interview and these were then typed up shortly after each interview

with notes incorporating my observations, such as impression of tone of voice and notable pauses.

This approach used to manage the qualitative data was primarily informed by the six step process described by Halcomb and Davidson (2006). The steps suggested in this model are:

- 1 Making contextual notes whilst audio recording the interview
- 2 Writing a reflective journal immediately after the interview
- 3 Revising or amending fieldnotes whilst listening back to the recording
- 4 Preliminary content analysis of interview
- 5 Secondary content analysis of interview
- 6 Thematic review of all data

Although not specified by Halcomb and Davidson, I incorporated transcription into stage three as I felt this would be useful in retrieving material for analysis and writing up the research.

Pawson's (2006) guidance on analysing data in realist work rejects the technical process of coding verbatim text after fieldwork has been completed, in order to identify themes and then code them into contexts, mechanisms or outcomes. Rather he describes the realist analysis process as necessarily starting prior to fieldwork and continuing throughout, with programme theory being iteratively refined with each interview. In consideration of this point, Halcomb & Davidson's steps appeared to fit more naturally with a realist approach. The same note management process was utilised for practice observations.

3.3.7 Analyses

Data Stream One: Local, Regional and National Practice

Police Survey

The police survey was intended to give a simple overview of the attitude from police services throughout the country towards repeated detention. This element of the research was used primarily to provide a descriptive overview of repeated detention beyond the local region, as the response rate of 23% determined that

an extensive analysis was not viable. Unprompted further contact was initiated by three police respondents, which yielded further emailed correspondence and sharing of local policy documents. In order to maintain anonymity for responding areas in line with the agreement with my College of Policing liaison, and the individual forces, all survey respondents were assigned a numerical reference based on the order in which their replies were received. The 43 police forces covering England and Wales are divided into 10 geographical regions, identified in the current S136 data reported by the government. I used these regions to provide further detail reported in the following chapters (see section 4.3).

Practice Observations and Service Data

As described above with the police survey, the secondary data shared by collaborators from services neighbouring Sussex were used descriptively rather than subject to statistical analyses. Comments from practice observations were compiled for thematic analysis that was used to compliment policy assumptions from documents that were publicly available, such as the Section 136 codes of practice for England and Wales and the joint Department of Health and Home Office review referred to previously (Department of Health and Home Office, 2014a), and from the documents received from police contacts through local collaborations and the additional respondents to the police survey. This data is also reported in the first results chapter.

Data Stream Two: Secondary Analysis of Repeat Detainees

The analyses of quantitative data are also presented in the first findings chapter. The spreadsheet was first checked as far as possible for data entry errors (for example typing errors such as numbers having been transposed in dates and text included in numeric fields). The data was then imported to SPSS (Version 24) and frequencies run to provide further verification of data validity. Once issues had been cross-checked, descriptive statistics were obtained in order to give an overview of the dataset in relation to the number of people repeatedly detained and the frequencies of sociodemographic factors such as gender, ethnicity and home area. Data was then subject to cluster analysis to assist in identification of potential subgroups within the sample.

Cluster Analysis

Rather than a single technique, cluster analysis is the term used to describe a collection of techniques that have the purpose of classifying data by identifying group formations. Everitt (1993) states this type of analysis is particularly suited to generating rather than testing theories and he suggests that the value of cluster analysis is assessed by the utility of the resultant taxonomy. As this suggests, perhaps even more so than with inferential statistical techniques, the validity of groups proposed through cluster analysis is dependent on interpretation, however, Everitt suggests preliminary careful and critical scrutiny of data is essential in the initial stages of applying this method. The reason for this is that cluster analysis will produce groups regardless of whether such groups exist in reality, it is therefore the researcher's interpretation of the groups on which the validity of this technique relies (Pastor, 2010). The resultant clusters are naturally dependent on the variables included, Pastor cautions that because the technique is so highly sensitive, the presence of an irrelevant variable can obscure true clusters. For this reason, the fields incorporated into the analysis were not pre-determined, rather the descriptive statistics were scrutinised in order to identify which factors were tested. The purpose of cluster analysis in this instance was to identify sub groups of similar cases (people) rather than a typical or average repeat detainee across the whole sample, as this notion of a typical case would be a potentially misleading aggregate that would risk not being an accurate reflection of any of the members of the group.

Cluster analysis has been recognised of being suitable for health research (Clatworthy, Buick, Hankins, Weinman, & Horne, 2005). A comparable application of this technique to its use in the present study was demonstrated in an exploration of characteristics within a sample of clinically obese individuals in which distinct groups were identified that highlighted the heterogeneity of the population under study (Green et al., 2016). In this study factors such as lifestyle (levels of alcohol consumption and exercise) life satisfaction; age; gender and mental health (anxiety, depression, loneliness and overall well-being) all emerged as influential in defining six different groups. Likewise, cluster analysis has been used to elucidate the complexity involved in adolescent self-harmer by indicating sub-types (Stanford, Jones, & Hudson, 2017). Therefore, following this

application, the cluster analysis was used to examine whether any different sub-groups appeared to share similar characteristics within the overall sample of people who were repeatedly detained.

Data Stream Three: Qualitative Interview Data

Lived experience data is reported in the second findings chapter. Guidance on how to analyse data in realist research is abundant (Dalkin et al., 2015; Emmel et al., 2018; Pawson, 2013; Pawson & Tilley, 1997). In addition to attending multiple seminars, training events and workshops on this specific approach, I remained engaged in the realist community throughout the PhD via the highly active Realist Evaluation and Synthesis Standards (RAMESES) email discussion group. Realist analysis is an iterative process that should be an ineluctable element of the data collection activities within a study. The principle underlying this is analogous to that of constructing a building, each piece of data representing a component piece, such as a brick. Therefore, the role of the researcher is to select the material that will best fulfil the brief (in this case informants who are likely to be able to supply 'pieces of the puzzle') the construction progresses piece by piece with each interview contributing to the development of the explanatory constitution of contexts, mechanisms and outcomes. As a result, although separated into different elements in the design of this study, the analysis of the data streams was not approached as discrete activities that occurred on completion of each part, instead, it began with the first interview and continued throughout data collection.

VICTORE

The VICTORE mnemonic was used as a guiding framework to analyse the qualitative data and synthesise this with the other streams. A full description of this can be found in the earlier methodology section (3.2.2), however, the application of VICTORE in this study is briefly detailed below.

Volitions - This referred to the volitions of people repeatedly detained and also to professionals' concepts of the volitions of repeat detainees gained from practice observations.

Implementation –The study endeavoured to examine elements of the ‘implementation chain’ of people becoming high frequency detainees.

Contexts – The contexts in which the crises that led to detention were triggered, as well as the circumstances in which detentions were reduced: drawn from both qualitative interview accounts and the analyses of quantitative data.

Time - This aspect of the mnemonic was not extensively examined as it was considered more relevant to a conventional realistic evaluation of an intervention. Nonetheless, the impact of time was alluded to in interviewees’ references to the sense of fatigue accrued from serial experiences of poor care.

Outcomes – Recurrent detention, or the avoidance thereof was taken as an immediate outcome, as was the occurrence of crises. Hope also emerged as a pivotal outcome from the contexts presented interpreted as determining whether suicidal feelings were acted upon.

Rivalry - Once more, this appeared as a major factor of relevance as interviewees accounts held numerous details of people being ‘caught’ between different services.

Emergence –Pawson highlights this element is attributable to “*the remarkable sensitivity of people to their place in the world*” (2013, p. 42). At an intrinsic level, the findings suggested that repeated detention is an example of emergence, as considered in the discussion chapter.

In addition to assembling themes guided by the VICTORE mnemonic, realist research encourages the use of stakeholder consultation to help shape programme theories. This can be accomplished using a variety of methods such as focus groups and repeat interviews. Given the range of options, the time available and the importance of lived experience to this research, the present study adopted the deliberative workshop methodology which had been successfully employed in the prior *S136 in Sussex* study, having been introduced by SPT’s Involvement lead as an evolution from a reflexive review process

utilised within a previous project (Hann et al., 2015). This process is explained below.

Deliberative Workshop

The purpose of this consultation was to guide the analysis with a further level of lived experience expertise. My involvement in this event also revealed it to be a valuable way to enable the researcher to identify and examine assumptions they may have made in interpreting the data. For this reason, I felt the method would be invaluable in the present study where I had less opportunity to discuss and challenge my own interpretations through discussion with a 'project team'.

The workshop is facilitated by a person with lived experience consultation expertise who has been independent to the study and is attended by between 10 – 15 consultants with lived experience. In the parent study, delegates included some of those who had been interviewed about their detentions, however, given the smaller size of participant pool within my own research as well as the temporal proximity between interviews and workshop taking place, I felt it would potentially be too exposing for interviewees to participate in the workshop. Instead, members of the lived experience advisory group who consulted on the study were invited to take part (see further explanation in the following Ethics section, 3.3.8 in this chapter).

Very sadly, the Trust Involvement Lead who had introduced this method passed away in 2016. The interim co-ordinator who took the lead for the research theme under which my study grouped did not have prior experience of this particular approach and we therefore made some pragmatic adaptations to enable the workshop to take place. Owing to a smaller volume of data than had been the case in the parent *S136 in Sussex* project, the workshop for the present study took the form of a three-hour meeting, rather than a whole day event, which I co-facilitated. Five lived experience consultants took part, all of whom had multiple experiences of mental health crises and attempting to access emergency support as well as a range of complex mental health needs and diagnoses.

During the meeting I presented an overview of the study and the preliminary themes I felt were present in my initial review of the data. The co-facilitator and

myself then posed questions to the consultants in relation to the general topic area and we then examined some excerpts from transcripts that I believed to be indicative of the themes I had proposed. The workshop showed me that my initial interpretation had been overly instrumental in focus. My initial themes were Assessment, Section 136, Support and Suicide as well as a further assemblage of quotes to which I had been unable to assign a theme. The consultants' input drew me to what I felt was a deeper level of interpretation that attended to meaning more than process. The greatest illustration of this was that the consultants unanimously felt that 'Relationships' was the overarching theme of all the material we had reviewed and the discussions that took place in the meeting. Re-reviewing the transcripts in light of the deliberative workshop adjusted my interpretation to attune more to the meanings of experiences contained in the interview accounts. The material generated in this process was then used to guide the construction of the final qualitative analysis presented as a CMOc in Chapter Five and contributed to the programme theory which is developed in the Discussion Chapter.

3.3.8 Summary: Constructing the Programme Theory

This part of the chapter has outlined the four streams of data collection: police survey and practice observations as well as secondary documentary data; collation of anonymous secondary detention data and interviews with people who have been detained repeatedly. The data analysis for each stage has been described and the way in which the VICTORE mnemonic was applied has been outlined. On completion of the processes detailed above, the strands of data were brought together into the development of a provisional programme theory of repeated detention, which is presented in the Chapter Six. As explained in the methodology section of this chapter, this was an articulation of the context, mechanism, outcome interactions proposed to bring about to repeated detention as an emergent outcome.

Having described the methods by which this research was conducted, the final section of this chapter will examine the ethical considerations that were fundamental to the conduct of this work.

3.3.9 Ethical Issues

Whatever the circumstances for police involvement, detention under Section 136 takes place in highly emotionally charged situations, when it has become a recurrent experience it is clearly no less so. Indications from the parent research were that, in line with those detained only once, the majority of recurrent detentions involved concerns that the person was presenting a risk to self, in other words most detentions were because of concerns relating to suicide more than the person being perceived as presenting a risk to others. Consequently, it was obvious from the outset that this research was unquestionably based on a sensitive topic. Whilst the ethical conduct of any research is naturally important, it has an even greater imperative when the focus of research is on such as sensitive an area as recurrent suicidal behaviour. In seeking to be fully cognisant of the ethical issues prior to starting the study, it became apparent that there were implications both for participants and myself as the researcher. The following discussion will consider each aspect, beginning with the latter, before detailing the ethical review process that the study underwent.

Distress to the Researcher

As outlined, at the start of the PhD I had already been immersed in this work for the previous two years having been the research assistant on the parent project. This role had included transcribing the interviews and debriefing discussions after each interview with Professor Bendelow who had conducted those interviews. The likelihood of personal distress was therefore anticipated and was something about which discussions had already been held with my supervisory team and the doctoral college.

Dickson-Swift et al (2009) observed that even within social sciences, the research literature has traditionally paid scant attention to the issues raised for researchers during the conduct of research in sensitive topics. Heavily informed by the influential work of Hochschild (A. Hochschild, 1990; A. R. Hochschild, 1979, 1998) Dickson-Swift and colleagues explored how researchers spoke of their own emotional labour when working in sensitive areas that included experiences of abuse and terminal illnesses. Participants in the Dickson-Swift study related experiences of being very distressed by what they had been told in

some interviews. For some, aspects such as having had similar experiences in their own lives meant some interviews had affected them strongly. A number of researchers spoke about the intensity of conducting multiple interviews and how they had felt physically drained as well as describing being upset or emotionally vulnerable. Several described longer-term impacts on their usual social functioning.

Within this research, my own support structures were reviewed prior to starting interviews and it was felt by myself and my supervisors that in addition to the preparation from working in the area, I would also be able to draw on my extensive previous experience of working with vulnerable people who often had traumatic backgrounds, as I had done in both clinical and non-clinical settings. Nonetheless, I did find undertaking some of the interviews more emotionally demanding than I had anticipated, especially when conducting several interviews in quick succession. Discussion of this with other colleagues in my department who were also engaged in researching sensitive topics led to arrangements being made for informal peer support. Ultimately, within an area of social science research such as this, the risk of researcher distress cannot be entirely eliminated.

Lived Experience Guidance

The ethos of giving prominence to the voices of those detained was a primary concern within this body of research and the development of my own work was thus interwoven with guidance from lived experience advisory consultants from concept and design, through the funding application and continued throughout the life of the PhD. Sussex Partnership Trust's Involvement Lead, Ruth Chandler, was an expert by experience who was widely respected in the field of participation in mental health. Believing this research to be of great importance, Ruth had provided ongoing encouragement up to her death in 2016. An extended discussion with her in 2014 was fundamental in shaping aspects of the PhD investigation prior to seeking funding. In July the following year, the proposed study was outlined to our lived experience consultants at the deliberative workshop that was held as part of the analysis phase of the parent *S136 in Sussex* study (see section 3.3.6 above for an explanatory account of the

deliberative workshop). The fifteen consultants present, most of whom had direct experience of detention by the police, confirmed their opinion that the research is worthwhile and necessary and gave input to several methodological aspects of the study.

Additionally, a research advisory group of those with lived experience of detention under Section 136 and personality disorder diagnoses, as well as other complex and comorbid mental health diagnoses, was formed during November 2014. This subsequently developed into the Patient & Public Involvement (PPI) Consultation Group for the Trust's *Personality, Emergency Mental Health Care and Complex Needs* research theme; the theme was largely developed as a result of the programme of research arising from the original study and so continued to provide input as the PhD progressed. This group is hereafter referred to as the PPI Advisory Group.

Participant Safety

In acknowledging that people detained under Section 136 undoubtedly fall into the 'vulnerable participants' group within NHS research, SPT facilitated training in both Good Clinical Practice in Health Research and Mental Capacity Act /Deprivation of Liberty Safeguarding. The principles of the Mental Capacity Act formed the guiding framework for consent, in particular the first two:

- 1 Presume a person has capacity until established that capacity is lacking for each decision
- 2 Take all practical steps to maximise a person's ability to make a decision.

The consent process was therefore designed to accord with assessing capacity in whether each participant was able to understand the information and communicate the decision about participation based on that information. In essence, someone was only taken forward to interview if they presented as having the capacity to make an informed decision to consent, this was the case for all who responded to the invitation to take part, and included those with whom informal conversations were held at Lighthouse (see section 3.3.4 above).

A related detail given consideration at the outset was the provision of adequate time for potential participants to decide whether to take part. It was decided that

rather than set out a rigid time frame it would be better to allow as long as people chose to make their decision about participating. This was stated in the protocol and form for the Integrated Research Application System.

Initial PPI consultation on this project was primarily focussed on participants' emotional wellbeing and dealing with distress following interviews. Following completion of the first draft of the NHS Ethics Integrated Research Application System form, the PPI advisory group was convened. The meeting was chaired by the Trust's Involvement Lead and attended by three of the lived experience consultants, in addition to the consultant clinical psychologist who, as a clinical research fellow, jointly leads the *Personality, Emergency Mental Health Care and Complex Needs* research theme referred to above. At the meeting, the research element of this PhD was explained in depth, the proposed study documents were revised and discussions were held with particular focus on participant safety and addressing risks which may arise due to disclosures made by participants during interview.

It was agreed by all that any imminent risk of harm to the participant or others that was disclosed during the course of interview, should be immediately reported to services. More detailed conversation focussed on the 'grey area' of less significant distress, or the possibility that a participant may feel 'triggered' by something discussed during interview. The consultants felt interviewees would benefit from a follow up contact being made in the days immediately after an interview, which would enable me to check any less urgent concerns. It was also agreed that a clearer statement was needed in the Participant Information Sheet that any intent to cause serious harm, to self or others, disclosed by a participant would necessitate a breach of confidentiality by the researcher, which would be explained to interviewees during the consent process. The group proposed the development of a Risk Management Protocol (Appendix B) to sit alongside the main research protocol, with the purpose being to give sufficient, detailed consideration to issues of safety and welfare raised in the research and how these would be addressed.

Under the PPI guidance, the consent process was created to facilitate an open discussion with potential participants about the possibility of discussing

distressing topics and how this could be managed both during the interview and subsequently. The explanation of confidentiality to take place during this stage was designed to include discussion of the situations under which the researcher may contact care teams or participant-identified other source of support, to raise concerns. Participants in the original S136 study were noted to have raised the topic of contingency planning for their own distress before the start of the interview. Many were forthcoming with details of the support they had already put in place such as having a friend meet them after the interview or having arranged a meeting with their care-coordinator. The decision was therefore taken to formalise this process by asking participants to identify a contact or contacts (carers/ friends/ keyworkers etc.) whom they would be willing to be contacted by the researcher in the event of less severe concerns for the participant's wellbeing.

A widely practiced procedure for much mental health research within the NHS is for the contact in case of distress to be the participant's care-coordinator. The choice not to dictate that this be the case within the present study was a carefully considered and partly practical decision. Prior to receiving ethics approval this issue was raised to me by the Health Research Authority (see Ethical Review, final section below). Information from the original study had indicated that a number of people who are detained come from outside Sussex, therefore it could not automatically be assumed that the care co-ordinator could be contacted. However, the primary reason was that many of the parent project participants who had been under secondary mental health services had given accounts of fractured and poor relationships with their care teams. It was clear from a great number of people who were interviewed that the choice to take part in the *S136 in Sussex* study had been greatly influenced by the researcher being from the University rather than the Trust or police and that as a result they felt comfortable to disclose dissatisfaction with those services. Consequently, the PPI advisors confirmed that automatically referring to the care co-ordinator would countermand the ethos of honouring individuals' autonomy in managing their participation in the research.

Informed by many years of working with vulnerable populations and consequently being cognisant of safeguarding issues, the ethical review process prompted me

to articulate the differentiation I considered to exist between distress and risk. I raised this with the PPI advisors, who felt that interviewees too would expect matters relating to risk to be addressed differently. Under consideration of their guidance, it was decided to treat risk as separate from the continuum of distress and wellbeing. Specifically, as outlined above, the risk management protocol was developed to make clear the distinction between mild distress and concerns the researcher may have in relation to risk. Whilst potentially a source of informal support could be contacted if the participant was minimally distressed and was amenable to this intervention, in the case of the latter, there would be no question that the appropriate services would be contacted, regardless of the relationship or views the participant may have towards those services.

Another element formalised from experience in the parent study was the option for a participant to have a third person (i.e. a relative, friend, carer etc.) present during the interview. Some interviews had requested to do so in the prior project and so it was important to address in preparation for conducting this study. It was discussed in the ethics review that it should be made clear that in the instance of a potential participant choosing to be accompanied in interview, that person would be there in support of the interviewee rather than this being a joint interview. The decision was taken to ensure that it would be formally recorded in addition to the discussion that would take place during arrangements for the interview being made. A third person section was therefore incorporated into the consent form (Appendix C).

Finally, in relation to participant wellbeing, the consent process was designed to include a clear statement that interviewees could pause or stop at any time. This reinforced the information given to potential participants prior to participation (see Appendix D: Participant Information Sheet).

Ethical Review

Once the suggestions of the PPI advisors had been incorporated the ethics application was submitted to the University of Brighton External Research Ethics Committee (REC) Review Panel. Approval was received from this panel to proceed to the full REC subject to addressing feedback from two reviewers. The feedback predominantly related to making the Risk Management Protocol more

explicit about levels of distress and contingencies for managing this. Some additional comments were also made in relation to details within the Participant Information Sheets. Further alterations were therefore made to the documents to incorporate the guidance from these reviews.

The final application was then submitted to the REC and I attended a full REC review meeting the following month, accompanied by Professor Bendelow as my lead supervisor. During the meeting and in the feedback letter subsequently received, the committee also made several suggestions to further clarify the Risk Protocol, Consent Forms and Participant Information Sheets. Given concerns that participants be given ample opportunity to choose to withdraw from the study, the committee requested that a second stage consent process be created, to be completed after the interview. These changes were duly submitted, and full favourable opinion was received. In addition to the REC process, for all NHS research from April 2016 it became necessary to also gain approval from the Health Research Authority (HRA) before the study could begin, this process was commenced in parallel to the latter stages of the REC application and approval was also received from the HRA.

3.4 Chapter Summary

Continuing from the opening chapters in which the area of study was introduced alongside the bodies of literature that formed the framework upon which this research was based, this chapter has provided the justification of the methodological stance adopted in this work. My own position was first outlined; derived through experience working with vulnerable groups in applied mental health and criminal justice settings and my observations of the strengths and limitations of the evidence based practice employed in these contexts. Following this, Pawson and Tilley's realist evaluation was explained as an approach that was felt to be ideally suited to the task of developing an understanding of the complex range of social and psychological factors involved in repeated detention. This was accompanied by an account of the particular aspects of realist research used in this study to highlight the competing volitions and rivalries implicated in fuelling this phenomenon.

The methods section began by stating the research aim and questions. These were related to the central questions of traditional realist inquiry: what works, for whom, in what circumstances and why. The discussion progressed to detailing the data streams and analyses, explaining how a mixture of local and national qualitative and quantitative information was collected to address the research questions. Finally, the ethical considerations were outlined, underscoring how the perspectives of those with lived experience of distress and mental illness have guided the design and conduct of the study, as well as contributing to the analysis through the deliberative workshop process. Having reviewed the methodology and methods the following chapters will present the findings and construction of the provisional programme theory of repeated detention.

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4 FINDINGS I: DEFINING REPEATED DETENTION

4.1 Chapter Overview

The opening chapters introduced the gap in knowledge and understanding of repeated detention that this PhD has sought to address. Initially poorly understood and inconsistently monitored, Section 136 has long been an aspect of mental health legislation with which health services have appeared reticent to engage. However, particularly during the last decade its primary purpose to the police as suicide prevention has increasingly been recognised. Recent legislation has been aimed at effecting changes to end the use of police custody as a place of safety and to reduce the overall rates of use of S136. Yet it seems unlikely that achieving the latter will be possible without reducing the demand; effectively lessening the number of crisis situations that culminate in detention.

Like the crises that can lead to police intervention, S136 itself does not occur in a vacuum and so needed to be examined in a way that incorporated the important social elements which exert an effect. It has also been critical to gaining a comprehensive understanding of repeated detention that the experience of those so detained was placed at the heart of the study. As the previous methodology chapter described, the purpose of realist research is to understand what works, for whom, in what circumstances and why. Within what Pawson (2017) has termed a 'realist diagnostic evaluation' (see section 3.2.3) the focus of inquiry shifts from *what works?* to *what is the problem?* Thus, the related realist questions become *for whom, in what circumstances and why* does the problem occur?

This first findings chapter begins with a brief review of the data that has been used to address the topic before presenting the analyses which addressed the first elements of these questions, namely what is repeated detention, for whom does it occur and under what circumstances? The chapter does not seek to prove

the concept of repeated detention using statistical modelling but explores quantitative evidence that can assist in developing an understanding of the circumstances and characteristics of those who are detained recurrently. It also contends that although the phenomenon cannot be defined using a numerical boundary it is nonetheless widely recognised around England and Wales. Furthermore, this chapter will demonstrate that it is possible to identify distinct groups among people who are repeatedly detained and that consequently, these groups are likely to have specific support needs. This proposition gives rise to a further argument that any single approach is unlikely to successfully reduce repeat detention, leading to the second findings chapter which will present the lived experience data in relation to the final research question of why some people are detained in this way and what may help to disrupt these cycles.

4.2 Data Sources

As explained in the previous chapter, three streams of data were used to address the research questions. A detailed description of each of the data streams, including the justification for their use is provided in the previous chapter. The following section provides a brief description of the data that comprised each stream.

4.2.1 Data Stream One: Exploration of Local, Regional and National Practice

National Police Survey

The survey was circulated to the mental health leads of the 43 police constabularies that cover England and Wales by Mental Health Coordinator for the College of Policing and National Police Chiefs Council. The final self-selecting sample of survey replies comprised nine responses not including the four constabularies with which I had established collaborative relationships prior to distribution of the survey. Excluding the local collaborating areas this constituted a response rate of 23%. Although this was deemed satisfactory for the purposes of this study and the replies yielded some interesting information, the survey cannot be described as a complete census because not all forces made contact. The 43 constabularies are divided into 10 regions, which are used in the Home Office national reporting of S136 statistics. As Table 4.1 below indicates, a

diverse representation of England and Wales was achieved but as no response was received from two of the regions, the survey also cannot be considered a fully representative sample of all police areas in England and Wales.

Table 4.1: Police Survey Respondents

Police Region	Number of Forces	Number of Responses
North East	3	0
North West	5	1
Yorkshire and the Humber	4	1
East Midlands	5	2
West Midlands	4	0
East of England	5	1
London	2	1
South East	5	*4 (<i>Study Collaborators</i>)
South West	5	2
Wales	4	1

It is not possible to know why the remaining forces did not reply. One account for this may be that the non-responding recipients did not consider repeated detention to be a significant concern. As described in the opening chapters herein, S136 has generated a lot of public and media scrutiny in recent years, therefore it is likely that some areas chose not to respond from a sense of 'enquiry fatigue' (Baruch & Holtom, 2008). It is also probable that in the current climate of increasing demands and diminishing resources facing all public sector services, the survey was simply not prioritised. Furthermore, the pressure placed on police forces by preparing for the enactment of the Policing and Crime Act (PCA) will almost certainly have played a part. It is also possible that some may have anticipated the legislation creating solutions that would render this work obsolete and thus may not have considered the investigation of sufficient value to warrant a response. The moderate response rate itself addresses the question of how possible it is to identify repeat detention, indicating that a much more robust methodology would be needed to comprehensively identify repeated detention on a national level.

Local and Regional Practice: Secondary Data

Further contact was initiated by three areas replying to the National police survey: South Wales, City of London and Wiltshire. Within the correspondence that followed with these respondents, further information was discussed in relation to local practice around repeated detention and I was sent copies of some local policy documents. This data enhanced my understanding of how repeated detention was viewed in the contexts of those areas.

As described previously, at the start of the PhD collaborations had already been established within Sussex and with some neighbouring forces. Further regional collaborations were initiated within the first year of this research, this yielded four different datasets, including the comprehensive spreadsheet pertaining to Sussex that was part of the previous Section 136 project. These sources of data represented periods of time from 2012 to 2017 that ranged from 6 to 36 months. Whilst the Sussex dataset was the most comprehensive, it was possible to identify sufficient information relating to the total number of people, detentions and repeat detentions within each of the others to enable some inferences to be drawn, as shown further herein.

Local and Regional Practice: Ethnographic Observations

During the PhD I was given membership as the research liaison to the county-wide Mental Health Act Monitoring Committee jointly chaired by the Head of Social Work and Specialist Services at Sussex Partnership NHS Foundation Trust (SPT) and Sussex Police's Mental Health Liaison Officer. The meetings of this committee are held quarterly and are attended by leads or representatives for the Approved Mental Health Professional (AMHP) service, managers of the S136 suites and managers from the ambulance service, Child and Adolescent Mental Health (CAMH) services. The purpose of the group is to monitor operational issues in relation to the Mental Health Act in Sussex, including the rates of use of Section 136. As described in the opening chapter the PCA came into effect during this PhD. During the study I attended six of these Countywide Mental Health Act Monitoring Meetings between July 2016 and April 2018. Given the context discussed previously of the PCA being enacted during this time, many of the meetings at which I was present were concerned with preparation for these

critical changes. In particular, it was this committee who were responsible for local policies and practice around S136, including issues arising in relation to places of safety once custody was no longer to be considered an option in the majority of detentions.

Additionally, in relation to these preparations being made through the monitoring committee I was invited to attend two Section 136 Rapid Improvement Meetings held in 2017. The Rapid Improvement Meeting had originally been created the previous year to address a specific issue arising in relation to detention rates, however, as it had become clear that the PCA was proceeding and indications about the changes it would introduce began to emerge during the year prior to publication of the legislation, the meetings were retained as a forum for bringing together a wider range of professionals concerned with S136 in the county than attended the various management boards. The focus of the two meetings at which I was present involved developing contingencies for anticipated scenarios in which the HBPoS were full and custody would no longer be an option.

Finally, within Sussex, contact made through attendance at the above meetings led to me being invited to attend a police mental health liaison practice meeting arranged by the mental health triage nurses who were team leaders for the two East Sussex triage schemes in Hastings and Eastbourne. This meeting was attended by senior police officers, an AHMP lead and a matron from the ward on which one of the S136 place of safety suites in East Sussex is situated. A variety of practice issues were discussed including responses to “persistent callers”.

I was also invited to attend a multiagency training day and a multidisciplinary practitioner review meeting, both connected to the piloting of the Integrated Recovery Programme (latterly renamed Serenity Integrated Mentoring) developed in the Isle of Wight (Jennings & Matheson-Monnet, 2017). Both events were convened by the police sergeant who had devised the programme. The training day involved police officers, council workers and mental health staff and the multidisciplinary meeting and was attended by eight representatives of the local trust including Community Psychiatric Nurses (CPNs); a psychologist and a psychiatrist who had all been involved in the development and piloting of the programme.

4.2.2 Data Stream Two: Repeat Detainee Characteristics

In addition to the four datasets described in Data Stream One, a detailed spreadsheet was compiled and anonymised for me by the Mental Health Act Information and Quality Manager at Sussex Partnership Trust, who collates all monitoring data for Mental Health Act activity across the county. This spreadsheet comprised information on each incident of an individual who was detained more than once in East or West Sussex between 1st August 2014 and 31st December 2016, including the individuals' sociodemographic profile and details of the detention. The final dataset covered 28 months and comprised 563 detentions of 155 individuals. There were 34 instances of substantial missing data due to cases in which patients could not be located on the system or the MH1 forms, on which the details of the detention are recorded, not having been uploaded onto the patients' records. Missing data will be indicated where pertinent throughout the following sections.

Having outlined the data from which the findings were drawn, the next section of this chapter will progress to examination of the first research questions which attempt to address a definition of repeated detention.

4.3 What is Repeated Detention?

Research Question 1: To what extent is repeated detention a recognisable phenomenon in differing parts of England and Wales?

As discussed in the first chapter, repeated detention has not previously been defined in published literature but has been referred to in several studies, albeit in differing levels of detail. Therefore, an initial goal of this research was to attempt to advance a definition by establishing the extent to which repeated detention is recognised outside the immediate region of the study locality as well as to explore practitioners' perceptions of a characterisation. These elements were primarily addressed by the police mental health leads' survey and detention data collated from regional service collaborators; with the spreadsheet compiled for the study and information from the ethnographic observations also being used to

supplement this data. The first step taken was to investigate how widely repeated detention was recognised beyond the local area. The initial indication from my prior contact with the College of Policing had confirmed the broad impression I had gained from previous discussions with police and mental health professionals from elsewhere in the country, that repeated detention was a familiar issue. In attempting to quantify this within the study I sought an answer in the police survey as to what position had been adopted within the recipient's area on repeated detention (including an option that it was not considered an issue).

4.3.1 Recognition of Repeated Detention

With only one exception, all police survey respondents indicated that they were aware that some people were detained repeatedly in their regions, although the extent to which repeated detention was considered an issue of concern varied. Perhaps unsurprisingly, a greater level of concern was acknowledged from forces that covered large metropolitan conurbations. One respondent (R05; East Midlands) indicated that they did not recognise repeated detention as an issue, stating that only four patients had been detained more than once in the last eighteen months (two people detained twice and a further two who were each detained on four occasions). Whilst there was no indication in this response as to whether this was also historically the case, it may be of note that this area covered one of the locations in which the original UK Street Triage schemes were developed, prior to the Department of Health funded pilots referred to in the opening chapter (see section 1.3.4). Although the reply did not reference the scheme, a well-established multiagency partnership that related to Street Triage was clearly evident from this area as the survey had been sent by the police recipient to an NHS colleague who responded.

The impact of Triage was more apparent in the reply of another survey respondent who stated his area no longer considered recurrent detention to be a significant issue, which he attributed to the scheme:

“[W]e have drastically reduced our use of S136 and also repeated S136 both improved partnership working and better practices driven by Street Triage. Triage also allows for earlier intervention and we have seen less issues with repeat callers than in past years” [R04; East Midlands].

4.3.2 Defining Repeated Detention

The consensus among police respondents was that repeated detention was not something that could be strictly defined in numerical terms. Although some areas provided example time frames, such as two weeks (R08; Wales), six months (R03; East of England) or eighteen months (R05; East Midlands) each stated these were not strict criteria and that it was more the recurrence of detention itself that should trigger concern. As one respondent put it:

“[W]e may identify individuals who may not fit within that [14 day] criteria, but who are presenting frequently... and we would look into this also” [R08; Wales].

Other respondents did not give exact criteria, in general this appeared in concordance with the approach described by all survey informants, one reply summarised it thus:

“Anyone detained more than once should be considered carefully because it points to needs that haven’t been addressed” [R04; East Midlands].

Similarly, another respondent stated that:

“The frequency cannot be defined in generic terms; it is bespoke to the individual circumstances of the incidents and the individual concerned” [R07; Yorkshire and the Humber].

Finally, perhaps the most conclusive observation that flexibility was necessary in defining frequency was conveyed thus:

“We have previously tried to dictate a frequency to alert a professionals meeting etc e.g. twice in 30 days 3 times in 6 months, but it was not successful.” [R09; North West].

The replies from the police survey indicated that the concept of repeated detention is not easily defined in numerical terms, indeed the responses appeared unanimous in feeling that quantifying either the number of detentions or the time frame within which they take place, would be less productive than taking recurrent detentions on a case-by-case basis that examines individual circumstances. A similar observation has recently been made that whilst frequent presentation to A&E seems to be universally recognised and much more extensively researched than recurrent S136 detention, an exact classification for ‘frequent presentation’ has yet to be advanced (Tye, 2018). A fixed definition may

not be possible or particularly productive in either case. Certainly, in relation to S136 any recurrent detention may indicate unmet need, as was suggested by the police respondent quoted above, so the timeframe within which it occurs may be a less relevant factor. Hence, maintaining flexibility in the interpretation of the concept may hold a greater utility in practice. This will be explored in more detail subsequently. Whilst it may not be possible to provide a precise boundary, repeated detention certainly appears to be a widely recognised phenomenon. The following step taken was to attempt to examine the extent to which it may occur.

4.3.3 Extent of Repeated Detention

Unfortunately the police survey did not yield information on the rate at which repeated detention was seen in respondents' areas, however the three sets of regional data obtained through local collaborations each contained sufficient data to be combined with the anonymous Sussex data that constituted Data Stream 2, as well as the prior dataset from the *Section 136 in Sussex* study (Bendelow et al., 2016) which had examined a separate 12 month timeframe. Altogether this provided five different sources of information and these revealed an interesting pattern. Table 4.2 below presents the key information:

Table 4.2: Proportion of Repeated Detentions in Collaborating Areas

Area	Length of dataset reported	<i>Total Number of</i>		<i>Proportion of</i>	
		Detentions in dataset	People in dataset	Detentions that were repeats	People who were detained repeatedly
A	28 months	2611	2203	22%	7%
A	12 months	1421	1142	30%	13%
B	36 months	1091	821	37%	16%
C	12 months	171	69	32%	12%
D	6 months	601	475	32%	13%
Average		1179	942	31%	12%

As can be seen, despite the different timeframes and geographical areas that are represented in this table, the lack of variation in the proportion of detentions and,

to a slightly lesser extent, the proportion of people who constituted the repeat detention cohorts in each dataset are striking. It appears that a consistent average emerged such that people being repeatedly detained make up around 31% of detentions.

The research of Pipe et al. (1991) referred to in the opening chapter had reported 34% of the people whose records they reviewed had been detained under Section 136 on more than one occasion. Taken in combination with this finding, it is possible to infer that the proportion of people who are detained more than once may also have been remarkably stable over time, despite the substantive changes outlined in the opening chapters. More recently, research published by Burgess, White and O'Brien (2017) described a follow up conducted on a cohort of people who had been detained to a London health based place of safety under Section 136 during a period of 6 months in 2012. This study reported that 17% of the original 242 people detained were subsequently re-detained in the year following the date of initial Section 136. A further element of the Burgess et al. study was the difference in the number of times people were reported as having been detained. Although specific data on frequencies of individual detentions was not reported, some information was available that is presented in the next section.

The police survey indicated respondents were disinclined to put forward a precise frequency with which recurrent detention would be considered problematic, however quantitative data appears to suggest that a distinction may be drawn between people detained twice and those detained with much greater frequencies. This issue points to consideration of the second research question, which relates to the heterogeneity of individuals who are detained on multiple occasions, this chapter now turns to examination of Research Question 2 examining the characteristics of people who are repeatedly detained.

4.4 Who is Repeatedly Detained?

Research Question 2: Are people who are repeatedly detained a single heterogeneous group or are there any distinct characteristics within a sample of people who have been detained on multiple occasions?

This second research question points to two aspects of the realist formulation of inquiry, namely ‘to whom does the problem relate and under what circumstances?’ Each shall be examined in turn. Data addressing this component of the study were primarily drawn from the anonymised spreadsheet of recurrent detentions in Sussex covering a 28 month period.

4.4.1 Home Areas of People Repeatedly Detained

As mentioned herein previously, one issue within the locality of study its partly coastal location and the transport hub of Gatwick airport, which both elevate the number of detentions in part by attracting people from other parts of the country and beyond. As a result, one aspect investigated in the present research was where people who were repeatedly detained were from. The person’s home area was divided in line with the main SPT localities and Place of Safety provision, therefore although Sussex is in reality divided into two counties East and West this following data is presented as sub divided into four regions. People who lived outside Sussex were divided into those from the adjacent counties of Hampshire, Surrey, or Kent, who were categorised as ‘Out of Area-Neighbouring’. The people who were recorded as having any other home area were nominated ‘Out of Area-Remote’.

The 46 detentions of 16 people from outside the area confirmed that whilst it is not the greatest contributory factor to repeated detention, there is an issue within Sussex related to people travelling to the area from elsewhere. Indeed, one of the people from a non-neighbouring area was detained seven times, another person from a neighbouring county was detained in Sussex on five occasions and a further three people from non-neighbouring areas were detained on four occasions. This data corroborates the concerns that had been raised by multiple local sources that the ‘hotspots’ particular to Sussex that are recognised as drawing some people to the area also repeatedly exert this effect on some individuals.

As described in more detail in the following chapter, two of the lived experience interviewees who had been detained high frequency in Sussex both lived out outside the county and both had also been detained on multiple occasions in their home areas, although each told me they were less likely to be detained by their

local police forces than when in Sussex. The implication from this is twofold. Firstly, it shows that nationwide data collection would be needed to properly gauge the extent of repeated detention. Secondly it suggests multiagency support plans may need to be developed in collaboration with services from different regions, certainly for areas such as Sussex where there is a recognised issue with people travelling to certain locations. Both of these issues are considered further herein.

Two locations within the area were reported in our previous study as likely to have been responsible for this, the presence of the highest cliff in the UK, which despite multiple long-standing measures that have been implemented by public health and other bodies, retains an unfortunate international reputation as a 'suicide hotspot' within the definition discussed in the opening chapter (Cox et al., 2013). Secondly, we had identified that a disproportionate number of detentions were linked to Gatwick airport. Within the present dataset, a total of 5 detentions of three individuals originated at Gatwick. Of these, one person was detained twice, on both occasions at the same location, a second person who was detained three times in total was detained there twice and the third person was detained on seven occasions, one of which was at Gatwick.

Table 4.3: Home Area and Number of Detentions

Home Area	<i>Total Number of</i>			
	People		Detentions	
East Sussex	51	(33%)	192	(34%)
Brighton & Hove	35	(22%)	127	(23%)
West Sussex	28	(18%)	129	(23%)
North Sussex	18	(12%)	51	(9%)
Out of Area-Remote	11	(7%)	33	(6%)
No Fixed Address	7	(5%)	18	(3%)
Out of Area-Neighbouring	5	(3%)	13	(2%)
Totals	155	(100%)	563	(100%)

This indicates that whilst a key location for single detentions, the airport does not appear to be a key location for people who are repeatedly detained. In contrast,

70 detentions were made at, or directly related to Beachy Head. Furthermore, of the 29 individuals who were detained at Beachy Head only nine were detained there once. This location was also a recurrent factor in the detentions of seven of the people who were detained on five or more occasions.

4.4.2 Gender and Number of Detentions

As indicated in the opening chapter, the established gender profile of those detained under other parts of the Mental Health Act, and indeed the national statistics published for overall uses of Section 136, consistently report over 50% of those detained are males (Home Office and Department of Health, 2014b; NHS Digital, 2016, 2018) So too were a greater number of males detained in the cohort described in the Burgess et al. (2017) study referred to above, although the authors did not specify gender in relation to their repeated detainees. In contrast, the present repeat detention cohort reversed this trend with 85 females (55%) and 70 males (45%) having been detained more than once in the index time frame.

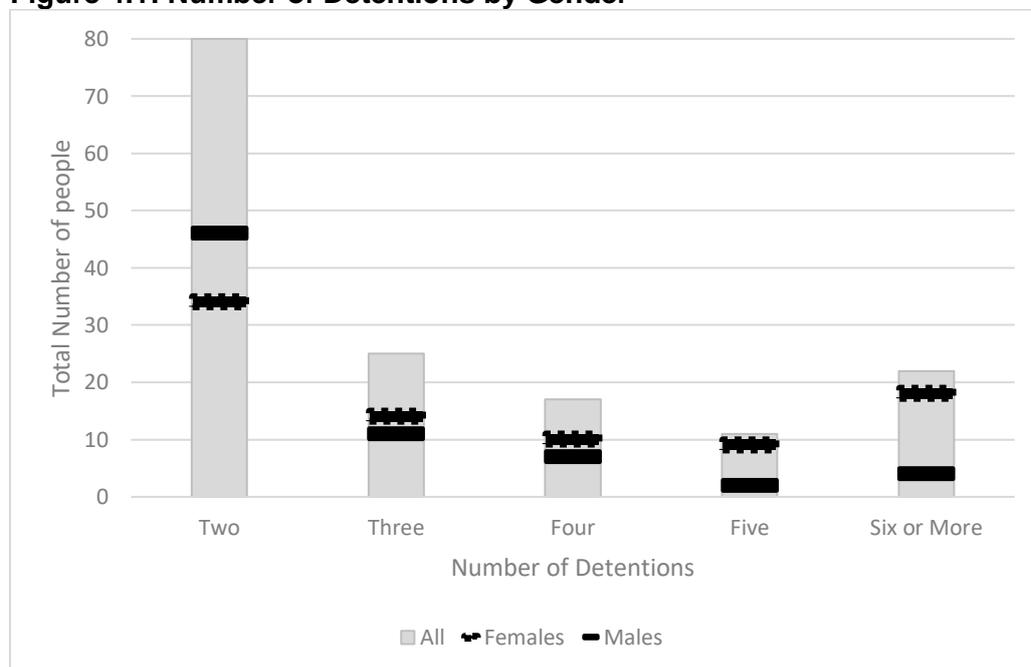
The previous *S136 in Sussex* study data, there was a notable difference in the number of people recorded to have been detained twice during the time frame. The Burgess et al. research did not report the number of times with which people in their study were detained, however the authors did state that 39 of the people in their cohort who were repeatedly detained were subject to between one and four further detentions and that two people were both detained on more than 10 occasions. Their findings echoed those of our parent research that most multiple detentions were people being detained twice and the current dataset provided further support for this. In total, 80 people (48% of individuals) were detained on two occasions and constituted 52% of all detentions. Among the remaining seventy-five people who were detained three or more times, the highest number of detentions for an individual was 19, followed by 15, 14, 13 and 12.

As predicted by the prior Sussex study and the present literature review, gender constituted a stark differential factor within the data. A slight difference was observed from the parent project results in which more males than females were detained respectively on two, three and four occasions. As shown in Figure 4.1 below, this data revealed that whilst more males were again detained twice,

females then outnumbered males in all other frequencies of detentions. As had been observed previously, the gender difference also became much greater at five and more detentions with females appearing exclusively in the group of individuals with the highest number of detentions (those each having been detained on between 12 and 19 occasions).

Examining the highest frequencies 18 females and four males were detained on six or more occasions. Specifically, two males and three females were each detained six times; one male and four females were detained seven times; two females were each detained eight times; one female was detained nine times; one male and three females were each detained ten times, and the remaining seven highest frequencies were females. The differential gender profile found overall concurs with that recently reported by Eswaravel and O'Brien (2018) in a longitudinal study of adolescent detentions under S136. The authors found that more females than males were detained among those aged under 18, with the majority constituting 16-year-old females of white ethnicity who had been placed under Section 136 for self-harm or attempted suicide. In considering repeated detention, these findings indicate gender is a highly significant factor, differentiating this particular cohort from the wider population of people who are detained either on one or two occasions.

Figure 4.1: Number of Detentions by Gender



4.4.3 Gender and Age

Whereas there was a difference from the trends observed relating to gender, the findings on age indicated those repeatedly detained did not appear to differ greatly from the broader cohort of all people detained. National data reported by NHS England (NHS Digital, 2017; 2018) indicate the modal age range for detention is 18-34 with the fewest number of people detained being aged 65 and over. In the current data, Table 4.4 shows two people who were aged between 60 – 78 were detained on five occasions and the average age of people detained repeatedly was 32. Splitting the groups by gender revealed that the males who were recurrently detained were on average slightly older, having an average age of 34 whereas the females had an average age of 30.

Table 4.4: Age of People Detained by Gender and Number of Detentions

Number of Detentions	Number of People	Gender	
		Male	Female
Age Range (Mean)			
Two	80	15 – 54 (34)	16 – 78 (33)
Three	25	18 – 64 (36)	18 – 51 (27)
Four	17	26 – 55 (38)	15 – 44 (28)
Five	11	21 – 24 (23)	19 – 52 (32)
Six or more	22	23 – 44 (30)	16 – 50 (27)
Total	155	15 – 64 (34)	15 – 78 (30)
All		15 – 78 (32)	

Consideration of this data by number of detentions per individual revealed a little more variation but shows ages were still clustered around 30 years. The present recurrent detention data therefore indicates that in contrast to the gender patterns discussed above, the age distribution appears be in line with national data.

4.4.4 Ethnicity and Number of Detentions

Within the present data, seven people (representing 5% of all in the dataset) who were detained 17 times (3% of total detentions) had no ethnicity recorded at any point. The ethnicity of the vast majority of people detained was recorded as 'White UK' with 135 people (87%) falling into this category and accounting for 505

(90%) detentions. The remaining 13 (8%) people who were detained on 41 occasions (7%) were collapsed into an 'Any other ethnicity' category. Seven people who were originally recorded as 'White other' were included in this group because of the small numbers of under consideration; no other ethnicity was represented by more than one person. Eleven of those appearing in the 'any other ethnicity' category were each detained on two or three occasions. The remaining two people in this group who were detained on more than three occasions were both identified as of 'White other' ethnicity. The disproportionate detention of people of black and minority ethnic origin was discussed in the opening chapters as being an area of concern more generally in both the mental health and criminal justice systems and the overrepresentation of people of black ethnicity relative to the population as a whole within the annual S136 data reported by NHS Digital. The present data suggests that within the South East coastal areas at least, ethnicity appears less of a concern among those repeatedly detained under Section 136.

4.4.5 Type and Number of Diagnoses and Detentions

Thirty-six people had no diagnosis recorded on 87 of their detentions and were excluded from the remainder of the present analysis of diagnosis. A further two people who were detained seven times had no recorded mental health diagnoses connected to their records but the notes of both people stated they were problematic drug / alcohol users, these were collapsed into the 'other' category for analysis purposes.

Excluding those with no recorded diagnosis who were marked 'unknown', for the majority of people (111) recorded diagnoses did not differ between their 415 separate detentions. In one instance, there was a slight variation in the condition noted on the middle of the individual's three detentions and another person had three diagnoses recorded on the notes of their first three detentions but only one of these recorded in their subsequent four detentions. Two people who were detained nine times in total, had entirely different conditions listed between their detentions; for the first person, this was a different diagnosis on their first detention, where two conditions were listed and then a different condition identified on their subsequent three detentions. In the second such instance the

same diagnosis was recorded on the notes the first three times the individual was detained and then a different condition was listed on the fourth. A further six people who were detained on 29 occasions (each between four and six times) had additional conditions noted in later detentions that then remained consistent on subsequent records. Finally, one person who was detained eight times had three conditions listed on the first three occasions they were detained but only one of these on their latter five detentions.

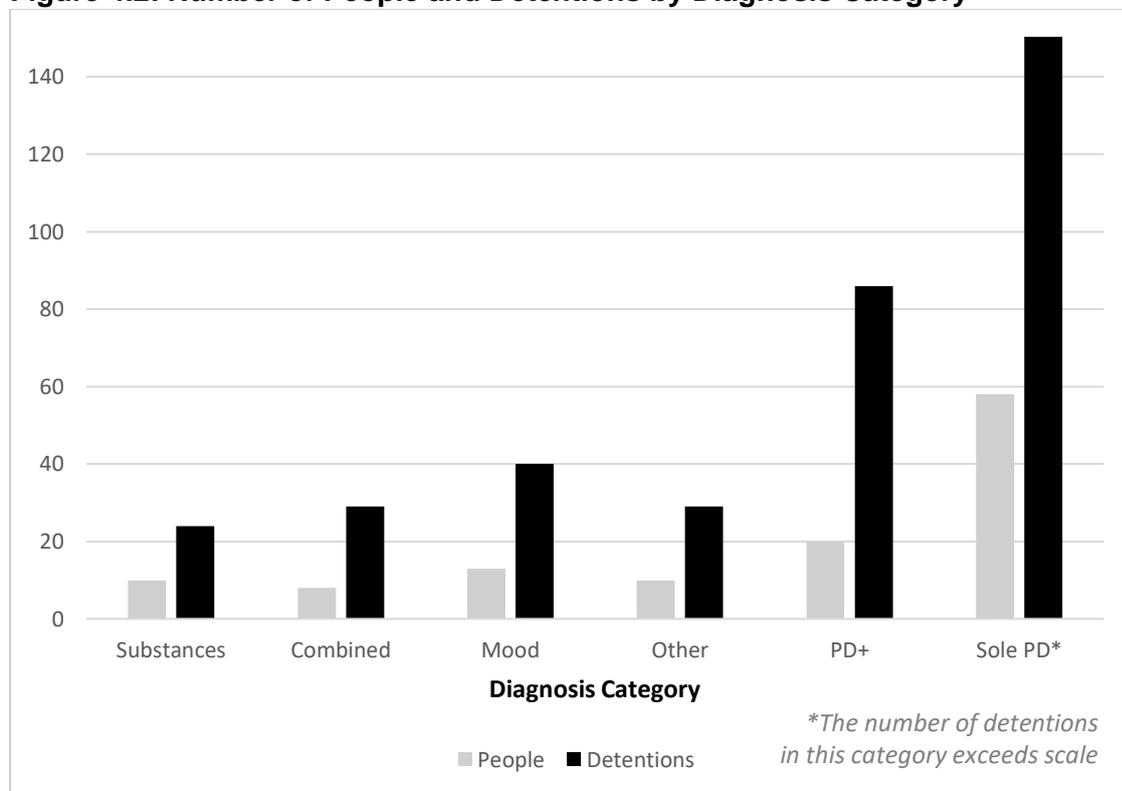
Without further information on why these individuals were recorded as having different diagnoses it is not possible to draw definitive conclusions, however these 56 instances are of note in relation to the debates presented in the initial chapters around psychiatric diagnosis. It is also not possible to know how the assessments for these individuals may have been impacted by these differing diagnoses. Relatedly, multiple diagnoses were not uncommon. A single diagnosis was recorded in relation to 307 detentions (55%) but in 28% (159 detentions) different diagnoses were documented. In most instances (82, 15%) two diagnoses were recorded. Three conditions were related to a further 58 detentions (10%) and four diagnoses were listed in relation to 19 detentions (3%).

Figure 4.2 presented below indicates that the greatest number of single diagnoses linked to the highest number of detentions was personality disorder. Sixty-one people (39%) with single diagnoses of personality disorder accounted for a total of 273 detentions (48%). The majority of instances were linked to diagnoses of borderline or emotionally unstable personality disorder. Schizoid personality disorder and emotional intensity disorder also appeared in this category. A further twenty people (13%) who were detained on 86 occasions (15%) were recorded as having multiple diagnoses that included some form of personality disorder.

Eight people (5%) with other comorbid diagnoses (not including any form of personality disorder) accounted for 29 detentions (5%). Thirteen people (8%) recorded as having mood or anxiety disorders including depression; dysthymia; bipolar affective disorder and generalised anxiety disorder, accounted for 40 detentions (7%). Ten people (6%) who were detained 24 times in total (4%) were identified as having *'mental and behavioural disorder due to alcohol,*

cannabinoids or other substance abuse but with the exception of these instances substance misuse rarely featured as a pertinent factor within the diagnoses recorded. Twelve people (7%) with other single diagnoses that included psychoses, learning disability and post-traumatic stress disorder accounted for a further 29 detentions (5%).

Figure 4.2: Number of People and Detentions by Diagnosis Category



Given the indications presented in the initial chapters around mental health crises and suicide, the comparatively small number of people and detentions linked to mood and trauma related diagnoses is surprising. However, these findings do echo those reported in the extant research specifically focussed on S136 presented in first chapter, albeit those studies had mostly been based on much smaller samples, such as Spence and McPhillips (1995). Further support for the dominant presence of personality disorder diagnoses also came from the ethnographic and regional work. All participants who originally engaged in the Hampshire specialist programme for repeated detention had diagnoses of borderline or emotionally unstable personality disorder (Jennings and Matheson-Monnet, 2017). Likewise, one respondent to the police survey, who was from a

densely populated metropolitan area (R09; North West) referred to working with the personality disorder team in her Trust as part of her area's response to repeated detentions.

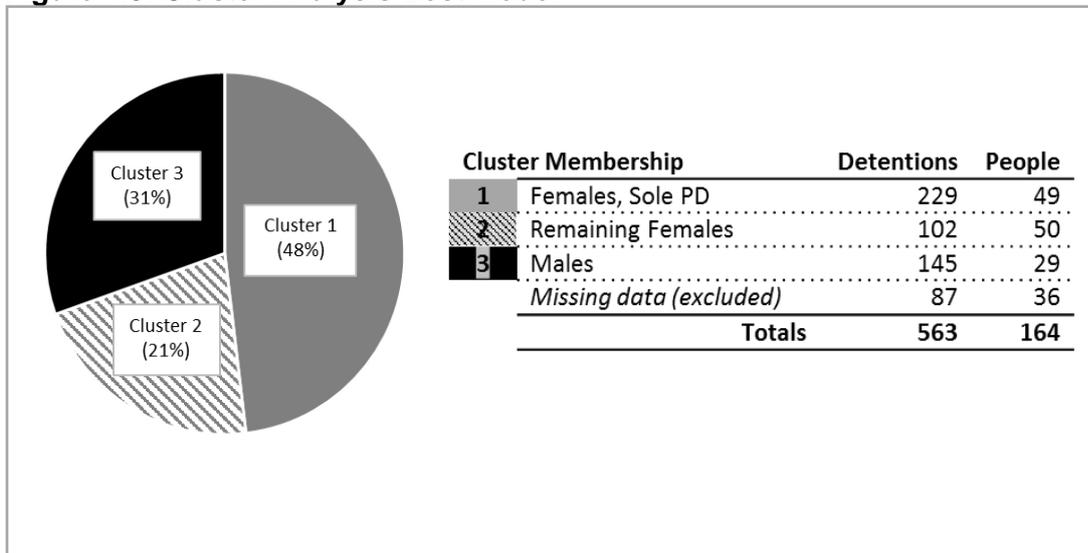
Whilst this data provides very strong support for the diagnosis of personality disorder being highly visible in the records of people who are repeatedly detained, and especially so for those detained with high frequency, this correlation is of no explanatory value. To indicate a more comprehensive account for the phenomenon, the latter elements of the realist inquiry framework need to be considered, namely under what circumstances are people repeatedly detained and critically, why? The latter aspect will be reviewed in the following chapter but first the present consideration will turn addressing the former question, which is more nuanced to the context in which multiple detentions occur.

4.4.6 Sub-groups within Repeated Detainees (Cluster Analysis)

Cluster analysis is a technique to explore data in order to look for groupings (Everitt, 1993). Given the size of the final data set, two step cluster analysis was selected as the technique best able to manage a large quantity of data as well as mixed categorical and continuous data. Log-likelihood was used as the distance measure (further explanation of cluster analysis is provided in the previous chapter, please see section 3.3.6). SPSS (Version 25) was used for this. As described above, a number of differences were recorded in some individuals' diagnoses on different occasions, which resulted in eight individuals appearing in more than one category. Accordingly, this analysis was run on the detentions rather than the individuals within the dataset. Diagnosis was included in all models tested using the simplified categories of 'Sole PD' which constituted each detention where the person's record noted they had a single diagnosis of any personality disorder; 'PD+' representing each incidence of a person having been recorded as having any personality disorder alongside one or more other diagnosis and a final category of 'Any Other' comprising any detention in which the person was recorded as having any diagnosis that did not include a personality disorder. As previously explained, the 36 cases corresponding to 87 detentions in which the person had no diagnosis information or the detailed record of their detention had been missing were excluded from the analysis.

The best model produced contained three separate clusters that were comprised of three factors (Figure 4.3 below; please see Appendix E for model summary). Gender made the strongest contribution to defining cluster membership, followed closely by diagnosis. Age made a small additional contribution, however testing the model without including age produced a weaker result.

Figure 4.3: Cluster Analysis Best Model



Cluster 1 formed the largest grouping, comprising 229 detentions (48%). This group contained 49 individuals who were all female and each had a single recorded diagnosis of any personality disorder. Excluding those with no recorded diagnosis at detention, 69% of the females in this sample fell within Cluster 1. This group had an age range of 17 – 52 years, with a mean age of 27.

Cluster 2 constituted 21% of the model representing 102 detentions. This group was comprised of the remaining 29 females having a diagnosis recorded at detention (31%). A comorbid diagnosis of a personality disorder was the most frequent category, accounting for 50% of the diagnoses in this group. The age range for Cluster 2 was 14 – 52, with a mean age of 28.

The final group was Cluster 3, constituting 145 detentions of 50 individuals, all of whom were male. Within this group, 12 individuals who were detained 31 times had a sole diagnosis of personality disorder. The model indicated that the largest proportion of diagnoses in this cluster was the ‘any other’ category, which

constituted 56% of the diagnosis types in this cluster. The age range for this Cluster was 14 – 64, with a mean age of 34.

Within each of the three clusters age was not normally distributed (see Appendix F for Distribution Charts). Given the cluster analysis was conducted on detention incidents (cases) rather than individuals within the data, the occurrence of repeats would account for this; ages of people who were detained with very high frequencies during the 28 months would have been represented multiple times, thereby skewing the data. A Non-parametric test was therefore conducted on the age data presented in Table 4.5, below.

There was a significant difference between mean ages for the clusters ($H = 34.54$, $df 2$, $p < .05$). Given the small difference between mean age in Clusters 1 and 2, the likelihood was this difference was present in Cluster 3, comprised of the males who were repeatedly detained.

Table 4.5: Table 4.5: Average Age by Cluster Membership

Cluster	N	Mean Age	(SD)
1 Females with Sole Diagnosis of Any Personality Disorder	229	27.38	(8.21)
2 Females with Any Other Diagnosis	102	28.07	(9.85)
3 All Males in Dataset with Any Diagnosis	145	34.01	(11.12)

The cluster analysis and overall diagnosis data reported above indicate strong support for the existence of a link between a diagnosis of personality disorder and repeated detention. Furthermore, this finding indicates the largest grouping of people who are repeatedly detained reverses the general trend data that is reported nationally for all S136 detentions, in which most detentions are of males. This indicates that the population of those who are detained repeatedly differs significantly from the overall cohort of people detained under S136. Additionally, as stated previously, according to nationally reported data the majority of those detained are males falling in the 18 – 35 year age group, therefore it is possible that the cluster of males in the present dataset may more closely resemble those

'typically' detained. However, the aim of this research was to understand not just *who* is subject to recurrent detention but critically *why* this occurs. As discussed in the literature chapters, it has been suggested that between 14% - 17% of the general population may meet the criteria for diagnosis of a personality disorder (see section 2.3.4). Clearly, repeated detention would be more prevalent if people who could be diagnosed with a personality disorder were all repeatedly detained. Hence, having this diagnosis cannot of itself provide an explanation for how some people come to be detained on a repeated basis.

Realist research views the context as a key element of how outcomes, such as detention by the police, are produced. The following section will therefore now begin the exploration of the circumstances surrounding recurrent detention as suggested by the quantitative Sussex data.

4.5 Under What Circumstances are People Repeatedly Detained?

4.5.1 Reason for Detention

The bodies of literature reviewed in the opening chapters provided a clear indication that suicide and self-harm would be significant factors in recurrent detention. Similarly, although the police survey did not specifically ask for information about the circumstances of detention the reply from one respondent whose force covered a densely populated metropolitan area (R06) stated that a recurrent factor in the repeat detentions within their jurisdiction was "*threatening suicide*" at certain locations that would carry a high risk of harm in line with the 'hotspot' definition given by Cox et al. (2003) referred to in the opening chapter (see section 1.5.1).

Of the 563 detentions in the 28 month Sussex dataset (Data Stream 2) the reason for detention was unknown in 40 incidents (7%). Suicide or deliberate self-harm was the reason for the greatest number of detentions (481), excluding those cases with missing data this equated to 92%. Seventy of these incidents involved Beachy Head. Detention appeared to have been made because of a risk of harm to others or behaviour that may have been deemed bizarre in a further

42 cases (7%). It is further of note that in 16 of these cases, the record mentioned that the person had also expressed a desire to harm themselves or to end their own life but that appeared likely to have been a secondary consideration to the threat posed to others at the time of detention. One example of this was an incident in which the person who was detained had self-harmed but when the police arrived the person was seen to be threatening others who were present. Another example was a person disclosing that they were experiencing voices telling them to harm others who told police they wanted to end their own life as a result of this.

This data categorically supports the assertion that repeated detention is almost always linked to suicide prevention or self-harm. With the high prevalence of suicidality (suicidal thoughts and actions) and self-harm linked to personality disorder diagnoses, these two findings appear to support the literature reviewed in the initial chapters. Yet, as has already been argued, although the self-destructive behaviour that may be linked to the presence of such a diagnosis may provide a reason for the police action of detaining a person for their own safety, it does not explain why that situation has arisen causing a person to become actively suicidal. Nor does it offer an account of how recurrence of detention may be reduced. As was expounded in the earlier chapters, the diagnosis of personality disorder, suicidal behaviour, and indeed police action all arise within complex social contexts and it is therefore important to understand the interactions that take place within those contexts.

4.5.2 How Police Were Alerted

The information detailing how the police came to be aware of the person or the situation that led to detention is not specifically recorded on the form that is completed to record the details of each S136. Most notes did give sufficient detail for this field to be populated, however it was not possible to ascertain how the police had been alerted on 172 occasions, which constituted 30% of the dataset. Where data was available, 93 different entries initially appeared in this category but on further consideration it transpired that many of these were variations of similar information, such as paramedic; ambulance crew; ambulance staff. A new variable was therefore created for analysis which collapsed the detail into seven

categories (see Figure 4.4 below). The number of cases appearing in each category are presented in brackets with a description of the main entries that constituted each subcategory. As this shows, an interesting pattern emerged for the incidents where detail was available on how the police had been alerted to the situation that resulted in each detention. As discussed in the previous literature (see sections 1.4.5, 1.5.4 and 2.3.5) a commonly made assertion in relation to people who are recurrently suicidal, especially once labelled with personality disorder, is that they are not serious or only 'attention seeking'. This is indicative of the negative views frequently objected to by advocacy groups that are reminiscent of Jeffery's 'normal rubbish' (see section 2.2.5). Allied to this view an opinion was expressed on multiple occasions that those being detained recurrently were not 'really' suicidal. One mental health practitioner gave the example in a meeting observation of commonly being called to assess someone who they had seen the previous day (on a previous S136 detention) and who had said they would '*kick off*' if they were not admitted.

Examining the data on how the police were alerted however revealed that someone close to the person, a partner, friend or member of their family called the police most often: 93 times. A member of the public alerted the police on 85 occasions and various non-mental health related services contacted the police in 28 incidents. On 60 occasions the police were alerted by healthcare staff, this included A&E when the person had absconded partway through treatment for overdose or self-injury. Mental health services alerted the police on 21 occasions.

The police themselves initiated contact on 16 occasions. This including Street Triage patrols: a team in which a senior psychiatric nurse, usually drawn from the Crisis Team, accompanies a police officer in responding to calls to the police that are related to mental health. It should be noted that although having been recorded as the police having initiated contact, most of the situations involving Street Triage are likely to have originated through an external party contacting the police and Triage having been assigned to respond. However, the absence of this data was not the sole reason for collapsing this category to the overarching classification of 'police'.

Figure 4.4: How Police were Alerted

Family (93)

Any relative, partner, spouse or friend. Carers were also included in this category as the original data did not detail whether carers were formal employed or familial.

Person (88)

Instances in which the person detained made contact, including having called or emailed an allied service.

Public (85)

In addition to members of the public, shop staff, taxi drivers, station staff and hotel workers were also included in this category, as were neighbours.

Healthcare (60)

Any physical health care services were placed into this category, including paramedics, emergency department and hospital security staff or GP practices. Telephone service staff, such as 111 and Mental Health Line were also grouped into this category

Allied Services (28)

This category contained all non-statutory services not otherwise covered but involved in mental health or welfare, chaplains at the Beachy Head coastal patrol, hostel or accommodation staff and Samaritans.

Mental Health (21)

Community Mental Health Team, Crisis Team, staff from any community or inpatient mental health settings (as opposed to hospital staff), support workers and mental health placement staff

Police (16)

Included Street Triage and Automatic Number Plate Recognition alerts or police CCTV operators.

During ethnographic observations both nurses and police officers working on the Triage patrols had spoken about times when they are not 'tasked' to dealing with a matter to which they had been called. In these discussions they had described predominantly 'patrolling' in these times. This may be visiting areas where homeless communities are known to frequent or following up on people with whom they have had prior contact. Thus, a Street Triage team may spontaneously discover a vulnerable person without having been directed to that individual, as much as can be the case with a neighbourhood police patrol. The detail of more than one of these records stated '*Found by Street Triage*' thereby making it unclear whether Triage had already been looking for the individual

under circumstances in which they may have been asked to search for a vulnerable missing person, or whether they had come across the person by chance.

As discussed in Chapter 1 (section 1.3.4) Rogers (1990) reported on how contact resulting in detentions had been initiated and found that most often it was members of the public who alerted the police, with police initiating contact in only a very small number of cases. Rogers' conclusion was that S136 thereby provided an example of social control from below, namely being generated from the public not the 'state' as was considered in the literature reviews. This assertion would appear to remain valid almost thirty years later, regardless of the very different social context in which the police are now operating.

A further key aspect of the question of how the police to be involved in situations that result in recurrent detention is the cases in which the individual had contacted the police directly. Instances of the detained individual initiating contact with the police were raised by practitioners in a number of the ethnographic observations as assumed to be linked to personality disorder; these examples were cited as examples of the archetypal attention seeking or manipulative behaviour, often described by both police and mental health professionals as the person "saying" they're suicidal, the implication of this phraseology being that the person was driving a set of circumstances using language from which they anticipated a specific response. On initial coding, the police were alerted by the person themselves on 88 occasions. Yet interrogation of the qualitative description provided in these cases revealed considerable variation in the nuances of those situations.

Further examination of the 88 cases that stated the person had contacted the police sub-divided the records into four further categories. In nine instances no qualitative data was provided, or it was unclear from what was recorded how the person had contacted the police. In twelve cases the notes stated that the individual had contacted the police but the qualitative notes indicated that another agency had been involved, for example multiple records stated the individual had called the emergency services rather than specifically the police or had called the mental health line (a telephone support and information service run by the

secondary care mental health trust). In other such instances the person had first contacted staff at locations such as Gatwick airport or train station workers. The third sub-category yielded a further eight detentions that were linked to the individual having initiated contact with the police, but the qualitative notes referred to the person having first made contact with another service that they had then either left or been sent away from. For example, on several occasions the individual had gone to A&E after self-harming or taking an overdose, and then either had been discharged or medically cleared or had left.

Whilst the precise detail of these prior contacts was not available it appears clear that in many cases the person had attempted to access some form of assistance from services other than the police. In some of the acute hospital examples there had been some form of conflict with staff noted that was connected to the person having left. One person who was noted to have contacted the police directly had been detained earlier but had absconded from the Section 136 Suite. Although no further detail was provided this incident is of additional relevance to the study of people who had come to police notice then subsequently fled, which was discussed in section 1.4.5 of the opening chapter (Pakes et al., 2014). In the present research, absconding may appear to provide a tangible example that parallels can be drawn between the cases that were described in the Pakes' research and the repeated detainees in the present dataset. In total there were 27 mentions within this data of the person attempting to or having absconded, in many cases this was prior to being detained, usually when the police had been alerted by others and the person had then been located. However, there were also multiple instances of individuals having absconded from hospital in some cases after prolonged waits in emergency departments or prior to completing treatment for overdose.

Seeking or initiating police contact directly, for example calling the police from a 'hotspot' location and advising them of suicidal intent was linked to 59 detentions. Further examination of these instances showed that almost half (28) were linked to eight people who had between them been detained on a total of 46 occasions within the dataset. The majority or all of the detentions of these eight individuals fitted this pattern of directly initiating police contact when suicidal. Six within this

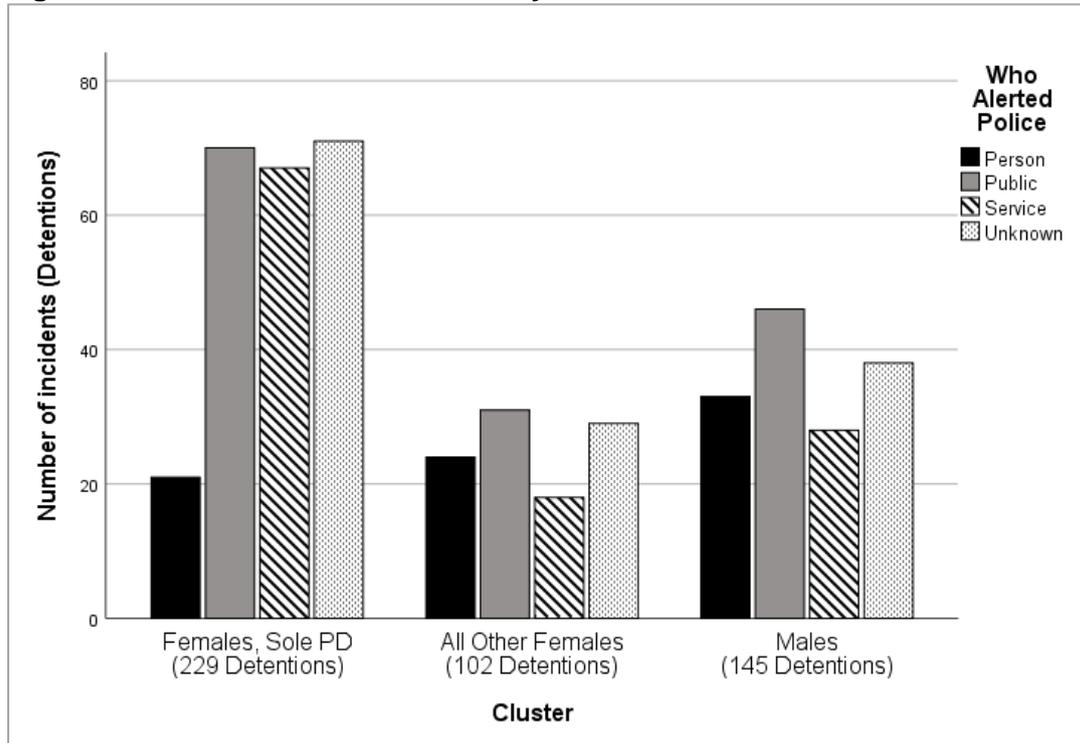
sub-set of people were males; one of the eight had no mental health diagnosis but was recorded as a problematic alcohol user. One other person had a diagnosis of multiple developmental disorders. The remaining six all had personality disorders with additional conditions. Therefore, it is interesting that the 'typical' repeat detainee profile described by service staff to be a female with a diagnosis of personality disorder who is detained following threats of suicidal behaviour does not appear to have been supported within this element of the data.

On occasion within ethnographic observations a distinction was made by practitioners between people who were detained as suicide prevention or due to self-harming and "*very unwell people*". A phrase that was used to denote those experiencing unusual phenomena or psychotic episodes, echoing the persisting uncertainty within the mental health profession as to whether personality disorder is a 'real' mental illness discussed earlier (Kendell, 2002, see section 2.3.5). Therefore, it is of further relevance to note that of the total number of 88 incidents where initiating police contact was attributed to the person who was subsequently detained, eleven related to concerns about the person fearing they presented a risk to others or fearing for their safety from others. Almost all of these eleven examples related to the person experiencing delusions or hallucinations, for example voices commanding them to harm someone. This small but significant proportion of the cases in which the detained person alerted the police directly represent a perhaps under-acknowledged sub-set of the cases in which the police become involved in the public response to mental health. Therefore, clearly some individuals, albeit potentially a minority of those experiencing mental illness or acute psychological distress, would appear to regard the police as a source of help.

Finally, examination of this data in relation to the previous Cluster Analysis (4.4.5) revealed the most interesting data about how police had been alerted. As Figure 4.5 below indicates, despite the largest proportion of detentions relating to Cluster 1, females with a single diagnosis of personality disorder, the fewest incidents of the person initiating contact were recorded in this cluster. Conversely, males initiated contact with the police with the greatest frequency.

Whilst the large number of unknown data for each cluster means caution should be applied in consideration of this finding, it does indicate that this aspect may be of value to consider in further investigations.

Figure 4.5: How Police were Alerted by Clusters



The information on each of these situations was limited in most cases to one or two sentences recorded in the form completed presumably at the point of handover between the detaining officer and the place of safety staff. As stated above, it is therefore not possible to make assertions as to the exact sequences of events nor to infer the critical elements of decision making by those individuals that led them to make contact with the police on each occasion that they chose to do so. Notwithstanding the logistical complexities of undertaking such an inquiry, the circumstances by which the police come to be involved in situations that result in detention is certainly an area that merits further investigation, and one in which triangulation of data from the records held by both police and health services would be beneficial.

4.6 Chapter Summary

This chapter has presented the findings predominantly related to the data drawn from the national police survey and the Sussex 28 month dataset of repeated detentions. It has indicated that repeated detention is widely recognised, beyond solely the coastal region of South East England, but cannot be strictly defined. Repeated detention is overwhelmingly related to suicide and self-harm. Regional data has indicated that an average of a third of all S136 detentions may be accounted for by individuals being subject to multiple detentions. However, the further data has suggested clear differences can be detected, both within cohorts of people detained on multiple occasions and between repeat detainees and the overall population of people who are subject to S136. The data has further revealed that the overwhelming majority of those subject to high frequencies of detention are females and that most have a single diagnosis of a personality disorder. In comparison to the other sub-groups into which females with other diagnoses and males fall respectively, few females detained with the highest frequencies contact the police directly. In contrast, it appears the public and people known to those who are subsequently detained, initiate police contact the most often among this group. Whilst these findings address the questions of what repeated detention is, who is detained in this way and under what circumstances, the more detailed information relating to why some people are detained in this way forms the central focus of the following chapter, which draws on the qualitative data from six interviews and the analysis guided by lived experience through the deliberative workshop.

5 FINDINGS II: LIVED EXPERIENCE OF REPEATED DETENTION

5.1 Chapter Overview

The data presented in this chapter builds upon the findings discussed in the previous chapter. It continues the exploration of repeated detention that began to provide a comprehensive overview of the phenomenon using quantitative data from Sussex and descriptive information elicited from the national police survey. Whilst Chapter Four yielded useful information on the broad parameters of recurrent detention, the sources of that data could only give an indication from an external perspective. Hence, this chapter advances the realist consideration of why people are repeatedly detained by drawing on valuable insights gained from the qualitative interviews with people who had lived experience of recurrent suicidal crises and multiple detentions under Section 136. Specifically, this discussion addresses Research Question 3: What can be learned about the care needs of this group from their accounts of their own experiences?

The chapter begins with a brief recap of the methods by which participants were recruited as this provides initial important information as to the different contexts of the individuals who took part in this element of the research. Anonymised profiles of the interviewees are then introduced before the chapter turns to the analysis of the lived experience accounts with a brief review of the deliberative workshop methodology that was employed. This chapter will extend the proposition advanced in the previous findings, that recurrent detention is inextricably linked to suicidal crises. However, rather than focus on those points of crisis or detention, the data will be used to argue that a critical but too frequently overlooked element is the longer-term support available to people in need. The interviewee accounts will illustrate how appropriate, continued support can begin to reduce the frequency and severity of crisis episodes. The factors involved in triggering those repeated crises will also be examined, further demonstrating the connection recognised in the literature between trauma or

childhood adversity and poor mental health outcomes. This data is presented employing a framework that was developed in collaboration with the lived experience consultants with whom excerpts of the qualitative data were jointly analysed in the deliberative workshop. The chapter will conclude with a summary of the proposed critical factors and their association to one another, leading towards the final model of repeated detention that is proposed at the start of the following discussion chapter.

5.2 Lived Experience Interview Data

Data stream 3, the lived experience perspective, consisted of six in-depth, semi-structured narrative interviews and a partially co-produced analysis in which elements of the qualitative data were reviewed with lived experience consultants in a deliberative workshop.

5.2.1 Interviewee Participants

Four participants were recruited from the Lighthouse in Hove, a this is a support service for patients of Sussex Partnership Trust who have a diagnosis of borderline or emotionally unstable personality disorder that is a jointly run partnership between the Trust and third sector organisations. More detail on the Lighthouse is provided in the methodology chapter (see section 3.3.5). In addition, the East Sussex S136 Monitoring Board identified several individuals who had been detained with very high frequencies in Sussex during the previous three years and sent invitation letters to these individuals on my behalf. A further two participants were recruited via this method. Both these respondents lived outside Sussex and therefore chose to take part in telephone interviews.

Each of the narrative interviews lasted between forty-five minutes to an hour and a half. The length of interview was determined by the interviewee. Further information on the Lighthouse and recruitment to this data stream is provided in the methods section of the previous chapter. The rationale and methods used for analysis of this data is also detailed therein. Briefly, thematic areas were drawn from the interviews and discussed with the lived experience advisory group in a review meeting convened for this purpose. The framework derived from this process was then used to re-review each of the interviews and was then further

refined using guidance derived from the bodies of literature discussed in the opening chapters (please see sections 3.3.6 Data Stream Three: Qualitative Interview Data for a more detailed account of the processes used).

All interviewee participants were female and of white British origin. At the time of interview, five participants fell into the 'Working Age Adult' category, one being in her mid 20's, the majority were in their 40's. One participant aged over 65 fell into SPT's 'Older Adult' category. One participant had recently gained employment, several of the others spoke about hoping to return to work in the future and one described being very actively involved in voluntary work and mental health advocacy campaigning, which appeared from her description to amount in time spent to at least equivalent to part-time work. One participant described previously having had a career in social work and another within the police force, both had lost these roles, in which they had each worked in excess of fifteen years, when their mental health had deteriorated. One of these participants specified that she had taken medical retirement, whilst the other did not detail the circumstances under which she had left her job but felt she would be unable to return to this career. All but one of the participants lived alone, with the other being in supported accommodation at the time of interview. As the theme of relationships emerged as a key area, further details of factors linked to the participants' family and social ties are presented below within the relevant sections of this chapter.

5.2.2 Deliberative Workshop Consultation

As detailed in the methods chapter, the deliberative workshop took the form of a three-hour meeting that was attended by five lived experience consultants, one of whom co-facilitated the meeting with me. During the meeting I presented an overview of the study and then discussed some of the emergent themes from my initial review of the data. I also shared excerpts from some of the transcripts to highlight these themes. Alongside the co-facilitator I then posed questions to the consultants, who discussed the topic areas and responded with their interpretations of the data. This process guided me to re-focus my interpretation and enabled me to refine the initial themes I had generated. Further detail of my

provisional emergent themes and the refined themes from the consultation are detailed in the methods section (see section 3.3.6 Deliberative Workshop).

Having described the recruitment, interview procedures and analyses including the deliberative workshop, profiles of the interview participants will now be presented. Each interview was assigned a pseudonym by which that individual's data is identified throughout.

5.2.3 Lighthouse Member Interviewees

'Anna'

Anna was in her forties. Speaking of her childhood, she described her father as having been “*lovely*” to her mother but “*very physically and emotionally abusive*” towards her, noting that the only times her parents had ever argued had been whenever her mother had tried to defend her. It appeared clear from Anna's interview that the abuse she experienced at her father's hands had exerted a negative and long-term influence on her in a number of ways from an early age. Each of the qualitative interviews opened with an invitation to the participant to tell me a little about themselves. Anna's response to this question was to begin by informing me that she had had mental health issues since she was 16. She identified herself as having a relentless drive to over-achieve, which seemed to have originated from trying to meet the exacting standards set for her by her father when she was a child. Anna described the impact of this as having been that “*I've always grown up feeling like I'm not good enough. That whatever I do is never good enough.*” This had been despite her going to university and succeeding in a highly challenging career of fifteen years, in which she had risen to a senior position.

Anna had been diagnosed with recurrent clinical depression in her late twenties. Subsequently, she had suffered the devastating bereavements of first her mother and then her best friend, who had died within a few years of one another. Anna felt that it had been her mother's death that triggered her emotional intensity disorder but said that she had not been formally diagnosed until a few months after losing her friend, who was thought to have died by suicide. She also stated that she had post-traumatic stress disorder and that this was tied to death and conflict.

Anna described having been left to deal with the emotional intensity alone for a number of years and said that during that time she had been:

“all over the place. I couldn’t structure my day, I couldn’t manage anything, I couldn’t manage emotions, I couldn’t manage what I was going to do, I couldn’t make decisions. The slightest thing I’d be sobbing hysterically.”

She contrasted this to previously having maintained her career despite periodic episodes of sick leave to manage her depression:

“I could juggle twenty thousand plates all at once, now I can’t juggle two. And it saddens me, to be honest, that I can’t do the job that I worked for, trained hard for.”

Anna related having taken frequent overdoses in the past, whilst on a few occasions she had done so with the intent to end her life, she also referred to many of these occasions as having been part of a pattern of self-harming that also included drinking excessively and inflicting other injuries on herself. Anna felt she had *“made huge amounts of progress”* since joining the Lighthouse two years previously. Although she had required two hospital admissions to address severe bouts of depression, she observed that she had drastically reduced her previous self-harming. She recounted that it had been nine months since she had last taken an overdose, something about which she described herself as being immensely proud. Furthermore, she had added that: *“I haven’t burned myself in eighteen months”* and that she was addressing her drinking:

“I was drinking two bottles of wine a night, that’s 14 bottles of wine a week, I’m now drinking four bottles of wine a week... I allow myself to have a drink Tuesday, Friday, Saturday. And... that’s working for me.”

She summarised her life now as being much improved and despite experiencing frequent and severe fluctuations of mood due to the emotional intensity she stated that she felt *“much less chaotic... much more in control”* having the support of Lighthouse and being able to access that support.

‘Beth’

Beth described having had many years of contact with mental health services but said that this had been sporadic as she had experienced long periods in which she had not been in touch with services. She spoke about her mental health

having deteriorated again around three years previously and that she had not been able to work since that point. Beth had been referred to the Lighthouse about a year into this period and at the time of interview had been a member for about eighteen months. Although much less frequent now, Beth said she had experienced a lot of crises in which she had self-harmed by overdosing and cutting, on multiple occasions this had brought her into contact with the ambulance and police services. During one detention under S136, Beth described having been kept handcuffed for a long time, as she was taken to hospital to treat the overdose she had taken, but once there had been handcuffed to the bed until she was placed on a drip. On this occasion she said she had been told more than once that she would be handcuffed again and could be taken to custody if she attempted to leave. She described that as a “*nightmare*” and the worst thing she could imagine, saying she was aware others had been detained to custody. Although it had never been her experience, she said the thought of that prospect “*just fills me with horror. I just think that must be just the worse. When you’re in that state already then to be put in a cell.*” So strongly was her fear of this prospect that Beth said being able to express this was a main motivation for her to take part in the study.

As related by Anna, Beth described herself as feeling more stable than she had been when she was referred to Lighthouse, but in contrast she felt there was a cyclical element to her mental health difficulties and said she wasn’t sure how much of her current improving trajectory was attributable to being with Lighthouse, saying: “*Yeah well I think partly it was a natural progression anyway. I mean I had been better for a lot of years and then I had this down turn. You know, I think that was gonna pass.*” Nonetheless, she said that having the support of the service had been useful in supporting her when experiencing crises as well as giving her a way to structure her day that she had been lacking since she stopped working.

‘Emma’

Emma had been a member of the Lighthouse for around two and a half years. She described herself as having “*quite a history of mental health difficulties*” that included diagnoses of emotionally unstable personality disorder and post-

traumatic stress disorder and she had been detained under S136 many times, especially prior to joining the Lighthouse. As a child Emma had been abused by a member of her immediate family, which she had disclosed two years previously leading to a criminal prosecution that she had understandably found a very difficult period.

'Diane'

Diane had been a member of the Lighthouse for almost a year at the time of interview. She described it as having saved her life, saying that since joining she had *"had a couple of suicide attempts but, nothing like I used to, I mean I was doing it once a week."* Diane said she had gone from being *"a bit of a hermit"* to having somewhere she felt safe, welcomed and supported. Before this Diane said she had been detained under Section 136 several times and Diane identified her diagnoses as Emotional Intensity Disorder, Depression and Anxiety. In common with each of the other participants, she had been admitted to hospital and undergone numerous other Mental Health Act assessments. Diane also identified that, especially following the death of her mother, she had experienced multiple suicidal crises that had resulted in several detentions under Section 136. Most often she said these had arisen when she had taken overdoses or had been drunk and tried to walk into the sea. Of her experiences of 136, Diane said: *"None of them have been very good.... I think it's a horrible experience. Very frightening."*

5.2.4 Out of Area Interviewees

'Heather'

Heather stated she had a *"long history with 136's in Sussex"* but was rarely subject to detention in her own area as the police in her locality *"try very hard not to 136 me if they can persuade me by any other means they won't 136 me."* Heather said she had always been drawn to Beachy Head, not only when feeling suicidal but also that at times she found being there could be calming for her, however, she also identified the complexities involved for the police, stating that *"I can see the police have no other option to get you away from the cliffs."* She said she had been unwell for 12 years and at the time of interview although not having

been detained for several months said that she felt she was heading towards another 136.

Heather said her current diagnosis was complex post-traumatic stress disorder, which had originating from the birth of her daughter that had resulted in Heather having to go into intensive care as both she and her baby had almost died. She also suffered from anorexia and depression. When her mental health had first deteriorated Heather had been sexually abused by a worker in her local Crisis Team, who had threatened suicide if she told anyone. She said the abuse had eventually come out two years previously but said that "*the last two years have been worse*" as the individual had left the service and no prosecution had been pursued. Heather stated that "*Nobody realises how affected I am by hearing that. I'm still left with the thoughts I am responsible if he kills himself.*" In addition, Heather said she had previously been diagnosed with emotionally unstable personality disorder but that "*I've had three separate assessments and I don't have a diagnosis of personality disorder.*" Despite this, Heather said the diagnosis often came back into her notes and that mental health services responded differently to her as a result.

'Kate'

Kate said she had been detained many times in Sussex and a few times in her home area. Concordant with Heather's account, Kate said she had a history of having felt drawn to Beachy Head and that "*the decision that I'm going to go... feels like a relief in itself.*" Kate said that the first few times she had made the journey it had been impulsive, with the first time being when she had been diagnosed with borderline personality disorder and immediately discharged from hospital. However, she said that she had planned the suicide attempts she had made in more recent years. In the year leading up to receiving the diagnosis, Kate said she had already been prescribed antidepressants and had begun to take overdoses and subsequently to self-harm. She also disclosed suffering from Bulimia at the time of interview. During the five years in which her mental health had deteriorated, Kate said she had lost custody of her children to her abusive ex-husband.

Having introduced each of the participants through their profiles above, the findings of the analysis will now be presented addressing the final research question using a realist research framework.

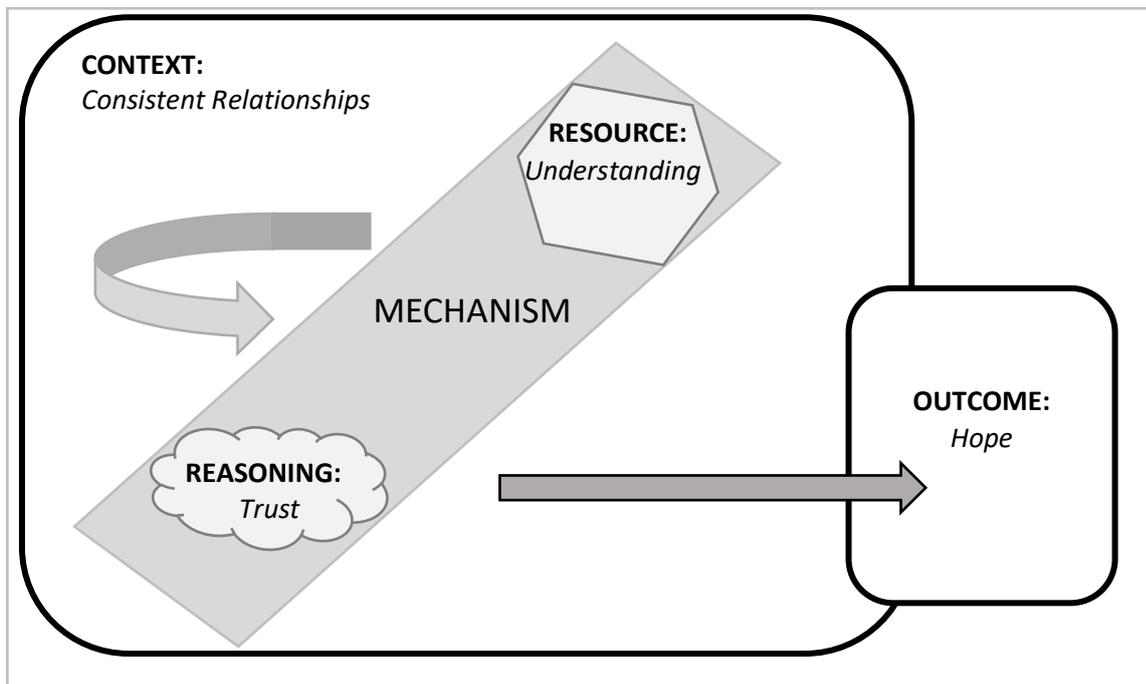
5.3 Context – Mechanism – Outcome Configuration

The interpretation of the qualitative data identified four themes that appeared to be interrelated. Conceived as a Context – Mechanism – Outcome configuration (CMOc) the narrative accounts revealed how these factors could interact to disrupt a cycle of recurrent suicidal crises and that when absent or reversed could work to maintain crisis cycles and thus repeated detention. Although not investigating a particular intervention, the therapeutic environment of the Lighthouse as described in the methodology chapter was a critical part of the macro-context of member participants. On commencing the analysis it was immediately apparent that there was a stark difference between the interviewees who were members of the Lighthouse; all of whom described being well supported, and the out of area participants. It was possible to explore this dimension further as two of the members, Anna and Diane, spoke in length about their experiences before joining the Lighthouse; their accounts of those times closely mirrored Kate and Heather's, whereas when they spoke about their lives since joining each reflected the same elements that were in Emma and Beth's interviews. A full realist evaluation would consider the Lighthouse as an intervention or could take any of the individual therapies or practices that are delivered there as focal points. But in analysing the qualitative data in this study, I nonetheless found a context, mechanism, outcome configuration that appeared to be operating to either support people to manage triggers or, when not assembled into that CMOc, left an individual vulnerable to attempting suicide.

Within this CMOc (shown in Figure 5.1 below) the outcome was conceived of as 'Hope,' with the opposite hopelessness being the gateway into a suicide attempt. The mechanism was disaggregated into the constituents of 'resource' and 'reasoning' following Dalkin et al.'s (2015) development of this conceptualisation, originally proposed by Pawson & Tilley (1997). Thus, 'Understanding' was considered to be the resource provided in the model and 'Trust' as the

interconnected reasoning response which understanding could generate in individuals. An additional feedback process was hypothesised, such that once the initial understanding that was introduced to the model by the community had engendered trust, this promoted conditions in which the individual was able to gain further understanding (labelled insight, for clarity) and self-trust, or self-assurance. A social context of ‘Consistent Relationships’ was considered to be the necessary pre-condition for these mechanistic components to be able to work together. The theme of ‘relationships’ was the main element agreed between myself and the deliberative workshop consultants to be the most significant in exploring the critical themes in the data.

Figure 5.1: Context Mechanism Outcome Configuration



5.3.1 Outcome: Hope - “I have a total lack of hope”

Given both the literature and the data in the previous chapter showed that recurrent detention is strongly linked to suicide and self-harm, it is perhaps unsurprising that hope was the first theme to be detected in the data. The personality development pathways map (Haigh, 2011) which was described previously, conceptualises the ‘routes’ through a life-course perspective from birth to potential death by suicide or life-long offending. Hopelessness, labelled

as despair, appears, as the final 'stop' before suicide in Haigh's presentation. Furthermore, Davidson et al. (2009) have found that hope is negatively associated with two core dimensions of the interpersonal model of suicide. This dimension was the clearest differential factor which was immediately evident in the interviewees' accounts and was also perceptible in individuals' tones. Participants' descriptions of their futures were completely divided between those who were receiving support from the Lighthouse and the out of area participants who lacked an equivalent support and felt their needs could not be met. Further examination of the data indicated this sense was also present in how interviewees viewed themselves, as well as the ways in which they spoke about their previous suicide attempts. The out of area participants both conveyed ambivalence about their futures but in broad terms it seemed both believed they would eventually complete suicide. Talking about the mental health services with which she had been in contact, both in her home area and in Sussex, Heather stated:

"Everything that happens is merely a sticking plaster until the next 136. They know it. I know it... [so] half of me wants some help, the other half wants to be dead."

Similarly, as Kate spoke about the adversity she had experienced in her life and her resultant recurrent suicidal behaviour, she stated in a flat tone that:

"People say I bring it on myself. I suppose I do." And later in the interview: "I have a total lack of hope."

In contrast to the two non-member interviewees whose outlooks shared a sense of emptiness with absent or bleak futures, those who were members of Lighthouse all made more than one reference to their plans or aspirations in terms that clearly signalled they envisioned a life ahead for themselves. For example, talking about the Lighthouse, Beth said:

"It's a service I'm hoping to move on from, you know, it's not a permanent service for me, I know it is for some people.... I'm working towards coming here less"

Kate and Heather's absence of hope seemed partly driven by a sense that there was nothing mental health services could offer that would make a meaningful difference to their recurrent distress. For each, this view had seemingly been reinforced by services who had recurrently discharged them from inpatient wards

before they felt ready. Having been admitted to hospital from 136 detentions on a number of occasions, Heather said:

“Often wards say ‘we can recognise you’re worse’ but they discharge you anyway.”

This attested to Heather that she could not be helped.

Accessing adequate support had been a key theme in the qualitative data of interviewees who had been repeatedly detained in the *S136 in Sussex* study. The frustration present in the accounts of Heather and other participants often appeared of secondary importance to the meaning individuals ascribed to being discharged or not being able to access treatment. Heather had been told she needed therapy in a residential setting but that she would not meet the admission criteria for the facilities to which she could be referred. Whilst she expressed some frustration about this, mostly she appeared resigned:

“I’ve been pinged back and forwards, psychological therapy, community support... it’s all just fire-fighting. Apparently I have the ‘wrong sort of trauma’ – I’m considered too risky to treat in the community... no one knows how to help me.”

Heather said this had left her unable envision a long-term future for herself as she felt despair that nothing would ever change.

Kate told me she had been referred to a Therapeutic Community and described having been highly optimistic that this would be a turning point for her. Sadly, she said this placement had *“broken down after three months.”* Although she didn’t divulge further details about what had happened she said that it had confirmed to her that:

“No-one can help me. Even the specialist service couldn’t put up with me.”

As with Heather, Kate interpreted services not being able to meet her needs as her fault, indicating both had internalised the biomedical narrative citing psychological illness as being caused by individual flaws. As Heather observed:

“The attitude of services is ‘if you have a PD diagnosis we can’t help you’.”

The Foucauldian discourse contends that that power operates not only by external control but because individuals incorporate these structures into their

world view. Similarly, as stated in the third chapter, Bracken & Thomas (2004) have stated that upon accepting they are fundamentally flawed, and individual is bound to conclude they are of less worth to society. The interpersonal theory of suicide posits that burdensomeness is one of the triggers of the desire for suicide, thus blaming themselves for their suffering concords with these theoretical positions on which the biomedical approach has so often been criticised by survivor groups. As Heather summarised:

“The whole mental health system seems set up to fuel my desperation and hopelessness”.

This chimed with Anna’s recollection of the three years between her symptoms developing and being diagnosed with Emotional Intensity Disorder (EID). Before engaging in psychotherapy she stated that she had blamed herself. Anna recalled that:

“I was taking regular overdoses, probably monthly, because I just couldn’t manage the feelings... that the EID was causing. That, I couldn’t manage feeling such a failure. I couldn’t manage... the pain of living. I couldn’t see that it would ever end.”

Juxtaposed with her previous sense of futility, Anna had explained what she had learned through therapy at the Lighthouse and how this had helped her to almost entirely eliminate her previous self-harming, as well as to recognise when her emotions had reached a dangerous level of intensity and to access support at those times. She went on to say that she wanted to begin to learn to plan ahead for managing difficult situations, saying:

“but what I also recognise is what I need to start learning to do now, is kind of work out in advance... to try to work out, how I’m gonna manage emotions if those things happen. So that’s the next thing that I want to work on.”

Anna’s implicit knowledge that she had a future was echoed by the other Lighthouse members, all of whom spoke about future plans assuredly. Further confirming the importance of therapy in cementing a sense that hope was possible and justifiable, Emma said after pushing for trauma therapy for many years, it had been agreed in the week prior to interview that she would begin within the following three months. She explained that plans were being put in

place to ensure she was additionally supported at the Lighthouse to help mitigate the risk of treatment having a destabilising effect on her.

Meanwhile, other participants who were members of the Lighthouse spoke about gaining employment in the future, including Beth who said she was who was looking for voluntary work. These plans indicated not only that the members could envisage a future for themselves but also that they foresaw further recovery in managing their issues. The inherent optimism conveyed by these comments contrasted sharply to Kate's declaration that she felt a failure in all respects of her life. Having mentioned the loss of her career earlier in the interview she had also described in detail the painful fractured relationship she had with her children of whom her abusive ex-husband now had custody (relationships that are further examined subsequently). She indicated her bleak determinism with an acutely harrowing statement:

"I've failed at my marriage. I've failed at being a parent. Suicide's just another thing I've failed at."

Likewise, reflecting back on her most serious suicide attempt in which she had almost succeeded in ending her life, Anna relayed that she had been referred to the crisis team following a prior overdose but they had rapidly discharged her:

"And I was desperate, just so desperate. Because I so wanted the help. But it was not forthcoming. And then I truly believed that no help would come, that I could not be helped anymore. That I'd just gone past that point that I could not be helped"

(Claire) *"Sorry, was that the switch for you?"*

(Anna) *"That triggered me to... [overdose]? Yeah. Yeah. The switch for me was when I took the fifty Zopiclone. And they sent me home with the Crisis Team who discharged me after two days. And I truly believed... I'm not proud of it now. But I believed that it was my only option. That I was always going to be ill. That I was always going to feel like this. And it was never, **ever** going to change. And no one cared anyway... And I just felt so alone."*

Anna said that upon reaching that point she had saved her medication for three weeks and then taken this with wine and vodka. She had been unconscious in hospital for two days following this attempt and said that when she woke up she was furious that services had intervened. In contrast, she said more recently

when she had been experiencing an enduring period of depression in which she had again begun to feel hopeless, that she had felt contained by services including Lighthouse working with her to keep her safe. This had also influenced her conception of surviving chronic depressive episodes in the future:

“I do have a diagnosis of recurrent clinical depression, it will come back, the next time it will be dealt with more swiftly, maybe I’ll go in to hospital more quickly, and hopefully it will shorten the length of it.”

Anna’s resilient stance towards an undeniably bleak experience appeared a strong testament to her confidence that she possessed a future and that she could even manage the challenges presented by future periods of depression. It also provided an indication as to how this dimension of hope had been fostered. Hope has been demonstrated to have a moderating effect between entrapment and suicidal ideation in work on the Integrated Volitional Model of Suicide (Tucker, O’Connor & Wingate, 2016). The way in which Heather and Kate each spoke about feeling they had no future as there was nothing that could help them was conveyed a sense of entrapment. Feeling unbearable pain coupled with a perception that there is no option to alleviate that distress either immediately but worse so in the long term, increases desperation, compounding the individual’s disturbance and amplifying suicidal thoughts.

Lighthouse member Diane, summarised it thus:

“There’s been a huge change in me [since joining Lighthouse] I’ve had a couple of suicide attempts but, nothing like I used to, I mean I was doing it once a week. And now, I’d rather come down here and talk to someone. Or if I can’t make it down here I at least I can get in touch with someone on the phone. And talk to somebody on the phone. And it’ll calm me down. Instead of trying to commit suicide now I, you know, they’re so helpful! Everybody is just... I can’t praise this place enough. I’m so happy! I’d say it’s saved my life! It really has.”

As these excerpts show, individuals’ capacity to progress beyond recurrent suicide attempts could be seen as dependent upon hope. Dalkin et al. (2015) have used the analogy of a dimmer switch to posit that a CMOc does not always operate in a binary sense of ‘firing’ or not. According with their conceptualisation, rather than simply being present or absent, hope appeared to be strengthened or

diminished by the meaning inferred from the individual's situation. Hope was therefore being influenced by mechanistic processes, including the reasoning introduced by the resource within the context. As Diane's quote above begins to suggest, more than the individual components of the service, the relational element of the Lighthouse had been key central to her recovery from recurrent suicide attempts. Finally, Nathan (2018) has contended that it is part of a therapist's duty when working with 'severe borderline patients' to "*carry the burden of hope. A key life-enhancing element*" (ibid, p.72). This assertion underlines the importance of both hope and the therapeutic relationship and it is the theorised context of relationships, to which the examination now turns.

5.3.2 Context: Relationships - "I'm just completely at home here"

In viewing excerpts from some of the interviews, the lived experience advisors felt 'relationships' was the most critical theme inherent in the data. Furthermore, it was unanimously stated by the advisors that 'relationships' also encompassed the discussions of their own differing experiences of care that had arisen during the analysis process. As the interplay between each thematic element was further deliberated, it appeared that relationships had the power to influence whether and how the other proposed components of the model functioned. Thus, in providing the medium in which understanding and trust could be fostered or inhibited, this central element was designated as the context. The data indicated that not only were positive relationships a prerequisite of recovery but that the reverse had substantially contributed to developing the problems that had triggered participants' recurrent suicidality, which also reinforced this allocation. Consequently, it was posited that the data indicated relationships could form a detrimental or beneficial context, as will now be described.

Relationships as Detrimental Context

Connections with families were complicated for almost all participants and frequently these relationships had contributed to the difficulties they experienced. Anna had been diagnosed with recurrent clinical depression when her daughter had been two years old. As a result of not trying to impact her childhood, Anna said:

“So I learned very quickly how to hide it for short periods of time. And I didn’t want her growing up thinking she had to be my carer.”

However, she was aware that these experiences likely continued to have an impact on their relationship into the present and she went on to describe their current relationship as difficult:

“She, never speaks to me when I have to go into hospital. I don’t know why. I don’t know if it triggers something, from when she was younger and I had hospital admissions, and maybe she felt a bit abandoned. But she’s very prickly. And she’s ... a mum of her own now. So yeah. I love her dearly, but she can be my biggest risk factor or my biggest protective factor.”

Anna went on to explain how she had learned through psychotherapeutic work at the Lighthouse how certain recurrent patterns of thinking become ‘filters’ through which the world is viewed and that are often triggers to emotional distress. As a result she understood that her daughter was linked or likely to prompt several of her filters:

*“She constantly triggers my ‘I’m not good enough as a mum.’ ‘I’m not good enough as a person.’ All my rejection stuff. She constantly, she **constantly** triggers all of that.”*

Additionally, Anna referred to consequences of having been physically and emotionally abused by her own father when she had been a child. She said that two years previously she had ended contact with him and that he had seemed remorselessness when she had attempted to explain to him how she felt:

*“And my dad just triggered me all the time. So I just had to cut him out. He made me so, so ill... **He’s** the reason I am the way that I am.”*

Both Anna and another interviewee, Emma, spoke about abuse experienced in their own childhoods also having a huge impact on their mental health. Emma recounted that when she had first disclosed having been sexually abused by a close relative, the rest of her family had not been supportive of her. The perpetrator was subsequently prosecuted, and she described the lead up to the trial as a time when she was frequently detained due to recurrent suicide attempts, describing how she had eventually had a planned admission:

“because everything was falling apart because the abuse had only just come out to my family. Erm. So my family was kind of falling apart

and. My [abuser] had been recently arrested and nobody was talking to me”.

Similarly, the effect of familial relationships was also a major factor for Kate. She spoke about having been in an abusive marriage and also described her relationship with her own family, including her sister who lived abroad as “*strained*”. Kate told me her biggest triggers were her “*Ex being vile and my kids.*” Echoing Anna’s words about her relationship with her daughter, Kate described that her own teenage daughter had mental health problems and was in foster care at the time of the interview; she said they had a “*very difficult relationship.*”

Additionally, speaking of her younger child, to whom she now had limited access, she stated:

“I can’t be a part time parent – I can’t stand not having my son here but also can’t stand having him here knowing he’s going to be going again in a few hours.”

Kate disclosed that separating from her children had been involved in one of her most serious suicide attempts. For both women, it appeared feeling the acute pain of detachment from their children, either through physical distance or emotionally, had a hugely detrimental effect on their ability to feel hopeful.

Another element of this theme touched on by some interviewees was relationships that they experienced as being supportive yet tinged with guilt. As the interview explored her social network, Kate said she had a friend who was the: “*one person who has stuck by me*” but to whom she felt she was a burden. In contrast to Kate, Heather was still married and described her husband as supportive but at the time of the interview they were not living together. Although Heather chose not to give further details of this, she described her mental ill-health as having brought considerable complications to their relationship and expressed feelings of guilt. Echoing Kate’s sentiments in talking about her good friend, Heather said her husband had: “*had twelve years living with a deeply depressed person.*” Her original trauma had been exacerbated by having been sexually abused by a mental health worker some years previously and she said following this she had become distant and withdrawn from her husband. Heather said with understandable bitterness that the abuse had: “*ruined my marriage.*”

These accounts provide an example of the complexities involved in relationships. Having positive relationships in which one feels cared for is undoubtedly a key factor in mental wellbeing (Beckman et al. 2000). Social isolation was thus a pertinent factor for both the out of area participants and was also present in the accounts of the Lighthouse members when describing their situations before joining the service. Diane spoke about her life prior to being referred to the Lighthouse as desolate:

“Er, I was a bit of a hermit actually. I wouldn’t leave the house. Erm... I was scared of everything outside the house... and, I didn’t go out very much. My Care coordinator came to the home because I couldn’t get out. Erm, so yeah, I was just stuck indoors and getting more down every day. ... Yeah I had quite a few suicide attempts in that time... I wasn’t eating properly, I wasn’t cooking for myself, I was just staying in bed most of the time, sleeping, didn’t bother getting undressed.”

Whilst the single close bonds to a long term good friend and a spouse that were described by Heather and Kate were ostensibly more favourable than Diane’s past seclusion, both described feeling that they were an encumbrance upon the people who were supportive to them. Perceived burdensomeness plays a role in the Interpersonal Theory of Suicide (Van Orden et al, 2010). Of particular salience for this data, Christensen et al. (2013) tested the constructs of that theory in a community cohort of 6133 people and found that among only the females in their sample:

“perceived burdensomeness either alone or in combination with thwarted belongingness was associated with increased plans/attempts” (p. 231).

The same study found that belongingness did not contribute to ideation in the portion of their cohort aged in their 40’s. The authors attributed this to the predominant marital and parental status of this group, meaning most had close familial connections. If this assumption was accurate, it would further suggest those for whom very limited supportive social bonds exist are likely to be at increased risk of suicide. For women such as Kate and Heather, a broad lack of intimate social ties appeared not only to have intensified their feelings of isolation, but also to have been concomitant with their perceived burdensomeness upon the individuals with whom they had close bonds. This aspect of their contexts severely impeded their ability to recover from trauma and to build (or re-build)

self-worth and develop hope. Indeed, the reverse was evident in their continuing experiences of despair.

As indicated, relationships had been directly implicated in triggering suicide attempts for Emma, Kate and Anna. None of the participants who disclosed surviving traumatic experiences cited these events themselves as the proximal causes of their suicide attempts. Instead it was how the impact of those traumas had subsequently been mediated. Effectively, the contexts in which they found themselves had enabled feelings of hopelessness to be triggered. The temporal element of this finding is further expounded in the discussion.

Whilst bonding social capital, namely relationships with close friends and family, constituted one component of this context, relationships with mental health service staff were also critical for all participants, as will now be examined.

Relationships as Favourable Context

As discussed in the opening chapters, social capital, including connectedness, is recognised as having a significant effect on life outcomes. Haigh's 'map' summarising the development and trajectory of personality disorder symptoms incorporates multiple points at which positive or negative social circumstances can have an impact. A further aspect of this is in the sense of belonging that is often fractured as a consequence of adverse childhood experiences or abuse experienced in adulthood.

The previous section described how the messages interpreted by participants as rejection from services had fuelled hopelessness and suicide attempts. These thwarted attempts at help-seeking also intimated the potential importance of relationships with professionals being experienced as positive.

Supportive relationships are unsurprisingly a key part of recovery and in particular being able to experience the reparative effects of a relationship that is based on unconditional positive regard in a way that is often critically lacking for adult survivors of abuse and adverse childhood experiences. The impact relationships could have on managing suicidal feelings was summed up by Heather in stating: "*Sometimes all I need is to feel that somebody cares.*" However, despite each having a close social tie, Heather and Kate each

conveyed a sense of not having anyone 'with them' in managing their suicidal feelings. Kate said she did have a good relationship with her therapist, but this didn't feel sufficient to her to keep her safe or to provide her with a hope for her future:

"I see my psychotherapist once a week, he is probably the only person who understands me. But him understanding me doesn't change my life."

Within this excerpt, Kate not only encapsulated a yearning for difference in her life but moreover, that a single strong, beneficial relationship with a mental health professional was insufficient to repair the damage done to her self-worth by the suffering she had endured. Anna too, in describing her self-harm and suicidality prior to joining Lighthouse, had spoken about having had a very good relationship with her previous care coordinator: *"I felt he had my back, ... he was brilliant"*.

Yet despite his support she said of that time that: *"I hate to use it, but I was loopy loo... I was just absolutely all over the place."* Under those circumstances, Anna said her care-coordinator had been: *"doing his best to help me, but he couldn't do it all on his own."* This she said had meant that she felt suicide was her only option.

In recognition of the critical importance of relationships as a nurturing context to facilitate recovery from the impact of trauma, the psychologist who had set up the Lighthouse had explained to me that attachment work formed the founding principles at the heart of the service. The participant profiles at the start of this chapter indicate that many of the interviewees disclosed adverse childhood experiences. Surviving these sorts of traumas are recognised as risk factors for developing adult mental illness and death by suicide, as discussed in the earlier chapters. Developmental psychology considers the attachment styles formed during infancy as significantly influencing child and adulthood psychosocial outcomes and the exploration of how attachment mediates between adult trauma and childhood experiences of abuse and neglect discussed in the literature chapter (Evans, Steel & DiLillio, 2013) is of particular salience (Hocking, Simons & Surette, 2016). Given the near-deleterious consequences of these experiences within this population, the reparative solution offered by the Lighthouse is to

provide an environment which cultivated a sense of security through multiple but consistent attachments.

Beth's words encapsulated this way of working:

"You know they do get to know you, and I think their sort of ethos is to get you to bond with the whole team rather than just the one person. So you do have a key worker but there's always somebody else there ...so you've got the whole team really not just one person. Ugh, so yeah... that's good."

Anna too reflected on how this approach offered reassurance:

"they work as a team. Know you as a team. And that makes me feel a lot safer. That makes me feel listened to. I feel supported. I feel like the staff understand... the nature of this illness. How it affects us."

Thus, a critical element facilitated by the consistency of the approach by which multiple relationships were used to provide a stable and secure context. The reflection of how this developed sense of security remodelled the probable contexts in which initial damage had been inflicted on participants' psychosocial functioning was evident in the words of Beth and Diane, both mirroring the same sentiment:

"now, I'm just completely at home here and, you know [I] know lots of people and you know it feels quite, I'm happy with [coming in]" (Beth).

"You know I do feel at home here" (Diane).

In both instances 'home' denoted a sense of safety and assuredness that was absent in the narratives of the non-members. Embedded in this concept of home was the feeling of safety, which was mentioned by almost all participants, perhaps best summarised by Emma's observation that when in crisis, the Lighthouse:

"encourage you to come in, or usually encourage you to come in. Erm. And just use the area, to be safe, and just ask for support if you need it."

Furthermore, the sense of connectedness was reinforced by bonds developed with other members that appeared to play an important part in the positive changes they had made since joining. For example Anna said that: *"I've made friends here who I'm quite close to"* and described how a small group of would socialise outside the Lighthouse, taking it in turns to go to each other's houses for

takeaways. Beth also spoke about having formed friendships at the Lighthouse: *“Sometimes I come in just to meet friends, have coffee, lunch, whatever.”*

For most of the interviewee members the positive terms with which they the supportive environment of Lighthouse was described seemed to diverge from other experiences of mental health services, where the majority of participants from both groups spoke about poor relationships. This view is summarised in the words of Beth:

“I didn’t get on with having a care co-ordinator, seeing a psychiatrist. I don’t get on with Mental Health People really, I don’t find it helpful I feel like they’re just ticking boxes but here [Lighthouse] it’s not like that, even though it is a mental health service it doesn’t feel like one.”

Thus, the positive regard with which the Lighthouse support was framed appeared to significantly lessen the impact of poor relationships with other mental health professionals. Whilst Anna emphasised that she was aware other people she knew had beneficial relationships with their care coordinators and had described her previous worker of three years as *“absolutely brilliant”*, she expressed less cohesion with the person currently in this role, who she felt largely approached working with her as a *“tick-box exercise.”* Despite meeting weekly for almost eighteen months, she said: *“I don’t find her visits helpful. Very often I feel worse after she’s gone.”*

Elements of the way in which relationships were operationalised within this analysis concord with Coyle’s (2018) summation that dehumanisation could be a causal element in patients’ dissatisfaction with healthcare services; when individuals had felt a health care professional had objectified them by treating them in a standardised way that didn’t permit the patient to participate in decisions about their care. Friedson (1975) termed the difference in how patients and professionals view their interactions a ‘perspective distance’. With this concept he suggested that whilst doctors refer to their medical training in seeking to identify typical features of a patient’s presentation in order to guide treatment decisions, the patient draws upon their autobiographical knowledge. This provides potential for conflict within the differing approaches as medical professionals attempt to bring distance to an encounter from which their patients are seeking proximity.

In stark contrast to the conducive context of multiple consistent relationships provided by the Lighthouse was Heather's account of how her local Trust had responded when the sexual abuse she had experienced had been revealed. Coupled with other issues in not being able to access therapy, described previously, she and Kate both described a sense of abandonment by mental health services. In each case this underwrote the feeling that there was no hope of reprieve to their situations:

"I'm too frightened to ask for help for fear of rejection and then feeling even more alone. So, I won't ask for a hospital admission... I wonder how much the mental health system has contributed to me feeling constantly suicidal."

With this quote, Heather indicated how more than a lack of care, the experiences with mental health services left her feeling further traumatised, an impact posited by Shay (2014) as likely to be caused by moral injury, the betrayal of ethics by someone in legitimate authority. Whilst Shay developed this theory from working with traumatised veterans who felt their superiors had taken wrong decisions that had caused injuries and loss of life, equivalent dynamics are present both in the perpetrator of her abuse but can also be discerned in how Heather viewed the Trust's handling of the situation once it had been revealed.

Under less extreme circumstances, the impact of the way in which health professionals related to individuals also echoed elements of moral injury, as it could be argued one would expect people working with mental illness and psychological distress to be attuned to the potential for iatrogenesis. Anna recounted a conversation that had taken place several days before the interview in which her care coordinator had acknowledged some difficulties in their relationship:

"And I said, 'I'm not really quite sure that you get me.' And she said, 'No. I'm not quite sure that I get you either.' And I just sat there and went [pause; nonplussed expression] It's very rare for me to be speechless. And I was just... Absolutely. Speechless really."

As Anna's words intimate, understanding formed a seemingly central feature of the conducive relational context of the Lighthouse, wherein a trauma-informed approach was consistently present governing interactions. Understanding the importance of such awareness progresses the examination to the mechanisms

by which hope or conversely hopelessness could be activated by the context hitherto explained.

5.3.3 Mechanism (Resource and Reasoning)

As alluded to above, spending time in a safe relational context had facilitated Lighthouse members to develop a sense of security. The reverse was the case for the out-of-area participants lacking a positive context and for whom hope had been inhibited. The realist approach considers outcomes as being caused by mechanisms within a context, thus hope had been activated, or impeded for individuals in a detrimental context, by a mechanistic process. Although still experiencing suicidal thoughts and at times engaging in self-harming or suicidal behaviour, interviewees at the Lighthouse presented the extent and severity being greatly ameliorated by knowing they had the support of people who understood them and could help to manage periods of intense emotional distress. Trust was produced through being part of this community of understanding. As these two themes of trust and understanding both appeared to be key in the interview accounts, the mechanism was conceptualised as a dyadic process in which the resources brought into a situation are linked to the response triggered in individuals benefitting from that resource. A further level to this mechanism appeared that once trust had been fostered it in turn facilitated self-understanding, which it is theorised enabled individuals to build a sense of independent trust that they had the ability to manage their distress and move forward. Hope was thereby amplified by the initiation of this mechanism.

Resource: Understanding - “finally... I understood that it wasn’t my fault”

For each individual, the sense that mental health professionals really ‘saw’ them, perceiving beyond the person’s diagnosis or actions to understand that their distress arose from previous experiences, was of great importance. The previous section on hope explained how perceptions conveyed by services’ decision making, such as being discharged from crisis services or not being referred to specialist support contributed to suicidal despair. Anna gave an example of this which began to elucidate how the mechanism operated, when the crisis team had declined a referral for her following an overdose:

“And they didn’t communicate to me the reasons why they wouldn’t work with me. So I felt left, rejected and abandoned. And like no one cared about what would happen to me.”

The crisis team’s lack of understanding of how Anna could interpret their decision worsened an already severe situation. Similarly, talking about assessments, Emma had articulated how the lack of understanding she frequently perceived affected her:

“In a way it makes me feel like.... Erm.... Almost like I’m less of a person. Because. They’re just coming in saying ‘Right, how are you gonna get home and what are you gonna do when you get home? Ok. Bye.’ Kind of thing. Which is probably because they’re busy and overstretched and everything, but it makes you feel like you’re not, important?”

Kate too spoke of a distinctly different point for her when she changed from making impulsive to well-planned suicide attempts but which mental health services did not pick up on because by that time she had already made a number of attempts. In both Kate and Emma’s examples it appeared the assessments they received felt more to them like tick box exercises than true assessments. Yet as indicated by these experiences which exacerbated the seriousness of subsequent events, mental health professionals failing to fully explore the reasons for suicide attempts or to explain the outcome of those assessments could be very dangerous.

A further issue raised in the literature chapter was the lack of concordance surrounding interpretations of self-harm. Kate remarked on the impact of the lack of understanding shown towards her by health service staff:

“What really upsets me is when medics say, “It’s just superficial scarring.” Even when I’m not in crisis I have to look at those scars.”

And later in the interview she added:

“The thing that haunts me is my suicide attempts. When I sleep, I dream of it...I had an hour’s sleep last night. My suicide attempts were traumatising and now I’ve been re-traumatised.”

In addition, a recurrent theme in a number of interviews was services appeared to privilege the ‘typical case’ based approach depicted by Friedson’s (1975) perspective difference referred to previously. Typically for many interviewees this

led to services enforcing boundaries because of their personality disorder diagnoses but not only were such actions interpreted as punishment but they were often reported as being contrary to other needs. These inconsistencies were highly destabilising, compounding situations in which participants already felt highly vulnerable. Following one S136 detention, Diane recalled:

“I was Sectioned and put in, er [name of hospital]. At the time. Er, but it didn’t help that when I got [there], I felt safe, and calm, and then the doctor, twenty-four hours later turned round and says ‘Yeah, oh yeah I know her she’s ok, I’ll take her off Section. She can go home.’

Diane informed me that:

“[S]omewhere in my paperwork, one of my CPNs has put that hospital does me no good. Which is a lie.... Because it does. It does help me. I feel calmer when I come out.”

Inconsistent or conditional parenting has been recognised as a key factor in the development of personality difficulties mediating the development of insecure attachment styles (Haigh, 2011; Hocking, Simons & Surette, 2014). Thus, being subject to comparable dynamics in their relationships with services reinforced the damaging messages that had contributed to embedding prior trauma and further undermined individual’s resilience. This incomprehension of the potential iatrogenic impact of words and actions seemed to underpin the generally unfavourable terms in which mental health staff were viewed by interviewees.

Kate spoke about times when she had heard professionals in an adjacent room talking about her or other patients:

“I’ve been under detention and heard the nurse talking to the officer handing over saying, ‘Oh she’s a runner then?’ Or being referred to as ‘The Section 136 in there’.”

In contrast both to the staff to whom Kate referred and of the incident presented above in which Diane was discharged from Section 3 on the day after being detained, professionals being open to improving their understanding of the individual could significantly alter outcomes. Diane gave an example of a different occasion in which she had been detained under Section 3 for some time, following the doctor seeking a better understanding of her needs she was moved from the inpatient ward to a residential home rather than being discharged:

“I was Sectioned in hospital. Erm. The doctor was good but I felt he didn’t understand me. And... just before I went into the care home, he said I’ll take you off Section 3. And I said Right, I’ll go home and kill myself then. And he said oh I’ll put you back on Section 3 then. So I said you just don’t understand me, and he said ‘[Diane] I’m here to help, what don’t I understand?’”

A non-judgemental stance was clearly a pivotal element of the relational context. Understanding the individual’s distress was fundamental to the resolution of crises. Heather gave two examples of occasions in which understanding had averted a S136 detention. One incident she said an officer had persuaded her to call someone from her care team and the three of them had arranged for her to leave the cliffs and travel to a location where she could be met by a source of support.

In another instance Heather spoke of an officer who had found her in her car in the early hours of a morning. Despite heavy rain, the officer refused to leave her but also did not detain her. Instead, she stood in the rain for a prolonged period, speaking to Heather about how she was feeling and what options there were available to resolve the situation. Heather described them as being at a “*stalemate*” but on reflecting back she sounded surprised that the officer hadn’t made her feel like she was a nuisance or timewasting. Eventually she said she had come to feel more concern for the officer standing in the rain than over her own distress and so had been willing to go home.

The latent capacity of understanding to impact the outcome of one-off encounters provided an indication of the process taking place over the longer term. For Kate, the absence of understanding in her context of detrimental relationships exacerbated her suffering. At the time of the interview she explained how this was manifesting in bulimia:

“I’m constantly in a state of stress even when I look like I’m coping. People are of the opinion that I’m fine; I’m functioning. Every night I binge and purge several times, as soon as I get through the door. But as long as you’re not ending up in A&E, you’re fine. As long as you’re not placing a burden on services it doesn’t matter what your quality of life is.”

Contrasting with the lack of understanding presented in the above accounts were the descriptions of the non-medicalised approach of the Lighthouse, in which members were treated as individuals rather than being as a diagnosis or a 'case'. Beth's quote in the previous section that the Lighthouse didn't feel like a mental health service was also echoed in Diane's description of her first days as a member when there was a clear intent enacted by everyone she met to get to know who she was by name, as well as in sharing tables at lunch rather than sitting apart as staff.

The Lighthouse Centre's adoption of the trauma informed principles discussed in Chapter 2 drew on the conducive context of consistent relationships and displayed understanding, both of members, who were treated as individuals and of the experience of emotional intensity that had dominated and threatened to curtail members' lives.

Within SPT, the 'first line treatment for EU/BPD is Systems Training for Emotional Predictability and Problem Solving (STEPPS) which is a foundation level treatment programme that is delivered in a group setting (R. Harvey, Black, & Blum, 2010). STEPPS combines psychoeducation, such as learning about cognitive filters, with practical problem-solving skills to manage intense emotions. Most members at Lighthouse will have completed this soon after joining if they have not been able to access it through community mental health teams beforehand. The psychotherapeutic options available at the Lighthouse then include Stairways, which builds on STEPPS by advancing understanding and emotional regulation techniques.

Engaging in this work appeared to have provided members with an alternative perspective that in turn had helped alter their self-images. An example was provided by Anna, stating that:

"STEPPS finally made me feel like I understood what was happening to me.... And I understood that it wasn't my fault that I had this. Because I did blame myself."

Anna's quote was a direct contrast to Kate's words given earlier that she blamed herself for her problems, and the same tone that was present in Heather's guilt over her marriage. The effect of understanding also suffused Anna's description

of her previous care-coordinator: “[he] was very consistent, very stable, he never messed me around [changing appointments, in contrast to her subsequent CPN]:

I felt he understood me, I felt he listened to me and when he listened he really heard me. And so, after a while if I said ‘Dad said this to me.’ He would know exactly what that would mean for me, without me having to explain ‘Dad said this and so that made me feel, like shit, like I hate myself, like I wanna die’.”

Further contrasting with Kate’s context, in which she had spoken about one close friend, Anna also illuminated a further benefit she had gained from spending time with other people who shared the same diagnosis and had received the same psychoeducational input was that members could understand and normalise each other’s behaviour. In addition to the group of friends that had formed through the Lighthouse and socialised outside that setting, this was related in terms of members sharing jokes about the diagnosis rather than about themselves as people. An anecdote shared by Anna encapsulated this:

“We have quite a lot of Friday night quizzes and I feel like, the answer to the questions, if I have to cross something off, I get quite upset by it, not upset but I feel: ‘It’s messy, it’s like a mess.’ And we joke about it: ‘That’s your Unrelenting Standards’ – That’s another filter thing.”

Juxtaposed with the beneficial context of consistent relationships, the resource of understanding introduced in the conducive context of the Lighthouse was employed to foster secure attachment, a component of which was activated as the dyadic response of trust. The proposed model herein posits that in turn, the stimulation of trust facilitates the individual to engage in learning about themselves, thereby enabling a second level of self-trust to be activated. Whilst still experiencing set-backs and challenges as well as recognising the persistent nature of their problems, the Lighthouse members appeared more secure in themselves, they also displayed a greater confidence that they could attain a level of stability and progress forward; a sense that was absent in Heather and Kate’s accounts.

Reasoning: Trust - “And then I’d know, that I was settled”

Heather described her mistrust of mental health professionals as a result of being abused as well as the subsequent response of her local mental health Trust on discovering what had happened to her. Crucially, she said the impact of the

experience had never been fully acknowledged by the Trust. Heather summarised the consequence of this as being:

“The decision making by mental health has ruptured my trust and confidence. I never really recovered from that point. So where do you go when you need help and the only source of help has made things worse?”

Despite being subjected to sexual abuse being an extreme example, Heather’s words also related to the consequences of her local mental health Trust’s failure to understand her distress over the way they had dealt with the matter. In turn this had left her feeling unable to trust the services; a consequence that extended beyond the impact of the abuse to her assessment of their ability to adequately support her.

A very significant excerpt in determining the analytic discussion is presented below in full as it resonated strongly for several of the deliberative workshop participants. This quote is taken from Emma talking about her experience with alterations in her mental health care arrangements that were happening at the time of the interview. As with Heather’s account of the abuse she had experienced, the impact, not only of these changes but seemingly more so of the way in which this was being dealt with by the services involved were deeply affecting Emma:

“[T]he psychiatrist, has cut me down from once weekly appointments, to monthly appointments. And he’s also switching my medication back to my GP. Erm, where previously he’s always prescribed it when he saw me once a week. So, that’s quite a big change for me. And it’s really left me kind of, out in the wild. A bit.... And he’s explained why it’s happening, and... the reasonable part of me can understand that. But, the rest of me can’t! ...and I think that’s where the kind of EUPD comes in a bit really and all my filters and everything. And it doesn’t help because they said that the GP I’ve got is a good GP for mental health, and it’ll be a smooth transition, and not to panic ...but... it’s just been nothing but a disaster, since. ... This was last Wednesday I found out and I’ve been trying to get an appointment with my GP for, tomorrow [Wednesday] ever since. And they won’t give me one because they say I’ve got to phone up on the day to get an appointment. That they can’t do an appointment in advance. That they haven’t had the letter yet from, the psychiatrist, so, they can’t give me any medication even if I do get an appointment and, yeah,

it's just been blowing my mind. [My care coordinator] has said, to reassure me, that if it all goes completely wrong, that they will do me a week, of medication. Er, but that doesn't really reassure me. Cos it's like well if I can't get it this week, am I gonna be able to get it the next week? And then it's getting closer to Christmas, and am I gonna be able to get appointments over Christmas? And am I gonna be able to see them? It's just. Yeah, it's all a bit of a mess. If they'd just give me an appointment, like a week in advance then that'd be fine. I could put it in my diary, I could know that everything's, sort of fine. And that's what I had with my psychiatrist, you know, I saw him. He'd give me my prescription. And then we'd book the appointment for the next week and I'd know that, I was settled."

The discussion which arose in relation to this excerpt touched on a number of areas and the interpretation of this quotation touches on each element of the proposed theory of repeat detention. Firstly, two of the consultants immediately described having had similar experiences of discontinuity in medication due to service factors outside their control. These incidents were described as deeply unsettling, frustrating and frightening when it came to medication on which people depended for maintenance of their physical as well as mental stability. Associated with this was a sense that organisational factors within mental health services at times seemed to intensify problems.

The lack of understanding of the impact by professionals was explained by the consultants as a factor that could set services at odds with the concept of a therapeutic or supportive relationship. Coupled with clear communication breakdowns such as that suggested by Emma's care coordinator seemingly not really hearing what was driving her distress; her concerns centring not only around securing the first appointment but further that this was likely to be a recurrent situation each week thereafter. Again, this related to lack of understanding and in turn this undermined Emma's ability to feel secure or that she was able to rely on services, either her community mental health team or the GP. All of which took place in a context of sudden disruption to the relationship she had with her psychiatrist. Although Emma was aware that there were sound reasons for this, it appeared that the way the alteration in her care arrangements was being implemented was causing more distress than the change itself. However, the inconsistency also introduced turned a context in which she had felt

settled into one that that felt very unsafe to her. For Emma, this issue represented not only a potential disruption of several days in her medication but a deeply unsettling and therefore destabilising change, for which no consideration or accommodation appeared to have been made.

The opposite practice was for example praised by Diane talking about possible things mental health services could put in place to make her feel more supported:

"[I]f the care coordinator's going to be changed, I'd like to know in advance, what's going to happen. And obviously maybe meet the new care coordinator with the old care coordinator so I get to know them. Instead what's been happening is they've just been turning up. And I don't know who they are, or what's happening. And like my one does at the moment, if she's going to be off on holiday or something she'll tell me in advance, so I can prepare myself in advance, cos she knows that helps me rather than like a lot of them just say 'Oh I'm on holiday next week for three weeks, you know, so you can't contact me.'"

A further interpretation of the difficulties described herein is possible when considering the Power Threat Meaning Framework. Many of the situations in which participants had described feeling unsafe appeared to have been compounded by services (those with power) not understanding the meaning to the individuals of those situations, leading to exacerbate the individuals' feelings of being powerless and further threatened.

The sense of safety created for members by the consistent relational context of the Lighthouse and the resource of understanding provided by staff seemed key in supporting reductions in self-harming and suicide attempts as members had become able to trust that a sufficient support structure was in place when they needed it. Prior to joining Lighthouse, and for Heather and Kate, it was only the police from whom such a level of consistency could be found. As Heather stated:

The police are the only people who have to do something. They can't leave you... So I have really mixed feelings on 136.

Contained in Heather's words was the level of trust in the police that appeared to have been critical for the Lighthouse members who had reduced their self-harm and suicide attempts; knowing that when in crisis they could rely on a caring response. Heather explained that mental health services in her area were not

able to provide this, as she described service changes she had seen in the time she had been in touch with them:

The crisis team in each area used to be static, they knew the area well. For financial reasons, I believe, they took all the local bases out and based them all centrally and lost the social workers from the Local Authority, now teams are driving miles. Staff are demotivated so there's a huge turnover and it feels like a call centre. It's been acknowledged at the board level. All the good people left and so it's mostly foreign support workers now. You call and get "Have you made yourself a nice cup of tea? Have you had a nice bath?" I've done the tea. Had a walk. Now I need help! They're the last resort and when the last resort fails you're stuffed

Once more, these experiences left Heather feeling unable to trust the service to provide support when she was in crisis.

Reciprocal Trust

A further element that arose in several interviews and separately in the deliberative workshop was also coded as trust. This aspect related to being treated as credible by services, essentially being trusted. Several examples emerged of services dismissing what individuals told them about their own experiences. Heather touched on this referring to dissociative episodes:

"Sometimes I dissociate when I get extremely distressed. I can sometimes tell when it's going to happen but other times... I remember being in the supermarket at 11am and then at 2am I was on Beachy Head with a frozen bottle of water. No matter how much I tell people I get dismissed. You're just perceived as another manipulative person who's attention seeking."

Allied to this, Heather had detailed that in order to block out her trauma and achieve a sense of 'rest' she would at times take more tranquilisers than her prescribed dosage, which she found was no longer sufficient to enable her to sleep. She explained this was not with the intent of ending her life as she did not take enough to be fatal, but it would be sufficient to make her unconscious for a few hours. Heather described with regret and frustration that this too was always interpreted as a suicide attempt, despite her ability to articulate a difference.

Correspondingly, a number of participants spoke said that services would routinely disregard what they told them, this appeared to be the case in Mental

Health Act assessments as well as in more routine interactions. For example, Anna was clear in the difference between feeling suicidal when she was suffering a period of depression and the more impulsive suicidality of what she termed episodes of emotional intensity:

*“I know the difference between an EID episode and a depressive episode. The depression is relentless, it’s day in day out; lethargy, don’t want to live, but the Emotional Intensity just feels so frantic, it just feels so **desperate**. It just feels so... up ‘there’. And out there. And no control. No control. But I usually come down after a few days, whereas with the depression it just goes on and on and on for months”.*

Anna explained that through the support of the Lighthouse she was now “*much more in control*” of suicidal thinking triggered by EID but that when experiencing depression she could not keep herself safe. Despite this, Anna said that when suffering a depressive episode her care coordinator and others in the Trust refused to consider admitting her to hospital regardless of her becoming increasingly more suicidal, because the NICE guidelines advise inpatient treatment is not helpful for personality disorder.

5.4 Chapter Summary

This chapter has addressed the crucial final question of why some people are repeatedly detained. The focus has been the data taken from the interviews of six women who had been diagnosed with personality disorder and who had endured ongoing suicidality. The themes were shaped through the partially co-produced analysis with consultants identifying as having complex needs and lived experience of mental health crises and emergencies. A CMO configuration has been presented to account for repeated detention through recurrent suicidality. This model proposes that the association between key factors that were present in the data can either maintain or interrupt a cycle of multiple detentions.

The fundamental contextual element of relationships determines whether an individual feels trust as a result of being understood, which in turn generates self-understanding and self-assurance (self-trust), critically triggering an outcome of hope. However, where the relational context is detrimental, an individual does not

receive sufficient understanding from those around them giving rise to further deterioration in their capacity to trust professionals to be able to help, simultaneously extinguishing the individual's belief in their own ability to attain a life that feels bearable. In such a context, hopelessness is generated, leading towards acting upon suicidal thoughts. Importantly, once a person's suicide attempt has been prevented by the police detaining them under S136 several times, it would seem that although the experience of detention is rarely positive, the police become the reliable source of sustaining life when all other options have been exhausted.

The following chapter brings together both findings chapters to further develop this psychosocial account of how repeated detention can be seen through a realist lens as an emergent outcome. The discussion will draw on the bodies of literature discussed in the first two chapters, relating the role of social factors and trauma as well as the pivotal importance of relationships in driving the chronic suicidality that can both lead to repeated detention and, potentially, ameliorate the impact of adversity.

6 DISCUSSION:

A REALIST CONCEPTUALISATION

OF REPEATED DETENTION

6.1 Chapter Overview

The previous two chapters have presented the data arising from each research question. This chapter brings that work together to address the overarching research aim of providing a conceptual psychosocial understanding of repeated detention. A brief review of the way in which realist principles have been adopted will first be provided before the key findings of the study are considered in relation to the bodies of literature reviewed in the opening chapters. Drawing on the realist approach explained in the methodology chapter, a proposed 'programme theory' of repeated detention is presented as a means to explain the assemblage of complexities which the findings have indicated to have a causal role in generating this phenomenon.

The key themes of gender and trauma will first be examined, suggesting that inadequate provision of responses to mitigate the impact of trauma coupled with the influence of social capital ultimately have a differential impact for males and females, consigning the latter to a trajectory of high frequency repeated detention. This theorised route into recurrent detention will reflect on the bodies of literature presented initially to provide an account for the mechanisms that generate this outcome, demonstrating the contribution this research makes to understandings of trauma and suicide. The diagnosis of personality disorder and the influence of the biomedical paradigm on responses to recurrent suicide will then be discussed. Section 136 in the broader current social context will then be considered, re-examining the debates around defining a mental health crisis in the light of the findings of this study. The chapter will close with a consideration of the pivotal role of a consistent 'community of care' in averting recurrent detention.

A final summary of the study, including its limitations together with

recommendations for policy, practice and future research will in turn be discussed in the subsequent conclusion chapter.

6.2 A Psychosocial Consideration of Repeated Detention Through a Realist Inquiry Lens

Chapter Three explained that realist methodology seeks to address questions through abstracting assemblages of components that can provide causal accounts by indicating the relationships between contexts, mechanisms and outcomes, which are described as configurations (CMOc). Although not a true realist evaluation, the data from the present study can provide a realist account of high frequency repeated detention as a phenomenon that results from a series of interconnected CMOc.

The methodology chapter also presented Pawson's (2006) acronym of VICTORE (Volitions, Implementation, Context, Time, Outcome, Rivalry and Emergence). Theorising the relationships between the elements that this study has demonstrated are involved in repeated detention by utilising the VICTORE lens, indicates that what Pawson (2017) termed a realist diagnostic evaluation of repeated detention is both achievable and useful. Whilst Pawson has suggested VICTORE is an aide-memoire to assist the researcher in remaining mindful of unseen elements of their subject of study, within the present context I believe there is value to highlighting how components of this framework have drawn focus to enable explication of important constituents of repeated detention. The following section presents an adaptation of the ripple effect model developed from a realist evaluation of community based participatory research (Jagosh et al., 2015). This conceptualisation indicates repeated detention is an emergent outcome resulting from an 'implementation chain' or sequence of CMOc in which context at the meso-level is in part constituted by the previous outcome. This proposed programme theory of repeated detention will now be expounded.

6.3 Trauma and Gender

This research has demonstrated that recurrent detention is not only a proxy for recurrent suicidal behaviour but also a complex issue born of multiple adversities

and influenced by a myriad of social and psychological aspects. High frequency repeated detention is an almost exclusively female issue, revealing gender to be a crucial factor. As indicated in the review of S136 literature presented in Chapter One, the more reliable national data on S136 use overall, which has been reported in recent years has shown that more males than females are detained. In contrast, the more detailed and recent research on the topic including Eswaravel and O'Brien (2018), our parent research in Sussex (Bendelow, Warrington, Jones, & Markham, 2019) and indications from practitioners who had informed the development of this PhD (Jennings and Matheson-Monnet, 2017) had suggested multiple detention was a more significant issue amongst females. The findings from this research have confirmed this to be the case, but in combination with the qualitative data I would posit the first three CMOc are broadly applicable to males or females.

As indicated throughout this study, the experience of trauma underpins recurrent detention and can be conceived of as having both a distal and proximal causal influence when drawing on the layered ontology in which realism is grounded. Trauma was present in the accounts of each lived experience narrative interview. The major adverse events experienced included having been the victim of physical, emotional and sexual abuse. In line with the literature on trauma described previously, loss (either directly through bereavements or manifested in symbolic losses such as forfeiture of important roles) was identified specifically by several of the participants. In other cases, betrayal and moral injury (Shay, 1991, 2014) would clearly have been implicated, such as in Emma's experience of having been sexually abused by a close relative as a child and then being rejected by other members of her family when the abuse was disclosed. Similarly, a sense of entrapment is commonly a psychological consequence of intimate partner violence (Coker, Smith, Bethea, King, & Mckeown, 2000) as Kate's references to her abusive marriage conveyed. Entrapment is recognised as having a causal role in the development of post-traumatic stress disorder symptomology, depression and suicidality (Gilbert & Allan, 1998; Gooding et al., 2015; Taylor et al., 2011). Although some participants made only passing reference to events they had experienced, how these events were framed within the interviews revealed connections in almost every case to the recurrent suicidal

crises that had prompted their detentions. Whether occurring during childhood or later in adult relationships, it was apparent that the consequences of these experiences were deeply felt and enduring. Heather had avowed her ability to trust others had been shattered and Kate and Anna had described how their own self-images had been devastated.

Information was not specifically sought about the circumstances surrounding each person's traumatic experiences, however the literature suggests gender and trauma may be jointly implicated in recurrent detention through a bi-directional relationship between socialisation and expectation that influences behaviour and thereby determines outcomes. Whilst a trauma reaction follows a traumatic event (or series of events) it is not inevitable that this will result in the sort of psychological and functional difficulties labelled as personality disorder or post-traumatic stress syndrome (PTSD). Indeed, it has been estimated that fewer than 10% of people develop PTSD following exposure to trauma (Hulbert & Anderson, 2018).

The individual's perception of having no control in a situation has been linked to the development and embedding of a traumatised reaction, hence the power threat meaning framework situating power and meaning as central elements of uncovering the narrative of an individual's development of psychological distress. In this way the PTMF concurs with the work of Paul Gilbert and colleagues (Gilbert & Allan, 1998; Gooding et al., 2015; Taylor et al., 2011)) examining the role of psychological entrapment in subsequent mental illness including depression and suicidal behaviour. Shay (1991; 2014) also contends it is the meanings attached to experiences that alter an individual's sense of self, the world around them and their relationship to it. Essentially, through a continual process of making and re-making meaning, how an experience is interpreted shapes the individual's reaction to that experience, which in turn influences their subsequent interpretation and so on.

Social capital is conceptualised as the resources embedded in social networks and is thus synonymous with mechanisms in realist terms. In line with the extant ACE research, low social capital, particularly the lack of supportive strong bonds to an 'always available adult' who can provide a protective influence that buffers

against the detrimental impact of adverse experiences, creates a context in which the mixed messages conferred by abuse and neglect are internalised to shape an individual's view of self (unworthy) and others (untrustworthy). For the individual this means adverse and traumatic experiences are interpreted and contextualised not as inexcusable occurrences for which they bear no blame; instead feelings of culpability are 'encoded' into filters on world and self-views, influencing maladaptive defence and coping strategies that set the individual as 'deviant' from societal expectation. Literature and experience both from this study and my prior work in criminal justice, would suggest these strategies initially manifest in similar ways for males and females, namely substance misuse, poor quality and fractured relationships, further weakening any residual strong social ties.

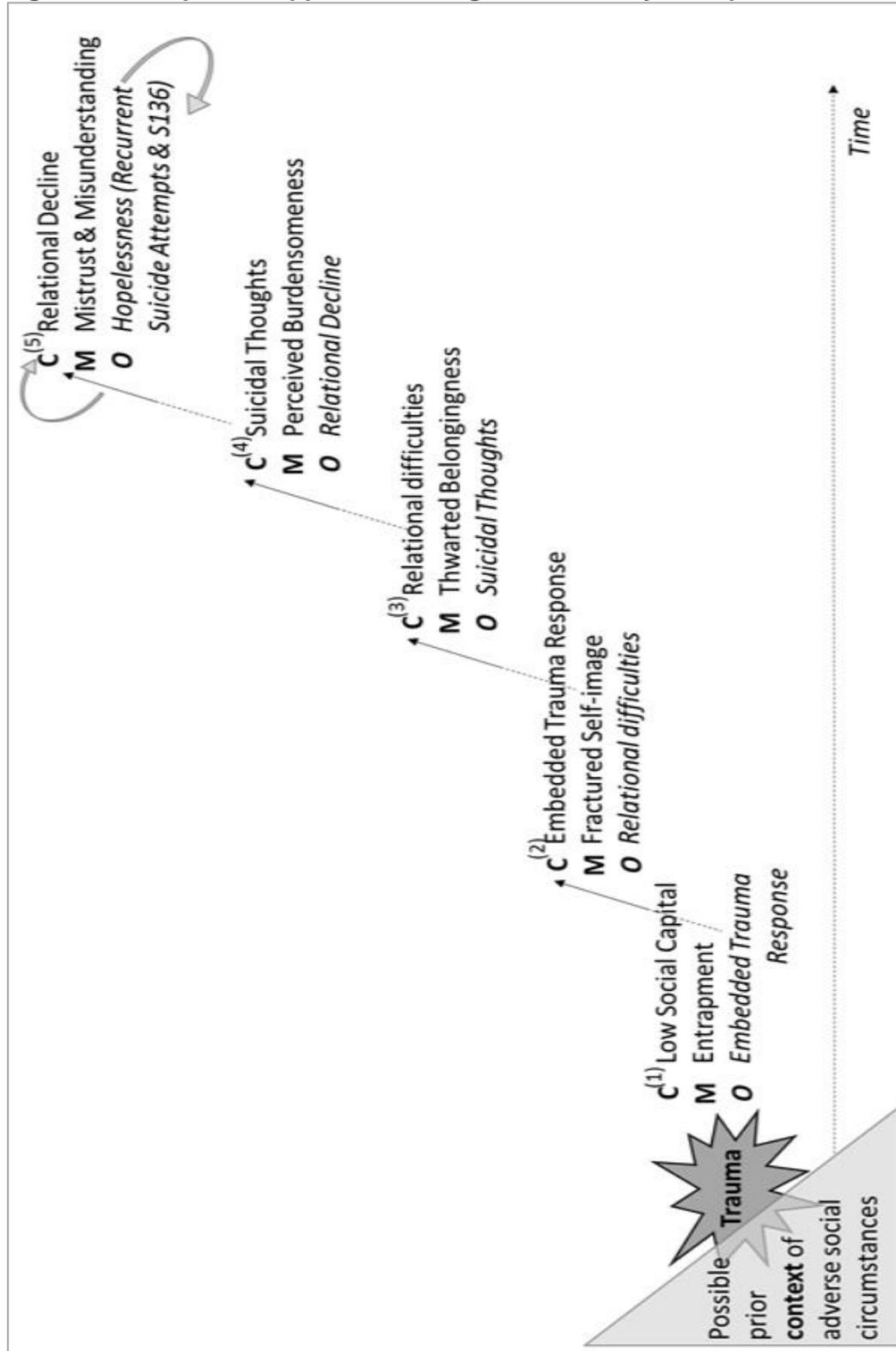
Drawing on the extant research discussed above, it is thus proposed that for those prevented from accessing support or appropriate buffers (generally through a context of low social capital) at the time trauma or traumas take place, the interpretation of those events will have a mechanistic role in which the direct or implied powerlessness determines the individual's evaluation of the trauma. The resultant outcome is then be more liable to be an ongoing impact or 'embedded' trauma response. This corresponds to the role of perceived social support buffering the development of depression in later life for those who were exposed to childhood adversity, especially abuse (Cheong et al., 2017).

Inherently, powerlessness is an almost inevitable element of childhood, which is liable to be experienced as entrapment if that child is subjected to trauma. Cheong's research signals that elements of the context with which a child experiences adversity must take a mechanistic role in influencing the subsequent impact of those events. Where there is no available adult to ameliorate the impact of that abuse, the betrayal hypothesised by Shay (ibid) to be a key factor in the development of PTSD, is likely to be more deeply felt. Within the present model, trauma that is not adequately addressed subsequently becomes a contextual factor for the individual, triggering a mechanistic response that alters their self-image and view of others; in turn this will impair current and future relationships, further lessening opportunities for the essential relational component of recovery from trauma.

It is in the stage at which the outcome of these relational difficulties and thwarted belongingness takes place (CMOc 3) that I suggest gender comes into effect, differentiating between the trajectories most often appearing for individuals who have reached such a point. Gender has been observed to interact with sociocultural characteristics such as financial status, ethnicity and social norms, resulting in males being both less able to recognise poor mental health (Hoy & Hallman, 2012) and more reluctant to seek help (Howerton et al., 2007). As intimated in Haigh's (2009) personality development pathway (explained in the first chapter, section 1.5.4), many of the same contributory factors underlie offending and suicide. On this basis, it is not unreasonable to infer males experiencing these preliminary CMOc would have a greater propensity to be criminalised and/or become more likely to complete suicide within few attempts. Conversely, females may be more likely to be medicalised around this stage (C. Shaw & Proctor, 2005) receiving diagnoses of emotionally unstable personality disorder that convey further mixed messages about seeking help and being needy. The likelihood of recurrent suicide attempts becomes increased through the manifestation of rivalry presented in the previous chapter.

The competing messages conveyed by the police (and often also indirectly the public) intervening in suicide attempts coupled with mental health services 'backing off' as Heather described it, exacerbate the perceived burdensomeness and begin to reinforce the repetition of distress-crisis cycles rendering the individual further conflicted. Simultaneously, it is at this point that the dynamics in which their prior trauma response became embedded likely begin to be mirrored. Accordingly, CMOc 5 as presented in Figure 6.1 above represents the configuration described in detail in the previous chapter (Figure 5.1). Herein, the cyclical patterns of recurrent suicidality and repeated detention emerge from a detrimental relational context driven by the mechanistic processes of lack of understanding from services and lack of trust between the individual and those charged with their care. The outcome being the individual is rendered feeling hopeless.

Figure 6.1: Proposed Ripple Effect Programme Theory of Repeat Detention



The interpersonal theory of suicide (Chu et al., 2017; Joiner, 2005; Van Orden et al., 2010) posits that desire and capability for completing suicide, including the increased tolerance for self-inflicted injury, are implicated in such deaths. Further, this theory has articulated the role of hopelessness arising from the sense of being a burden as a proximal causal factor in generating the desire for suicide (Van Orden, Cukrowicz, Witte, & Joiner, 2012). Although Cheavens et al. (2016) found hope was not a moderator between thwarted belongingness and suicidal ideation, this study suggests that the presence or absence of hope is a pivotal factor in progressing a suicidal individual to attempt to take their life. Applying this body of work to repeated detention, which the present study has confirmed is a proxy for recurrent suicide attempts, suggests that those who accrue multiple detentions under S136 are highly vulnerable to completing suicide. Tragically, this study has unintentionally provided further evidence of this.

Through this 'implementation chain' presentation of the series of CMOc, the evolving nature of context over time is demonstrated. The outcomes that become subsequent key contextual elements further compound individuals' difficulties. A significant impact of each CMOc is to further reduce the individual's likelihood of accessing adequate support. Overall, this period can be seen as the point at which social capital is further reduced through deteriorating social bonds and impaired social functioning. The participant profiles presented in the previous chapter outlined aspects of this having already been the case for the interviewees whose histories at the point of interview incorporated unemployment, with worsening mental illness resulting in some cases in the end of highly skilled careers. The complex interactions between downward mobility and the health implications of pressures arising from loss of employment, in terms of both financial and emotional strains are broadly recognised (Boardman, 2011; Poulton et al., 2002; Thornicroft, 1991; Tiffin, Pearce, & Parker, 2005; Walker & Fincham, 2011). So too has research described previously revealed that for those with severe mental health problems and low social capital, the importance of professionals to provide connectedness is amplified (Sweet et al., 2018). The findings presented in the previous chapter provided further support for this.

Relationships were of pivotal importance within the lived experience data. This

dimension included relationships with peers, connecting to the concept of bonding social capital, but also critically the relationship dynamics governing interactions with professionals, expressed as linking social capital. Whilst the social connectedness of relationships with family and friends was perhaps inevitably cited as important in shaping interviewees trajectories around crisis, on a micro level of individual incidents, understanding was shown to have a great capacity to influence the outcome of a situation, promoting or inhibiting trust.

The deliberative workshop consultants also identified the nature of contact with mental health professionals as a critical factor, which was strongly felt to be part of this theme. Mental health staff, likely heavily influenced by biomedically dominated training and organisational cultures, were generally referred to in unfavourable terms. It is my contention, informed by the lived experience accounts and the deliberative workshop that some of the behaviour that is often labelled as 'manipulative' by workers is a manifestation of elements of this internal conflict of will. If an individual who has already experienced multiple adversities is understandably experiencing transient mind sets between two unappealing choices: continuing to struggle onwards or giving up altogether, little wonder that these tensions are likely to be reflected, or even projected into interactions with others (Nathan, 2006). However, these conflicts are often perceived as confirmatory indicators of personality disorder diagnoses, which had been Heather's experience. In turn the response of services to the diagnosis over the person triggered further conflicting volitions, as Heather had stated: "*half of me wants some help, the other half wants to be dead*". Yet as the final CMOc which was presented in the previous chapter indicates, the dismissive attitude of mental health services which appears suggestive to the individual that their repeated suicide attempts are assumed not to be seriously intended to end life, can further exacerbate crises (Sulzer, 2015). During the deliberative workshop, several consultants made the observation that 'the system' can convey a sense that in order to navigate the constraints determined by organisational boundaries, such as securing a GP appointment for a repeat prescription of medication before the current prescription runs out. Individuals sometimes felt they had to employ strategies that they knew would be classed as manipulative when again confronted with two unappealing choices. This point draws focus to the

organisational elements of context and biomedicine.

6.4 Influence of the Biomedical Paradigm

Arguments against the biomedical model that were discussed in the opening chapters have indicated that 'personality disorder' is simply pathologised terminology for the development and maintenance of relational difficulties (see sections 1.5.4 and 2.3.4). Participants referred to their difficulties and the causes of those problems in a number of ways, yet there were strong similarities in the underlying meaning and impact as well as in accounts of suicidality and the surrounding circumstances. This study has demonstrated that there is only value to labelling those commonalities as a medical disorder if it provides access to treatment.

Within the multitude of complexities that have been presented herein as constituting the problem of repeated detention, language is a highly significant factor. Whilst the critical importance of language was explicated in relation to patient involvement in Chapter Two (section 2.4.3) the discourse around the power of terminology is woven throughout this thesis. Groups and individuals have suggested the profession of mental health can only progress if reparation is made through abandoning the use of denigrating labels such as 'personality disorder'. Although not specifically seeking to support or refute the PTMF, the data in this study corresponds more closely to the Foucauldian philosophy that a drastic change is needed in how mental dis-ease is conceptualised. However, as acknowledged by proponents of a new paradigm, such change will be slow to be implemented and is certainly not without substantial resistance (Johnstone & Boyle, 2014). The medicalised language of diagnosis has not been used throughout this thesis in agreement with the biomedical paradigm but as a reflection of the context in which this work is based and where progressive terminology would appear incongruous in relaying other sources. Nonetheless, the findings of this work unambiguously reinforce the need for significant change in the thinking and actions surrounding psychological distress.

Better understanding of suicidal distress, not only by those engaged with people in the longer term but also by professionals in particular, with whom interactions

may be very brief, is crucial. Without this consistency a situation emerges in which one party responds to an individual's distress with compassion (for example the police officer standing outside Heather's car in the rain at 3a.m., refusing to leave her) but another adopts an aloof approach, sometimes under the misnomer of boundary-setting, which is interpreted as indifference (conveyed in Kate's description of healthcare staff referring to *'the suicidal in there'* or all participants' accounts of encountering the extent of their distress being underrated). These mixed messages could be understood as 'rivalries' using Pawson's VICTORE framework, explained in the methodology chapter (sections 3.2.2 and 3.3.5). Consideration of such rivalries is vital; the impact can be to diminish the individual's ability to hold hope and dissuade them from future help-seeking, but worse, the individual can be re-traumatised by replication of the circumstances under which their original trauma took place.

Similarly, interviewees spoke about the frustrations of being at a point of desperation, having their distress recognised by the police response officers, which resulted in detention, but then no action arising from assessment being interpreted as mental health professionals not taking distress seriously. A further example was contained in Diane's experience of having been admitted to hospital from a S136 but then being discharged by a different psychiatrist the following day. It is at this point the rivalries manifesting both between the conflicting stances of police and mental health services and in the individuals' own volitions explained previously, contribute to the cyclical emergence of repeated suicidal attempts in which the police are recurrently expected to intervene.

A primary purpose of the ethnographic observations was to enhance the awareness of how practitioners' organisational contexts exerted an influence. A recent realist study into collaborative mental health care observed:

"Practitioners work within organisations, and the day-to-day operation of organisations impacts on the extent to which practitioners can deliver services that are person-centred... Practitioners rarely consciously decide to work in a non-collaborative way, but non-collaborative practice can arise from the decisions that practitioners make within the organisational and incentive structures, and cultural contexts, in which they work. (Pearson et al., 2015, pp 5-7)"

Thus, the impact of organisational context cannot be overlooked, nor can the broader social context. The pervading social crisis intricately linked to the tightening of social welfare and public sector resources in the broader context of the global financial crisis has rapidly escalated the sense of detachment that has been linked to rising rates of job insecurity, familial financial burdens and homelessness. These indices of social capital are widely recognised as impacting on health outcomes and mortality (S. Evans et al., 2005; Sweet et al., 2018; Wang, Mann, Lloyd-Evans, Ma, & Johnson, 2001). Each individually, let alone cumulatively are likely to have contributed to increasing psychological distress and further problems that are often associated including substance misuse (A. Webber, Clark, & Kelly, 2016; Zisman & O'Brien, 2015) as well as deteriorating interpersonal relationships (Hawkey & Cacioppo, 2010). Furthermore, under this climate, several years of service cuts have left both the police and health services depleted and workers feeling exhausted (Care Quality Commission, 2018; HM Inspectorate of Constabulary and Fire & Rescue Services, 2018).

The opening chapters indicated that the dominant biomedical model of diagnosis heavily influences the organisational context of mental health services. The constraints placed on practitioners too often appear to inhibit them from supporting people who have developed patterns of thinking and behaving that place those individuals outside the 'norm', leaving them liable to be labelled personality disordered within the biomedical paradigm. Under the adverse circumstances frequently observed during the study to have contributed to staff shortages across each of the related mental health and social care agencies operating in Sussex, the operational pressures on the remaining workers continued to increase. Intrapersonal conflicts can arise in such contexts that impact workers performance (Kingori, 2013). In turn this can increase the emotional labour necessitated in performance of medical roles (Kerasidou & Horn, 2016; Kerasidou, Kingori, & Legido-Quigley, 2016). As described in the opening chapters, healthcare staff do not always display compassion to those presenting with problems that are typically ascribed to personality disorder: suicide attempts, self-harm and relational difficulties (Jeffery, 1979; Sheehan et al., 2016). Commonly, misunderstanding the nature of presenting difficulties and a related apprehension around ability to address those difficulties may underlie

these reactions (S. Clark & John Chuan, 2016; Hoff, Hallisey, & Hoff, 2009; Tye, 2018).

The label of personality disorder undeniably had some utility in generating a wealth of research (Newton-Howes, Mulder and Tyrer, 2015). As reviewed (see section 2.3.5) this diagnostic category has brought evidenced multiple effective psychological treatment options as well as improving knowledge of how trauma and adversity are interwoven in the complexity of causing and maintaining these types of difficulties. However, the findings of the present study suggest that the concept of 'the diagnosis of personality disorder' has at best limited utility, and that this extends only as far as robust treatment options are available. Whilst the data indicated that diagnoses of personality disorder were implicated in repeated detention, the lived experience accounts highlighted the importance of understanding that relationships are at the heart of both the problems and potentially the solutions of people who are recurrently suicidal. Where sound treatment that draws on the aforementioned evidence base to provide consistent care grounded in trauma informed principles, recovery from cycles of hopelessness, suicidal despair and repeated detention became achievable.

6.5 Section 136 and Repeated Detention in the Broader Context

Although taking part in a study about Section 136, the accounts of the lived experience interviewees did not dwell on their detentions in detail, beyond predominantly referring to experience of being detained as being unpleasant. As a result, although the framework that emerged from the analysis to illustrate the connections between relationships, trust, understanding and hope provided an explanation of how crises were triggered, it gave a clearer narrative as to how these factors could construct a route out of that cycle. Naturally, a critical factor in this was my role in conducting the interviews. Having at the time only recently concluded work in which over 30 stories of the experience of being detained had formed a key part of the data, I was keen not to simply replicate the interviews from our parent research within this study. Consequently, I purposely designed my topic guide so that the focus was not predominantly on S136. Yet, it is still of

note that where alternatives to detention or reducing the frequency of detentions were explored, it was clear that the participants' focus was on being supported to avoid escalating to the point of suicidal crisis more than on how people would like services to respond when they did get to that point. For the participants, the important points related to the problems that had led them to recurrent suicidal crises and how that build up could be managed differently.

Assessments formed another area of focus. Returning to consideration of how mental health emergency or crisis is defined and by whom. It was very clear in the interview accounts that each of my participants considered being suicidal as a mental health emergency. It is this imminent threat to life to which the police respond by detaining someone under S136, yet continually, mental health services appear to see this differently. There is no unified definition of a mental health emergency and as yet there remains no mental health emergency service. The process of S136 is of itself an intervention, however, rather than effecting change rivalries embedded within the context may have the reverse impact in which repeated detention becomes an emergent outcome for a small number of individuals.

The initial chapters presented the Foucauldian discourse that views S136 as an example not of care but of state control of social deviancy; designed to deliver those whose behaviour breaks social convention into the jurisdiction of medical control (1.3.4 and 2.2.5). Chapter Two also explained the process of medicalisation by which suicide has come to be considered within the category of 'mentally disordered behaviours', certainly within the lay conception if not always by medical professionals, which enabled attempting suicide to be decriminalised (section 2.2.4). The findings of this study have detailed that the police rarely appear to initiate contact but generally become involved at the request of concerned members of the public, people known to person in distress or indeed the person themselves. Repeated detention is therefore not the result of the police or state seeking to control social deviants, rather, it is categorically tied to the social response to suicidal or self-harming behaviour.

The notions of mental health crisis or emotional distress requiring urgent assistance exist within lay conception but as neither are 'diagnoses' under the

biomedical paradigm, medical professionals can be reluctant to accede (Dolan & Holt, 2013). Therefore, the current mental health crisis provision is often considered inadequate or inaccessible by people experiencing extreme distress. The role of the crisis team (generally referred to a Crisis Resolution and Home Treatment Team) is to deliver a short term focused 'burst' of intensive work, ultimately aimed at stabilising an individual out of a period of crisis, ideally without admitting them to hospital (Johnson et al., 2005). The purpose of these teams is assuredly not about long-term work. Whilst this short-term intense approach can be effective with some 'forms' of mental health crisis, three visits a day for a week will be of very little use to someone experiencing entrenched difficulties arising from historic experiences that have left a profound level of psychological distress, as this study has shown. So too, may a short admission to hospital sometimes be unavoidable during a period of crisis, in order to facilitate a person being kept safe with round the clock nursing, but again, in the longer term it will not address core issues driving suicidality. For those repeatedly detained, S136 is a further example of this paradox. Detention will prevent a person ending their life when in a state of acute distress, but whilst it may also provide sufficient time to deescalate out of the immediate point of crisis, it does not address the reason for that crisis any more than a further few hours or days in hospital would do. This dilemma is further liable to being confounded by a decision to admit someone at one assessment being reversed less than 24 hours later.

Somebody experiencing recurrent suicidal urges won't be stabilised or 'cured' by a short stay in hospital, nor will a week of intensive visits by even a highly skilled mental health worker address the underlying need. Understanding this, it is reasonable that crisis teams may be unwilling to engage with someone experiencing recurrent suicidal crises, even if they have not been formally diagnosed with a personality disorder. Likewise, a Mental Health Act assessment may be unlikely to recommend admission under those circumstances, as again, it will not address the issues driving those crises. The need is long term, consistent work on relational issues and self-image. Sadly, it seems that in the absence of adequate long-term therapeutic input, the focus of response is too often mis-directed to putting boundaries in place. Yet, as the present findings suggest, without explanation those boundaries are frequently interpreted as services

'backing off' as Heather put it, implicitly perceived as rejection and blaming the individual, coupled with confirmation that they cannot be helped.

From this perspective, if the focus of all agencies involved remains on the point of crisis, the police will continue to be called upon to 'plug the gap' by intervening recurrently to prevent suicide. This research has shown that people need to be enabled to reduce the *incidence* of suicidal crises, not to trained to deal differently with those crises tacitly accepting the inevitability of recurrence. It is critical that people detained with high frequencies through recurrent suicidality be supported to challenge the impact of past trauma that enables the individual to restructure their interpretations away from self-recrimination and hopelessness.

6.6 Chapter Summary: Breaking the Cycle with a Community of Consistent Care

Ninety-seven detentions were accrued by people aged 21 and under. There are a multitude of issues faced by younger people, many of which are described in the preceding literatures as factors that are frequently linked to vulnerability to extreme distress of psychological disturbance in adulthood. However, the majority of those detained with high frequencies, as well as those who generously gave of their time and experience to take part in this research, were adults, many of whose lives had been indelibly scarred by childhood experiences. Research outlined in the initial chapters has identified certain protective factors can mitigate the impact of adverse childhood experiences, in particular demonstrating the importance of consistent and reliable social ties to an 'Always Available Adult' (Cheong et al., 2017).

This study suggests that once this opportunity has been missed and an individual has progressed to the entrenched level of difficulties described herein, a single caring influence is likely to be insufficient to repair the damage done to the grown individual's fractured sense of self and others. Anna and Kate's continued suicidality despite having such positive ties to understanding and empathetic mental health professionals evidenced this. Likewise, a single organisation that is not cognisant of the delicate balance required in providing reparative trust bonds may be just as problematic. As Heather observed, the police are obliged to

step in, performing the Always Available Adult role at the point of crisis. Yet, the above implementation conceptualisation indicates, over time rather than mitigate suicidality, this can lead to a dangerous cycle of repeated detention. Thus, where social systems have originally failed, often through allowing an individual to be victimised and then compounding this through inadequately addressing the consequence of that trauma, a reparative social system may hold the solution. As the case of the Lighthouse suggested, rather than an Always Available Adult, an Always Available Community may provide a sufficiently safe context of consistent relationships in which healing can take place.

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7 CONCLUSIONS

7.1 Chapter Overview

This study has provided a vital examination of a previously under-researched phenomenon, that of repeated detentions by the police under S136 of the Mental Health Act. A multi-method investigation into the psychosocial components of recurrent detention has revealed important factors that are implicated in the multiple detentions of this distinct cohort within the wider population of people who are detained under S136. In doing so it has illuminated critical dynamics that are key in safely supporting people to break cycles of frequent emotional crises. The study also contributes to the body of evidence in relation to S136 more broadly.

This brief final chapter opens with a summary of the main findings and limitations of the study. The contributions to knowledge and understanding this work has made to academic discourse and then policy and practice are considered. Recommendations for further research will be suggested before concluding comments draw the thesis to a close.

7.2 Summary of Key Findings

The aim of this study has been to develop a psychosocial understanding of repeated detention. The key findings of the research have been that:

- Repeated detention is almost entirely linked to suicide and self-harm.
- More women than men are repeatedly detained in general and specifically those detained with very high frequencies are females who have diagnoses of borderline or emotionally unstable personality disorder.
- Addressing the repeated suicidal crises experienced by people who have been detained with high frequencies requires a coordinated multiagency, 'wraparound' approach, to both keep them safe in the short term *and* to work to address the underlying trauma over the longer-term using a consistent relational approach.

In addition, this study has demonstrated that recurrent detention is a widely recognised, although not easily definable, phenomenon. Further, within the South East of England, repeated detention accounts for a third of S136 detentions.

7.3 Research Limitations

The choice to recruit from the Lighthouse was motivated by increasing access to potential participants from a relevant population, rather than an intent to investigate the service or the impact of membership, but in reviewing the lived experience data it was immediately apparent that there was a stark difference between the interviewees who were members of the service and those who were from out of area and felt they did not have adequate support. As noted, there was a strong resemblance between the Lighthouse members' experiences prior to joining the service and the accounts of the out of area participants, from which inferences have been drawn about the impact of receiving insufficient support. However, it must be acknowledged that had the interviews been conducted and reviewed over a longer period within the study, this aspect could have been more thoroughly examined in subsequent interviews.

The small number of interviews constituting the lived experience data is a further limitation. Although the themes that emerged appeared robust in the amount of data supporting them, the endorsement and iterative development through the lived experience consultants taking part in the deliberative workshop, and the literature by which they were supported, nonetheless it is of relevance to note that the model developed herein was based on the accounts of only two people from outside Sussex and four individuals living within the area.

The self-selecting nature of the sample may also have impacted the data. It would have been interesting to investigate whether participants who lived in Sussex but were not members of the Lighthouse or its 'sister' services elsewhere in the county, would have had experiences that more closely resembled those of the out of area interviewees or the Lighthouse members. Future research would thus benefit from more purposive and extensive sampling to explore the versatility of the model and the temporal dimension of the posited trajectory.

It must also be noted that my own bias and that of the lived experience advisors who took part in the deliberative workshop meeting will inevitably have been incorporated into the model I have proposed, especially given my choice to give greater weight to the voice of lived experience within my findings. Whether a different, larger and more diverse group of informants, incorporating the programme theories of professional stakeholders would produce the same model or support that proposed herein remains unexplored. In addition to drawing on a larger sample, engaging a range of other stakeholders in the process of theorising the development of recurrent detention would have mitigated against this shortcoming. For this reason, further research on this subject is strongly recommended (see below).

The findings have provided evidence that repeated detention is a widely recognised phenomenon that is not tied to any particular geography. The average of 30% of multiple S136 cohorts being repeated detentions appears fairly robust in the South East Coast region being drawn from different localities and time periods, however it has not been possible to infer whether this rate of repeated detention can be generalised to elsewhere in England and Wales.

7.4 Contribution to Academic Literature and Research

Repeated detention under S136 has been largely overlooked by research literature, hence the primary contribution of this work has been to draw focus to this topic. The study has confirmed there is a widespread recognition of recurrent detention in England and Wales. The people detained with the highest frequencies are females with histories of trauma who are frequently poorly served by mainstream mental health services, contributing to recurrent suicidal crises. Suicide is a global health concern that ends a life in the UK every two minutes. Understanding how to reduce suicide is therefore a pressing concern. As discussed in Chapter One, Cheavens et al. (2016) have stated that most people who feel suicidal will not ultimately take their own lives, however it is also acknowledged that one of the most significant risk factors for death by suicide is a prior history of attempts (Beghi et al., 2013). Likewise, self-harm is recognised as elevating the risk of suicide (Horrocks et al., 2003). The moral imperative that

repeated detention be addressed has been highlighted by the qualitative data from this study, which has unequivocally demonstrated the misery of existing with enduring suicidality arising from unresolved trauma. This research has theorised the mechanistic connection between trust and understanding by which hope can be stimulated in the context of consistent relationships to propel recovery. The advancement of this conception has underscored the intrinsic value of the multidisciplinary approach and the realist stance adopted.

Much of the extant suicidality research discussed herein has used quantitative methodology, measuring the presence of dimensions with psychometric scales. It has also had a dominant focus on refining risk assessment. A strength of the present study is therefore in its presentation of the qualitative lived experience account of these aspects. It is my contention that theorising the way in which hope may be influenced by the other components within this milieu of human existence enriches models, such as the Interpersonal Theory of Suicide with which it accords (Van Orden et al., 2010). The specific contribution of this model has been to reveal the way in which trust and understanding are integral and interrelated elements of facilitating hope to reduce repeated suicidality and therefore recurrent detention. The escalation in risk for those who 'train' themselves to complete suicide by increasing their tolerance to self-harm also features in the Interpersonal Theory. Importantly, this study also supports that element of the Theory, further emphasising the need to treat recurrent suicide attempts and self-harm as serious indicators of extreme distress. This study has highlighted the danger of regarding people who are repeatedly detained as merely 'attention-seeking'.

Furthermore, in spotlighting the overlaps between repeated detention, suicidality and emotional and mental health crises, this work illuminates the need for research to be multidisciplinary in scope. The common routes to chronic suicidality, social disenfranchisement and entry to the criminal justice system for those surviving multiple adverse childhood experiences have been demonstrated previously. Nonetheless, studies are too often focussed on specific populations in single contexts such as 'offenders', 'care-leavers' or 'people with a diagnosis of personality disorder'. Whilst this is understandable, it hinders much needed

advancements in understanding how best to support those in need. For example, the work discussed earlier herein that has been undertaken around the offender personality disorder pathway has revealed invaluable gains for staff working in psychologically informed ways that incorporate a core understanding of trauma. The present study has provided further confirmation of the presence of trauma being a crucial consideration for a highly vulnerable population of women whose complex needs are rarely best-served by biomedically dominated mainstream mental health services. Commonly, the needs of this group are not adequately addressed but this research has highlighted the frequency with which iatrogenic consequences result from contact with services that are not mindful of the risk of retraumatisation.

Gender has also been a critical element of this study, with the findings demonstrating that it is females who are detained repeatedly with the highest frequencies, contra to the wider cohort of all people detained under S136 in which the number of males detained greatly outweighs females. Consequently, this research provides further support to the concerns presented by the feminist critiques of mental illness discussed in Chapter Two. These findings add further weight to the parent *S136 in Sussex* study (Bendelow, Warrington and Jones, 2016), the Isle of Wight research (Jennings and Mattheson-Monnet, 2017) and Eswaravel and O'Brien (2018). In doing so, the present work has made an important contribution to suicide research.

Coupled with trend data on suicides and the criminal justice system, and drawing particularly on sociological work, these findings suggest that in being socialised to be less violent and more communicative, females having a greater willingness to seek help and may become recurrently suicidal whilst males miss this 'opportunity', having a greater propensity to complete suicide. The study has elucidated the unintended rivalry contained in the mixed messages given by different actors within the process of S136 detention. At the point of suicidal crisis where the police intervene, the person in need is given the message that the responding officers do not want that person to end their life. In contrast, an apparently negative attitude encountered by health service professionals once the individual then arrives at the next part of detention may serve to trigger or

reinforce messages of worthlessness or hopelessness.

Although tragic, ironically it therefore appeared that the cycles of hopelessness and help-seeking that triggered recurrent detentions and maintained life may also have further fuelled successive cycles. The perceived rejection by mental health services coupled with the reliable acknowledgement of distress manifested through police intervention, mirrored the rivalry of will in which individuals found themselves torn between hope of survival and despair. Even if only at a subconscious level, multiple detentions reinforced to the individual that there is last minute hope of salvation.

Crucially, this research also adds to the discourse around biomedical models of mental health and specifically the medicalisation of recurrent distress. The interviewees in this study had been labelled as personality disordered, for some in spite of multiple assessments disputing this 'diagnosis'. The participants who had been supported through the Lighthouse had eventually found an assurance through greater understanding of their acute emotional distress, recurrent self-harming and suicide attempts. But all accounts indicated ways in which the shadow of personality disorder pervaded interactions with mainstream mental health services, frequently hindering access to care. Whilst unpalatable, these findings call attention to the continuing need to interrogate the biomedical narrative.

The emergent outcome of those described by Sulzer (2015) as *de facto* demedicalised by virtue of being designated as personality disordered, illustrates that attempting to disaggregate the complexities of recurrent detention in order to tackle any one issue in isolation seems likely bound to fail. Rather, an understanding that not only tolerates complexity but seeks to map it comprehensively, is necessitated. This research has confirmed that realist research, through searching for complex relationships between people, their experiences and the contexts in which these take place, is ideally suited for such a task. Hence, this PhD also presents a significant contribution to the methodological debates within the realist community. Whilst the study may not be deemed a 'true' realist evaluation as it has not been centred on an intervention in the traditional manner, it is my contention that my application of a realist stance

has kept this research intrinsically realist. My study has sought to identify the generative causal factors involved in repeated detention and to theorise an account of how these elements interact to trigger this phenomenon. In doing so, this work contributes to advancing the dialogue initiated by Pawson and Tilley (2004) in relation to formative realist evaluations and continued in Pawson's (2017) framing of a realist diagnostic evaluation. Rather than seeking to assess how a program produces change, this research has looked to uncover 'who is repeatedly detained, under what circumstances and why'.

7.5 Implications for Policy and Practice

This study has demonstrated repeated detention to be a broadly recognised phenomenon, consequently this work has important implications for developing policy as well as practice within both policing and mental health. The accounts provided both by those who have been detained with high frequency and from other stakeholders throughout the life of this work, have indicated the shared sense of futility provoked by feeling locked into the vicious cycle of recurrent suicidal crises. The raw pain of the individuals experiencing repeated periods of despair has at times been mirrored in the frustration of frontline staff responding to the same individual on multiple occasions. This pattern demonstrated in the proposed program theory of high frequency repeated detention has the potential to become self-perpetuating, further heightening the risk that the individual will eventually complete suicide.

Schemes such as the Serenity Mentoring programme (Jennings and Mattheson-Monnet, 2017) and the Newcastle relational project (Tye, 2018) have not only demonstrated the possibility of providing a route out of cyclical despair for the person in need, but have also further underlined the power of supporting practitioners to better understand and therefore support the people who so often present in crisis. The narrative of over-dependence on services is all too often associated with those experiencing frequent crises and labelled with 'personality disorder'. This pejorative attitude provides nothing by way of solution and frequently serves merely to encourage or justify an unhelpfully punitive response to help-seeking. The proposed model has illustrated how this response can in

itself be an instrumental mechanism in triggering further crisis. Consequently, this work has the potential to be of significant benefit for clinicians as well as for the police.

The presence or absence of a belief in having a future represented the most significant factor, differentiating the interviewees for whom frequent suicide attempts and so detention under S136, remained an ongoing aspect of their lives from those for whom such desperate cycles appeared to be largely part of their past. Constructive, consistent support that can provide a foundation for emotional development that is a critical foundation upon which hope and thus a future can be based. The significant impact of the trauma-informed approach of the Lighthouse that was apparent in the member interviews spotlights feasible ways in which practice can be adapted to bring about tangible changes that have the potential to be highly beneficial to both patients and services.

Whilst long-term sustained support is vital to ultimately effect such a change, this study has indicated that in the short term, repeated detention could be reduced by an improved response for suicidal crises. Funding has been announced for a number of pilots of various emotional and mental health emergency provision sites (Quaile, 2018). The Street Triage schemes began national piloting in October 2013 and within 5 years all but one police force in England and Wales had rolled out a triage model (HM Inspectorate of Constabulary and Fire & Rescue Services, 2018). The speed with which this radical development became embedded in practice demonstrates the willingness and capacity of services to implement the sort of considerable change that has been recognised as necessary to improve emergency mental health care. The reductions in detention rates thought to be brought about initially by the Triage schemes may however not have been sustained in the longer term. This research has highlighted one possible strand of the complex response to the question of why this may not have been the case. Despite those appearing with the highest frequencies within detention data being a small sub-group of all who are repeatedly detained, improving the care and support available to this group could have a significant impact that would extend beyond reducing S136 rates.

If recurrent suicidal crises are to be curtailed, long-term solutions are necessary.

These must be built around understanding of emotional intensity and relational difficulties. As this study has demonstrated, an individual who is detained repeatedly has typically experienced not only trauma but years of inappropriate management of the consequences of those experiences, resulting in a dangerously degraded self-image, a fractured view of their validity as a person and the reliability of those around them. It is therefore only natural that it will take years to truly repair this damage. Services need to be shaped with an understanding that recurrent suicidal behaviour is driven by traumagenic responses that are often exacerbated by indifferent responses arising from the understandable but highly detrimental frustrations of workers such as mental health practitioners. The consequences of allowing these frustrations to enter the relationship dynamic do not only impact on the interaction with that worker but serve to further strengthen the devalued self-image that in turn drives an individual towards feeling hopeless and repeatedly attempting suicide.

7.6 Recommendations for Further Research

The feasibility of engaging multiple stakeholders has now been robustly demonstrated. As found in the parent study, the responses to the police survey reinforced the broad willingness of services to better understand and therefore address the issues related to S136 by engaging in research. Additional work applying the realist approach to further refine the proposed theory of repeated detention advanced herein would certainly be beneficial. Notwithstanding the likelihood of considerable challenges in both information sharing and protecting confidentiality, establishing a nationwide picture of repeated detention that incorporates detentions in different counties would be of great use. Relatedly, it would also be useful to establish whether the 30% rate found in the South East region is also present elsewhere in England and Wales, as indicated in the limited literature that has reported this data.

This study has revealed further indications but insufficient evidence to support the presumption that many people who are repeatedly detained are also likely to be in frequent contact with a range of other organisations, and probably to have difficulties in engaging with those services also. Multiagency approaches that

safely co-ordinate support are critical to closing the gaps through which this vulnerable group of people fall continually. It would therefore be of enormous benefit for further investigations should involve the range of relevant social care and physical health services to which those recurrently detained are also likely to be known, such as GPs, housing, substance misuse and family services. Rigorously researching this element will be invaluable as this study has indicated no single agency is likely to be able to adequately meet the needs of this cohort of people. It is therefore imperative that the evidence base around best practice in multiagency work be used to provide services with the flexibility and impetus to collaborate with each other and the person in need in a way that truly understands the interwoven complexity of their lives and thus creates adequately tailored support. This is especially crucial given the accounts of how feeling let down or rejected by professionals was often the final tipping point to serious suicide attempts. Further iterative testing of the model of repeated detention will evidence reliable routes out of the cycle out of recurrent suicide attempts and develop best practice in supporting individuals through this progression. Drawing on a larger range of different stakeholder groups will also strengthen the model and enhance its utility.

The comparison of data from this research with the similar anonymous dataset covering a different period of twelve months that had been used in the parent S136 in Sussex study has also yielded interesting results, but without non-anonymised longitudinal data, the assumption that most people are detained only once cannot be tested. It is possible therefore that the greater period of time over which data recorded over several years may reveal that some people are recurrently detained but over a longer period. Whether these hypothesised people may then enter a phase of high frequency detention thus also remains untested. Therefore, mixed methods research extending over several years could be beneficial in developing an understanding of whether there is such a progression or trajectory for those detained with high frequency. The sad likelihood is that some people will complete suicide after so many attempts; tragically, I was advised by the next of kin of one of my participants that she had passed away prior to the end of my research. Longitudinal data would also demonstrate these outcomes, which could combat some of the complacency in

professional services experienced by those who have accrued multiple suicide attempts.

Finally, this study has also raised an interesting consideration of the circumstances under which the public may be inclined to intervene. Since Rogers' study in 1990, little S136 research has examined the involvement of others and specifically the role of the public, prior to police detention. Yet the broad variation contained in the present data as to how the police were alerted indicates this may be a fruitful area of focus for further research into ways to reduce detention rates in highlighting opportunities for alternatives to police involvement.

7.7 Concluding Comments

Sixty years after the original Mental Health Act revived the 18th century police power to detain those deemed unsafe to go abroad owing to mental illness, the need to reduce the rate of detentions under S136 has become critical. This study has demonstrated how the lacuna of provision for emotional crises means those in distress often feel ever more desperate acts are necessary to access support or that nothing can help and therefore suicide is their only remaining option. The opening chapters of this thesis examined how defining extreme distress has troubled scholars, practitioners and those experiencing that distress for centuries. A consensus appears unlikely to be reached on the question of precisely what constitutes a mental health *problem* and therefore the attendant question of how a mental health *crisis* should be defined remains a contentious one. Little wonder then that whilst there appears a widespread sense that a crisis or emergency must necessitate a response, the agreement on what that response should be and whose responsibility it is, continues to elude all concerned. Likewise, although this study has indicated that recurrent detention resists strict definition, it has established the widespread recognition of this phenomenon and confirmed the potential utility of seeking effective means to address the needs of those detained repeatedly.

Ongoing review will be essential to examine what, if any impact the Policing and Crime Act (2017) will have upon repeated detention. With Sir Simon Wessely's

independent review of the Mental Health Act having been completed at the end of 2018 (gov.uk, 2018), it is possible that further substantial changes to mental health emergency and crisis care may lay ahead. At present, there is no mandatory monitoring of the frequency with which individuals are subject to S136. However, this research has demonstrated that practitioners around the country are aware of issues surrounding recurrent detention.

This study has provided a detailed account of the information held on individuals who are recurrently detained in the English South East coastal counties of East and West Sussex. Additionally, the data provided by the neighbouring localities has indicated there are consistencies in the rate at which repeated detention occurs. Further research would be beneficial to understand whether the patterns observed in relation to diagnosis and response are reflected elsewhere, as has been indicated by some of the police survey responses. However, as has been emphasised throughout this thesis, it will be essential to ensure such research goes beyond merely providing further pejorative labelling of already disempowered individuals designated as personality disordered. As the account provided here has indicated, such a 'diagnosis' if it is to remain for the foreseeable future, must be seen as a proxy for extreme vulnerability.

Assuredly, a commonly observed phenomenon across almost all services is the presence of a small number of individuals whose needs confer a high demand on organisations, frequently outstripping the available resources to meet those needs. This study has provided further support to empirical work indicating the likelihood that this is the same group of people. The crucial importance of a multilateral approach to recurrent detention has thereby been highlighted in this work, which has indicated several promising routes through which the dangerous pattern of repeated detentions may be safely interrupted and brought to an end. Whilst the solution to breaking the cycle of suicidal distress is unlikely to be an even distribution of time and work from all agencies, it is nonetheless imperative that services work together to seal the gaps through which these vulnerable individuals recurrently fall.

This research has demonstrated the complexities involved in the distressing phenomenon of repeated detention. The findings have indicated how some

factors currently inherent to the services that seek to support people in crisis may unwittingly contribute to maintaining repeated detention; highlighting the plight of a small group of people rendered as a social precariat through serial societal neglect. For some, this contributes to *de facto demedicalisation* (Sulzer, 2015) by being labelled as personality disordered and thereby effectively excluded from services. The role of mental ill health in downward social mobility has been well documented in Foucauldian appraisals of the use of power and social control in psychiatry (Pilgrim, 1997; Pilgrim & Bentall, 1999) and the creation of an 'underclass' in the hospital episodes vividly described in Jefferys' *Normal Rubbish* (1979). Alongside broader concepts of medicalisation of distress and gendered critiques of diagnosis, a more detailed or certainly nuanced framework is necessary to provide a more comprehensive account of recurrent distress in our modern society (Busfield, 2017). A modern society in which Roy Porter has astutely observed, ancient problems indeed persist (2002). Despite the intent of the Policing and Crime Act to improve conditions, the wording of Section 136 remains startlingly indistinguishable from that of the 1744 Vagrancy Act.

Set in a context of national-level financial adversity, beleaguered public sector services have begun to work together to tackle some of the issues related to this area, but systemic change will be needed to effect true change. Such reform will not be brought about by directing accusations at one service or another. This thesis has demonstrated repeated detention to be an invidious cycle of mutual misery into which individuals and services become trapped. Mental health professionals no more desire to be unsupported and overburdened, unable to hold hope for their vulnerable clients than do the police to be continually arresting people for their own protection. Moreover, individuals do not want to remain locked into recurrent experiences of suicidal despair.

Rather than attention seeking, this study has confirmed the position of Pakes, Shalev-Greene and Marsh (2014) that patterns of crisis, trauma and disenfranchisement from services beset those who are repeatedly detained. Caught in the nexus of care and control, the S136 detention of individuals in this group becomes merely a pause in the perilous cycle of desperation within which they have become ensnared. Whilst completed suicide may be prevented at the

point of detention, the likelihood of a subsequent attempt may be paradoxically increased. Thus, it is imperative that high frequency S136 be viewed not simply as a troublesome resource demand or inappropriate police action, but as a lens through which to identify some of the most vulnerable members of society in greatest need of alternative provision of care.

8 REFERENCES

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Appendices

Appendix A: Email Chain with Inspector Michael Brown, College of Policing & National Police Chiefs Council Mental Health Coordinator

1/12/2019

RE: Section 136 Study

RE: Section 136 Study

Claire Warrington

Sent: 28 February 2017 17:48

To: Michael Brown [Michael.Brown2@college.pnn.police.uk]

Michael, thank you so much for this.

I'm very grateful - the more so knowing how flat out you must be. Good luck climbing the email mountain (sorry to add another one but had to say thank you!)

*Best wishes,
Claire*

Claire Warrington
Doctoral Student: Section 136 of the Mental Health Act
School of Applied Social Science
University of Brighton (Mayfield House, Falmer)

Email c.a.warrington@brighton.ac.uk

<https://www.brighton.ac.uk/research-students/claire-warrington>

From: Michael Brown [Michael.Brown2@college.pnn.police.uk]

Sent: 28 February 2017 15:35

To: Claire Warrington

Subject: RE: Section 136 Study

Claire,

Sorry for delay – I'm drowning in emails, currently!!

I can tell you now there are no 'schemes' like Pauls SIM project. There are forces who do various things to monitor 'repeats' and that leads to different kinds of discussions between police / MH. As you might expect, some of that repeat 'problem-solving' is better developed where areas have street triage schemes of one kind or another.

I've sent your questions around all England / Wales mental health leads as for replies to you.

Hope that helps but do let me know if you need anything else or want to discuss.

Michael./

<https://staffmail.brighton.ac.uk/owa/?ae=Item&t=IPM.Note&id=RgAAAACI%27pDIUwSS6ZrYzK6Z%27TIBwAYIhCY9g51SaJT40WUvE1YAAAAtH...> 1/4

1/12/2019

RE: Section 136 Study

From: Claire Warrington [mailto:C.A.Warrington@brighton.ac.uk]
Sent: 12 February 2017 14:00
To: Michael Brown <Michael.Brown2@college.pnn.police.uk>
Subject: Section 136 Study

Dear Michael,

I don't know whether you'll remember we had a brief Twitter conversation about a year ago in relation to my PhD, which is looking at repeated detention under Section 136. I am now starting my data collection. I will be focussing mainly on the local area and am already collaborating with Sarah Gates, Amy Macleod and Paul Jennings, who have suggested I contact you.

My original intention was to contact each force individually to try to 'map' levels of concern and any practice specifically around repeated detentions but I am aware that with the Policing and Crime Act now passed a lot of areas will be feeling under even more pressure than the already excessive amounts that have only been on an increasing trajectory for years now and I am picking up that police simply don't have time to be picking up the phone to academics. However, I am still keen to try to get a picture of the thoughts on repeated detention from a wider area and so I have revised this down to make as 'light touch' as possible in the hope that you might consider assisting me with this.

I am asking whether repeated detention is on the radar in individual counties, I hope to get a measure of this and to find out if there are any other schemes like Sergeant Jennings' Serenity Integrated Mentoring project for people detained with high frequency.

The two questions I am asking (below email footer here) can be answered simply in a couple of seconds and I am therefore hoping that I might get a solid response rate if you would be willing to circulate this?

I have also attached a one page study overview and would of course be more than happy to discuss the project further, however I am mindful that you are also bound to be busy in preparing to change roles next month and I am therefore very grateful for your time in reading this email and any assistance you may be willing to give.

*Best wishes,
Claire*

Claire Warrington
Doctoral Student: Section 136 of the Mental Health Act
School of Applied Social Science
University of Brighton (Mayfield House, Falmer)

Email c.a.warrington@brighton.ac.uk
<https://www.brighton.ac.uk/research-students/claire-warrington>

Frequent Detainees under Section 136 of the Mental Health Act: Repeated Detention and Practitioner Responses

POLICE SURVEY

<https://staffmail.brighton.ac.uk/owa/?ae=Item&t=IPM.Note&id=RgAAAACI%27pDIUwSS6ZrYzk6Z%2TT1BwAYIhCY9g51SaJT40WUvE1YAAAATH...> 2/4

1/12/2019

RE: Section 136 Study

I am a PhD candidate at the University of Brighton, researching people who are repeatedly detained under Section 136. My research is mostly based in Sussex, Hampshire and Surrey, but I am interested to know whether repeated detention is considered an issue in other parts of England and Wales.

Please tell me which county you work in:

1 What is your area's position on repeated detention?

A - Not an issue here

B - Aware some people are detained repeatedly but do not consider it a significant issue

C - Aware of a few individuals detained with high frequency but we do not have the resources to examine the issue further

D - When an individual is being repeatedly detained we alert mental health partners and ask them to take action

E - We have arrangements in place to address repeated detention (please briefly describe)

2 What frequency would you consider problematic for an individual being detained under Section 136?

Please return by email to c.a.warrington@brighton.ac.uk

Should you wish to discuss this research please let me know the most convenient way to contact you, however I am aware of time pressures and so will not contact you again unless requested to do so.

Many thanks for your time.

Claire Warrington

c.a.warrington@brighton.ac.uk

01273 643960

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Any opinions expressed in this email are those of the individual and not necessarily those of the College of Policing Limited.
It is intended only for the person(s) to whom it is addressed and may contain privileged information.

<https://staffmail.brighton.ac.uk/bwa/7ae-Item&t-IPM.Note&Id-RgAAAACI%27pDIUwSS6ZrYzK6Z%27TtBwAYhCY9g51SaJT40WUVE1YAAAAH...> 3/4

Appendix B: Risk Management Protocol

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Frequent Detainees under Section 136 of the Mental Health Act: Repeated Detention and Practitioner Responses

Risk Management Protocol

Version 3 02/01/2017

This protocol has been developed following discussion with lived experience consultants and clinicians to detail how concerns about participant welfare that arise during the interview process will be addressed.

The aim of the interview is to provide a confidential space for the participant to share such views and experiences as they feel appropriate and it is not expected that extreme distress will occur, nor that the relevant action will become necessary, however it is acknowledged by the research team that many of the interviews are likely to touch on sensitive topics around distress and support. It is further acknowledged that the researcher is not a trained clinician in a position to manage clinical risk.

Should a participant in this study give indication that there is an imminent risk of harm to themselves, or others, the researcher will be under obligation to inform relevant local services. Participants will be informed of this during the consent process.
An imminent risk of harm is defined within this study as an expression of intent with plan to cause harm endangering life.

In the case of less acute distress or a participant describing feeling triggered, the researcher will explore support structures and seek permission to contact services if this is felt to be appropriate by the researcher and participant.

Participant name:

Interview date, time & location

In case of concern after interview

Formal support:

Informal support

Mild distress (e.g., Tearfulness; voice becomes choked with emotion / difficulty speaking; participant becomes distracted / restless)

Researcher will:

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind participant they can stop at any time they wish

Severe distress (e.g., Uncontrolled crying, inability to talk coherently, Panic attack- e.g. hyperventilation, shaking)

Researcher will:

- 1) Intervene to terminate the interview
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation

In addition to the above, in case of any distress

- 1) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to highly stressful events
- 2) If any unresolved issues arise during the interview, accept and validate participant's distress, but suggest that they discuss with mental health professionals and remind them that this is not designed as a therapeutic interaction
- 3) Details of counselling / therapeutic services available will be offered to participants

Emergency Situations

It is not anticipated that emergency situations will arise during the interview, however researcher will familiarise herself with emergency procedures in each site prior to interview commencing and will be prepared to contact emergency services as necessary.

As outlined in the Participant Information Sheet and reviewed in the Consent Form, in the event of a participant making the interviewer aware of a serious expression of intent with plan to cause harm endangering life of the participant or anyone else, the participant's care team will be advised, as will the emergency services if necessary.

Appendix C: Consent Form

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Frequent detainees under Section 136 of the Mental Health Act: Repeated detention and practitioner responses

CONSENT FORM

Phase 3: LIVED EXPERIENCE OF DETENTION
Document Version 4: 17/02/2017

Name of chief investigator: Claire Warrington
IRAS Reference: 199739

**Please
Initial**

- 1 I confirm that I have read and understood the information sheet (Frequent Detainees under Section 136) and have had the opportunity to ask questions.
- 2 I confirm that I have had enough time to think about whether or not I want to be included in the study.
- 3 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care being affected.
- 4 I understand that any information I give is confidential and will not be stored in such a way that it can be traced back to me. I understand that the interview data I provide will be made anonymous and stored for further analysis.
- 5 I understand that the views I express during my interview and direct quotes may be made public but that the researchers will protect my identity when doing this.
- 6 I have discussed the circumstances under which my confidentiality may not be protected and the study document Risk Management Protocol.
- 7 I am willing for my interview to be audio recorded.
- 8 I agree to take part in this study.

Please turn over

Frequent detainees under Section 136 of the Mental Health Act: Repeated detention and practitioner responses

For use if third party present:

I have asked _____ to be present to support me today.
(Insert name here) How this may affect confidentiality has been discussed.

Signature (interviewee)

Date

Please print name

Signature (researcher)

Date

Name of researcher

I would like to send everyone who has taken part in this study a summary of the findings and information on what is happening next in this body of research.

Please give your contact details below if you are happy to be sent this information:

Email: _____

Address: _____

Appendix D: Participant Information Sheet

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*Phase 3: Participants with Lived Experience of Repeated Detention under S136
Document Version 3: 17th January 2017 IRAS Ref: 199739*

PARTICIPANT INFORMATION SHEET

Frequent detainees under Section 136 of the Mental Health Act: Repeated detention and practitioner responses

Dear Potential Participant,

My name is Claire, I am a researcher in mental health at the University of Brighton.

I would like to invite you to take part in this research study but before you decide I would like you to understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish, and let me know if there is anything that is not clear or if you would like more information.

Please take as much time as you need to decide whether or not you wish to take part.

Thank you for reading this information.

1. What is the purpose of the research?

Section 136 of the Mental Health Act (1983) gives the police the power to take individuals who are thought to be a danger to themselves or to others, to a Place of Safety for a mental health assessment.

It is recognised by the NHS, police and others that some people are detained under Section 136 many times.

This study is trying to find out more about the needs of people who are repeatedly detained under Section 136.

2. Why have I been invited?

The Mental Health Act Monitoring Team who hold records of all detentions in your area have identified you as someone who has been detained under Section 136 several times.

3. Do I have to take part?

No. It is up to you to decide whether or not to join the study and you are not obliged to take part.

If you decide to take part, I will go through a consent form with you before we start but you are free to withdraw at any time and without giving a reason.

Any care you may be receiving will not be affected by your decision, even if you have received this invite from someone in your care team.

4. What will happen to me if I take part?

You will be asked to take part in an interview. The interview will probably last between 45 minutes to one hour.

With your permission, your interview will be audio-recorded and I may also make some notes during the interview.

5. What are the possible benefits of taking part?

There is no direct benefit to you in taking part in this research although some participants find talking about their experiences rewarding.

We hope the findings from this research will reveal areas for improvement in the care of those who are repeatedly detained under Section 136 and possibly help us to develop alternatives.

Both the police and mental health professionals are keen for the research to help them understand how they can make improvements.

6. What are the risks of taking part?

It is possible that you could find talking about your experiences upsetting.

If you do agree to take part, we will discuss sources of support before we start the interview.

7. Can I change my mind about participating?

Yes. You can choose to stop the interview at any point and you can withdraw from the study at any point without giving a reason, even if you had said you would take part.

If you decide after the interview that you no longer wish to be part of the study or do not want information that you have already shared to be included in the research, please contact me by phone or email. If you do so, I will not use any direct quotes from your interview and if you advise me you wish to withdraw before analysis has started I will be able to destroy your interview notes and any transcript that has been completed.

8. Will my information be kept confidential?

Yes. Although you may have received this invite from someone in your care team, what we discuss in interview will not be shared with them directly.

Only myself and my supervisor, Professor Bendelow, will have access to any notes I make and the recording of the interview and I will be transcribing it myself.

When the findings of this study are shared with others we will never use interviewees' real names and we will be careful about using any details that might identify you. In areas where there are unique models or practices, descriptions of these may identify the area and related workers. If this is the case I will consult with all interviewees before publicising data that may identify services or participants.

All research data, including any personal information which may be collected during the research process will be securely stored.

The only exception to this is if during the interview you said something that led a member of the research team to believe that your immediate safety, or that of someone else, was at risk. Under these circumstances I will have to pass this information to the appropriate local services. I will discuss this with you in detail before you sign the consent form, explaining the circumstances under which I may need to break your confidentiality.

9. What will happen to the results of the research study?

At the end of this study we will produce a summary of the findings and you will be sent a copy of this.

We will also use this research to publish articles in academic journals and in conference presentations.

The views of our interviewees will be made anonymous before we share any findings, so that you will not be identifiable from any results of the study.

10. Who is funding the research?

The research is being funded by a Humanities and Social Science doctoral studentship grant from the Wellcome Trust, an independent science and research charitable organisation.

11. Who has approved this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests.

This study has been approved by the London South East Coast Surrey Research Ethics Committee (Ref 16/LO/2069).

12. Complaints

If you are concerned about any aspect of this study, you should ask to speak to:

Taffy Bakasa, Lead Governance Officer,

email: researchgovernance@sussexpartnership.nhs.uk Tel: 0300 304 0088

Or The Patient Advice and Liaison Service (PALS) Tel: 0300 304 2198

pals@sussexpartnership.nhs.uk

13. Contact Details:

Please do not hesitate to contact me if you have any questions about this study

Tel: 07399 311 965 or email: c.a.warrington@brighton.ac.uk

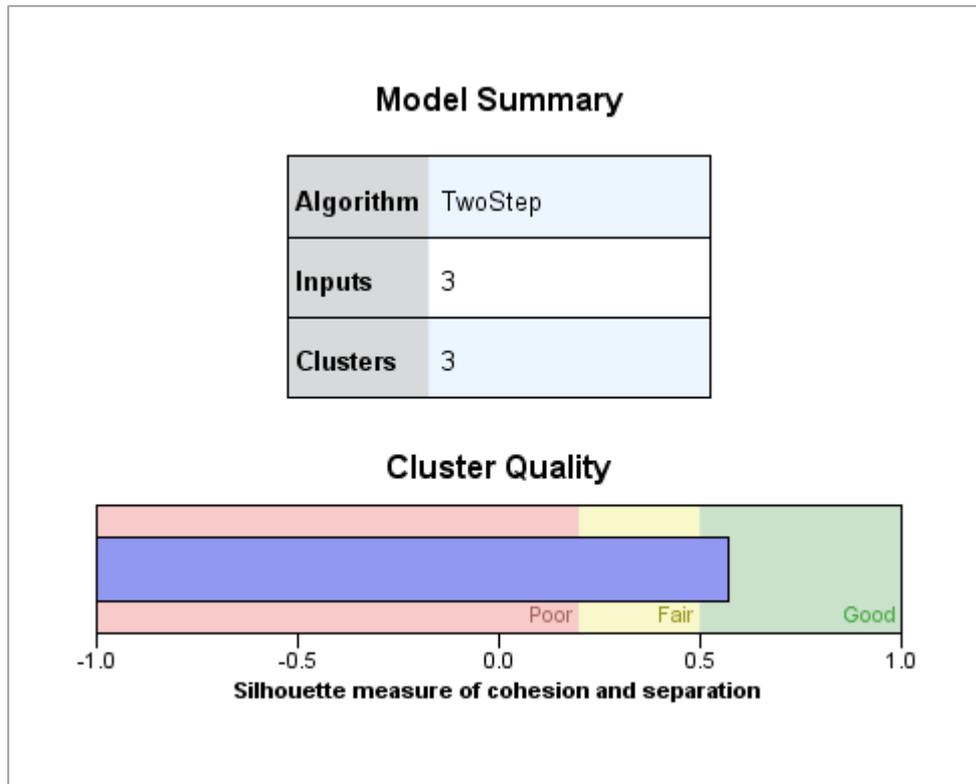
You can also leave a message at 01273 265896

Thank you for taking the time to read this information sheet.

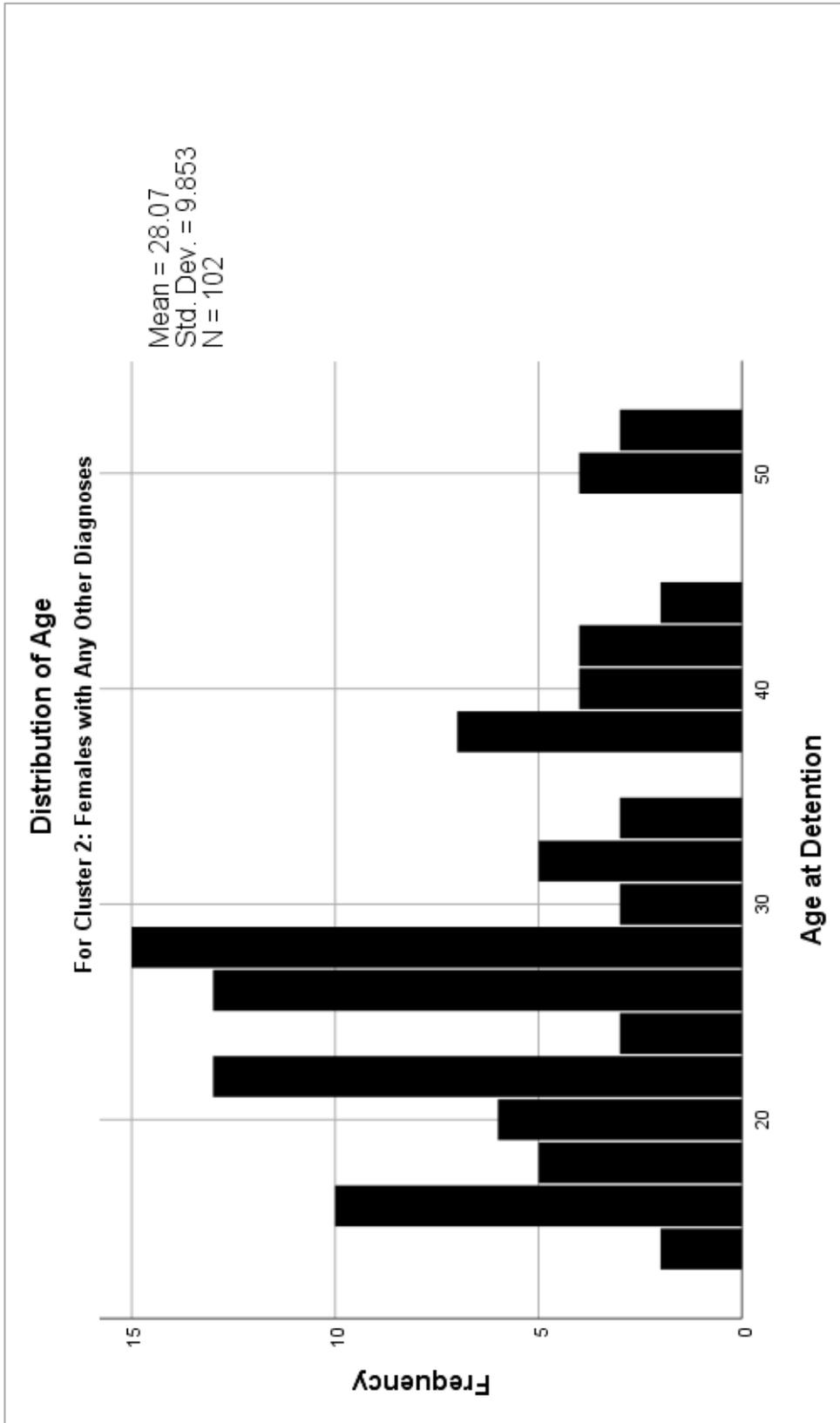
Claire Warrington

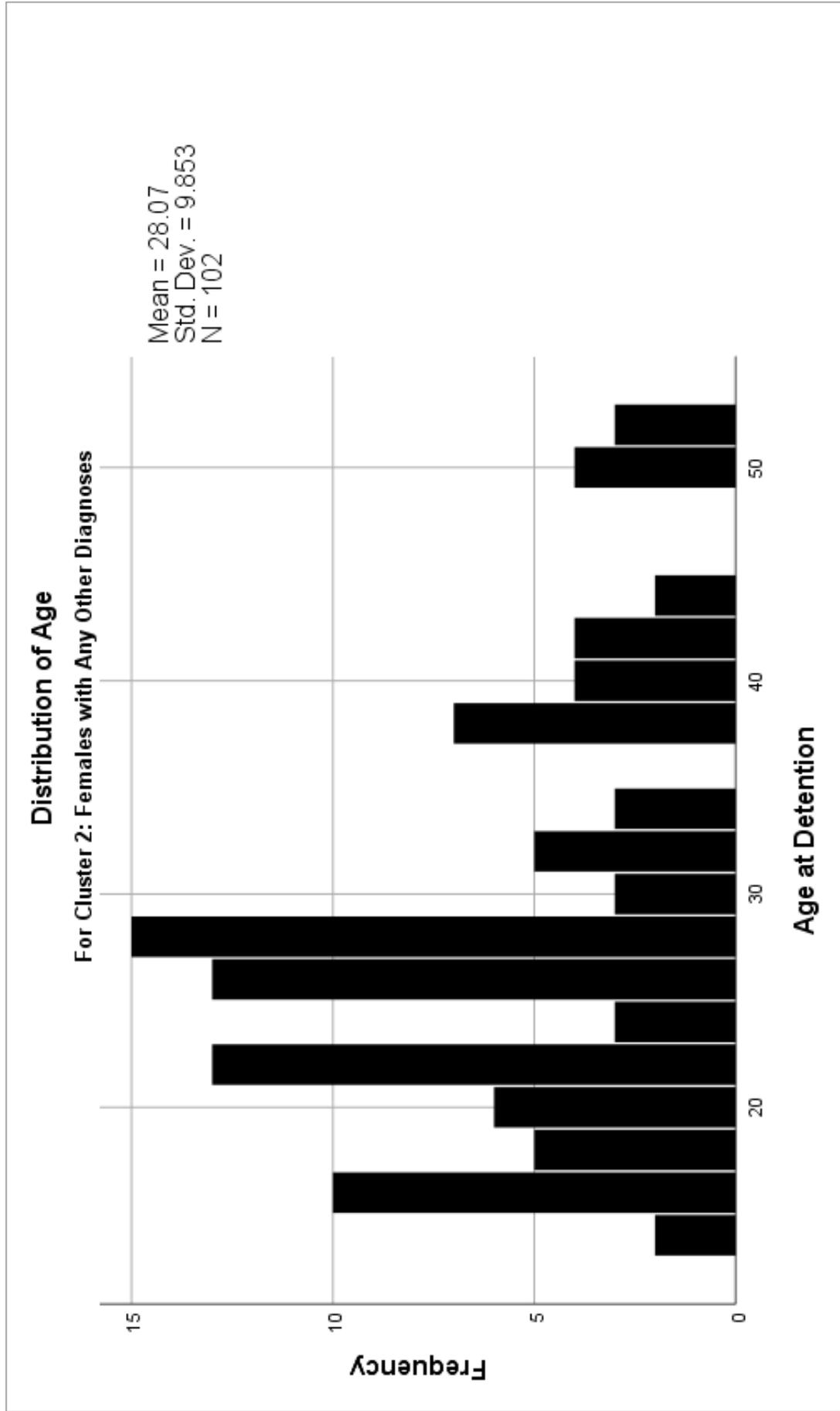
School of Applied Social Sciences, University of Brighton

Appendix E: Cluster Analysis Model Summary



Appendix F: Charts for Distribution of Age (By Clusters)





Distribution of Age
For Cluster 3: All Males

Mean = 34.01
Std. Dev. = 11.126
N = 145

