

1 Article

2 Repeated Police Mental Health Act Detentions in 3 England and Wales: Trauma and Recurrent 4 Suicidality

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9 **Abstract:** Most police Mental Health Act (Section 136) detentions in England and Wales relate to
10 suicide prevention. Despite attempts to reduce detention rates, numbers have risen almost
11 continually. Although Section 136 has been subject to much academic and public policy scrutiny,
12 the topic of individuals being detained on multiple occasions remains under-researched and thus
13 poorly understood. A mixed methods study combined six in-depth interviews with people who
14 had experienced numerous suicidal crises and police intervention, with detailed police and mental
15 health records. A national police survey provided wider context. Consultants with lived experience
16 of complex mental health problems jointly analysed interviews. Repeated detention is a nationally
17 recognised issue. In South East England it almost exclusively relates to suicide or self-harm and
18 accounts for a third of all detentions. Females are detained with the highest frequencies. The
19 qualitative accounts revealed complex histories of unresolved trauma that had catastrophically
20 damaged interviewee's relational foundations, rendering them disenfranchised from services and
21 consigned to relying on police intervention in repeated suicidal crises. A model is proposed that
22 offers a way to conceptualise the phenomenon of repeated detention, highlighting that long-term
23 solutions to sustain change are imperative, as reactive-only responses can perpetuate crisis cycles.

24 **Keywords:** Police Mental Health Act; Section 136; repeated detention; suicide and suicide
25 prevention; trauma; personality disorder; lived experience
26

27 1. Introduction

28 Under Section 136 of the Mental Health Act in England and Wales a police officer, rather than a
29 mental health professional is empowered to remove an individual from a public place to a place of
30 safety. The decision to detain is based upon the assessed likelihood in the officers' opinion that the
31 individual appears to present an immediate risk of causing harm to self or others by reason of their
32 mental health. Once detained to a place of safety a Mental Health Act assessment determines
33 whether the individual should be admitted to a mental health inpatient unit, either voluntarily or
34 under a further Section of the Mental Health Act. If admission is not considered necessary, the
35 person can be released. The number of such cases resulting in referral to community services is not
36 formally recorded, but concerns have been raised at the number of detentions that do not end with
37 any form of admission [1,2]. The number of people subject to detention who are already known to
38 secondary care mental health services is also unrecorded, as is the incidence of individuals being
39 detained on multiple occasions.

40 Section 136 (S136) has long been a controversial aspect of the Mental Health Act and scrutiny
41 from government, leading bodies and within academic literature has increased during the last
42 decade [3–8]. One reason driving this ongoing focus has been the rates at which people have been
43 detained, which appeared to have risen steeply during this time. Prior to 2015, detentions in which
44 police custody was used as a place of safety were not consistently reported and consequently it was

45 not possible to obtain accurate figures, but research for the Independent Police Complaints
46 Commission in 2008 estimated that in the year 2005/6 there had been 17,417 uses of S136 [4]. The
47 number of detentions in the year 2018/19 was reported to have risen to 33,238 [9].

48 Many complex factors are involved in the changes in S136 detention rates [10]. One highly
49 pertinent issue that has been highlighted by several studies is that S136 is closely tied to suicide
50 prevention. Estimates place between 55% and 81% of detentions as being linked to concerns about
51 the detained person's risk to their own life rather than to the threat of harming others [11,12]. A
52 recent comprehensive study investigating the use of S136 in the adjacent South East England
53 counties of East and West Sussex revealed many important elements involved in the historically
54 high rates of detention seen within that area [13]. In addition to confirming the high incidence of
55 detentions related to suicide prevention, the findings indicated one issue requiring further
56 investigation was that a small number of people had been detained multiple times. In one year
57 across the two adjacent counties, one hundred and forty-two people (13% of all detained) accounted
58 for a third of all detentions, with two individuals being detained 44 times in total.

59 Local and national stakeholders, both professionals and people with lived experience engaged
60 in the above study confirmed that repeated detention was a significant issue that was felt to deserve
61 further investigation. National data on repeated detention is not available as there is no requirement
62 to measure or report on this and very little research has examined this aspect of S136 despite many
63 studies having indicated incidence of fewer people detained than the number of detentions
64 examined [14–17]. However, two small studies have specifically focussed on the subject, both
65 concluding that there was a strong correlation between those detained recurrently and the diagnoses
66 of personality disorder, in the latter case, specifically emotionally unstable personality disorder
67 [18,19].

68 The topic of diagnosis in mental illness has prompted much debate [20–22]. But even within this
69 context, the concept of emotionally unstable personality disorder stands out as particularly heavily
70 contested, with the validity of the condition having been questioned in literature as well as by
71 mental health professionals and some said to have the condition [23–25]. One of the main concerns
72 are the negative attitudes recognised to persist within both professional and lay groups towards
73 those said towards have the diagnosis [26–29]. Such negativity is often linked to the 'challenging'
74 patterns of unpredictable behaviour that typify the diagnosis. Not unrelatedly, there is a high
75 incidence of traumatic backgrounds amongst those so diagnosed, with over 90% of a cohort of
76 patients diagnosed with borderline personality disorder having disclosed trauma [30]. Survivors of
77 childhood trauma and multiple adversities are recognised as being at greatly elevated risk of
78 self-harming and death by suicide, as well as having damaged relational capacities [31–34]. Poor and
79 unstable interpersonal relationships and self-destructive behaviours, including self-harm and
80 suicide attempts are part of the diagnostic criteria for borderline or emotionally unstable personality
81 disorder.

82 Those with a personality disorder diagnosis face a significantly reduced life expectancy
83 compared to the general population [35,36]. Whilst this is not exclusively due to self-inflicted deaths,
84 this group are at a 20-fold increased risk of suicide [37]. Overall, there were 6,507 death by suicide in
85 the UK in 2018, a significant rise from the previous year [38]. Worldwide, suicide remains the one of
86 the greatest causes of death, labelled '*a global imperative*' by the World Health Organization [39]. Prior
87 suicide attempts are one of the greatest risk factors predicting future completion of suicide [40]. It is
88 therefore vital to investigate the links between repeated police Mental Health Act detention and
89 suicidality.

90 This research has examined repeated Section 136 detentions to provide a framework by which
91 the phenomenon can be better understood. The long-term impact of unresolved trauma was shown
92 to have left a small number of women highly vulnerable to recurrent suicidal crises in which it was
93 often the police who offered the only consistent response through detaining under Section 136.
94 Inconsistencies in the responses of mental health services at times unwittingly exacerbated feelings
95 of hopelessness that triggered suicide attempts. However, individuals who had been able to access
96 trauma-informed support benefitted from reparative relational contexts and had been able to reduce

97 the frequency and severity of suicidal feelings. Whilst the diagnosis of personality disorder does
98 appear to be implicated in high frequency repeated detention, it is the core components of
99 relationships impacting on trust and understanding that had the power to influence hope, thereby
100 disrupting dangerous cycles of suicidal crises necessitating police detentions. This model indicates
101 fruitful areas for intervention that could offer substantial benefits to individuals' quality of life and
102 significantly reduce the burden of frequent detentions on public services.

103 2. Materials and Methods

104 This mixed methods research incorporated three strands of data: police and mental health
105 service information on repeated detentions within the South East of England provided a profile of
106 people who are repeatedly detained within the region; a national police survey was used to indicate
107 the extent to which the phenomenon was recognised elsewhere in England and Wales; and critically,
108 in-depth interviews with six women who had survived recurrent suicidal crises and multiple
109 detentions gave an account of the factors that drive repeated detention from the perspective of lived
110 experience.

111 A short qualitative questionnaire was distributed through the mental health lead of College of
112 Policing to each police force in England and Wales. This approach was chosen over approaching
113 mental health services to ensure a full coverage of England and Wales by circumventing the
114 complexity of different NHS trusts, which are commissioned to provide varying services across the
115 country. In total, responses were received from 13 of the 43 police forces with a broad geographic
116 representation, which constituted an overall response rate of 30%. Whilst not providing detailed
117 information from each constabulary to which Section 136 applies, the questionnaire yielded a
118 representative indication of national police views on repeated detention.

119 A second layer of detail was obtained by analysing an anonymous dataset compiled for this
120 study, which provided information on each incident in East and West Sussex of people being
121 detained more than once between August 2014 and December 2016. Two step cluster analysis was
122 used to examine the characteristics of the second sample of individuals repeatedly detained using
123 log-likelihood as the distance measure to produce an exploratory indication of groupings. This
124 technique was chosen because it is suitable for large samples containing ordinal and categorical data.
125 Three further counties within the South East of England also supplied information on their repeated
126 detentions, which were combined with the 2012 detention data from the previous S136 in Sussex
127 study [13] to give a more detailed indication of incidence.

128 Finally, six in-depth semi-structured interviews were conducted with individuals who had
129 survived numerous suicide attempts and had experienced multiple Mental Health Act detentions,
130 including S136. Interviews lasted between 45 – 90 minutes, with the length determined by the
131 interviewee. The multiagency Sussex Mental Health Act Monitoring Board, which reviews S136
132 detentions and related local policy and practice issues identified and contacted the ten individuals
133 who had been detained with the highest frequencies over the preceding three years. Letters were
134 sent advising that an independent researcher was conducting a study on repeated S136 detention.
135 No personal details were shared with the researcher without individuals' consent, but potential
136 participants were sent details of the study and invited to contact the researcher. Two participants
137 were recruited through this method. A further four participants were recruited through a specialist
138 centre run by the same mental health trust in partnership with third sector agencies. The service is a
139 non-residential facility that supports people with a diagnosis of personality disorder through a
140 range of psychotherapeutic input and social support. Critically, it's work is based on principles of a
141 trauma-informed approach that centres on understanding attachment. This service was selected for
142 recruitment because the study was likely to be of interest to several of the members. The researcher
143 attended a community meeting and explained the study. A sign-up sheet was left with the
144 receptionist and the researcher then maintained contact with the centre over the following three
145 months, attending to discuss the study further with interested members. The four members who
146 took part in interviews had each been engaged with the service in excess of a year.

147 Thematic analysis of interviews was supported by consultants who had lived experience of
 148 crises arising from complex mental health difficulties. Interviewees were assigned pseudonyms and
 149 identifying information was concealed by the researcher prior to this stage. The joint analysis took
 150 the form of a three-hour meeting that was attended by five lived experience consultants, one of
 151 whom co-facilitated the meeting with the researcher. During the meeting an overview of the study
 152 was presented, which was followed by a discussion around the emergent themes from the
 153 researcher's initial review of the data. Excerpts from the transcripts were used to highlight these
 154 themes. The co-facilitators then posed questions to the consultants, who discussed the topic areas
 155 and responded with their interpretations of the data. At the end of the meeting the discussions were
 156 summarised, leading to revised themes being agreed upon.

157 As well as guiding the analysis through the above process, patient and public involvement (PPI)
 158 consultants supported this research through scrutiny from initial design, pre-ethics scrutiny and
 159 advice on study documents. Favourable opinion under NHS Health Research Authority was given
 160 for the qualitative research element by NRES South East Coast Committee – Brighton & Sussex
 161 (15/LO/1219). The remaining data collection was approved by South East Coast - Surrey Research
 162 Committee (16/LO/2069).

163 3. Findings

164 3.1. Service perspectives on repeated detention

165 All police survey respondents recognised repeated detention occurring to some extent within
 166 their area, with some adding they felt it signalled unmet need. All felt repeats necessitated a
 167 multiagency response. Rather than attempting to precisely define a threshold at which detentions
 168 should be considered problematic and trigger a review, the replies received indicated the
 169 circumstances of an individual's detention should be scrutinised to dictate what action services may
 170 need to take to support the person away from recurrent crises.

171 Although the police survey did not ask for specific information on the reasons for repeated
 172 detentions, several replies indicated that multiple detentions in respondents' forces were linked to
 173 suicide prevention and mentioned high risk behaviour linked to certain geographic locations in
 174 which people were recognised as being detained on several occasions.

175 Of the 563 multiple detentions of 155 individuals that took place during the index period of
 176 28-months, the reason for detention was unknown in 40 incidents (7%). Suicide or deliberate
 177 self-harm was the reason for the greatest number of detentions (481). Excluding those cases with
 178 missing data this equated to 92%. Suicide was identified as a secondary factor in a further 16 (3%)
 179 incidents. Herein, detention had been based on the apparent risk posed by the detained person to
 180 others or their mental state being of greater concern than their potential risk of self-harm. Examples
 181 in this category included people carrying a weapon in busy public places with which they were
 182 threatening to harm themselves. Only 26 detentions (5%) were entirely unrelated to concerns about
 183 the detained person's risk to self. Not only does this data provide additional strong support for the
 184 connection between S136 and suicide prevention, but it further indicates that repeated detention is
 185 particularly linked to self-harm.

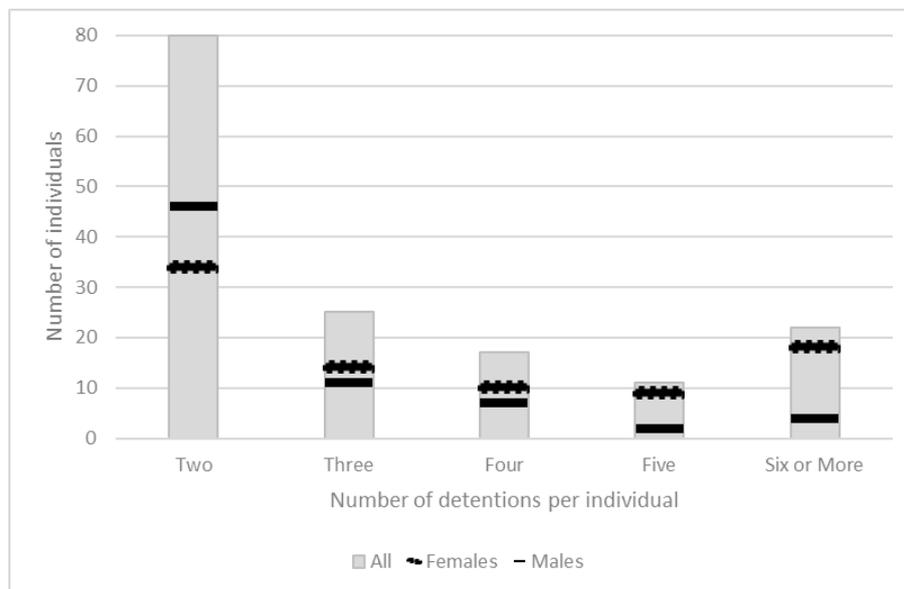
186 Most responses to the police survey identified some form of regular or ad-hoc monitoring of
 187 repeats was in place. Likewise, the anonymous regional data compiled from police and mental
 188 health services covering the other three areas in the region reflected that concerns about some
 189 individuals coming to repeated police notice through S136. Despite covering different time frames as
 190 well as diverse localities, the data shown in Table 1 revealed strong similarities in the proportion of
 191 repeats found, indicating an overall average of 31% of all detentions being repeats.

192 **Table 1.** Proportion of repeated detentions in collaborating areas

Area	Dataset	Total Number of	Proportion of
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	length	Detentions in dataset	People in dataset	Repeated detentions	People 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%

193 Analysis of the Sussex dataset specifically compiled for this study showed considerable gender
 194 differences across the number of detentions per individual. As shown in Figure 1, half of all people
 195 subject to multiple S136 were detained twice (51%) and 57% of this group were male. However,
 196 overall only 45% of those subject to repeated detention were male and it was exclusively females
 197 who were detained with the highest frequencies.



198

199 **Figure 1.** Number of multiple detentions by gender

200 Diagnosis information was missing for 34 people who were detained on 84 occasions, these
 201 cases were excluded from the subsequent analyses. Among the remaining individuals who were
 202 detained repeatedly, 58 people (49%) with single diagnoses of personality disorder accounted for a
 203 total of 262 detentions (55%). The diagnosis linked to the highest number of detentions was
 204 emotionally unstable personality disorder, four other sub-types of personality disorder were
 205 recorded in relation to eight people detained on 20 occasions. A further 20 individuals (17%) who
 206 were detained on 86 occasions (18%) were recorded as having multiple diagnoses that included
 207 some form of personality disorder. A broad range of other diagnoses including learning disability,
 208 depression, anxiety, post-traumatic stress disorder, psychoses and substance misuse disorders were
 209 recorded for 43 (36%) people who were related to 131 (28%) detentions, but no single diagnosis type
 210 related to more than ten detentions.

211 To explore gender and diagnosis further, the data was subject to two step cluster analysis; an
 212 exploratory technique used to suggest patterning within large data sets containing mixed categorical
 213 and continuous variables. Owing to the small numbers of individuals observed with many common
 214 diagnoses, the data was divided into single diagnosis of any personality disorder; diagnosis of any

215 personality disorder plus one or more other diagnosis and any other diagnosis. A model was
216 produced that suggested the presence of three sub groupings.

217 As shown in Table 2, the greatest number of detentions (229 in total, 48%) were related to the
218 first cluster. This group comprised 49 females, with a mean age of 27. Each person in this group had
219 a single diagnosis recorded of either borderline or emotionally unstable personality disorder. The
220 remaining 50 females for whom diagnosis data was recorded formed the second cluster which was
221 related to 102 detentions. The average age of the second group was 28 (SD 9.85). Finally, the third
222 group constituted the 29 males within the dataset for whom any diagnosis was recorded. This group
223 represented 145 (31%) detentions and had an average age of 34 (SD 11.12).

224 **Table 2.** Sub groupings of those repeatedly detained

Characteristics	Number of associated			
	Detentions		Individuals	
Females with sole diagnoses of a personality disorder	229	(48%)	49	(38%)
Females with any other diagnoses	102	(21%)	50	(39%)
All males in dataset (all diagnoses)	145	(31%)	29	(23%)

225 3.2. Lived experience of repeated suicidal crises

226 The qualitative data was analysed using a realist-informed approach [41] that sought to identify
227 how the mechanisms functioning within a context produce an outcome, in this case the suicide
228 attempts that could lead to detention. Thematic analysis revealed multifaceted issues including
229 histories of trauma, often experiences of childhood abuse, which marked participants' narratives.
230 The traumatic experiences themselves were not cited as the proximal causes of suicide attempts;
231 rather, it was the enduring legacy of unresolved psychological impact, particularly as manifesting in
232 relational problems. Medicalised approaches employed by mental health services were commonly
233 experienced as disempowering and could exacerbate these difficulties and mediated participants'
234 suicidal feelings.

235 The lived experience advisors who jointly analysed the qualitative data agreed unanimously
236 that 'relationships' was the most critical theme. This has been highlighted as of great importance for
237 patients diagnosed with personality disorder as a central feature of both the development and
238 resolution of difficulties [42]. Interviewees described how their relational contexts could determine
239 whether feelings of hopelessness had been triggered or managed at varying times.

240 Many participants spoke about feeling isolated. Prior to joining the support service Diane
241 described herself as having been "*a bit of a hermit*" saying that being overwhelmed by anxiety, she
242 had barely left her house and rarely saw anyone other than her care co-ordinator who had visited
243 her at home. Professional relationships have greater importance for patients with serious mental
244 illness [43] and other participants also mentioned these as key in talking about themselves. Kate
245 stated:

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

248 Likewise, another interviewee, Anna said that prior to joining the support service her care
249 co-ordinator had been: "*doing his best to help me, but he couldn't do it all on his own.*" This she said had
250 meant that during that time she had often felt suicide was her only option as she could not be
251 helped.

252 Another element of this theme touched on by some interviewees was personal relationships
253 that were experienced as being supportive yet tinged with guilt. As the interview further explored
254 her social network, Kate said "*the one person who has stuck by me*" was a friend to whom she felt she
255 was a burden. Similarly, Heather talked about her husband being very supportive of her, but she

256 described great guilt at how her mental illness had affected him, saying it had “ruined” their
257 marriage.

258 Interviewees engaged with the support service benefitted from consistency in both their
259 professional and personal relationships developed with other members. This appeared to provide a
260 reparative environment that had fostered positive change. Beth explained that the service
261 purposefully works to ensure that all staff know each member as an individual:

262 *“You know they do get to know you, and I think their sort of ethos is to get you to bond with the whole*
263 *team rather than just the one person. So you do have a key worker but there’s always somebody else*
264 *there ...so you’ve got the whole team really not just one person.”*

265 Anna reiterated this, explaining how the collective approach contrasted her previous good
266 relationship with her care co-ordinator, which although supportive and beneficial had been
267 insufficient to move her past frequent suicide attempts:

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

270 Conversely, inconsistent relationships with both family members and care workers for some
271 participants mirrored or continued the circumstances surrounding their traumatic backgrounds.
272 Diane said she had also been told at one time that the mental health team were not a long-term
273 service and that her case may be closed, although she felt she needed ongoing specialist support. As
274 a result of these experiences she said she felt vulnerable and that each time she has a new care
275 co-ordinator assigned to her it would take her several months to begin to believe they would not
276 discharge her from the service. Related to this, participants mentioned the different approaches of
277 different mental health professionals coupled with how frequently in some cases care teams were
278 changed, meant individuals were left feeling unsettled.

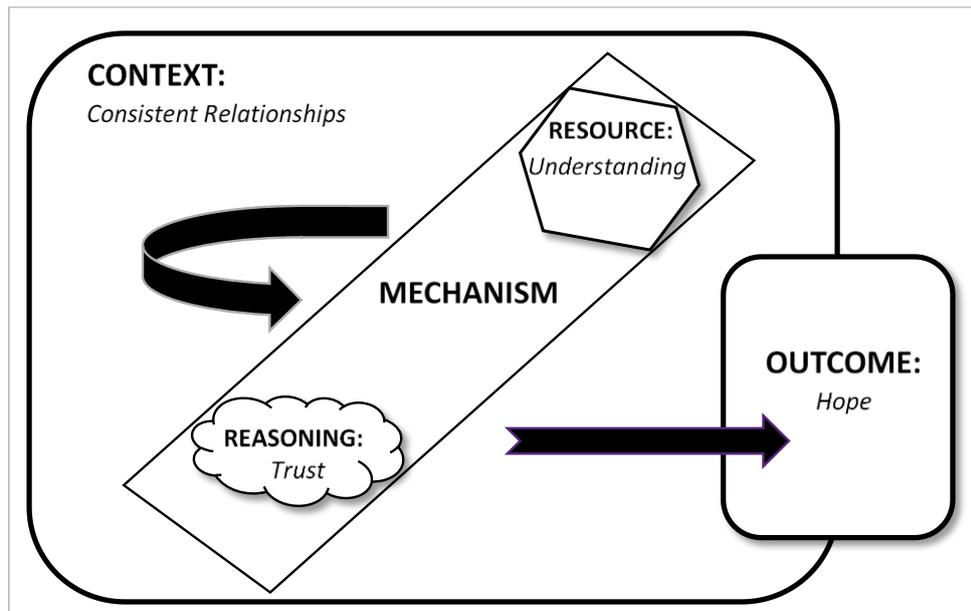
279 In many cases relational contexts had also been implicated in the genesis of individuals’
280 difficulties, experiencing abuses perpetrated within previously assumed trusted relationships.
281 Feeling disempowered or that an element of betrayal has been implicated in trauma has been
282 strongly linked to traumagenic responses becoming embedded [44,45]. Complexities in relationships
283 with their own children also provoked distressing feelings of guilt and failure. A uniquely
284 harrowing statement from Kate expressed this sentiment:

285 *“I’ve failed at my marriage. I’ve failed at being a parent. Suicide’s just another thing I’ve failed at.”*

286 Relationships heavily influenced the other components within the model, enabling activation
287 when the context was favourable, as shown in Figure 2. The mechanistic elements of trust and
288 understanding operated in tandem. The experience of being understood and well-supported had
289 over time enabled participants within this positive context to reconstruct their self-images. For
290 example, Anna stated that she had come to realise that her extreme thinking and resulting patterns
291 of self-destructive behaviour had developed as responses to the multiple traumas she had survived,
292 reflecting on the change the support service had facilitated for her she said:

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

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297
298



299 **Figure 2.** Positive relational context triggering hope by the activation of understanding and trust

300 A sense of being understood was crucial for all participants. Yet as Kate's words about her
 301 therapist had indicated, this of itself was insufficient to provide a sense of safety. Nonetheless,
 302 services demonstrating an understanding of the way in which their decision-making could be
 303 interpreted was of great significance. Several interviewees spoke of the impact of being rapidly
 304 discharged without explanation, for example, having received resuscitation in hospital following a
 305 suicide attempt, Anna had been discharged to the care of a Crisis team who had closed her case the
 306 following day. Recalling this, Anna said:

307 *"they didn't communicate to me the reasons why they wouldn't work with me. I felt rejected and*
 308 *abandoned. And like no one cared about what would happen to me."*

309 She had subsequently taken another overdose, believing she could not be helped and said she had
 310 initially been furious when she had been taken back to hospital as she had been intent on ending her
 311 life. Heather had similarly been discharged from hospital being told by staff they felt she was worse
 312 than at admission. She observed that:

313 *"The attitude of services is 'if you have a personality disorder diagnosis, we can't help you'."*

314 A seeming failure to consider the impact of how communication around clinical decisions could be
 315 framed spoke to lack of understanding that impeded recovery. Diane too, spoke of an occasion in
 316 which she had been admitted to hospital late at night from a S136 detention but discharged by a
 317 different psychiatrist when ward rounds were conducted the next morning:

318 *"when I got to [name of hospital] I felt safe, and calm, and then the doctor, the next day turned round*
 319 *and says 'Yeah, oh yeah I know her she's ok, I'll take her off Section. She can go home.'*

320 Diane's experiences also pointed to 'trust', which was allied to understanding. Trust emerged from
 321 the foundation of consistently stable relationships in which understanding was developed and
 322 maintained. Heather avowed her ability to trust professionals had been shattered by detrimental
 323 contexts in which she had experienced inconsistency founded on insufficient understanding:

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

327 The final element of the model related to whether feelings of hope were activated, resulting in
 328 suicidal feelings being managed. In the reverse, feelings of hopelessness became overwhelming and
 329 triggered individuals to act on suicidal feelings. Participants describing positive contexts in which
 330 they benefitted from multiple consistent relationships that were stable over time spoke with a

331 distinct future orientation and referred to their futures with a sense of agency. Anna and Beth both
332 spoke about learning to anticipate and plan for difficult situations, indicating implicit beliefs in their
333 further recoveries in the future. Emma too spoke about plans agreed with her care team for her to
334 engage in trauma-focussed therapy within the next few months. Beth echoed a similar sentiment,
335 speaking assuredly about her future she referred to the support centre as: *“a service I’m hoping to move
336 on from.”* Diane described the service as having saved her life and Anna said her self-harming as well
337 as suicide attempts had been virtually eliminated. In stark contrast, participants who felt they did
338 not have access to adequate support revealed ambivalence toward their ability to sustain their own
339 lives in the long term.

340 Hopelessness was recurrently produced as the culmination of the elements described, leaving
341 individuals feeling powerless to overcome suicidal feelings. When reaching this point of crisis,
342 feelings of being a burden to close contacts or being unable to seek support from other services, the
343 police offered the only consistent response in intervening in suicide attempts. Kate said she found
344 the process of being detained harrowing and that it was something: *“I wouldn’t wish on my worst
345 enemy.”* Likewise, Heather described various strategies she had employed to attempt to avoid being
346 detained by the police when trying to take her life. Reflecting on this she stated:

347 *“The police are the only people who have to do something. They can’t leave you... So I have really mixed
348 feelings on 136.”*

349 Heather and Kate had both concluded there was little their mental health teams could offer to make
350 a meaningful difference. For Kate, an out of area therapeutic placement had broken down, leaving
351 her to feel she was unmanageable, and Heather had been told the form of trauma therapy most
352 likely to benefit her was not available. She said this left her feeling that:

353 *“Everything that happens is merely a sticking plaster until the next 136. [Services] know it. I know it. [so]
354 half of me wants some help, the other half wants to be dead.”*

355 4. Discussion

356 This study has taken a multifactorial approach to develop an understanding of repeated
357 detention by the police under S136 of the Mental Health Act. The research has demonstrated the
358 phenomenon to be widely recognised throughout England and Wales, and to predominantly relate
359 to suicide prevention and self-harm. Repeated detention accounts for close to a third of all
360 detentions. It is a small number of females, likely diagnosed with emotionally unstable personality
361 disorder, who are detained with the highest frequencies. For these individuals, the consequences of
362 prior experiences of trauma are commonly exacerbated in detrimental contexts of inconsistent
363 relationships, lack of understanding and mistrust, prompting hopelessness and recurrent suicide
364 attempts. In the absence of adequate systemic support, the police provide a consistent response by
365 intervening repeatedly to detain. However, this model can operate in reverse to produce beneficial
366 outcomes. A favourable relational context that is maintained over time can enable understanding to
367 generate trust, stimulating hope and thereby reducing the frequency and intensity of suicidal
368 feelings.

369 Many of those detained more than once were males who were subject to two detentions,
370 suggesting this group may be representative of the wider cohort of people detained under S136, for
371 whom a period of crisis culminates in police intervention that can then prompt appropriate
372 help-seeking and access to support services, albeit through a harrowing experience of being
373 detained [13,46]. However, this research has confirmed that those subject to the highest numbers of
374 police Mental Health Act detentions are almost exclusively female. This is the inverse of national
375 detention data and of overall S136 trends in the study locality. Likewise, locally, nationally and
376 worldwide, more men than women die by suicide. These two factors may have contributed to
377 hitherto obscuring the needs of the small number of females who are subject to frequent detentions.

378 Information was not specifically sought about the circumstances surrounding each person’s
379 historical traumas, but these experiences were nonetheless apparent throughout interviewees’
380 narratives. The accounts in both this and the prior *S136 in Sussex* study contained multiple examples
381 of women whose diagnosis of emotionally unstable personality disorder appeared to have been

382 heavily based on their repeated suicide attempts and histories of abuse. Yet this diagnosis is still too
383 frequently experienced as *de facto demedicalization* [27], being an exclusionary factor from many
384 mainstream mental health services. The entrenched nature of the relational difficulties that are
385 frequently seen as one of the primary indications of borderline or emotionally unstable personality
386 disorder commonly see this group of patients marked out as hard to engage and challenging to work
387 with, often owing to the difficult emotions working with such emotional instability can provoke in
388 staff [42]. Healthcare professionals can consider those identified as having borderline or emotionally
389 unstable personality disorder to be less ill than other psychiatric patients and thus less deserving of
390 empathy [47]. This study has provided further support to findings that negative healthcare attitudes
391 can be counter-therapeutic [48]. In turn, this can contribute to increasingly desperate attempts to
392 access support that are all too often dismissed as 'attention seeking behaviour.'

393 A sense of rejection from mental health services can be experienced as reiterating individual's
394 feelings of worthlessness and hopelessness. Believing there is nothing that could alleviate their
395 recurrent distress drains the individual's scant resources to combat suicidal urges [49]. Participants'
396 descriptions of suicidal feelings and prior attempts indicated the presence or absence of hope
397 influenced the course of action when in crisis. An inability to conceptualise a future was shared by
398 both the interviewees who did not have access to sufficient support and the accounts of their
399 experiences prior to joining the support service by participants who were members of the centre. All
400 too often, this sense of futility had seemingly been reinforced by interpretations of inconsistencies
401 perpetuated by mental health services. Hopelessness inevitably features in multiple models of
402 suicide [50–52]. The present study strengthens understanding of the pathways to suicide attempts,
403 enhancing the interpretations of how attachment [53] and agency [54] are likely mediators in the
404 development of *suicidal exhaustion* [49]. These factors are of particular salience to women diagnosed
405 with emotionally unstable personality disorder, for whom histories of childhood adversity and
406 trauma can become the overarching context within which the inherent inconsistencies of an
407 under-resourced mental health service can too often be re-traumatising with devastating effect.

408 Whilst many women diagnosed with borderline or emotionally unstable personality disorder
409 will survive numerous suicide attempts, self-inflicted death remains a very real and significant risk
410 that cannot be ignored. The progress support service interviewees had made in managing their
411 mental health and no longer falling victim to uncontrollable suicidality is testament to the
412 possibilities inherent in services adopting a trauma-informed long-term view to supporting
413 vulnerable adults over time. It is thus imperative that rather than dismissing or excluding trauma
414 survivors, services adopt long term approaches to work with individuals' strengths. This research
415 has underscored the need for interventions that can disrupt the cycle of suicidal crises and police
416 detention.

417 It should be noted that although a strength of this study is in the variety of data sources
418 employed, the self-selecting samples of both police survey respondents and interviewees is likely to
419 have influenced the findings. All interviewees were working age adult females, therefore further
420 research would be necessary to understand whether the model applies to other cohorts. Extending
421 the number of participants and including more detailed perspectives from police and mental health
422 professionals would also greatly strengthen these findings.

423 5. Conclusions

424 Understanding repeated S136 Mental Health Act detention through both the lens of lived
425 experience and the perspectives of police and mental health services is critical to developing safe
426 pathways away from the dangerous cycle of despair and crisis. This study has highlighted how a
427 consistent relational context that remains stable over time can enable individuals to manage
428 recurrent suicidality through repairing the fractured self-image that can result from surviving
429 trauma and adversity. This has important implications for multiagency police and mental health
430 partnerships to work with those for whom frequent police intervention has become a recurrent
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