

RESPONDING TO PEOPLE IN MENTAL DISTRESS

EXPLORING THE PREVENTATIVE ROLE
OF NEW ZEALAND POLICE IN THE
COMMUNITY



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Executive summary

Police across the globe are significantly involved in engaging with individuals who are experiencing mental distress. Research suggests, however, that relying on police as first responders for mental health-related events can lead to inappropriate treatment, which is experienced as degrading, discriminatory, and traumatic.

The preventative, victim-focused operation model – Prevention First – guides police practice in Aotearoa, New Zealand (New Zealand Police, 2023b). In this report, we present the findings of a five-year study that examined how a Prevention First approach is implemented and experienced when police officers respond to mental health-related events. Prevention First describes how the police aim to practice in a way that fulfils their vision of ensuring that everyone is safe and feels secure.

What our research involved

The research project used a co-production methodology, where the research team collaborated with both the police and whānau/citizens¹ who have experienced mental distress. The research was conducted in three parts.

1. The team co-created narratives with 28 whānau/citizens to understand how police respond to mental distress.
2. To better understand the police experience, we conducted case studies across three police districts, observing police practices through 53 ride-alongs and interviewing 53 frontline police officers. We also analysed 70 calls to the Police Emergency Communication Centre and interviewed 23 senior police officers with leadership experience in mental health liaison, prevention management, and partnering with Māori communities.
3. The third part of the research involved combining the experiences of both police officers and whānau/citizens to create a comprehensive synthesis of police responses to mental health-related events.

This report details the research findings and recommends changes that can be made.

The significance of trauma

Through the narratives shared by whānau/citizens, it became evident that they attributed their experiences of mental distress to trauma. Trauma was described as the result of multiple, severe, and sustained traumatic events, circumstances, or experiences that occurred from childhood through to adulthood. It is, therefore, important for the police to recognise the value of trauma-informed approaches that focus on acknowledging what has happened to someone rather than trying to identify what is wrong with them.

We also heard stories of intergenerational and collective experiences of trauma, which are often overlooked in Westernised trauma-informed approaches. For Māori, a trauma-informed approach considers the importance of the wider community, including whānau, hapū, iwi, and hapori. It also acknowledges intergenerational and historical trauma and interlocking impacts of ongoing colonisation. It incorporates a te ao Māori worldview and Māori healing concepts and practices.

Trauma-informed care is a compassionate approach that aims to help individuals thrive. It prioritises treating whānau/citizens with kindness, humanity, compassion, dignity, respect, and generosity while upholding their mana. The relationship between whānau and those supporting them is critical for whānau healing. These relationships can foster safety, security, hope, and trust. Trauma-informed approaches also respect the autonomy of whānau and create opportunities for them to feel empowered to make their own decisions about their lives and livelihoods.

1. We have chosen to use the whānau/citizens terminology throughout this report to honour the diverse voices of our participants. The use of this terminology is deliberate, in recognising rights of citizenship to all and the unique obligations to Māori under te Tiriti o Waitangi. In some instances, we also use other terms when referring to existing literature, such as "service users" or "participants."

Humanistic approaches

The study found that when frontline police officers took a humanistic approach, it resulted in a positive experience for many participants. Many of the officers interviewed described their approaches to mental health-related events as similar to the humanism participants found helpful. Therefore, the study provides examples from both whānau/citizens and frontline police officers about what a humanistic response may look like and the consequences when it does not happen.

This research found the following fundamental principles were imperative for frontline police officers to follow while interacting with whānau/citizens:

1. Connection: including connection existing by history, family, friends, ethnicity, age, and gender; attempts by police to make connections with whānau/citizens; and whānau/citizens having an opportunity to speak and police actively listening to that. Barriers to connection include the power imbalance and uniform (padded up; all their gear), boundaries, lack of communication, whānau/citizens being ignored, and lack of engagement.

2. Respect and genuine concern: including respect for human dignity – an overarching theme whānau/citizens expressed regarding how they should be treated during humanistic engagement. Whānau/citizens believed they had the fundamental right to be treated with respect and dignity. This related to the total engagement process from when the interaction commenced to when it ended. This value placed on respect and dignity was best reflected in descriptions of interactions when whānau/citizens felt humiliated. In these situations, the feeling of being made fun of was prominent. The other aspect of this theme – genuine concern – involved police responding and resolving situations positively and empoweringly for the whānau/citizens involved. This often involves the police going out of their way (beyond the call of duty) to assist. In contrast, a lack of genuine concern leaves whānau/citizens with no control over their situation and highly vulnerable, including having the blame put back on them.

3. Information provision: whānau/citizens appreciated it when frontline police officers communicated clearly, explained what would happen during the interaction, and kept them updated throughout the process.

However, not all frontline police officers felt their humanistic responses were adequate for mental health-related events. Instead, they described the need for better training or other specialised clinicians to lead responses. While the findings support both these propositions, based on the whānau/citizen stories, frontline police officers should be encouraged to respond according to the fundamental principles of a humanistic response.

New Zealand Police as default responders

Content analysis of calls to the Police Emergency Communication Centres showed that frontline police officers are being used as a primary and/or default mental health and social support service. Many calls, however, were assessed by the research team as not necessarily requiring a police response and, instead, could have been supported through a mental health or social service-led response. The Earlier Mental Health Response triage line did not appear to be used in any calls and warrants further exploration. In the case studies, frontline police officers confirmed that they were often relied upon as the primary or default mental health and social support service. They expressed frustration with systematic issues, such as the chronic underfunding of mental health services and being forced to fill the gaps. They described a self-fulfilling prophecy, where frontline police officers feel a moral obligation to attend events always, perpetuating the demand cycle. Senior police officers interviewed nationally reported challenges in collaborating effectively with mental health services while remaining sympathetic to the resource constraints of mental health and community services.

Bias, racism and criminalisation

Content analysis of calls indicated that many calls coded '1M' (mental health) have a mental health component. Still, it is regularly incidental to the call's primary purpose, which is often a social issue. In these instances, it was unclear why the call was coded 1M. Frontline police officers also spoke about the wide range of events that are coded 1M and the need to refrain from pre-judgement continually.

However, there were examples of biased, racist, and discriminatory pre-judgements of whānau/citizens, which then shaped how frontline police officers responded. A diverse police service was considered as one way to reduce prejudgements. Diversity was also regarded as key to supporting connections between frontline police officers and whānau/citizens, emphasising the importance of this as a core value for New Zealand Police. Some frontline police officers expressed conflict between treating whānau/citizens equally and responding equitably based on individual needs. Treating whānau/citizens equally applies to not acting unfairly – e.g. nobody should be treated unfairly. However, to treat whānau/citizens responsively in an equitable way, there may be a need to treat whānau/citizens differently, and part of that is being responsive to connecting with whānau/citizens through diversity.

As the number of mental health-related calls has increased, there appears to be immense frustration among frontline police officers. This frustration may contribute to bias and is particularly evident when officers receive repeated callouts to the same individuals, sometimes derogatorily referred to as “frequent fliers.” Frontline police officers described these individuals as stuck in repeating cycles due to a lack of follow-up or regular engagement with mental health or social services. Frontline police officers have explained that many of these whānau/citizens have been diagnosed by mental health professionals as having “behavioural issues” that do not require a clinical or, sometimes, police response.

The topic of criminalisation emerged as a dominant theme during the research. This included the use of police cars, handcuffs, cells, and dogs, which whānau/citizens felt should not be used on individuals who are unwell and have not committed any illegal activity. Whānau/citizens were concerned about how they would be perceived if they were treated in such a manner by the police. For many, experiencing mental distress while encountering police is an emotional and life-altering experience. Even though it happened in the past, treating whānau/citizens in an impersonal way or criminalising their distress can worsen their trauma and harm their trust and confidence in the police.

After a negative encounter with the police, whānau/citizens have expressed their fear of future engagements not only when experiencing mental distress but also in other situations, such as reporting a crime. This fear originates from the belief that they may face similar negative experiences in the future. This is a concerning issue, particularly considering that individuals who experience mental distress are especially vulnerable to being victimised. To address this, a proactive approach to restoring a person's mana using hohou te rongo or restorative practices should be used calmly and respectfully so that people in mental distress can, at that moment, feel seen and heard. These approaches can increase trust and rapport and strengthen ongoing engagement or future interactions without traumatising the whānau/citizen. Such approaches are growing in healthcare settings when things go wrong (see <https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/restorative-practice-and-hohou-te-rongo/>).

Frontline police officers expressed their concerns about the potential criminalisation and harm that may arise from their use of cells for detainment and their police powers in mental health-related events. Many frontline police officers acknowledge that they are not always the right people to respond to such situations and that their actions may create harmful experiences. They also explained that they often find themselves working in a “grey zone” where they are faced with either “arresting” or “doing nothing”, even though they know neither option is the right thing to do. The frontline police officers talked about their frustration, disheartenment, and moral distress in these situations. Some of them experienced disheartenment regarding the current system-wide limitations in dealing with mental health-related events and feeling unable to fulfil their duties as police officers and provide the necessary assistance to those in need.

It is essential to understand that when officers use a humanistic approach, they can minimise experiences of discrimination and criminalisation and reduce further traumatisation.

Alternative ways of working

We received feedback from senior police officers across the country that when agencies collaborate and cooperate, it can lead to positive outcomes for the community and the police, provided they are well-resourced. Some examples of such collaboration include sharing information, creating health-led safety plans, making referrals easy, maintaining regular communication, and building meaningful partnerships with health and community providers.

Senior police officers suggested alternative approaches and defined the role the police should have in responding to mental health-related events. The range of ideas included:

- Co-response models such as that trialled in Wellington, particularly for 1X (threatens/attempts suicide) coded call-outs that may require a police presence to ensure safety.
- Increased community policing initiatives, such as the Neighbourhood Policing Team in Canterbury or Family Violence Intervention teams, to enhance prevention.
- Development of 24/7 safe health triaging spaces to take whānau/citizens to as an alternative to specialist mental services. This idea connected strongly with the concept of police as referrers only, with less involvement in continued responding.
- Enhanced promotion and professional development of de-escalation, conflict resolution and non-lethal strategies among all police districts.
- More opportunities for health and police professionals to train and learn together.
- The introduction of a mental health worker or peer navigator embedded within the police station.

With each of these ideas, some risks must be considered when reflecting on the whānau/citizen stories in this study and the broader literature. The criminalisation experienced by whānau/citizens in this study may be exacerbated when mental health and social support approaches are integrated into police spaces or if police are a routine part of multiagency responses. Most wider studies have indicated the requirement for careful consideration of alternative approaches or models, with robust research as to their effectiveness for all parties. This research also indicates the benefits of not imposing blanket nationwide initiatives, with the findings suggesting partnerships with community organisations to prioritise localised solutions as positive.

Recommendations

We recommend that the New Zealand Police proactively work to transition from police-led responses to mental health/social-led responses to both 1M and 1X. This would require re-thinking emergency responses to mental health-related crisis events, as well as the common occurrence of welfare checks related to 1M coded events. Acknowledging this will require significant planning, resource distribution and cross-sector cultural change, we recommend the following immediate improvements for police responses:

1. Consider adopting a trauma-informed approach to support frontline police officers to engage and respond to whānau/citizens with experience of mental distress and, more generally.
2. Reaffirm a trauma-informed humanistic response at a policy level, given that it correlates with Prevention First, New Zealand Police values (PRIMED)² and aligns with the needs of whānau/citizens.
3. Conduct focused research to determine why the Earlier Mental Health Response triage line is not working and consider if 111 Communications could implement a direct mental health option.
4. Consider increasing the visibility of Prevention First approaches to mental health-related events at different levels of police, from recruitment to The Royal New Zealand Police College's training and ongoing district work programmes. This should include real-world exemplars of strategies

2. New Zealand Police are guided by the values of professionalism, respect, integrity, and their commitment to Māori and Te Tiriti o Waitangi principles, empathy, and diversity (PRIMED) (New Zealand Police, 2022b).

and techniques that illustrate 'good' personal interaction in alignment with a trauma-informed humanistic response.

5. Endorsement and investment from the national level to further support district-led initiatives with partners and iwi, including:
 - Advocacy to bolster investment in community-based services (e.g. Kaupapa Māori and/or NGO community providers) to improve district capacity and options for social support of whānau/citizens.
 - Consider rethinking the rotation policy for permanent leadership roles in Mental Health Liaison and Prevention Management to create consistent and sustainable partnerships.
6. Emphasise and reassure frontline police officers that humanistic responses are of value and assistance to whānau/citizens
7. Proactively counter bias, racism, and discrimination and amplify trauma-informed humanistic approaches through the implementation at The Royal New Zealand Police College's initial training and nationwide through continuous training in police districts focused on:
 - Te Ao Māori and tikanga, including space to build stronger community relationships and partnerships.
 - Racism, stereotyping, and bias to assist frontline police officers in supporting diverse whānau/citizens who may or may not experience mental distress.
 - Practical negotiation skills and trauma-informed humanistic approaches, including through a Te Ao Māori worldview.
 - A humanistic response to distress (including the avoidance of criminalisation).
8. Continue to diversify the police service, emphasising various lived experiences, genders, sexuality and cultural backgrounds to contribute positive connections and understanding.
9. Consider proactively applying a restorative approach when things go wrong during a police and whānau/ citizen/community interaction.
10. Consider cultural and professional supervision and compassion fatigue training to support the mental well-being of police officers.



Introduction

Globally, police have long-standing, significant, and growing involvement with whānau/citizens experiencing mental distress. (Bitner, 1967; Chappell, 2014; Mclean & Marshall, 2010; Morabito, 2018; Teplin & Pruett, 1992). People who experience mental distress are more likely to be victimised (Brekke et al., 2001; Casiano et al., 2020; Hiday et al., 2002; Khalifeh et al., 2015), socially excluded (Boardman, 2011; Gordon et al., 2017), and, when in crisis, subjected to coercive measures by police (Holman et al., 2018; Kesic et al., 2010; Livingston et al., 2014; Teplin, 1984). International research indicates that people experiencing mental distress have been inappropriately detained in police cells for assessment, exposed to significant use of force, and experienced contact with police as degrading and stigmatising (Boscarato, Lee, Kroschel, Hollander, & Brennan, 2014; Faubert, 2023; Her Majesty's Inspectorate of Constabulary et al., 2013; Livingston et al., 2014; Morabito et al., 2017; O'Brien et al., 2011; A. C Watson et al., 2010; White & Ready, 2009).

The preventative, victim-focused operation strategy – Prevention First – guides police practice in Aotearoa, New Zealand (New Zealand Police, 2023b). Prevention First is the operational model for New Zealand police and describes how police aim to practice in a way that delivers their vision for everyone to be safe and feel safe. The operational model recognises the need to take evidence-based approaches most likely to prevent crime and harm, which means, in some situations, using a strong enforcement response, whereas in others, responding to the underlying causes. Prevention First aims to achieve policing by consent by strongly focusing on working in partnership with communities, particularly iwi, to produce preventative outcomes. How, then, is Prevention First operationalised when police respond to mental health-related events in the community? In this report, we detail the findings of a five-year study that aimed to answer this question by exploring how Prevention First is practised and experienced when police respond to mental health events.

The research utilised a co-production methodology, where the research team worked together with both police and whānau/citizens who experience mental distress. The research involved three parts. In part one, the team co-created stories with whānau/citizens who have experienced mental distress and their interactions with police, aiming to understand the practice of police in responding to mental distress. Part 2 involved observing police practices during mental health-related events in different parts of New Zealand and conducting interviews with police nationwide. The third part of the research involved combining the experiences of police and community members to create a comprehensive analysis of police responses to mental health-related events. This report presents a detailed analysis of the findings and provides recommendations for change.

The report is divided into four parts.

- Part 1 briefly contextualises this project by providing an overview of existing research about police response to mental health-related events internationally.
- Part 2 covers the methodology used in the whānau/citizens experience part of the study and presents a thematic analysis of stories co-created with individuals who experienced mental distress during a police response.
- Part 3 focuses on the police experience, offering the findings from a small study of calls to the police national call centre, frontline case studies, and interviews with police stakeholders. We describe what each of these aspects of data collection included and present the core findings from each source of information.
- Part 4 synthesises the findings from the whānau/citizens and police experience parts of the study and considers their implications for future policing of mental health-related events.

The report concludes with a set of recommendations directed at the New Zealand Police and the broader community that supports whānau/citizens experiencing mental distress. It is essential to understand that the New Zealand Police alone cannot provide solutions; instead, solutions require multi-sector commitment.

Part one | Contextualising the project

This section briefly contextualises this project by providing an overview of existing research about police response to mental health-related events in Aotearoa, New Zealand and internationally.

Defining 'mental health-related events'

The New Zealand Police have two event codes, assigned by call takers in the Police Emergency Communication Centres, that directly relate to mental health: 1M, capturing non-criminal events where mental distress is a factor, and 1X, capturing events related to threatening or attempting suicide (Li et al., 2020). For either of these event codes, the person involved may or may not have a diagnosed mental illness by mental health services. The 1M code captures a spectrum of needs, some of which may not be coded and prioritised as a 'crisis' by communicators at Police Emergency Communication Centres. It is also important to note that a non-crisis event may also be coded 1X if suicide has been mentioned, but the call has been deemed low risk/priority. There is discretion, therefore, in the coding of calls by call takers.

In this research, we adopt a broad definition of 'mental distress' and 'mental health-related events'. We recognise mental distress as something that arises from diverse intersecting stressors, such as health, economic and socio-political stressors (Gluckman, 2017). In doing so, we divert from international research akin to ours that predominantly focuses on 'mental health crises', leaving non-crisis distress understudied. Recent research has revealed that lower priority 1M calls are causing an increased demand on the New Zealand Police, as stated by Li et al. (2020). Furthermore, Holman et al. (2018) demonstrated that a high proportion of individuals who had contact with police while experiencing mental distress were not currently engaged with mental health services. Previous international research has mainly focused on interactions between police and individuals who have a diagnosed mental illness, which implies that only people with mental illness interact with police during mental distress. However, we aim to avoid this assumption in our research by adopting a broader understanding of mental distress.

We also recognise that the police may interact with whānau/citizens who are experiencing distress across a variety of job types, not just those coded 1M or 1X (New Zealand Police, 2023a). For example, family harm events. As such, we have included voices from within the New Zealand Police who work in various spaces and the collection of diverse whānau/citizen stories.

New Zealand Police involvement with mental health-related events

New Zealand Police frequently respond to mental health-related events; therefore, mental health has been recognised as one of the six drivers of police demand (New Zealand Police, 2023b). The most recent New Zealand Police annual report, covering the 2022/23 financial year, showed that police attended 77,043 mental health-related events (involving a person having a mental health crisis, in distress, or threatening suicide) (New Zealand Police, 2023a).

The involvement of the New Zealand Police in mental health-related events has steadily increased. The latest figures show a 64% increase in the last five years. The New Zealand Police predict that these increases will continue. They point to the impact of stressors contributing to mental distress – including, in recent years, the COVID-19 pandemic and its lasting impacts (New Zealand Police, 2023a).

The Mental Health (Compulsory Assessment and Treatment) Act (1992) grants police the legal authority to intervene in situations involving individuals diagnosed with a mental disorder. Under section 109, police have the power to take a person believed to be 'mentally disordered' from a public place to an appropriate place for assessment, such as an emergency department, police station or mental health facility. This power does not apply to people on private property. A similar power arises under section 38, where police are required to assist a Duly Authorised Officer (DAO) in transporting a person believed to be mentally disordered to a place for examination. In the first case, the police act on their initiative, and in the second case, in response to a request from a mental health practitioner.

Recent research has investigated the difficulties faced by the New Zealand Police in fulfilling their

organisational preference of taking individuals in mental distress to the emergency department for assessment. According to van der Harst (2022), frontline police officers reported various challenges in dealing with such situations. Interactions with emergency departments were often time-consuming, and the long waits in emergency departments were seen to take frontline police officers away from the duties involving criminal behaviours and/or protecting the public.

Additionally, frontline police officers recognised their professional boundaries as police officers (i.e. not mental health clinicians) and worked within them. However, they felt they often had pressure to 'make the right call', which was difficult for them due to not having mental health expertise (e.g. If I transport this person to the ED, will they fall under the admission criteria?) (van der Harst, 2021). They found clinical determinations of whether someone met the admission criteria were confusing. People might be experiencing significant distress without meeting the threshold for compulsory assessment. In such cases, they were assessed as needing voluntary, rather than compulsory, mental health care. Frontline police officers reported that in these cases, people were often returned to the community, where they presented again to the police. This situation was described as a 'revolving door' and made officers feel frustrated and cynical. To address this issue, van der Harst (2021) developed a theory of 'doing your best' to describe how police attempted to navigate the organisational preference of taking people to an emergency department. There is a need for further research to investigate whether the challenges faced in the emergency department affect the decision-making of frontline police officers on the ground.

The New Zealand Police have also reported that the high demand for responses to mental health-related events is driven by government and community expectations that police should resolve these sorts of jobs (New Zealand Police, 2023a). Police are on-call 24/7 and cover all of Aotearoa, New Zealand, unlike many specialised mental health services, such as the Mental Health Crisis Assessment Teams (CATs) in certain regions (Ministry of Health, 2020). Access to CATs is often limited by geography, transport needs, or higher thresholds for access, meaning the person needs to be distressed 'enough' to receive attention.

The Government Inquiry into Mental Health and Addictions (2018) highlighted the widespread lack of wrap-around services that support whānau/citizens to help them meet their needs before reaching a point of distress. Even when these services exist, they are often under pressure, making them inaccessible due to long wait times or restrictive criteria for access (Government Inquiry into Mental Health and Addiction, 2018). Further, The 2021/22 New Zealand Health Survey indicated that, increasingly, people are reporting unmet needs for professional mental health support (Ministry of Health, 2022). Many whānau/citizens experiencing mental distress may require diverse support other than specialist mental health services; however, anecdotally, police officers report limited options to support whānau/citizens beyond transporting them to the emergency department (Macdonald, 2018).

The increasing demand for mental health-related events is putting pressure on frontline police officers with already limited resources. In recent years, the New Zealand Police have reported an inability to respond to all mental health-related calls for service. In the 2020/2021 annual report, the New Zealand Police have reported feeling limited in their responses to whānau/citizens in mental distress, with around half of all mental health call-outs having to be cancelled without police attendance (New Zealand Police, 2023a). Because they are not mental health professionals, police are limited to determining whether, in their view, there is a need for urgent assessment by a health professional. In responding to these events, frontline police officers experience institutional barriers (e.g. limited time to spend resolving each response) and a paucity of other services (i.e. Davey et al., (2021) report that mental health services do not have the resources to admit patients). Additionally, police have expressed a concern that the volume of mental health-related responses is reducing their capacity to respond to other jobs, therefore contributing to longer response times (New Zealand Police, 2023a).

New Zealand Police are guided by the values of professionalism, respect, integrity, and their commitment to Māori and Te Tiriti o Waitangi principles, empathy, and diversity (PRIMED). These values direct police to collectively practise an ethic of care, apply the law fairly, conduct dignified interactions with all individuals, and partner with communities to create solutions that help people feel safe (New Zealand Police, 2022b). A 2021-2022 survey on trust and confidence found that 69% of participants had high trust and confidence in the police. However, participants who identify as Māori and/or living in the more deprived areas of Aotearoa, New Zealand, have consistently reported significantly lower or no trust and confidence in New Zealand Police (Gravitas Research and Strategy Ltd, 2020; New Zealand Police, 2022a), indicating

difficulties with realising the potential of PRIMED and Prevention First for Māori (New Zealand Police, 2017).

When police decisions apply discretion, then biases and racism may result in an unfair application of policy, including in mental health-related events. O'Brien et al. (2011) found that when police responded to a mental health emergency where the person was Māori, they were more likely to take a criminal justice approach rather than a mental health approach, demonstrated by an inequitable and higher use of TASERS. Further, use of force was found to be high in one study for people experiencing mental distress (Holman, 2018), and are more likely to receive an armed, and often fatal, response from the police (O'Brien et al., 2021). Māori have the highest rate of mental health service use (Gibb & Cunningham, 2018; Te Whatu Ora, 2023), are more likely to be subjected to coercive mental health treatment (Ministry of Health, 2023) and are more likely to be arrested, charged in court and incarcerated (Ministry of Justice, 2023). Therefore, the translation of policy into practice when responding to mental health events poses eclectic challenges and mixed responses for police that remain significantly under-researched in the New Zealand context.

In Aotearoa, New Zealand, police cells are one context where police can detain someone under the Mental Health (Compulsory Assessment and Treatment) Act 1992 for a mental health assessment. However, policy custody is far from an ideal environment for acute mental health care. A 2015 Independent Police Conduct Authority report found that police custody in Aotearoa, New Zealand, constituted a high-risk environment for harm, e.g., through undetected overdose, self-harm, and suicide attempts (Independent Police Conduct Authority, March 2015). Furthermore, the directive of the Aotearoa, New Zealand Police is that officers should transport someone to have an assessment in "the least restrictive environment that is possible" (Ministry of Health, 2021; p. 10), either in the person's home or in a health setting such as an emergency department.

This directive is supported by a Memorandum of Understanding (MoU) between the New Zealand Police and the Ministry of Health. The MoU states that police cells should be used as a last resort, for example, if someone behaves violently and cannot be assessed in another environment (Ministry of Health, 2021). In three districts, however, police stations have trialled a mental health nurse located in the custody suite to help identify and support the mental health needs of people in custody. These initiatives had positive outcomes for police, such as quicker identification and triaging for people in custody in mental distress, improved referral pathways, and better support for police officers (Paulin & Carswell, 2010). Since then, The Canterbury district custody hub has embedded mental health nurses and is funded by Te Whatu Ora (previously the District Health Board).

A recent study explored the experiences of people in Aotearoa, New Zealand, who had interacted with the police while they were attempting suicide or supporting a whānau member (Hunter, 2023). Participants (n=5) reported that the communication style of the police greatly influenced their experience of the interaction. Two participants noted that the communication of the police, including being calm and using positive language, was a positive aspect of the interaction. However, the other three participants found the police to have poor communication and named this as a negative interaction feature. Poor communication included invalidating and trivialising language and not giving information. Further, these negative interactions with the police worsened suicidal participants' mental state at the time of the interaction (Hunter, 2023).

New Zealand Police have taken proactive measures to improve their response to whānau/citizens experiencing mental distress. They have implemented e-learning modules to reduce discrimination and improve communication with such individuals (Davey et al., 2021). The voices of people with lived experience ('service users') are included in this training for police officers. This service-used-led training aims to bring about behaviour change and reduce discrimination. The modules were focused on destigmatisation and assisting police to engage with people experiencing mental distress in more positive ways, supported by examples of the stories of positive and shared challenges of service users. Police participants reported finding these modules to be helpful and informative, with an improved ability to recognise mental distress and engage empathetically with someone in mental distress. It was noted that virtual training may have been less ideal for participants than face-to-face training and could have limited other positive effects; however, the practical benefit of e-learning is that information can be widely disseminated within the workforce (Davey et al., 2021). This training has since been replaced with 'Responding to People in Mental Distress' – a two-hour face-to-face session informed by lived experience videos.

Additionally, New Zealand Police have collaborated with Whakarongorau Aotearoa, whom Te Whatu Ora contracts to facilitate the Earlier Mental Health Response trial line. This allows 111 callers to speak with mental health practitioners (New Zealand Police, 2017a). It is important to note that some preventative initiatives may not be evident to the public, and the police may have taken other preventative actions that have not been researched and documented.

Wellington district police piloted a co-response team between 2020 and 2021. This co-response team constituted a police officer, a mental health worker, and a paramedic. It was intended that the team would respond to jobs related to mental distress and provide guidance to other on-the-ground responders. The primary objectives of this team were to offer safe, dignified, and respectful assistance along with mental health triaging that could be conducted in an individual's home instead of police cells or emergency departments. Additionally, the team aimed to decrease the employment of police detention under the Mental Health (Compulsory Assessment and Treatment) Act (1992) (Every-Palmer et al., 2022). The pilot evaluation reported successful outcomes. During co-responses, most mental health assessments happened in the person's home. The emergency department was utilised less, and wait times were shorter. The ability to make referrals for follow-up support was enhanced. Participants who received a response from the co-response team reported positive experiences and satisfaction with the team. Successful collaboration between participating services was reported (Every-Palmer et al., 2022). There are now several local district-led initiatives implementing co-response teams. In August 2023, the then Minister of Police announced that these teams would be introduced nationwide over the next several years (Beehive.govt.nz, 2023).

However, some initiatives, such as the co-response model piloted in Wellington, can be seen as reactive rather than preventative. Māori and Pacific New Zealanders have expressed support for a hypothetical co-response model that does not include police but paramedics and trauma—and culture-informed health and mental health professionals (ActionStation, 2020).

The global involvement of police in mental health-related events

Globally, police have a long history of responding to mental health-related issues. International research in the 1960s began to document police playing an increasing role in interacting with people in mental distress, for example, making referrals for emergency psychiatric care (Bittner, 1967b). These interactions became more common in the following decades, particularly when large psychiatric hospitals began to close without sufficient community mental health support being put in place to meet the needs of people (Dawson & Gledhill, 2013; Lurigio et al., 2008).

In the following, we provide a brief overview of the current international research related to:

- Police decision-making in mental health-related events
- Lived experiences of police responses
- Response models and interventions

The potential for police to do preventative work around mental distress is also under-studied internationally. International studies that have been completed have prioritised police and clinicians working together to reduce coercion, facilitate access to specialist mental health services and connect people in crime hotspots with health and social resources (Cummins & Edmondson, 2016; Dyer et al., 2015; Herrington, 2012; Horspool K et al., 2016; Kubiak S et al., 2017; McKenna et al., 2015; Watson & Fulambarker, 2012; A. C Watson et al., 2010; Wood & Beierschmitt, 2014; Wood & Watson, 2017). Therefore, there remains a lack of research exploring the proactive, problem-solving, relational ethic of policing in the majority of non-emergency mental health events that police attend (Wood & Beierschmitt, 2014).

Police decision-making in mental health-related events

Research has shown that several factors influence the decision-making of police officers. Mental health-related events often present multiple ways, which can pose a challenge for police officers in deciding which approach to take. Lurigio et al. (2008) proposed that police officers typically have three goals when interacting with someone in mental distress: 1) to exert control over the person, in the sense of containing or arresting them, 2) to de-escalate the situation and prevent harm to the individual or others, and 3) to

facilitate access to support resources outside of the criminal justice system. Achieving these three goals can be difficult, and police may need to decide which to prioritise.

Police officers may attend mental health-related events where someone is experiencing mental distress but are also reported as behaving in a way that police perceive to be threatening, dangerous or criminal. Police officers might experience tension in these contexts when they see their primary function as enforcing the law and also feel they lack training about how to take on more of a mental health-focused role (being sensitive, supportive, and de-escalating distress) (Lurigio et al., 2008). In addition, they may perceive arrest to be the most helpful response for a person in mental distress because a lack of mental health resources in their community means they are more likely to receive treatment for mental or psychiatric issues in prison than in the community (Lamb et al., 2002; Lurigio et al., 2008).

Research has also shown that it can be difficult for police officers to handle situations involving individuals who are experiencing mental distress while also adhering to legal mandates. In their observational research, Wood et al. (2017) used the term 'grey zone' to describe situations where police officers may not have a clear legal mandate to intervene but must use their discretion to find solutions. In such cases, police officers usually prefer informal ad hoc actions instead of enforcing the law (Bittner, 1967b; Wood et al., 2017). This grey zone presents a challenge to police officers, and there is a need for more observational research to understand how they arrive at their decisions in these circumstances. The authors suggested that informal police actions are often not recorded or analysed, leading to a lack of understanding about the choices police officers make (Wood et al., 2017).

Morabito (2007) conceptualised that police decision-making regarding whether to arrest (or not) in mental health-related events is influenced by "horizons of context" (p. 1583). This conceptualisation builds on work by Bittner (1967) and describes how contextual features of an interaction guide officers' decision-making. These features include the police officer's workload, perceptions of the community's mental health resources and their effectiveness, characteristics of the officer and the person in mental distress, and the severity of criminal behaviour (Morabito, 2007). Wood et al. (2017) later demonstrated the relevance of this framework, where participants were influenced by these factors, such as mental health resources in the local area while navigating the grey zone.

Earlier research conducted by Godfredson et al. (2010), found that police officers often reported a discrepancy between their desired outcome and the most likely outcome when interacting with someone who is experiencing mental distress. This suggests that they encountered certain constraints that prevented them from resolving the situation as they would have liked to. Interestingly, most participants indicated they did not require additional training in responding to such situations. This could imply that participants did not see their inability to reconcile their desired and likely outcomes as a matter of training or expertise. Instead, they saw it as a matter of external resources and options.

Police officers have been observed to be hesitant in initiating a formal mental health intervention, such as taking a person experiencing mental distress to an emergency department. This reluctance has been noted since the early studies by Bittner (1967; 1967a, 1967b), Teplin and Pruett (1992). The latter identified that police officers may avoid initiating hospitalisation due to the strict criteria for involuntary hospitalisation, which often means that the person experiencing mental distress will not be admitted. However, the person's fit with the criteria for involuntary hospitalisation was only one factor influencing whether police would take this approach. Initiating hospitalisation also requires time and administrative work for police, and there were added complexities, such as hospitals not accepting someone who is acting violently. Therefore, police officers' perceived options were to arrest the person or take no formal action (Teplin & Pruett, 1992).

Bittner (1967) observed that police officers could discern how involuntary commitment to a hospital draws many parallels to having someone jailed and often did not feel comfortable deciding whether a person met the threshold for this coercive option. As a result, they would find an alternative to involuntary hospitalisation unless they felt it was abundantly justified. Additionally, police officers have reported frustration in navigating the mental health system, such as spending a great deal of time with a person in a hospital waiting room or encountering the same individual multiple times because they have been admitted and then quickly released from the hospital (Bittner, 1967b). The latter has come to be known as a 'revolving door policy' and may indicate insufficient health resourcing to provide ongoing support or

solutions for people experiencing mental distress (Godfredson et al., 2011).

The decisions police officers make in these circumstances are highly consequential and long-lasting for the person experiencing mental distress. Police officers have the power to decide whether or not to use a formal criminal justice response (e.g. arresting someone); they are often considered gatekeepers to the police or criminal justice systems (Lamb et al., 2002). If a police officer views an arrest as the most appropriate thing to do, rather than, say, referring a person to a mental health service, this person has now been put in contact with the criminal justice system. There is an overrepresentation of individuals with mental illness in prisons worldwide. Imprisonment results in a loss of personal freedom, limited or no opportunities for rehabilitation, and the absence of a therapeutic environment that can help improve or prevent mental health from deteriorating (Buttle, 2017; Jordan, 2011; Teplin, 2000). Once a person is convicted of a crime, they are more likely to be involved in future criminal justice proceedings, and the police may treat them differently based on their criminal record, thus creating a vicious cycle (Teplin, 2000).

The process of criminalising individuals with mental health issues presents significant challenges for the criminal justice system in terms of resources (Lurigio et al., 2008). Studies indicate that police officers often have the opportunity to divert individuals experiencing mental distress from the criminal justice system (Barrett & Janopaul-Naylor, 2016; Compton, Anderson, et al., 2017; Compton, Halpern, et al., 2017). However, the success of this outcome is dependent on the availability, feasibility, awareness, and selection of diversion options (Lamb et al., 2002).

Lived experiences of police responses

There is a small but growing body of research exploring the lived experiences of people who have interacted with the police officers during a mental health-related event. People who have been diagnosed with a mental illness commonly reported multiple interactions with the police. These interactions occurred for a variety of reasons, including mental health crises (Livingston et al., 2014; Watson et al., 2008).

Several major international studies have found that people diagnosed with a mental illness often experience negative interactions with the police (Boscarato, Lee, Kroschel, Hollander, Brennan, et al., 2014; Livingston et al., 2014; Watson et al., 2008). These negative experiences include an over-reactive approach, verbal abuse, and being disrespected. As a result, participants have reported feeling humiliated and viewing the interaction as unfair, dissatisfying, and coercive. Many also felt intimidated, with police officers asserting power over them and making them feel like criminals. The use of force was also common, with one-quarter of participants in one study reporting minor injuries sustained during police interactions due to the use of force, such as handcuffs, physical restraint, being pushed, or punched (Livingston et al., 2014). Additionally, the presence of police officers has been experienced as intense and forceful for people who have experienced involuntary transportation under the (New South Wales) Mental Health Act (Bradbury et al., 2017).

Research has raised concerns about the way police interact with people experiencing mental distress (Vinson & Dennis, 2021). For instance, one study found that their participants often had to wait for extended periods in police custody before being attended to by mental health professionals, which only made their distress worse. Detaining people in mental distress can have serious negative consequences (Boscarato, Lee, Kroschel, Hollander, Brennan, et al., 2014). Cummins (2008) noted that police custody is a place where self-harm and suicidal behaviour are prevalent among all participants, and the experience of being detained is both stressful and dehumanising. Furthermore, police officers are not adequately trained to provide mental health support to detainees who are experiencing psychological distress. In some cases, the detention of people experiencing mental distress even results in death (Chappell & Ryan, 2017).

In circumstances where police detention is used, Cummins (2012) posits that an opportunity exists where mental health needs must be assessed. Many people in police custody have unmet mental health needs but are seldom connected to mental health services. As such, the author argued that the police must have workable partnerships with mental health agencies to facilitate this. Several police stations also have a mental health nurse located in the custody suite to facilitate the identification and support of the mental health needs of people in custody. This initiative has had positive outcomes, such as quicker identification and triaging for those in custody in mental distress, enhanced referral pathways, and

support for police officers (Paulin & Carswell, 2010). Further, studies report that participants who had interacted with police officers while experiencing mental distress reported positive interactions with the police, mainly being treated fairly and with dignity and respect. Conversely, not being given a voice in the interaction was experienced negatively (Boscarato, Lee, Kroschel, Hollander, Brennan, et al., 2014; Faubert, 2023; Livingston et al., 2014; Watson et al., 2008).

These findings build on wider police studies that have shown exchanges where police treat people as people with dignity and respect, allow them a voice during encounters, conduct transparent decision-making, build community trust in police, and increase participants' likelihood of abiding by the law (McCord, 1995; Tyler, 2006). These exchanges follow principles of procedural justice: 1) treating people with dignity and respect, 2) displaying trustworthy motives, 3) making unbiased decisions, and 4) giving people an opportunity to express their views. Research applying procedural justice principles to avoid coercive experiences for those in mental health proceedings reports that coercion can be seen as the antithesis of procedural justice. An early study found that limiting peoples' ability to make choices and decisions correlated with their perceptions of coercion. Subsequent studies found a strong inverse correlation between consumers' perceptions of procedural justice and perceptions of coercion in mental health settings (Lidz et al., 1995). Other studies have shown positive experiences where engagement with the police was perceived as dignified and respectful (Furness et al., 2016; Watson & Angell, 2007; A. C. Watson et al., 2010). This can be contrasted to unjust interactions that participants found threatening and over-reactive (Boscarato, Lee, Kroschel, Hollander, Brennan, et al., 2014).

Watson's seminal work led to the creation of the Police Contact Experience Scale, which measures perceptions of procedural justice and coercion of citizens in mental health crises (A. C. Watson et al., 2010). More recent qualitative studies have explored the importance of communication styles in creating procedural interactions; for example, Bradbury et al. (2017) participants reported that a gentle, non-violent communication style from the police was experienced as positive. In Faubert (2023), participants identified positive aspects of being treated with kindness, feeling like the police officers were empathetic and validating, and being connected to support. By contrast, Hunter (2023) found that negative experiences lacked procedural justice principles. Overall, research has illustrated the need for police to use procedural justice as a framework for interacting with people in mental health emergencies.

Response models and interventions

International literature has identified that interagency partnerships with mental health services are essential to community mental health policing. Yet, challenges exist in creating models and interventions that promote interagency coordination and workable partnerships (Bradbury et al., 2017; Godfredson et al., 2011; Hollander et al., 2012).

Training models

The Memphis Crisis Intervention Team (CIT) model has been implemented across the United States and worldwide (University of Memphis CIT Centre, n.d.). It originated after a high-profile police shooting of a man with a history of mental illness in Memphis, Tennessee. In response, Memphis police worked with the United States National Alliance on Mental Illness to develop a specific response model for police to use when interacting with people in mental distress. Within this model, selected police are specially trained in mental health, and these officers respond to mental health-related calls either as the first responder or called in by the first responding officer. At least one CIT-trained officer must be on every shift. CIT officers undergo 40 hours of training, during which they become skilled in de-escalation, maintaining safety during interactions with people and being well-trained to recognise whether and how to refer someone to mental health care either formally (via hospital) or informally via community resources (University of Memphis CIT Centre, n.d.).

The CIT model has been highly praised, widely implemented, and viewed as easily transferrable between police departments (Lurigio et al., 2008). Positive findings such as reduced arrests have been touted (Franz & Borum, 2010). However, research on whether the CIT model consistently delivers positive outcomes is unclear. Positive initial outcomes, such as enhanced verbal de-escalation skills and perceptions of self-efficacy among CIT-trained officers, may decline after the training's conclusion (Davidson, 2016). Taheri's systematic review and meta-analysis (2016) found no evidence that the CIT model reduces arrests or

police use of force. A review by Rogers et al. (2019) found that CIT tended to have positive outcomes for police officers, such as enhanced satisfaction and a self-perception of using less force. However, there was no evidence that CIT improved officer and persons' safety or reduced arrests. Overall, research has demonstrated some evidence that CIT models enhance officers' choices to divert people in mental distress from the criminal justice system (Taheri, 2016; Rogers et al., 2019), but more robust research is needed to reach conclusions. Peterson and Densley (2018) concluded that the current research based on CIT is not yet consistent enough in its methods or findings to conclude that CIT can be considered an evidence-based practice.

When it comes to improving police responses, it is crucial to prioritise the voices of people who have personally experienced interactions with police officers. In various international studies, individuals with lived experiences have highlighted what they believe police training and responses should include. For instance, participants in Livingston et al.'s (2014) study emphasised the need for police officers to receive better training on how to communicate with individuals experiencing mental distress and how to prioritise non-violent responses. The study also recommended having mental health professionals present during police responses to mental health-related events. Similarly, participants in Watson et al.'s (2008) study suggested that police officers should remain calm and patient while allowing individuals to explain themselves. Participants also wanted to be treated with empathy and for police officers to know about mental illness, both in terms of asking about their mental state during their encounters and being trained on how to interact with individuals in mental distress. Lastly, participants in Boscarato et al.'s (2014) study favoured the idea of Australian police officers undergoing CIT (Crisis Intervention Team) training, as they believed that this would improve their ability to de-escalate and identify mental distress. However, they also expressed that the typical 40 hours of training would not be enough and that a longer duration of training would be necessary.

Police officers participating in UK-based research have also indicated that they find it valuable to hear from people with lived experiences of police responses during their training (Pinfold et al., 2005). In a study where people with lived experience delivered two workshops to police officers, results showed that police were significantly more likely to endorse key de-stigmatising messages after attending these workshops (for example, that "People with mental health problems are far less of a danger than most people believe"; p. 127). However, there was no significant evidence that the police officer's hypothetical actions towards people with mental illness changed after the workshops (for example, that they would not be afraid to talk to someone with schizophrenia) (Pinfold et al., 2005).

As reported earlier, communication styles that create procedural just interactions (Bradbury et al., 2017) are gaining popularity among police agencies. The main objective of this training is to teach police officers how to police in a way that promotes procedural justice, which can enhance trust in the police among people and, consequently, compliance with the law. There are two types of procedural justice training: script-based and skills-based (Council on Criminal Justice Task Force on Policing, 2021). Skills-based training appears to increase officers' belief that procedurally just methods effectively enhance positive interactions with the public and increase their use of procedurally just behaviours. However, it remains unclear whether procedural justice training reduces officers' use of force (Council on Criminal Justice Task Force on Policing, 2021). More applied research is needed into this type of training and, specifically, its effectiveness in improving police interactions with whānau/citizens in mental distress. This should be done in tandem with greater use of Watson's (2017) Police Contact Experience Scale, which measures the person's perceptions of procedural justice and coercion.

Co-response teams

There is a significant amount of research on various models where officers co-respond to mental distress situations alongside non-police workers with mental and/or physical health expertise. Non-police professionals sometimes act as self-dispatched first responders (Bailey et al., 2022). In contrast, they could arrive at an event after the first-responding police have identified that a co-response team would be appropriate (e.g. Lamanna et al., 2017). In the latter approach, regular police officers respond first and assess whether the situation is safe for the co-response team.

Marcus and Stergiopoulos (2022) conducted a study on co-response teams and found that the benefits of such teams are not always conclusive. While they can potentially reduce the use of force and arrests,

provide follow-up support and referrals, shorten wait times in emergency departments, and decrease apprehension under the Mental Health Act, the results of the studies were not always conclusive. One of the reasons for this was the methodological weaknesses in the studies. Additionally, it was noted that obtaining interagency collaboration to run co-response teams could be challenging (Marcus & Stergiopoulos, 2022).

However, the researchers also noted that co-response teams have been experienced positively by people experiencing mental distress (Marcus & Stergiopoulos, 2022) and enhance perceptions of procedural justice (Furness et al., 2016; Lamanna et al., 2017). Participants in Lamanna et al. (2017) reported that mental health nurses were particularly valuable for their knowledge about mental health, and participants valued the co-response team, treating them with compassion and empathy, taking an empowering approach, and working together with them collaboratively. No participants said they felt criminalised during co-responses. Participants in a study by Boscarato et al. (2014) also viewed co-response models favourably, explaining that the positive aspects were assessing mental health needs and swiftly facilitating non-hospital options. The need for co-response teams to arrive independently or simultaneously with regular police was also identified, rather than the job being initially responded to and triaged by police only (Boscarato et al., 2014).

Non-police responses

People who have had interactions with the police while in a state of mental distress have expressed their preference for removing police officers from such situations (Boscarato, Lee, Kroschel, Hollander, Brennan, et al., 2014; Hunter, 2023; Pope et al., 2023), including in Aotearoa New Zealand (ActionStation, 2020). Alternative response models exist where the police are not involved. Examples include:

- CAHOOTS (Crisis Assistance Helping Out on The Streets) has been operational in Oregon, USA, for over thirty years. In such cases, a team of mental health crisis workers and paramedics or nurses responds to the incidents instead of the police (Waters, 2021). Although this team can call for police backup, it seldom does (Gonzalez Miranda et al., 2023; Waters, 2021). The CAHOOTS team most commonly responds to welfare checks, typically handled by the regular police (Gonzalez Miranda et al., 2023). The CAHOOTS model reportedly responded to 17% of 911-dispatched calls in Eugene, Oregon, in 2020 and saved around \$8.M on public safety and \$14M on ambulance/emergency room treatment annually (CAHOOTS Consulting, 2020).
- Models similar to CAHOOTS, where a mental health professional and paramedic are dispatched to mental health-related jobs, operate in New York City and Denver (Denver Department of Safety and WellPower, 2022; NYC Mayor's Office of Community Mental Health, n.d.). These have led to fewer hospitalisations, more community support and follow-up care (NYC Mayor's Office of Community Mental Health, n.d.), and the diversion of these jobs – most commonly, welfare checks – from police to more appropriate services (Denver Department of Safety and WellPower, 2022). More recently, scepticism about the feasibility of this model has been raised, citing issues around the limited response scope (Smith, 2022).
- Baltimore, Maryland, has used the Behavioral Health Emergency Response Diversion (BHERD) Program (McNeilly et al., 2023). In the BHERD program, 911 calls related to behavioural health crises are transferred to a hotline staffed by community-based counsellors, who can dispatch clinicians to the job. An evaluation of the BHERD pilot in Baltimore found that most eligible calls transferred to this hotline could be fully diverted away from police and fire/emergency services (i.e., the job was fully resolved by the hotline without being directed back to emergency services; McNeilly et al., 2023).
- St Petersburg, Florida, uses the Community Assistance and Life Liaison (CALL) model for non-crime emergency calls, including mental health and substance use (University of South Florida Center for Justice Research & Policy, 2022). Emergency dispatchers divert these calls to either non-police 'navigators' or police, who first respond to a job and decide whether a CALL team would be more appropriate to take over the response. These navigators have studied mental health or social work-related fields and have experience in helping vulnerable clients. The key goals of the CALL team are to reduce police involvement in these types of jobs, provide

connections to long-term support services, and respond with a social service and mental wellness lens. Evaluations indicate that the CALL team is more likely to respond to mental health-related jobs than mental health and drug/alcohol intoxication issues, successfully diverting these responses from the police (University of South Florida Center for Justice Research & Policy, 2022).

- The Crisis Response Unit (CRU) in Olympia, Washington, is staffed by crisis response specialists who respond to mental health, poverty, homelessness, and substance use in the community. A nurse can also assist with first aid and non-acute medical care. The CRU can provide de-escalation, referrals, harm reduction, and transport to services (City of Olympia, n.d.) that seldom call for police backup for safety (only twice during its first 3,180 calls; The Council of State Governments Justice Centre, 2022). A valuable aspect of the CRU is its linkage to a programme called 'Familiar Faces', where people who have repeatedly contacted the police are supported by peer specialists who share their lived experiences.
- The Street Crisis Response Team (SCRT) model in San Francisco similarly includes people with peer experiences. In the SCRT model, the response team for behavioural health crises includes three team members: a paramedic, a behavioural health clinician, and a behavioural health peer specialist (City and County of San Francisco, 2022). SCRT is increasingly diverting calls from the police, and it can provide quicker response times and connections to social services. Most often, the SCRT can resolve the interaction, and the person can remain in the community with linkages to support services or be transported to a support service rather than to the hospital. Involuntary holds were not commonly utilised (7% of clients). People to whom the SCRT responded have reported positive interactions and a preference for being seen by the SCRT rather than the police. SCRT staff have reported that a benefit of their response model is the diversity in each response team and the enhanced ability this brings to connect with clients (City and County of San Francisco, 2022).

Other states in the US are increasingly adopting non-police crisis response teams. An initiative by the Council of State Governments Justice Centre aims to provide an online Toolkit to support jurisdictions aiming to implement non-police first-response models (The Council of State Governments Justice Centre, n.d.). Overall, research indicates that non-police response models are feasible and positive (Gonzalez Miranda et al., 2023). Positive outcomes include support for outcomes such as diverting responses away from regular police (e.g., McNeilly et al., 2023), improved response times, enhanced referrals and follow-up support, and reduced hospital admissions (though some of these have mixed evidence; Marcus & Stergiopoulos, 2022). In sum, findings show that the lived experiences of non-police responses are positive (Marcus & Stergiopoulos, 2022).



Part 2 | Whānau/citizen narratives of police encounters while experiencing mental distress

This part of our study reports on our exploration of whānau/citizens' experiences of police encounters whilst in mental distress. The overarching objective was to co-produce narratives with citizens, which indicate the role police played in mitigating or increasing mental distress.

Method

A community-based participatory approach involving peer-to-peer co-produced narratives with citizens was used (Roche et al., 2011). Sarah Gordon led the process with the support of Stella Black, PhD candidates Maddy Hayward and Kiri Hunter, and other lived experience advisors/interviewers. The inclusion criteria were whānau/citizens who had engaged with the police while experiencing mental distress. Maddy Hayward and Kiri Hunter focused on whānau/citizen experiences from the regions of Canterbury and Counties Manukau, respectively. Otherwise, whānau/citizens could come from anywhere in Aotearoa, New Zealand.

We asked participants to collaborate with us to produce their narrative on the role police played in mitigating or increasing their mental distress. Recruitment occurred by extending this general invitation to participate through mental health and disability information networks. This specifically included forums and organisations that provide information, news, resources, and support to whānau/citizens who experience mental distress. Additionally, those known to fit the inclusion criteria and who the team thought might potentially be interested in participating were also purposefully recruited using personal invitations. Participants had the option of whānau/family members and support persons of their choice taking part in the co-creation of their narrative.

As much as possible, narrative creation began with a kanohi-ki-te-kanohi (face-to-face) meeting between two interviewers and the participant/s. Sometimes, this was impossible due to restrictions in response to the COVID-19 pandemic. Participants were asked what characteristics of the interviewers their preference would be (e.g., male, female, Māori, lived experience), and we attempted to provide for this to the best of our ability. If the participant desired, we began with karakia (prayer). We then engaged in whakawhanaungatanga (establishing our relationship), where we asked each other: "Ko wai koe, nō hea koe? Who are you, where do you come from?"

A semi-structured approach was used to guide the interviews. We asked the participant to "communicate their story" about police engagement. It was then intended that participants would be asked to talk about their experience of police actions in terms of the service user framework of best-practice engagement developed by Sarah Gordon (2018): (i) be calm and calming, (ii) connect with the person, (iii) ask what is going on for the person, (iii) listen to the person, (iv) empathise with the person and (v) ask what would help the person. Participants were then asked to consider how each of these elements was or was not facilitated through their experience. Finally, participants were asked to describe how police actions served to mitigate and/or exacerbate their mental distress. The interview was closed by asking the participants how they felt about the kōrero (interview discussion), options for follow-up with us, and, if they wanted, a karakia whakamutunga (closing prayer). Depending on their preference, we contacted the participants between a day and a week later to check in with them and confirm the best way to work together to finalise their narrative.

With the participant's permission, the interview was audio-recorded and then transcribed. Based on that transcription, the interview produced a narrative of the participant's experience. That narrative then went back to the individual, and from there, an iterative process between the participant and the researcher took place via interactions by e-mail, phone, videoconferencing or, if possible, face-to-face to enable the participants to enhance, explain and shape their final narrative. Any features of the narratives that had the potential to identify individual members of the police were removed.

At narrative completion, participants were asked to provide photos for inclusion or advise the researchers on images they might like. These were then sourced, consented to by the participants, and included

in the narrative. The narrative was then designed, printed, and packaged with care and gifted back to participants as a taonga to keep.

Participants had the option of being named as the author of their own story or choosing to de-identify it by choosing a pseudonym. Participants were supported in making this decision with a 'thinking about disclosure' fact sheet (Gordon & Peterson, 2005), which provides participants with an outline of the pros and cons to be considered in making this decision. Participants were also given the option of how they would like us to use their stories in public presentations and writing, and these options were revisited at different stages throughout the story creation process. At the final stage of the process, once their narrative had been fully concluded and produced, participants were given the specific options:

- Have their narrative published on our project website; have their narrative used to inform the analysis of all the narratives and have quotes from their narrative used as examples in documents and presentations
- Don't have their narrative published on the project website; have their narrative used to inform the analysis of all the narratives and have quotes from their narrative used as examples in documents and presentations
- Don't have their narrative published on the project website; have it used to inform the analysis of all the narratives but don't have quotes from their narrative used as examples in documents and presentations

They were given the opportunity to withdraw from the study at any time. If they chose to withdraw, they were offered to remove their story from our collection or allow it to be used in a de-identified format.

The Braun and Clarke framework (Braun & Clarke, 2021) facilitated thematic analysis. This involved a combination of an inductive and deductive process. Initially, interview transcripts were independently analysed by two research team members (Sarah Gordon and Brian McKenna) through familiarisation by reading the transcripts several times over. Based on that familiarisation, the two researchers independently began coding the data based on their relevance to the research aims. Through this initial work, we could see a possible framework based on existing service-user-led best practices for police engagement in Aotearoa, New Zealand (Gordon et al., 2018), with international best practices for policing from a procedural justice perspective (A. C. Watson et al., 2010). A third researcher, Katey Thom, confirmed this. We then generated the codes into the following framework: calmness, connection, choice, fairness/openness, voice/active listening, validation/empathy, active communication, respect, safe space, compatibility, responsiveness, motivation, criminalisation, advising, discrimination, and kindness. Once this framework was developed, we proceeded to cluster the above codes we identified from the data together using the developed framework to form provisional themes based on content similarity. Once all narratives had been coded this way, we identified and confirmed the themes and sub-themes based on those parts of the framework populated through the coding process. Data related to content outside of our service user-led best practices of engagement (Gordon et al., 2018; A. C. Watson et al., 2010) continued to be inductively analysed from coding to the generation, reviewing, defining, and naming of themes. We then returned to the raw data to re-examine for inclusivity, accuracy and relevance and had a final discussion to confirm consensus. The other research team members reviewed draft themes and sub-themes, as well as the final review by the Police Oversight Committee. Slight revisions were made before full consensus and verification were finalised.

Findings

A total of 28 whānau/citizens participated in the interviews. One withdrew during the interview, feeling it was not the right time to discuss his experiences. Two withdrew after the interview. Another did not re-engage at all after the interview. Their narratives have not been included in this report. The main reason for withdrawal was feeling that the process was too triggering. It is important to note, however, that experiences differ; for some whānau/citizens interviewed, the process of sharing their traumatic stories and empowering them to have a voice in their narrative was therapeutic and healing.

Despite having the semi-structured interview schedule, most participants presented a reasonably full narrative in response to the initial question, asking them to communicate their story. Very few prompts were made during most of the interviews. The narratives that whānau/citizens provided informed

consent to be fully published are in a separate document accompanying this report. Fully publishing the narratives aims to provide complete transparency and support the participants and their experiences. This enables the audience to critique the thematic analysis undertaken by the researchers, which helps in the consideration of others. It also allows for the external application of reflexivity, such as how the beliefs and biases of the researchers may have influenced the work.

The following are the outcomes of the thematic analysis of the narratives. Most of the participants wished to remain anonymous in their accounts and thus used a pseudonym. The quotes are usually lengthier than a regular results section, as the primary focus remains on the views expressed by the whānau/citizens.

Trauma

Trauma was a common theme that emerged in almost all narratives. Whānau/citizens identified trauma as the root cause of their mental distress. Often, this trauma stemmed from multiple, severe, and sustained traumatic events, circumstances or experiences from childhood. These included intergenerational trauma, poverty, mental, physical, and sexual abuse, family harm, poor health, intimate partner abuse, cultural dislocation, fractured relationships, and loss of opportunity.

For example, after Annie was born, she was cared for by her grandparents. Her mum only intermittently and quite randomly visited her and her sister. Then, when her grandmother became too unwell to take care of them, Annie and her sister spent time living with different friends and family members. Annie eventually went into foster care. From 10 years of age, Annie found herself unsettled and in a constant state of flux. At 14 years of age, Annie was sexually assaulted, which contributed to ongoing experiences of mental distress and attempts to take her own life.

Noeline's experience of mental distress started when she was eight in response to being assaulted by her father. At 17, she finally got away by joining the Navy. She got pregnant not long after that:

And then my mother turned around and adopted her [my baby] out. I... didn't have a say in it. In those days... that's what they did. They just adopted you out. And I don't think I ever really recovered from that, or just sort of went downhill, really.

Gwynnie comes from a background characterised by significant challenges. Her father was a gang member, and her mother had an addiction to heroin. Her parents separated when she was a minor, which led to Gwynnie being uplifted by Child, Youth and Family Services. It was in State care that Gwynnie was sexually abused. Not long after this occurred, her partner died by suicide. These events were the impetus for Gwynnie's life spiralling downward rapidly.

Iharaira describes some of his childhood memories as being "pretty dented" because of the drug abuse and head knocks. He has big blanks in his memory, but he knows and feels they are centred on feelings related to whanaungatanga, being connected with whānau and te Ao Māori. So, at 16 years old, Iharaira found himself living on the streets. On reflection, Iharaira admits his resentment fuelled his stubbornness by blaming others for not loving him enough, making him turn to the streets searching for a family that would love him. By this time, Iharaira was committing crimes to survive, breaking into cars and houses:

I was breaking in and just raiding their fridges. It was really ugly, but I had to survive. I did what I had to do to survive.

Similarly, Tane describes his upbringing as being like a 'once a warrior' story with drinking, drugs and domestic violence right from a young age.

Hearing the stories about her mother's upbringing had a profound impact on Ana, often causing her to be worried for her and wanting to look after and protect her:

I became the mother. I felt like I had to be my mum's caretaker, and I think, in some ways, I took that role on my own. Because I wanted to fix her, I wanted to heal her... [I feared] I was going to lose her.

Ana was able to describe the experience of intergeneration trauma in detail, as this extract from her full story illustrates:

Ana's mother was born into a Māori family but spent most of her life being brought up in a Western European household. She experienced racism from both Māori and Pākehā; she felt like she didn't fit in anywhere. When her parents split up, Ana's mother was separated from her birth mother and her younger siblings. She and her older siblings were brought up by their father and his new wife. Her father was absent for the majority of her upbringing; however, whenever he was present, he was 'narcissistic' and uncaring towards his children. His wife was an affluent figure in her community; however, behind closed doors, she struggled with her physical and mental health, which impacted tremendously on Ana's mother.

At age 11, Ana's mother tragically lost her birth mother in a car accident. She was reunited with her younger siblings at their mother's tangihanga. The differences between them were stark; the older children felt out of place and didn't know what to do. After the burial of their mother, they were told off for breaching the protocols of being blessed and washing their hands after exiting the urupā (cemetery). All the children were told not to return to the marae. Ana believes the rejection, coupled with the loss of their mother, was a defining moment in the siblings' lives and their connection to their Māoritanga. "That loss is something I can feel to this day, even though I wasn't there," Ana says.

Ana attended a very rich white high school and recalls being among the only Māori brown-skinned students in her class. It was in this environment that she came to realise how different she was and that being brown, being Māori, and being different was something to be ashamed of. Ana explains:

I had been in school with these people for years, you know, I was probably in year twelve. So, I've been with these, with these kids for 12 years of my life, and they were my friends, you know. Or so I thought anyway, until I was sitting in this history class, and we were learning about black civil rights. And one of my classmates made a comment or like, drew some parallel between the black civil rights and the Treaty. I mean, they started talking about how Māori are lazy and dole bludgers and all of these really, really negative, stigmatising comments. And I was sitting there, and I was looking down at my hand ... I'm thinking, "I need to hide", you know, my skin from everybody... I was looking around the room and felt like people were looking at me. So that was like the first time that I genuinely felt that point of difference.

In addition, Ana felt that the kaupapa Māori service she was placed in was not the right option for her. She instantly disengaged after being asked if she would say a karakia. Being Māori and not knowing te reo made her angry that there was yet another thing that she was failing in:

"God, I can't even be Māori. I can't even be myself."

Some participants went further through their narrative to suggest how the police need to respond to trauma:

Remember that when you are talking to someone in distress, you are talking to all their trauma, the trauma of their parents, of their ancestors. In particular, Māori are still experiencing the impacts of colonisation and inter-generational trauma. Shift from

asking... thinking what is wrong with this person, to what has happened to this person. In doing that, you remove the judgment and allow this person to express their hurt.

I just think being able to get alongside somebody and be able to kind of interpret their behaviour and thinking about what, how did this person get here? – Louise and Joy

Beth firmly believes that the presentation of mental distress is very often a result of trauma. Hence, she argued the 'symptoms' of trauma need to be understood for what they really are and not understood as causing a person to be dangerous or in need of treatment and hospitalisation. Beth felt that part of a good understanding of trauma is a good understanding of dissociation, which is often a result of trauma. Most importantly, dissociation does not mean that a person is out of touch with reality with everything they are saying. Beth has experienced a trauma-informed response from the police:

It is good they have not only acknowledged the trauma and believed it but also enabled and supported me to take some action about it... I also think they even saw how the hurt little girl self-emerged as a result of trauma and were much more open to understanding the associated mental health issues linked to trauma.

Multiple instances of engagement

Most participants had multiple instances of police engagement, some of which continue to this day. For example, Beth continues to have quite frequent contact with the police. However, because the police now know Beth well, she no longer feels any threat of being committed to the hospital. She feels safe on the streets, which has meant she has been able to evangelise and go about helping people experiencing homelessness.

Police provided reassurance to Lin by telling her to contact them if her adult son Max experienced acute mental distress again. The family subsequently became well known to police, and to Lin's relief, their responses have always been timely:

Since Max has been unwell, we have rung police so many times... and actually, I'm very happy of their service, what they have given us at home. Some nights, I had to call them three to four... even four times, but they have been there all the time. Yeah, within 10-15 minutes, they... they are. So, I'm pretty pleased with their service was towards my difficulties.

They were actually very quick. And that surprised me that how fast they can work. We feel good that now we are all safe, that we've got our helpers here. So we all felt good...

Iharaira spoke about still getting into trouble with the police, seeing them now and then for the harm he was causing his partner. Kelly described her multiple interactions with the police whilst experiencing mental distress over a decade as varying from:

...absolutely terrible, like stick-in-your-mind kind of terrible experiences... through to some really empathetic, lovely people, who have been really helpful.

As a result, she observed that it was very easy for her to contrast the negative experiences she had had with ones that she had found very positive, as many participants were similarly able to do.

Tane knew that if it came to being arrested and ending up in police custody, then it was always bad:

There are no nice times in custody. Custody is shit. No matter what way you want to put it, even if, you [are] just visiting... you just like walked out like, "Oh, man, I'm glad I'm out of there, [I'm] glad I don't have to stay in" ... you [are] just isolated, [you're] like [an] animal in a cage, your rights are stripped from you. You don't get nothing; your shoelaces are taken, now your shoes are taken off.

Aaron felt like the treatment he received from police across multiple instances of engagement had been inconsistent. He said it depended on which officer he interacted with during each incident: "The other

problem is, you get a nice one. And the next time you have an experience with the police, it's a completely different person."

Recovery

Despite some whānau/citizens still having instances of engagement, most participants considered themselves to be in a good place currently. After being in and out of the hospital for many years, Beth recalls:

I haven't been in the hospital the whole time I've been in [my city, for over a decade] now... And I think that's really good too. Because other cities have felt like that threat was hanging over my head like anybody could complain [and get me] sent me off to the hospital, that kind of thing, but that doesn't seem to happen here. Even if it's isolating here, and I don't have as many supportive friends here as in other cities. I feel like it's not gonna happen, that it's safer and that people aren't going to hospitalise me. I don't want to be hospitalised again, and they seem to be okay with keeping me out of there, which is good for safety issues. It's much safer coming somewhere like here to respite rather than being put in supported housing or hospital...

The police and all these other agencies believe me about everything, so [I] don't have to worry about them thinking that I'm delusional and they're going to hospitalise me again – Beth

The services did help, giving Tane some positivity and hope, but they never managed to support lasting change until much later in his life. He never managed to finish most treatment programmes that he engaged with, except for the Alcohol and Other Drug Treatment Court, where he graduated. Although he admits to having never really engaged with that either:

Anyway, I went to the Drug Court; I was doing really well and had a job. I was complying. I was sort of like a role model for the Drug Court, but the thing was, I still wasn't 100%... actually, I was dealing methamphetamine on the side through the Drug Court. No one knew about that.

Hera reflects that life for her now is much more sedate and provides a 'back to nature' lifestyle. She proclaims, "That's probably the best thing I did... moving here for my own wellbeing and sanity."

Iharaira has been clean for a year. He had lived with his mum and stepdad while serving his home detention. Rebuilding these relationships has been a long and challenging struggle over the years, but he is grateful they have continued to be there for him.

Kelly expressed that for her, there have been fewer times that she has required police attendance when she has been experiencing extreme distress or crisis, and when they have, the experience has been more positive than in the past.

Tane finally decided to make permanent changes in his life. He believes that forced change does not work, and despite having supposedly 'failed' previously with several imposed interventions, Tane said they were not a waste. He applied his previous learning and is now living a different life after finding his way in recovery. Previously, Tane had never celebrated his birthday – he never saw the point, given he was either in prison, getting out of prison, or just returning to prison. Part of Tane's life now is celebrating his birthday.

Humanistic engagement

The theme of humanistic engagement includes the sub-themes of connection, respect and genuine concern, and information provision. Particularly because participants often experience multiple situations of engagement, each sub-theme is informed by aspects of participant engagement that they experienced as positive and aspects of participant engagement that they experienced as negative.

Connection

This sub-theme includes connections existing through history, whānau, family, friends, ethnicity, age, and gender; attempts by police to make connections with whānau/citizens to have the opportunity to speak, and for police to actively listen to that. Barriers to connection include the power imbalance and uniform ("padded up"; "all their gear"), boundaries, lack of communication, whānau/citizens being ignored, and lack of engagement.

Connection existing by way of history, whānau, family, friends, ethnicity, age, gender

Iharaira and Gwynnie both spoke about the impact of engaging with friends and whānau/family who are police staff:

Because I knew some of them, I had actually grown up at school with some of them, so when they saw me – because actually when they arrested me... They treated me like I was still their bro, and I was taken aback, like, "eh? You care? Why do you care?" They were like "bro, we were worried when we heard that you'd cut yourself."

When I was arrested last [the police officer] was my stepbrother. I was in the cells, and my stepbrother, so my dad's wife's son came out; he worked in the police station where I was arrested. He came and like, talked to me and made sure everything was alright. He took me outside for a cigarette and gave me a drink. That was cool. Maybe because he was my family, so other than that, I don't really have many good interactions with police. I haven't had the best experience with the police.

Hera and Kelly reflected on the importance of connection through gender and ethnicity:

Just for somebody to listen to me, or maybe even having a female and a male there, like not two males... I felt quite ganged up on. And that's probably a lot to do with my own issues as a child and sexual abuse and things, but two males coming to visit you is... just overwhelming... [Also] I look white, they were white... I just feel like they didn't have an understanding. Whereas if it had been a Māori police officer, they just have a way about them and their words and their energy... I just feel like my values align, and our values align, and they respect. We respect one another and whether your point is right or wrong. It's just about being listened to and being heard.

I am very aware that I am a small, young, white woman. I often reflect on how much worse my experiences may have been if I, for example, lived in my partner's body as a tall man with Samoan ancestry. I feel like I have probably benefitted a lot from my privilege during my experiences with the police.

Like other participants, Rachel reflected on how her privilege may have shaped her interactions with the police:

I recognise that I'm a Pākehā woman, middle class, who's not had experiences with the police before. And... I recognise that we live in a racist society, with people with different life experiences and that not everyone's experience of the police is going to be like mine. And... that the police is simply an institution made up of individual people, and there's good and bad, and I happened to have an unusual life experience where, for me, the police were very, very supportive. I also know it was a collaborative thing. So, I didn't come in with a suspicion of the police or a bad experience. And so... the empathy went back the other way. I was thinking, 'Imagine having a job that you, you have to come out and deal with the worst of society'... you know, a first response to a crime scene, the things that they must witness, and that they witness that, and that they have to stay empathetic. That would be very hard. But I endeavour to think, people are doing their best, and they're human beings.

It was also important for Rachel that she interacted mainly with policewomen:

I think something for me as a feminist is that I largely dealt with women. I think it just happened to be their team [that was on the case], and their team happened to be one with a lot of women. I guess that's significant for me, because I think of my stereotype of the police is a male dominated group.

When Beth met a female police officer, they emailed and met for coffee, forging connections through their shared Christian faith:

Not all that often because she [was] really busy... it was mainly as a friend. And I really want this to be taken in a positive way. Because I don't, I don't want people thinking that she was breaking professional boundaries or anything. She really went out of [her] way. And it made such a difference.

In contrast, participants identified barriers to connection of this nature. For Lisa, it was her profession:

They treated my professional career as meaning I could deal with all this... like, "Why didn't they make this Woman's Refuge referral much earlier?" ... I think they just looked at me as [this] educated, professional, white person who should have her shit together... and know better or something.

Also relevant to the potential barriers to the New Zealand Police and the theme of connection is Tama's view that he finds it hard to connect to his nurses and doctors because they are all Pākehā. Tama thinks they don't understand him or what it is about "being Māori." From a te ao Māori perspective, Tama knows he is different, but he also wishes he could speak te reo Māori to verbalise his thoughts better.

Attempts by police to make connections with whānau/citizens

Participants identified that officers attempted to make connections via their actions, what they were saying and how they were saying it, and/or body language and validation - recognition or affirmation that a person or their feelings or opinions are valid.

Ana felt that the younger police officer was "really lovely." He asked if they could go inside because it was a little cold outside. Ana recalls she kept apologising for wasting their time and that they must have had more important issues to deal with. The police officer said, "No, you are important."

Louise and Joy reflected:

I think a lot of it is more in the unsaid than what's said. So, the body language and the manner. Because you can tell when somebody is genuinely kind of interested and concerned... just through the way they look at you or engage with you, but definitely not making fun of somebody's distress.

In contrast, their experience involved:

Two policemen banged on the door looking for [Louise] here. They came inside, and we're kind of like, I don't know, it was quite a sort of... you imagine policemen? They're massively padded up and all of their gear, they've got big yellow jackets on... So that's kind of physically... you've got this sort of barrier.

John also experienced physical intimidation by police, coupled with coercive actions.

When the cop interviewed me, at one stage, she sat on the interview desk, which was like a school desk. And said that I'd done something that exaggerated what actually happened. I hadn't been before the court at this stage. The policewoman said if I didn't sign the statement [which was not correct], "That the longer you take, the worse it will be for you."

For Gwynnie, the lack of an attempt to make a connection involved her being escorted in an ambulance to the hospital. Despite her being in a highly distressing situation, the Senior Sergeant who escorted her to the hospital did not converse with her at all.

Niwa reflected that instead of police trying to connect with him while he was locked in a bathroom wanting to attempt suicide, police were forceful. He feels that if the police had instead communicated and attempted to connect with him, he would have been receptive to interacting with them:

They were going to knock down the door and put the Taser on me, I'm like, well, you don't do that. If someone's having mental health distress, you don't go and pull out your Taser ... it just made me feel scared. I don't know if I'll come out of being tasered. I didn't know how I would feel; I don't know if you'd end up dying from being tasered, or... they just don't care. That's all I say.

They could have just come to the door; they could have come in. I would have been more than happy to come out to talk to them if they said it quietly... There were a whole lot of people that were living in that flat complex; they could have just come to the door and said it quietly, not yell and scream.

Whānau/citizens having an opportunity to speak, and police actively listen

This sub-theme was focused on whānau/citizens being encouraged to voice what had happened to them and the police actively listening:

They listened intently, asking questions when necessary. – Ana

When the police officer listened and connected with her voice, Ana experienced their empathy and noted how this was reinforced by the officer being proactive in trying to understand and share their understanding of the distress being experienced by Ana. This was similar for Lisa and Kelly:

He was very verbal about understanding my predicament, telling me that he could see why this would upset me. – Lisa

And it was really distressing. And I had a police officer show up in that situation who got teary-eyed, said, "Oh my gosh, I'm an animal lover myself, and that sounds really distressing!" – Kelly

When Rachel gave a statement to the officer police after being a witness to a murder case, she experienced as empathetic and encouraging:

I gave the statement... It was a male police officer. He was really understanding... I found him good. Empathetic. Supportive. Understanding. Professional, but not in a detached way. I actually sat with [my neighbour] while she gave her statement over the phone... she just needed that emotional support. [She was] nervous about interacting with the police; I actually visited her another time where the police were there, and my impression was that they were very understanding and encouraging, and "Thank you for doing this" and "I know it's hard" and... Yeah, I found them empathetic.

In contrast, when the two white male police officers arrived at Hera and her husband's property, the first thing they did was enter the house to speak to her husband. Hera believes that by the time the police finally came to talk to her, they were unwilling to listen.

Respect and genuine concern

This sub-theme includes respect for human dignity and genuine concern. Whānau/citizens expressed an overarching theme regarding how they should be treated during humanistic engagement. They believed they had the basic right to be treated with respect and dignity. This related to the total engagement process from the time the interaction commenced to the time it ended.

For example, Ana offered the officers a seat in her house, directing them where to sit. When one of them sat too close to her, he moved back until she felt better. As a result:

I felt like this was my house, and they were respecting the fact that they're in my house... Even though I was in a weakened state, I was still in charge. I was still being respected because this was my space. This was my experience. This is my story.

This value placed on respect and dignity was best reflected in descriptions of interactions when whānau/citizens felt humiliated, which is the direct opposite of being treated with respect and dignity. In these situations, the feeling of being made fun of was prominent:

I had a big male police officer on either side of me, holding me by my arms. Now they're walking me down to an observation room, and it was the absolute lowest moment of my life. And they said, "This is your moment", as if we were walking down, you know, a red carpet to the Oscars. The officers' comment, made in apparent jest, affected me profoundly. This incident increased my resolve to challenge the stigma attached to my ongoing experience of mental distress. I thought... "No, this is not my moment. I'm going to go and do a bunch of stuff in my life... that is going to be my moment...and you don't get to choose!" You know, it just felt like an existential attack on me and telling me, essentially, that this is all that I'd amount to. I'd be like be a BPD [mental health condition] labelled person who would go in and out of ED having crises. – Kelly

It was like I was the butt of their jokes or something like he'd [the officer] said something... I can't remember, something about me not being very happy... or, "You don't look very happy" or something. And I was like..., "Neither do you", and they just thought that was hilarious...Terrified, terrified...I mean, there's no dignity, there's no compassion for what you're potentially going through, how you got to be in that place... I find it's really embarrassing. – Joy

"What's this?" [They reply], "It's the recreation relaxation room, can't you see, all these lovely chairs..." And he said to me, one of the cops, the male cop said, "Oh, you'll be able to rest and relax here" So the nurses come in. – Marion

I can't really remember much about what was said. I just know that one police officer laughed at me. I remember saying, "Why are you laughing at me?" He just said, "I'm not laughing at you." [But he] was looking at me and laughing... I just felt angry, and like, I'm trying to find a word that would describe that I just felt let down. – Hera

An extension of respect and dignity involved genuine concern on the part of the police to respond and resolve situations in a positive and empowering manner for the whānau/citizens involved. This often involved the police going out of their way (beyond the call of duty) to assist.

Kelly could relay two examples where genuine concern was an obvious feature of the engagement:

What were you here to do?" ... like, "What was it before this happened that you were here for?" ... "I just wanted to go for a swim" ... and he's like..."How about you jump in the car? I take you around the corner to [another swimming facility]. And if you go for a swim there, are you all good to catch the bus home after that?" So, like... just helped [me] get back onto plan as usual. And it really de-escalated things. – Kelly

Yeah, bit more of a hands-off approach. [The police] have come, checked in and said, "Yep, you guys know what you're doing... we're here if you need anything... is there anything we can do for you now?" ... and then have taken that direction, and that helping approach, rather than maybe coming in with the idea that they're going to apply the usual sort of lens or approach... and fix things, or intervene with their kind of criminal justice policing, training. – Kelly

For Gwynnie, it was the environment and procedures of the drug court where she felt she experienced genuine, positive and empowering interactions with the police:

The police, they just say how proud of you they are, how well you're doing and stuff like that. And then they might like so if you had like a sanction which is like a positive drug test. I mean, obviously, the police are going to hold you accountable and tell you what, you know what's going on. But mainly just positive stuff... It's more like they are looking at your behaviour rather than you.

Rachel also had a positive experience with the police in the wake of a court process. Throughout the experience of being a witness in a murder trial, the police made sure she and the other witnesses felt supported and knew what to expect. At the end of the trial, the police went out of their way to let the witnesses know they were appreciated:

At the end of the week, [the main contact policewoman] let me know that he'd been found guilty. And she actually sent the judge's summary and the sentencing, which didn't put our names in for our privacy but said... you know, "In particular, the courage and testimony of the three women at the apartment building." I mean, she didn't have to do any of that. And she did.

In contrast, a lack of genuine concern left whānau/citizens with no control over their situation and highly vulnerable, including by way of putting the blame back on individuals:

Physiologically, I was finding it really hard to be okay in my body. I was quite dissociated, quite distressed, and quite highly sensitive to stimuli. So... it was really hot in the car, and I asked them if they could have opened the windows a bit more because they were only open about a crack, about a couple of inches, that much [indicating]. And they actually wound the windows up when I asked them if they could wind them down. And I asked them if they could turn the radio down because it was really loud, and I was having trouble managing sensory input, and they turned the radio up. – Kelly

They came back to me the same night and said, "No, we're not going to charge him, and you need to stop reacting to this sort of stuff. You're being very dramatic about this." This is what they said to me, "You've been very dramatic, and you're giving him what he wants; you're giving him attention." – Lisa

Information provision

This sub-theme includes police officers explaining what will happen, keeping whānau/citizens updated, providing details as to where to access help, telling whānau/citizens what the police will do and then telling them when the police have done it.

Explaining what is going to happen/keeping whānau/citizens updated

Iharaira described the reasons why he needed to know what would happen and the implications for him and the police.

It's that not knowing what's going to happen is the scary bit, is the bit that I don't like. It's like I don't know whether I'm going to get out or when I will, but it's good to have that light at the end of the tunnel after you've done – like I knew and I know the process, and it's like if I have a bit of information to sort of cling to, then I can work through my problems and be cooperative. I'll cooperate. If you guys are pono with me and tika with me, I'll be straight up with you.

Joy reflected on the logistics in terms of keeping whānau/citizens updated in a manner that would be most helpful when they are experiencing distress:

...so, there were all sorts of services...not really linked... it would be good! having a coordinated approach with the services and having one central... "right, here's the telephone number that you're calling" and then... the person who's going to speak to you is going to be on shift... but then they're going to hand that over to somebody else. "We will manage or coordinate the police, and whatever else is going on, we'll tell you the story. Yeah, we'll work with you"... I rather than you getting all sorts of information... rather than being left to jump to conclusions of what's going on because you don't know.

Aaron's distress was exacerbated when he was in police custody and had no information from the police about how serious the situation was or what the consequences might be:

And at the time, I didn't know how severe it was. So, I thought I was gonna go to prison for 20 years. Because they don't tell people how long they're gonna go into prison for.

Hera described the lack of information provided while being detained in the cells. She does not recall anyone explaining what would happen to her, if she would be charged, and how long she would be held. Although, she calculates being held in the cells for at least three hours. She also recalls that despite telling the police officer earlier that she wanted to kill herself, at no time was her level of risk assessed while with the police. During that time in the cells, the only person who checked on her was a female police officer who had known Hera's relative. She believes she was only released because that officer took pity on her. The perceived impact of her connection and engagement with an officer with family relationships also relates to the theme of connection above.

Providing details as to where to access help

Several participants expressed the value of police officers assisting them in accessing help. This included both accessing further help from the police and accessing help from other agencies:

And they gave me phone numbers to ring, and I did that the next day. I rang them, and I talked to them because I was still emotionally sort of upset – Noeline.

We had a police officer who attended and [who] gave us each a pamphlet for the 'Are you ok?' number around domestic violence and family violence. [They] explained, "You know, you guys both look like you're struggling in different ways with this." [The police officer said] to my partner at the time... "You can call this number if you want some support," ... and that alleviated the ... only option of calling the police. [He said to me] "You can call this number if you like... because what's happening for you doesn't look okay, either." – Kelly

He gave me his name and number and told me to call him if I ever needed his help. He was very kind, supportive and helpful – Marion.

And I'm assuming this is through the police, who connected me with Victim Support. I had a contact person through them who has checked on me since it happened, and since the trial, and they offered counselling... And they offer 30 free sessions, which I think is an unheard-of amount of funded sessions. – Rachel

Telling whānau/citizens what you are going to do and then telling them when you have done it

Exemplifying the element of this sub-theme, Lisa expressed how important follow-up information provision was to her:

And he told me what he was going to do. And he rang me and told me when he had done it, and I was quite shocked about how fast he acted on it because it may have

even been like the night before we went into lockdown when it happened... And he kept me informed. And he dropped off the paperwork. Everything was just really responsive, caring and genuine... – Lisa

Rachel had an experience where the police told her they would do something and then did not follow through, causing distress for her and others involved:

[After the murder] I thought the building owner and the property managers need to know what's happened... they need to know, and I can't do it. I definitely had a conversation [with one of the police officers] ... And I said, 'Can you let the building owner know? Here's the phone number and the name. And then I thought, "Oh, I've done my bit, they'll communicate:... I really thought they would do it.

The police didn't notify them. What happened the next morning is a journalist had called the building owner, saying, you know, "There's been a murder at your building, do you have a statement?" She's hours earlier [Australian time zone], and then she can't reach her friends in New Zealand and doesn't know who to call and what to do and... I mean, the woman put her heart and soul into this building. So, I got a call from one of the property managers. And she was horrified, distressed, you know... trying to understand what was happening, not getting much information, and said, "Oh, I wish you'd rung me last night." We've since talked about it and debriefed later on, but it was the one regret. So, yeah, if there was feedback to the police, it would be about that...

Ana summarised what she conceptualises as an overarching humanistic approach to whānau/citizens experiencing mental distress:

Remove the power imbalance. Remove and provide reassurance that you're not there to throw your weight around or to arrest anybody. It's "reassuring" a person... and just being a human being. That's what it comes down to, is just "being a human being." You're entering into that space, not as a police officer, but as a human being that's willing to listen and willing to help and to be an ear.

Criminalisation

Criminalisation was one of the strongest themes to come through from participants. Criminalisation occurs when a New Zealand Police response to a mental health crisis involves treating the person as a criminal, for example, by use of handcuffs, multiple staff, restraints or dogs. The use of marked police vehicles can also cause feelings of criminalisation:

The negative [experience] was that they [police] handcuffed me and put my hands behind my back and put me in the back of the car. And they sat in the front of the car and don't speak to me in any shape or form. Like I was a baddy that sat in the back of the car. And then at the hospital, they went into the special zone for police cars and got me out, like, a bad person going into a police cell, except that I went into the hospital. And when the nurses came, two nurses stood on each side of me, like I was going to be really angry and lose it and fight, or whatever. I was treated like a criminal. I still feel really, really sad and angry about that. I just wanted to say, and I might have even said at the time, "I am sick. I'm not angry. I'm not violent. I am sick. In my head, things are not working the way they should be. I am not a criminal." I thought like if anybody could see me right now in the back of a police car, they will think I'm a criminal. –Annie

But yeah, we're just not happy with the way that the police have dealt with Mike, and that you know... he was the victim... yet he got put in handcuffs and put in [Mental Health facility]. – Katie

But the police came and stormed this bus, or that's how it felt from my position on the floor, curled up in a ball. [They] handcuffed me and dragged me off the bus. And this

was on one of the busiest roads in [city]. And I was handcuffed at this main kind of bus stop across the road from the Mall for what felt like ages while they were maybe [deciding] what to do with me. And I was handcuffed. I was really distressed. I was possibly having some kind of meltdown, mental health meltdown. I was crying and distraught. I wanted to leave, and I couldn't go anywhere, so I was throwing my body into a brick wall, a front fence of a business there next to the bus stop in front of all these spectators for I'm not sure how long. – Kelly

Although Iharaira was also apprehended, handcuffed, and put into a police car, he somehow got out again and tried to make a run for it down the road:

It was that cop. I can't remember his name, but he was the one who called the dog, and the dog did the thing. I remember that day clearly, even though I was quite drowsy. I can still remember that clear as day.

Concerning her son, Lin shares:

Yes, they have, they have... few times they have [applied handcuffs]. But most of the time, he just walked to the car... a few times, they had to do that when he tried not to go. I've seen it once, and then other times when the police come... I try not to be there, I don't want to see that... you know, forcing him and taking him... but I know a few times I've seen [my son] just walk and go and sit in the police car.

When the police did arrive, they generally asked Lin what she would have liked to have happened. The police might have removed her son, and transported him to the police station, where he stayed overnight.

This theme of criminalisation also included participant concerns about what others might think:

And you just think, you know, how often are you on [this busy road], walking down the street, and you'll bump into a colleague or a friend or someone who knew you from school? I had no idea how many people with whom I had a tangible relationship would have passed me, but I was an absolute spectacle for however long that took. And I don't think that that should ever happen to anyone. – Kelly

In this recent encounter, Joy adds, "Yes, I was immediately thinking, what are the neighbours thinking?" Aaron also had an experience where police turned up at his address. He said the situation felt public and intimidating: "It was at a flat I was in, so it felt intimidating because there's two other flatmates I didn't really know, and they could see."

In contrast, and particularly where participants have experienced the use of force on the part of the police, the appreciation for being treated non-coercively is striking, as exemplified by Annie and Lin. Annie was not handcuffed; the police officers sat alongside her in the car and talked while she travelled. One pair of officers stayed with Annie while waiting for the clinical team at the hospital and continued to engage naturally with her:

The lady talked to me and asked me what had happened. We sat and talked. I felt as if I was a person. It wasn't like I was a criminal or a non-person; they treated me like a person—not even a person who was unwell. They just treated me like a person. – Annie

Lin describes a better approach to engagement with her son:

Once, I had to call them. And the gentleman [police] just came in... had to sit with him [Max] in the garage... which I've got a few chairs there. And he had a very good talk with Max. That day, they didn't take him. The two of them were there and had a very good talk with him. Then, he was all nice and calm and went to sleep. So I thought, "What was that magic?" you know.

Cause and effect

This sub-theme results from a lack of humanistic engagement (cause). It included the effect of fear of future engagement, not only concerning engagement when experiencing mental distress but also in other engagements, such as the reporting of a crime or the impact of past experiences on future engagement and life generally:

Well, this is what I think... yeah... I used to be really pro-police. Now, I think how naive I was. I'd still think twice about ringing them for myself. And that's a really sad position to be in. – Lisa

But I know, later on, it just made me feel so terrible. Like... I'd never want to go to the police for help... for something like a robbery... it was always this fear of... are they going to believe me because I have got this history? – Louise and Joy

When it comes to mental health, they've got no idea. I still fear the police at times... I fear if my mental health goes down again, I'll go through those visits from the police and the handcuffs and all that again. – Aaron

Gwynnie attributed the lack of care from the police to her having prior convictions. For Gwynnie, the police officers did not engage and respond in a way that provided her with the reassurance she needed when in an unsafe situation, experiencing a threat, or reporting a crime.

Marion has managed to have some records corrected, and some apologies proffered. However, due to some of the records that still exist from that time, she cannot get a police clearance for her job. Marion remains significantly impacted by her negative experiences with police and mental health services.

Although he is no longer engaged in behaviours that would be of interest to police, Tane is cautious and has a sense of distrust because of those interactions that he has had over the course of his life where the police have acted harshly.

Summary

The common thread of having encountered police while experiencing mental distress is unquestionably an emotive and life-shaping experience. Although embedded in the past, these experiences and their repercussions resonate for many today and into the future. The whānau/citizen narratives revealed the following highly interrelated themes and sub-themes: trauma, multiple instances of engagement, recovery, humanistic engagement (with the sub-themes of connection, respect and genuine concern, and information provision), criminalisation, and cause and effect. Collectively, the narratives suggest that consistently applying a trauma-informed humanistic approach to engagement contributes to more positive experiences of encounters with police officers.

Part 3 | Police experiences of responding to mental health-related events

The section reports the analysis from calls to the Police Emergency Communication Centre, case studies, and national stakeholder interviews.

Calls to the Police Emergency Communication Centre

This part of the report focuses on analysing calls to the Police Emergency Communication Centre. Members of the public call the Police Emergency Communication Centre via the 111-emergency number or the Police 105 non-emergency number. The 2021/22 Police Annual Report shows that in that year, police attended 73,006 events involving a person in mental distress, an increase of 55% over the previous five years (New Zealand Police, 2023a).

Method

For this research, Tony O'Brien and Katey Thom undertook a content analysis of a purposive sample of 111 calls (n=70) received during the week of 13-19 January 2019 that were coded 1M ("mental health") or 1X ("threatens/attempts suicide"). Tony O'Brien, Maddy Hayward and Katey Thom also studied the Police Emergency Communication Centre by observing call takers and dispatch teams on five occasions, gaining insight into the volume and range of calls and the process of assigning classifications.

All calls to the Police Emergency Communication Centre are recorded. Our sample comprised a purposive sample of 70 calls coded 1M (n=35) and 1X (n=35), transcribed by one research team member on location at one Police Emergency Communication Centre location under police supervision. This sample was determined based on resources available, especially related to the transcription of calls and de-identification checks by the New Zealand Police. The Evidence-Based Policing Centre reviewed the transcripts for adequate de-identification. The 70 calls were purposively selected based on 1M/1X coding to give an equal sample of each. Therefore, the sample cannot be considered generalisable but is a likely indication of overall patterns.

There were three aims of the content analysis: 1) to identify several key variables in the transcripts during the content analysis, 2) to explore how call takers responded, 3) to analyse the overall purpose of the calls and consider how this call may have been responded to in different ways, at times, without the need for police involvement.

We gathered information about the calls to achieve our aims, such as location, day of the week, and time. We also looked for specific elements present, such as mental health, addiction, medical or drug usage issues, weapons, and violence. Additionally, we looked for any indicators of a history with the police or mental health services. While we aimed to collect demographic information, not all calls provided this data, so we have not reported it. This type of analysis was challenging to complete as many transcripts were short, abrupt, and varied in scope to allow for interactions inclusive of intentional practices by call takers. We found this analysis unreliable and have not included it in this report. Instead, our analysis involved applying a set of decision rules to form an understanding of whether (in our analysis) the calls were mental health (1M) or suicide-related (1X) and to understand the rationale for the police-led response. By "response", we mean that frontline police attended the address and were the first to respond ahead of health or social services. We did not set out to determine whether the approach by the communicator was right or wrong; rather, we focused on examining whether there were instances where other kinds of non-police-led support may have been more appropriately matched to the caller's needs. We have included tabulated information on our overall findings and decision rules in appendix 1.

Findings

Overall, 1M coded events were more likely from whānau/citizens calling for support for themselves, while 1X coded events were more likely to be from whānau or support people. No patterns were found in the time or day the calls were received. There was little mention of weapons across the sample. Violence was present more often in 1M than in 1X. However, self-harm and suicidality are higher with 1X, which corresponds with the coding of the call. Over half of 1X calls indicated a prior relationship with mental health services. Police often attended in 1X cases (60% of cases), and less than half (40%) of 1M cases; sometimes, it was unclear what the plan of action was in 1M cases. We could see little evidence of call transfers to the Earlier Mental Health triage line.

Application of decision rules

Applying our set of decision rules, we agreed with call taker classification in 24 out of 35 1X cases (70%) and 21 out of 35 1M cases (60%). In 10 out of the 33 1X cases attended by frontline police, we felt this response was unnecessary, but there were no other response options. For example, for the mental health (1M) calls, we identified 15 out of 35 cases in which frontline police officers did attend but, in our assessment, did not need police as a first response. We provide further analysis using this approach in the 1X and 1M code events in the sections below.

1M calls

Our analysis showed that many calls coded 1M had a mental health component, but it was often incidental to the call's main purpose, which was often about a social issue. Consequently, many calls were assessed as not requiring a frontline police officer response but rather a health or social service response. Examples of calls that were classified by call takers as 1M but which, in our analysis, were not primarily mental health-related were as follows:

- A caller was concerned about their pregnant friend being assaulted. There was no identified mental health issue, but women's refuge might have been considered (1M call 3).
- A caller expressed concerns that someone might be climbing a crane, but no mental health issue was identified (1M call 9).
- A caller phoned to complain about being mistreated by their father, who was not putting money in their account. The caller was likely staying in supported accommodation but did not identify a mental health issue (1M call 33).
- A caller phoned with concerns about their son's mental health and was offered a police-led phone follow-up. This could have been referred to mental health via the Earlier Mental Health Triage line (1M call 17).

Finally, there were three cases in which Police attended, but no mental health issue was identified.

1X calls

In many 1X calls, suicide was mentioned, but other options could have been explored before police responded, or suicide was not directly related to the call. Examples of such calls included:

- A call to the National Poisons Centre for information that was construed as suicide-related but could have been triaged to mental health or ambulance services (1X call 3).
- A visit by a frontline police officer to attempt to persuade a person to attend a hospital appointment where the person had recently been seen by a doctor who did not think it necessary to invoke the Mental Health Act (1X call 8).
- A call about a young person (under 18 years) whom the family was concerned about but whom mental health services had declined to see (1X call 25).

In each of these cases, frontline police officers responded when other services had either declined or had not been asked to respond.

Box 1 outlines a call where suicide had been mentioned, but options other than a response from the police could have been considered. Please note that pseudonyms have been used in all examples.

Box 1 Police respond to an 1X call arising from a social issue

Brett is a client of Work and Income New Zealand (WINZ) and also has a serious illness. A WINZ manager called to say Brett had expressed suicidal thoughts to community support staff, in part related to a letter stating that he had a significant debt with WINZ. Brett commented to the effect that he had contemplated suicide rather than pursue the recommended treatment. Police responded by visiting Brett for a welfare check. There was no advice, either from the community support staff or the Police, that Brett could contact a support service, and there was no advice sought from the mental health service. (1X call 24)

In some situations, determining whether a police response is necessary can be ambiguous. It can be unclear whether a mental health or support service should be the first point of contact. For instance, in one case (1X call 28), where the ambulance service refers to the need for a welfare check, but there is no immediate danger, it may not be clear who should respond. Although such cases are coded correctly as 1X, they may require a medical emergency response owing to the overdose situation at hand.

Welfare checks

We identified seven instances among the 35 1X code calls in which the police were either explicitly requested to undertake a welfare check or decided that a welfare check was needed. There were no requests for welfare checks among the 1M cases. A welfare check is a police procedure whereby frontline police officers attend the address of a person of interest because of general concern for the person's welfare. In the 1X sample of calls, the welfare check was initiated by a third party, and these were not confined to concerns related to mental distress. The request came from whānau and health professionals. In several cases, a welfare check appeared to be a mechanism for addressing concerns that suicidal thought was a possibility, although it had not necessarily been expressed. Box 2 summarises a call that led to a welfare check, but it appeared a mental health service response would be more appropriate. This correlates with our content analysis, which indicates that nearly half of 1X calls (49%) are related to a person with a known history of contact with mental health services.

Box 2. The call resulted in a welfare check that could have been triaged to a mental health service.

A person had recurrent crises and has been seen by a mental health team. The caller expressed concern for the person and his mother, who has also expressed suicidal thoughts. The person has previously expressed suicidal thoughts to other friends.

Summary

Content analysis showed that many calls coded 1M or 1X have a mental health component, but it is often incidental to the call's main purpose, which was often a social issue. The police seemed to operate with a low threshold for attending, usually to make a welfare check. In these instances, frontline police officers are sometimes used as a primary and/or default mental health and social support service. Together with analysis of interviews with frontline police officers (see next section), analysis of call centre data suggests the Earlier Mental Health Response triage line is not working to reduce the burden of mental distress-related calls (1M and 1X) on police. Our analysis indicates that some calls are inaccurately classified for reasons we could not access, and in other cases, classifying calls as either 1M or 1X could be misleading if it is thought to reflect the nature of police work accurately.

Limitations to this section of the report are the small number of transcripts and their variable length and quality. In addition, we were not able to validate the data extracted against other sources. However, the researchers established decision rules by consensus and discussed our findings as the analysis progressed.

Case studies

This section provides a thematic summary of the collective findings from three case studies of frontline policing that occurred in different areas across Bay of Plenty (BOP), Canterbury (CANT) and Counties Manukau (CM) police districts. The overarching objective was to explore how police experience responding to mental health-related events.

Method

Case studies of frontline policing took place in each of the three districts over six months in 2021-2023 by Katey Thom, Stella Black, Kiri Hunter and Maddy Hayward. Each case study used observations, informal conversations, and in-depth interviews with frontline police across urban, provincial, and rural settings. The three regions were identified in consultation with police as these three regions have high levels of events coded 1M or 1X and are areas where some team members had whakapapa ties within the BOP and existing relationships. The case studies focused on the daily practices of police, including the “grey work” they do that is often invisible to society but may display preventative action with local communities (e.g., callouts but also welfare checks by phone, community engagement, education, liaison with services, dealing with micro-politics).

The researchers spent time in each location fine-tuning the parameters of the case study with local police, including completing an induction to cover health and safety and confidentiality protocols and detailing the research's practicalities. Observations involved 'ride alongs' in an incident car (I-car) and time spent at the station and with custody units. Towards the end of the observations, interviews with frontline police officers took place to solidify evolving ideas about the experience of policing in the context of citizens experiencing mental distress.

Across these data collection methods, the analytical focus was directed towards generating insights into how policing in mental health events differs from practice-as-usual, how police understand the preventative nature of policing, how that policy focus shapes the way they interact and respond to citizens in mental distress; and what factors may place limits on their ability to achieve positive outcomes. A similar analysis process described in section 2 of thematic analysis was used to generate 10 themes strongly represented across the three case studies.

Findings

In total we 53 interviews of frontline police officers were undertaken and these were accompanied by numerous informal discussions and 53 ride alongs for full or partial day and night shifts. Below, we report findings from interviews with frontline police officers, which largely had members of the Public Safety Team (PST) and senior police officers who provided leadership for PST and worked in family harm or community-based police services. Sometimes these interviews were carried out in a group situation/hui. Composite stories from our observations are also woven into the findings to offer de-identified contextual stories revolving around what we observed.

Perceptions of substantial mental health callouts

In the three case studies, frontline police officers frequently mentioned the substantial time they spent responding to mental health-related events. They also expressed their perception that mental health issues dominate their work, and 1M and 1X callouts are increasing:

Our response for mental health is second as our busiest item, which is only behind family harm. Often, mental health is a part of the family harm anyway, which we can address at the same time. Over the four years I've worked on the frontline, mental health has been increasing in demand. (BOP, Frontline police officer 25)

Many frontline police officers reported they were new in their role and did not necessarily expect mental health events to be a core feature of their daily work. Even when they had some prior knowledge of how widely people were impacted by mental distress, the day-to-day extent of mental health-related callouts remained surprising and widespread:

I think I'm lucky in the aspect that my family has worked in the medical side first, so I understood how widespread it is from listening to my mother and where she works. So, I understood how mental health is not just kind of dealing with crazy people but also just the general population in one way or the other. There are so many flow-on effects from drug abuse and family violence, and it all can contribute to mental health as well. I knew how much policing would deal with mental health, family violence and drug use, so it was just me putting two and two together to say these people are getting seriously affected by their environment; they must be dealing with the mental health side of things as well. But still was surprising, still surprising. (BOP, Frontline police officer 22)

Frontline police officers described attending events where whānau/citizens were experiencing mental distress beyond 1M and 1X coded callouts, as suggested by the above quote. They have observed mental distress across job types and not just in jobs that are perceived as a 'crisis' situation:

Probably family harm. Even, like, vehicle crashes are probably a big one for me. Car crashes, family harm, even shoplifters, there's always a reason behind it. Pretty much everything we deal with, I would say, has an element of mental health to it. (CANT, Frontline police officer 5)

The data from both BOP and Counties Manukau also advanced the notion that mental distress was increasingly affecting younger people. Participants described how rangatahi, who are under social service care can be particularly fragile and vulnerable to emotional outbursts. From their care home settings, the agency would often call the police to assist:

Even with youth, it's become quite predominant recently. Especially with kids in Oranga Tamariki care, we're called if they have kind of mental distress or outbursts... to attend the residence... the Oranga Tamariki residence. (CM, Frontline police officer 5)

The very first job that I did this morning was a 14-year-old girl who was emailing her youth worker at her college, wanting to kill herself. So that was as soon as you turn up to work, you're straight into the 1X stuff. (BOP, Frontline police officer 19)

Based on these insights, Counties Manukau frontline police officer 5 confidently summarised her three most frequently attended mental distress incident types:

So, I'd say those are our kind of main interactions ... family harm, youth and then the mental health kind of solely mental health calls as well.

It is important to note that many incidents involving whānau/citizens experiencing mental distress did not involve criminal offending, and this conflicted with frontline police officers' commonsense understandings of the role of police in the community:

A lot of the time... that call won't be a job for us. I would argue that that lady, who you know, has a serial history of calling police with claims of this nature and has no flags for assaults police or criminal offending... she's just mentally ill, she's not a bad person, she's just mentally ill. (CM, Frontline police officer 4)

Yeah, well, when you think about policing, it's catching the bad guy, isn't it? It's the basic understanding of it. The helping people part is cool as well, but you'd never realise that sometimes that day is one of the worst days in their life, and you're trying to bring them back from there to some kind of normal. It's pretty bad. (BOP, Frontline police officer 26)

The lack of offending in mental health events was something frontline police officers considered when deciding how to respond:

They're not always offenders, and they're not usually doing anything wrong; it's just some of the things that they're saying out loud or to other people or sometimes to us

when we arrive can be quite concerning. It's not that they're doing anything wrong; it's more for their safety and other people's safety. What they're saying, are they actually going to do it, or are they actually not going to do it, or is this actually happening, or is it just like... well, not just, but is this a mental health episode that they could be going through? (BOP, Frontline police officer 11)

During the Canterbury case study, frontline police officers articulated that it is inherent in their duty as police officers to assist whānau/citizens and avoid taking unnecessary risks. This perception of increased involvement in mental health events due to risk aversiveness and drive to help has become self-perpetuating as system-wide deficits expand:

I think as police, like as people, we're go-getters. We like being out there, we like going to jobs, we like helping people, so in some respects, we may do ourselves a disservice because we know that no one else is there to help them. Because that's our personality trait: we want to help, we want to go get people, and we probably do ourselves a disservice at times by filling that gap. I guess. (CANT, Frontline police officer 5)

Frontline police officers in the Bay of Plenty and Counties Manukau expressed similar perceptions that as demand for mental health support has increased, outweighing the capacity of health and social care services to respond, police are often the professionals left to fill the gap:

But due to failings in the system, we are always the agency of last resort, and when that culture is pervasive enough for any length of time, then we go from being an agency of last resort to the agency of first resort because they know they can rely on us to respond. (CM, Frontline police officer 4)

Overall, frontline police officers reported being first responders to a high and ever-increasing number of mental health events that involved intersecting social issues.

Frontline approaches to mental health events

As the demand for police to respond to mental health events continues to increase, how do frontline police officers approach those in need of assistance? In the case studies, officers provided insightful descriptions of how they attempt to help whānau/citizens in mental health-related events. This section summarises the common practices described across the three case studies to understand better how frontline police officers assist in such situations.

Acting 'professional' but also 'humanistic'

Frontline police officers framed their overall approach to mental health-related events as behaving professionally and as relational human beings. This involved a general approach that included understanding the importance of key elements of relational interactions, such as respect, listening, compassion, and action:

It's just treating someone like they're a human being, talking to them, but also being aware of the reality of a particular situation. I guess it's being aware of what your job is, but being aware of who you are and who they are regarding the humanity side of things. (BOP, Frontline police officer 22)

Part of being humanistic was recognising and trying to break down the barrier between police and members of the public by telling whānau/citizens in mental distress that they were not in trouble and the police were there to help:

Yeah. I guess one of the things I do is try and reinforce that they're not in trouble because often police are trouble, right? I'm in trouble, but it's "Hey, you're not in any trouble. We're just here to talk." You're trying to break that barrier down between

police and the fact that now our job role is we're not always just showing up because someone's in trouble, right? We're social workers, too, and that's why "I'm here talking to you. It's not because you're in trouble. I'm here to help, so talk to me." Normally, it becomes a bit easier once that barrier is broken. (CANT, Frontline police officer 5)

Resisting pre-contextualisation and suspending judgement

Some particularly experienced frontline police officers described approaching each mental health-related event while attempting to set aside any preconceptions or prior knowledge of the whānau/citizens and place involved, even if they've responded to the same place or person before. This requires them to avoid making judgments and believe everyone should be seen with an open mind and without any pre-existing biases:

I think after a few years, you just drop all kinds of judgment as well, and so when you turn up, you're trying your best to make sure they know you're not judging them for what's going on and all that kind of stuff and really listening to what's going on with them because I just think the majority of people, that's what they're after (BOP, Frontline police officer 18)

I prefer that police go around and sight the person. Because as much as speaking to them, we're looking over their body for any signs of... I prefer it; police go around and see it because they're not just talking to that person... you look for baggy eyes, red eyes, cuts on their arms, cuts on their necks, self-harming cuts, their whole demeanour towards you... everything like... that is what you're looking at. (CM, Frontline police officer 3)

Active listening, empathy, and validation

The frontline police officers in all case study areas highlighted the need for patience and understanding when dealing with individuals experiencing mental health issues. They emphasised the importance of active listening, asking open-ended questions, and focusing on the person's goals and desires, which had the impact of providing reassurance or reaffirming an experience:

Ask them an open question and let them just finish, let them talk, and even if it's about something that seems totally obscure to me or something that I can't fathom or something that I don't really relate with, finding a relationship and just taking that time, instead of going in there with my plan and my solution and what I want out of the job. Once I've heard it out, what do they want? What's troubling them, and then what's their solution? A lot of the time, we don't go there. We tell them what we've seen, but we don't know what works for them because everyone's so different. (BOP, Frontline police officer 23)

Active listening and building rapport were identified as being key to helping find a mutually beneficial outcome to the situation:

Yeah, communication is your best. To start you're trying to communicate with someone, you're listening to what they say, and you show that you're listening to them. Building rapport with them to show understanding and then trying to work through whatever it is that you need them to do, even if it's to get themselves to get help. That's the best way to try and do it, but it depends on the situation. Like if someone is in trouble, then it kind of makes it a lot (all laughing), but the basic premise doesn't really change. All cops can talk to people, and some better than others, but that's always your first tool to use when trying to deal with someone who's in mental distress because anything else is going to be less effective in the long term for what you want to achieve with them. (CANT, Negotiations Officer 1)

Calm and conscious body language

Many frontline police officers spoke about approaching mental health-related events calmly, staying

relaxed, being aware of their tone of voice, and using gentle negotiation techniques:

Depending obviously on the situation on how we would approach it, but for myself, I try to approach it really calm and softly and go and sit down next to them and say, "look, what's happening, what's going on?" and just let them say what they want to say. If we have any concerns from there on, we then reassess from there to see whether it is okay to take them away for an assessment of some sort for the professionals in that area to be able to tell us, no, they're safe, this is just them, or no, this is real concerning, we need to take them to the ward or whatever. We try and make that approach as calmly.
(BOP, Frontline police officer 11)

I would personally deal with each situation as I approached... and that would... for me is kind of... not cornering a person that's in mental distress... those types of things. (CM, Frontline police officer 1)

Frontline police officers shared their methods for maintaining composure in increasingly risky situations, especially when a person's distress escalates. They outlined different de-escalation techniques, including keeping the person focused on their goals, avoiding possible triggers, and exhibiting calm and non-threatening body language. They emphasised the significance of taking things one step at a time and concentrating on the present moment.

Frontline police officers said that de-escalation did not work in some situations, and tactical options (e.g., handcuffs) and restraint would need to be used. But being calm as a starting point could help to avoid this and lead to better interactions between police and whānau/citizens in mental distress:

I think there's a lot of aspects of police communication which starts sort of down here, and then if that doesn't work, then be more forceful and louder, and then if that doesn't work, be more forceful and louder and then perhaps maybe you need to go into a tactical option to make people do what you want, which you can do. But if you think about the best outcome for the majority of people, if you can acknowledge the emotions and talk to them on that level, you'll de-escalate them much quicker and be more likely to have a better long-term outcome. (CANT, Negotiations Officer 1)

Building connections and being respectful of difference

Frontline police officers discussed the importance of attempting to connect with people by sharing some aspects of self and likeness between people:

It's easier for us to enter their world than it is for us to try and make them enter our world. (BOP, Frontline police officer 4)

Sometimes, frontline police officers worked together to pre-plan how they would approach a mental health-related event to reduce the possibility of escalating distress. For example, we observed instances where a female officer would lead in initial interactions with a female victim. In contrast, the male officers would hold back to reduce the possibility of being over-imposing and inducing fear in recognising what the police uniform and associated apparatus may symbolise to some whānau/citizens:

Just trying to be relatable. Trying to pick up with something that they would be interested in. We had a drunk 1M female in [location removed] last rotation last night, and she hated me. She loved [female Frontline police officer], who I was working with, so she dealt with her and sat in the back with her. They were talking about music and dancing and how beautiful [female Frontline police officer] is and all this sort of stuff, and you sit there and take it, it's like whatever to get you from A to B. (BOP, Frontline police officer 19)

Some participants spoke about how they would endeavour to pick up on matters of cultural significance during interactions:

A morning with two frontline police officers

We drive out into a sleepy town. It's a very cold, foggy, dark morning during winter, and it stays dark until late. Today, I am joining two frontline police officers; one is a newer officer, and the other has a few years of experience.

First, we checked on Jane, a young female, as part of a follow-up for a report of family harm. She didn't want to talk. I thought to myself, "it is way too early! Why did they have to go out this early?" It made no sense for the person involved and may have been scary for her kids, too, especially for someone experiencing the trauma of family harm. One officer explains to her that they can record that she will go into the central police station and lodge her report, and that will mean they will not come back, a preventative action to not have to invade her space again. After we got back in the car, I asked the frontline police officers why we had come so early. They explained the pressure from dispatch to tick off jobs waiting in the line of callouts.

Then, a 1X call comes in. I get the feeling the dispatch team know I am here and are directing 1M and 1X calls to our car. I asked about this, and the frontline police officers agreed this may be the case, but this is usual for them anyway. A worried friend called; she could not get hold of her friend Mel after receiving worrying text messages. We went to check in with her. I notice the officers keeping space between them and Mel, who describes her recent experiences with trauma events. She had asked for help from mental health services but was getting nowhere. She had good support from a tele-service but was now feeling suicidal. The frontline police officers showed understanding and empathised with her, checking if she had also laid any police complaints regarding the harm she had experienced. This felt to me as validating and made her almost smile. One frontline police officer tells her they could reach out to the crisis team, which might help her gain access to an assessment. She agrees, and the officer leaves the room we are in to ring mental health services. We talked some more, and the frontline police officer returned and handed the phone to her. She finally contacted the crisis team and made an appointment that afternoon to be assessed.

Now, we are off to a family harm follow-up. The police are trying to support Danielle in getting a protection order but know they cannot force this upon her. While her toddler cuddles my leg, she describes how her ex-partner keeps coming around a lot banging on doors; he is intimidating, demands access to kids and requests money. I sense an insinuation by the frontline police officers and Danielle that her ex-partner may be a drug dealer or under the Mental Health Act because she believes he gets depot injections. The frontline police officers encouraged her to reach out to an NGO that would support her in creating a protection order, but she seemed very afraid of the consequences of this action. We leave, and I say goodbye to her gorgeous toddler, feeling a sense of an incredibly risky situation; we are going, but I know you cannot force someone to put measures in place. I expressed my worry to one of the frontline police officers after we left. They explain how frustrating it can be, but he realises too

much pressure on victims does not lead to trust or follow-up with any referrals they make; he knows they will be visiting again and building good relationships matters.

We race to an 1X case and arrive at a public-facing workspace. The faces of the team at the workplace say it all; one person explains they are very worried for their employee and workmate Jono, who appeared to have heightened fear as he was hearing voices and was confusing in his thoughts. They explained that he expressed to them that he had a previous diagnosis of schizophrenia, and they were worried he might get violent. When we approached Jono, he showed extreme fearfulness at the sight of the police coming towards him. He exclaimed he was worried about the police using force against him, saying, "You are going to get me with those tasers". One frontline police officer took the lead and explained, "We are not there to do anything to you. We are not the experts, but we want to get you somewhere to get the support you need because I can tell you're unwell and your workmates are worried about you." The frontline police officers negotiate with him to come along with them in their car to the mental health service. His close workmate helped, keeping him connected to the idea that he just needed a little help to get back on top of his mental health. The frontline police officer alleviated any wavering anxiety by explaining that his property would be cared for and transported to his whānau. One frontline police officer guided him to the car but did not handcuff him.

On the way to the mental health service, one frontline police officer does their best to keep their conversation flowing in a way that connects with him as much as possible. This is hard work as the conversation is confused and muddled, but the frontline police officer is patient.

We get to the mental health service, and police take Jono into an interview room, where a mental health professional does a quick assessment on arrival. I stayed outside the room, recognising it was a small room, and I did not want to heighten any anxiety that Jono may have been feeling. We cannot leave but must wait for the full assessment to begin, which would allow for a formal handover. Jono talks non-stop; this is hard work for the frontline police officers, I think. The clinicians come, and I check my watch. It's been 20 mins. Handover occurs.

We head to the car. I reflect. It seemed like an okay process; the frontline police officer who led the response was calm, respectful, and patient, but I had a sinking feeling that I didn't feel like the police were the right people to turn up just now. I think it probably creates more anxiety for Jono because of what the police in uniform symbolises. But I also am not sure an ambulance would be any better, as this is maybe too much. What is the best approach? Probably a mental health team.

The frontline police officers ask me, "How did we do?" I ask them, "do you think you were the right people to respond?" They say, "Probably not, but it is what it is". I ask, "Why did you not handcuff him?". One frontline police officer replies, "It was not needed; it was not why they were there."

And the way that I tried to do that was through speaking about herself and where she was from, and her tūpuna and how she engages in te reo and how she engages with marae. I suppose. Yeah. Trying to talk about all of those types of things that she was really passionate about. (CM, Frontline police officer 1)

There were notable benefits to the acknowledgement of sociocultural imperatives. Frontline police officers understood that talking about topics of importance to whānau could lead to a quicker call resolution.

Other frontline police officers also discussed responding differently to respect people's cultures, such as observing tikanga when deaths have occurred:

[Frontline police officers responded to a] sudden death that's on a homestead. So we went out to [location removed], and the first thing I asked was, "Is it okay – do you want me to take my shoes off?" Just being respectful of their culture and what they want. They're like, "Nah, it's fine", but still I was saying to my colleague, I was like it's still good to ask and ask what they expect of you, kind of thing. Their brother or koro has just passed away; what's their process, because everyone's different. Pākehā families are completely other to Māori families. I was like, as long as you ask, you can't go wrong, kind of thing. I think dealing with that and then learning a bit more te reo because I'm shit at it. On my Dad's side, we haven't been brought up like that, and even he's really bad at it, which is kind of sad. For me, the pronunciation of names and places is such a huge thing. (BOP, Frontline police officer 8)

Being transparent about what happens next

During mental health-related events, frontline police officers described how it was crucial to have open discussions about the next steps and to avoid making promises that cannot be fulfilled. It is also important to follow through with the actions promised, with the goal of building trust between the police and those involved in the event, even if they have yet to find out the impact of these actions:

I have had those ones where... us seeing them... said to them [distressed person], "Look, this is what I'm doing, happy to come with me?" Yes. "If you're happy to, I'll put you in the back of the police car... and I'm going to put on your handcuffs..." Yes. And there are those people that genuinely want that help, that are willing, that know that they need it. (CM, Frontline police officer 3)

This officer described their effective use of a supportive communication method during a situation where there had been no resistance from the individual. They had clearly explained their intent to use restraint and transport them to a place of assessment and gained consent every step of the way.

Working together as a team: Diversity, camaraderie, and supervision

Frontline police officers highlighted the importance of viewing their approach to mental health-related events within the context of teamwork. They shared their experiences of working together by recognising the diversity of officers, the camaraderie offered by police teamwork, and the reassurance provided through guidance from senior officers. This section presents their insights in detail:

The growing diversity of ages, genders, sexual orientations and ethnicities of frontline police officers was described as a strength for most frontline police officers in the way it can help to expand how they approach different callouts and needs of whānau/citizens:

That's why diversity in the police is so important as well. Because there's no blanket, this is how you do a strategy. You need all the different backgrounds and, life experiences and cultures, and that's how you build your team to then tackle all the different situations. (BOP, Frontline police officer 4)

Frontline police officers' life experiences – and on-the-job experiences – were also described as

influencing their approach to mental health-related events.

I think it's something that we kinda... you either learn it through your age, for example... I mean, I didn't join the police until I was in my late 20s. And had been through having friends who had committed suicide and everything like that. So, I had that kind of bit of understanding around it. (CM, Frontline police officer 3)

I think for me it's more empathy and understanding that... instead of going in there with a book and dropping the book on a certain member of the family, I think I'd go in there with a closer to home – because I grew up in a – we had like 12 of us in a three or four bedroom house as well, and so we were pay check-to-pay check after Dad died and stuff. Mum's incredible, she's amazing to make all that still, everything functioning, food on the table and stuff like that, but there's a bit more... I have a bit more of a perspective than someone who may have grown up with a two-parent easy lifestyle, everything like that, which obviously goes beyond just my whakapapa, but that definitely relates directly. (BOP, Frontline police officer 23)

A crucial element of camaraderie among most frontline police officers was their ability to recognise their team's strengths and limitations and then use that knowledge to determine the most effective response. This often involved acknowledging and appreciating the diverse and complementary styles of policing within the team, which allowed them to approach situations from different angles and achieve better outcomes. Camaraderie and team support also allowed for immediate debriefing after challenging callouts and a strong feeling of support both on the job and with wider whānau/family circumstances:

It helps. It really does. They are a fantastic team. That camaraderie, that team. My wife and kids have got COVID-19, and my boss sent me home yesterday and said look after your family. That sort of support makes a job very easy to deal with. Police deal with more trauma in, what was it, one year or two years than someone deals with in a lifetime, and yeah, it's true, but it doesn't feel like it. (BOP, Frontline police officer 22)

Guidance, leadership, and socialisation from senior and more experienced frontline police officers were described as integral for approaching mental health-related events positively, as described above, and keeping their well-being positive. The senior frontline police officer recognised the way they needed to support the general well-being of their frontline team to benefit the community:

Yeah. It has gotten better as the years have gone on. It's almost become okay to say, "I'm not coping with this." Whereas when I started, hell no, you couldn't put your hand up and go, "I'm not coping." Now it's easier, and we've got access to better support, and through the [NZ Police] Association, through our union, we have access to a lot of stuff that can help our members. It is because we, as supervisors, know that if we're not looking after our crew, then they are not looking after the community, so we've got to look after them for them to be able to do their job and do it well. (BOP, Frontline police officer 27)

The newer, probationary frontline police officers expressed the positive support they received when being paired with experienced officers while learning on the job. Being paired up was also one way that frontline police learned strategies for interacting with whānau/citizens in mental distress:

Basically, sort of life-learned-stuff, you know you, what we've learned of people in the past, you know, I worked with a jailer up in [city removed], he was ex-Corrections he was amazing, really good at de-escalating people like, taking them through like breathing techniques, and even just like pitch, tone, speed of his voice, that sort of thing, aye, just really good at de-escalating - so you pick up things like that. Just that, and even asking people what tools they use, and you try and incorporate that into your practice as best you can but knowing that doesn't work for everyone. (CANT, Frontline police officer 3)

I've personally learned all this stuff... I don't proclaim to be an expert on the topic, but a lot of it is just on-the-job knowledge you just learn from... you talk to other cops; other cops are my best resource. (CM, Frontline police officer 4)

Anaru's 1X call

Two PST cars responded to a 1X-coded event. The young wahine had called 111, distressed that her 20-year-old boyfriend had tried to hang himself. Upon arrival, it took some time to separate the parties to determine what was happening and what had led to the call. The sergeant positioned himself at the beginning of the driveway to observe both his constables talking to the respective parties.

The young wahine gave a statement to one frontline police officer while another frontline police officer spoke to the boyfriend, Anaru. His mum was pacing around the property agitatedly, saying, "I'm just a mechanic that fixes cars, not people". Her partner also chipped in, making derogatory remarks about Anaru being "unwell, cracked, not right in the head and needed sorting". Anaru's mum stated that Anaru had recently attended the unveiling of his whāngai dad, and she believed he was still grieving.

Meanwhile, the other frontline police officer and Anaru were at the front of the property. Anaru had his head in his hands, leaning against the wooden fence; he was crying and in despair. The frontline police officer stretched out his long legs and sat on the grass next to Anaru, leaning against the fence, too. There is no direct eye-to-eye contact at this angle, while the frontline police officer connects with Anaru, gently asking him what is going on. Anaru continued crying, only pausing to take some deep breaths as he shared his story with the frontline police officer. Anaru shares some of the grief and trauma that has led to his actions. Two years ago, his biological father passed away. He carries so much guilt about not being able to do more to help his father. Then, his whāngai dad died a year ago. Losing both these tāne had left him feeling alone and isolated. He was finding it hard to cope because he had no one to talk to. His mum also had another partner, and he was a little resentful about that. Anaru divulged that he was stressed because his girlfriend was pregnant with twins.

After some time talking, Anaru had calmed down and was breathing normally. The frontline police officer asked if he was okay to wait while he spoke to his sergeant. Anaru nodded.

Anaru's girlfriend explained that she wanted to go home to her mother's place and wanted Anaru trespassed from there. Anaru's mum and her partner also wanted him to be trespassed from their property.

Two frontline police officers then drove Anaru unrestrained to the hospital.

As the hospital emergency rooms were still in the grips of COVID-19, the frontline police officers and Anaru were triaged and told by hospital staff that it was best for everyone to wait in the police car rather than in the waiting room for the Duly Authorised Officer (DAO). One frontline police officer was so incensed by this response and went against protocol, ringing the DAO directly about the need for an urgent response. Anaru was seen in minutes in the carpark to expedite admission. The DAO spoke to Anaru in a down-to-earth manner. Anaru expressed how he did not want to be admitted. The DAO said because he had hurt himself, clearly seeing the marks on his neck, that he needed to be checked out. After entering the hospital waiting area, the DAO leaves to find a room for Anaru. The DAO returned a short time later, explaining that the room was being deeply cleaned and that he would be seen soon. After 50 minutes at the hospital, the frontline police officers leave Anaru in the care of the DAO.

Reacting rather than doing prevention work

Most frontline police officers acknowledge the potential of Prevention First, particularly regarding mental health-related events where early intervention and support were perceived as ideal mechanisms to prevent reoccurring engagement with the police. However, most felt overwhelmed with reacting to priority one callouts and not getting to preventive practices:

Sometimes, it feels like you're really just dealing with the short-term quick resolve, versus there actually being a long-term fix happening for that person. (BOP, Frontline police officer 2)

So, we do a lot of work, as you said before, with Prevention First with massive resources and time spent dealing with Family Harm and things, community issues, but I don't think we don't resource that with our mental health response. So, I don't think we have too much of a preventative arm in that space at this point. We're just putting band-aids on things. (CANT, Frontline police officer 2)

I think it is the nature of it. Any prevention stuff you have to try and do when you're in the acute crisis bit, for the frontline. (CANT, Neighbourhood Policing Officer 3)

A reactionary approach was especially evident in 1M or 1X coded events, where they are often called at crisis points. In the field, the following situation unfolded over two minutes. This exemplified how urgent situations can be and how quickly police can react.

Frontline police officers described how they experienced the chronicity of lower priority or P2-coded events and their genuine concern at the continual supplanting of one P2-coded job over another seemingly more urgent situation:

We get on [shift], and there's usually at least twenty jobs waiting for us that haven't been attended, and then obviously, there's more coming in as we go. So, definitely... jobs get bumped down the list very fast, and unless it's imminent danger, it'll go to the bottom of the pile, which is really sad because someone's called us to help, and it might take us days to get there... or not at all. (CM, Frontline police officer 5)

Although frontline police officers may be present during difficult situations, some still see opportunities for a preventative approach in their actions:

It's a really good question because I feel like we're sort of the ambulance at the bottom of the cliff, attending when they're at their worst. What could we do to get that step back? And I guess it's kind of a backwards way of looking at it, but it is when we do attend, getting those referrals in place, getting the help, so that these events happen less frequently... Because preventing it in the first place is gold. (CANT, Family Protection Officer 4)

Other frontline police officers described shifting understandings of preventative practice as non-linear and, therefore, able to be done even if they are at a crisis point:

If you can get in there and be that pivot point or be that ripple effect if they want to change, but if it's not – like it's never going to be linear. Or with assessing and having them understand that "okay, cool, you've got schizophrenia, that is a manageable thing", and now that we're aware of this, we can make everyone else that's dressed in this uniform aware of this. Then we can respond accordingly and help you prevent further episodes by maybe getting a different wraparound service, getting you involved with a different counsellor or putting a report in. Then something actually changes in your life where you get on the appropriate meds if these ones aren't working, rather than just not taking them because they're not working and then we're the ambulance at the bottom of the cliff.

I feel like we definitely do get opportunities to be that gate at the top of the cliff and stop what's to come or maybe change our... once we have information, then we can respond accordingly next time and be better when there is going to be a next time. I definitely think Prevention First is a thing. I know it sounds a little bit cheesy, but I think we do have the ability to do that, and it's all about how far we want to take it. You can only be as involved as you want to be. There are definitely different styles of policing.
(BOP, Frontline police officer 21)

Frontline police officers gave examples of referral systems that aid them in supporting whānau/citizens while attending events, such as AWHI. AWHI is an interactive tool used by police to make a voluntary referral for whānau/citizens requiring additional help. Awhi means help in te reo Māori and uses the tikanga value of manaakitanga to care for others as a person-centred approach. However, they also signalled emerging challenges with it:

So, with AWHI, there's an ability for us to connect them, but they still have to do it themselves. I think that's a big ask of some people with really complex needs to go and deal with all that stuff because any of those are stressful enough on your own, but if you're not in any kind of distress or really struggling anyway. (CANT, Neighbourhood Policing Officer 3)

Overall, most frontline police officers felt reactionary in their everyday policing of mental health-related events with not much scope to do prevention, which they felt was more appropriate for mental health services to be leading:

But in the realm of mental health, I think... it's not that the onus is on us; it's that we don't have the capability to have a Prevention First mindset with regard to them because we don't have the training or the resources to deal with people with mental health. That's the job of mental health providers in the community who are themselves swamped. (CM, Frontline police officer 4)

This leads us to the structural issues that constrain frontline police officers from fully implementing Prevention First, which was a dominant discourse in our discussions with frontline police officers across the three case studies.

The high threshold for admission to mental health services

This theme encompasses various discussions that revolve around the limitations of mental health services, particularly for individuals who are diagnosed with behavioural issues or issues that do not fit specific criteria requiring in-patient admission. Many expressed frustrations over the inability to provide appropriate support to whānau/citizens not meeting such criteria. There were also common threads connecting certain constraints related to the practices of crisis teams and limitations in accessing help for individuals struggling with drug usage.

Frontline police officers reported that continual under-resourcing of crisis mental health services often meant it was very challenging to get whānau/citizens the support they needed. There was widespread frustration when the mental health agencies were not helpful, either in their advice to the police or by declining to help whānau/citizens in distress, as they felt this translated to more work for the police:

I remember back on PST when we attended these jobs a lot more, but the amount of times you go to a job, there's some sort of mental health element, and then you get on the phone to the crisis team, and they're like, "nah leave them alone, just go." It's like, well, we can see with the way they are, something else is going to happen, and I remember going back to the same house three times in a night, but there's no power to do anything more. Where's the light at the end of the tunnel for that? It's pretty frustrating. (CANT, Family Protection Officer 3)

They have their threshold. They have their line, just like, I guess, police... I've been to a situation where a girl was trying to commit suicide. I can't remember if it was that or just suffering from a sort of delirious mental health moment. I overheard one of the

DAOs say, "I would section you if I could, but we don't have beds available." For me, it was like, well, "so she's meeting the threshold, but you don't have the facilities, so then where does that duty of care lie? Are you going to not look after her, and then what happens out on the street, happens out on the street? But you can't take her in?" It was frustrating for me to hear that more than anything because, for once, someone's meeting the threshold, great, but they can't take them because they don't have the facilities available. So that was hard. (BOP, Frontline police officer 22)

When reporting challenges, frontline police officers often acknowledge the limited resources devoted to mental health services. However, collaborating with crisis and mental health teams was not easy. Multiple challenges were expressed, such as communication issues, lack of timeliness, and non-availability, particularly of DAOs who are required for compulsory assessment for inpatient mental health services:

I think in terms of - especially in that we take somebody to A&E, I think that there's quite a poor relationship there between DHB (now Te Whatu Ora) and police. I think

Zero to one thousand

It's a sunny Auckland day, following torrential rain and storms that have affected much of the country. The frontline unit is parked in the patrol car overlooking the high tide. They are taking time out for morning coffee and bakery food. This moment doesn't last.

The officers receive an emergency P1 job call from the dispatcher about attending a mental health crisis incident not far away. The time was 1005 hours, and the informant is a private boarding home manager. A male resident has been threatening people with a knife, which the manager has managed to remove from him.

The unit drives lights and sirens to the address. The offsider is trying to read the job text, and the driver is trying to navigate quickly to the address. He overshoots the turn-off and must spin around and drive back.

As the police car enters the cul-de-sac, the driver immediately stops the vehicle, and we are faced with a wide-eyed man with a beard covered in saliva and blood from his nose. One eye is black, and the swelling is evident, even from a distance. This is 'William' running wildly straight towards us, with several people behind him.

The driving officer leaps out of his door without a word to his partner, and she follows suit. The first officer has his Taser out and points it at William, who tries to open the rear passenger door of the police car. He is warned by both officers, "Stay back... just stop!!"

Another police unit has arrived, and William tries to open their patrol car door... these two officers leap out of their car and together, the three male officers hold William down on his knees and handcuff him with their hands behind his back. It is 1007hrs... William is detained from this point and is transferred to Middlemore Hospital ED in a police van.

they view us as an inconvenience. They never prioritise the work. There's always a massive waiting line, and their processes and procedures are really poor. I've had many a battle with charge nurses and various different mental health nurses about why it's taking so long, effectively. I believe there's a misconception there, where they look at it and go, "well, we have up to six hours to deal with this", as opposed to saying, "we need to deal with this as soon as possible, and it must be addressed within a six-hour window." When we've got calls for service and other responsibilities backing up, why do we have two cops sitting there in the A&E queue because they've brought in somebody who's mentally distressed? (CANT, Snr Sgt 1)

We can't just drop them at the hospital and leave them, and especially if they're in the police station, you cannot leave them. You have to stay with them. I find that a huge challenge. You want to get them help, and you've located them, and you are trying your best to help, but you're not a professional, so you need that extra support, but then it's just that time. Six hours, that's like half a shift. That's a long time if it was the whole... and all the other work you could have been doing at that time. (BOP, Frontline police officer 5)

Tensions between frontline police officers and DAOs were sometimes said to develop when DAOs directed actions contrary to police policy and the law—for example, requiring handcuffs when a frontline police officer deemed restraint inappropriate. One experienced police participant shared how they have challenged a directive from mental health personnel when they felt handcuffs were unwarranted:

I've been directed by DAOs to keep them in handcuffs. However, I felt that it's either not humane or I don't have reasonable grounds to keep them in the handcuffs. And I'll take them off because, at the end of the day, it's my decision. And, and I get that they want their safety and things... but at the end of the day, ... the only reason they're in it is because they're either a threat to themselves or myself or the public... outweighs it. They're not a criminal; they don't deserve to be in handcuffs. (CM, Frontline police officer 3)

I wouldn't say it's a directive [from mental health services], as such, but that kind of seemed like their expectation, just arrest them. So, they're not saying "you must arrest them"; they're saying you "should" arrest them. [...] If you're ringing me and bringing this to my attention, then you should be arresting them, is how I perceive those conversations in the past. (CANT, Community Services Officer 1)

In the following section, we discuss legal constraints that shape police responses to mental health-related events.

Intersecting alcohol and other drugs (AOD) use and mental distress can create another set of challenges when attempting to access mental health support for whānau/citizens. The lack of detoxification centres was raised as a major issue, and with hospitals sometimes turning whānau/citizens in distress away if they are intoxicated, frontline police officers reported occurrences of violations of the memorandum of understanding between police and health services:

He had been drinking, which in the Mental Health Act... actually says that it shouldn't affect whether they receive care or not, but it does. So, we called the mental health team, and they said, "Well, he's been drinking, so we're not going to assess him." (CM, Frontline police officer 5)

In other locations, there may be a long wait sitting with a person who is intoxicated until emergency staff can complete an assessment:

I guess a lot of it doesn't quite make sense to us on the frontline. Yeah, sure, they're busy, but there is a Memorandum of Understanding there that if we take someone to see them, they should see them, and they should be safe, right? They shouldn't just completely reject and turn down the help that that person needs. (CANT, Frontline police officer 5)

Overall, the frontline police officers were concerned that they were only ever supporting a “band-aid” approach rather than addressing underlying problems for long-term gains. This often means repeated callouts to respond to the same person, which can lead to biased and discriminatory responses, as detailed in section 8:

We have the processes that we do on the frontline. We ring crisis, we ring ED, we take people to ED, but there's very rarely someone there to see them when they need to be seen. It's pretty frustrating when we take somebody there to be seen, and they either sit there for hours or they leave the hospital, and more calls for service come in, and then we end up arresting them. It's a real ambulance at the bottom of a broken cliff when you have to go back there and arrest someone for an offence when you've taken them there in the first place to see a mental health expert. It's a bit of a kick in the guts, but what do you do, right? You can't have them out there offending. I'd say frustrating on the frontline is probably my word. (CANT, Frontline police officer 5)

Tenuous collaboration between agencies

Frontline police officers and Senior Sergeants acknowledged the difficult circumstances faced by both sides – police and mental health services – and the need for cooperation:

I suppose basically, for me, it's going and sitting down with those organisations outside of the police, our partners, that are supplying those services to the community, such as Hauora, facilities like that, our AWHI referrals, and just sitting down and having a kōrero with them, seeing how us as frontline police officers can work better with them to get more people through their doors that need the service, and it's as simple as that. (BOP, Frontline police officer 4)

However, when collaborative ventures were created, continual challenges were reported related to building strong relationships, coordinating meetings, and maintaining regular communication. We explored this further in our reporting from interviews with national stakeholders who hold senior positions in their police district and lead collaboration and partnerships. However, frontline police officers acknowledged the challenges in regular communication and relationship building between the police, DHBs (now Te Whatu Ora), and other relevant stakeholders due to operational demands, but it is crucial for effective collaboration. It suggests that face-to-face meetings and interactions help understand the personalities of the staff involved, overcome misunderstandings, and build relationships.

In the Canterbury case study, officers in the Family Protection Team contributed perspectives. They said their workgroup had opportunities to have these sorts of face-to-face meetings with other agencies and that they were helpful for uniting around preventative goals:

And in Family Harm from time to time, particularly in the mental health, there might be professional meetings, where a number of agencies will get together to work out a plan for, for future, around family harm. And their mental health. And or. Yeah. So we're not just doing it as police; it's a number of agencies, so there's a responsibility shared for trying to prevent further harm. (CANT, Family Protection Officer 1)

Where access and partnerships were growing, it was positive for frontline police officers to be connected to local community-based services:

We're really lucky now the local marae is really good. They do our Te Pae Oranga liwi

Two NPT ride-alongs

On my first ride-along with one of the Christchurch NPTs, we are cruising through the neighbourhood, and the officer is familiarising me with the area as we go. He has worked in this community for several years and has a wealth of knowledge about its history and inhabitants. As we drive through, he points out houses of interest: “[name removed] has lived in that house for ten years. She hates her neighbours, and they’re always arguing, but she’ll never move”. “There are two rival gang houses on this street”. He tells me how some houses used to be different before the earthquakes and how the area is getting built up. In several places, a section that once contained a single house now has ten townhouses standing on it. He said this housing density is translating into more issues in the neighbourhood. With people living right on top of each other, there are more neighbourly disputes, and it’s hard to keep people in disagreements away from each other when their front doors are just meters away from one another down a shared path.

He also knows many of the inhabitants well. As we turn a corner, he spots a guy across the road. “He always flags me down to chat about something or other, just watch”. Sure enough, the guy beckons the cop car over. We pull up, and the officer rolls down the window to chat with him. The officer is friendly - “Hey mate, what’s going on today?”. He listens to what’s going on for the man and recommends that he call 111 to get some frontline police officers to help him out. Something “happening now” is the job of the frontline. NPT doesn’t respond to jobs over the radio as the frontline does. They directly work on initiatives related to prevention, although they might get given files to work on, like a neighbourly dispute where they can go in and help the parties work through a solution.

A few minutes later, we spot another guy across the road. The officer tells me, “That’s [name removed]. He’s been evicted from his social housing for causing damage, and he’s got to be out of there tomorrow”. He pulls the car over and gestures the guy over to the window. He has a chat with him, clarifying the eviction notice, and reminds me he has a court date tomorrow. The guy is agitated and says, “How am I meant to move out? I’ve got nowhere to put all my stuff?!”. The officer says, “I’ll see if I can get you some help with packing supplies or storage. I’ll get your support worker from Housing First to come and see you”. He leaves him with his card and says, “Text me if you need anything”.

Next, we head to Housing First and Kainga Ora to discuss the situation. The officer sorts it out so that the guy can have help packing his belongings and storing them temporarily. He tells them, “It’s not completely by the book, but it’ll help things go much smoother”.

It’s an ad hoc solution that will alleviate this man’s stress about the eviction. The officer’s local knowledge – knowing this guy and his supports, needs, and barriers – and connections to local services were crucial here.

On another NPT ride-along, this time with the other NPT group in Christchurch, I got to see one of the community initiatives they’re involved with. Both NPTs do several initiatives – often joint initiatives with other agencies, like the Ministry of Education

– with children at local schools. They've noted the importance of providing positive experiences and opportunities for youth. On this ride-along, we attended a boxing session at a local primary school, which the NPT officers regularly attend to support the coach.

The session was about more than exercise. The coach talked to the kids about what they wanted to do when they grew up and got them to think about how they could set goals to achieve this. He told them they could do whatever they set their mind to, and no one could stop them.

The NPT officers told me initiatives like these aimed to support children into positive pathways for the future. Their neighbourhood experienced a fair bit of crime and gang involvement. The police, through partnerships with other agencies, were trying to put initiatives in place to prevent the younger generation from becoming involved in these.

The officers also said supporting the children was one of their main ways of establishing a positive, trusting relationship with their communities. They said there was a sentiment of "you look after our kids; I'll help you out". The kids were happy and excited to see the police at the boxing session. The officers told me that sometimes they'd end up seeing these kids in a different context – at their homes, for example, if the police turned up to talk to their parents trying to get intel. The parents were often unwilling to speak to the police until their child ran up and said, "That's officer so and so from boxing!" Then, the parents were often more willing to trust police with intel that could, in turn, help them to prevent crime.

community panels] stuff. So, they work with all the alternative resolutions, and they also have a doctor on site and nurses, they do counselling services and things like that. (CM, Frontline police officer 5)

One frontline police officer in South Auckland reiterated that there were inevitable delays when accessing services on behalf of their whānau members.

[There is]...nothing that... I guess we could action immediately. It's more of a referral kind of process. And then they [marae-based services] follow up in the following weeks. (CM, Frontline police officer 5)

Frontline police officers agreed that New Zealand Police hold some accountability for responding to whānau/citizens experiencing mental distress. However, they also acknowledged that there are wider issues that need addressing that are beyond the scope of the police role:

I think we are reaching out more to those different organisations [marae and iwi-based hauora provider services]. It's not something we would be able to fix on our own, nor do I think it is our responsibility to fix it. It's definitely our responsibility to be there and to help, but it's a big community kind of approach. (CM, Frontline police officer 1)

Frontline police officers mentioned helpful initiatives. One example involves collaboration between police and mental health professionals to create safety plans for adults and work together to respond differently to whānau/citizens observed with behavioural issues. Safety plans, led by mental health professionals, help police know how to respond to whānau/citizens whom they see often and understand as "repeating

cycles"; sometimes, the safety plans help to stop the repeat callouts by directing a tailored response. Safety plans were reported as helpful and preventive, but it was the exception rather than the rule. It relied upon whānau/citizens being in both the mental health and police systems. Senior police officers often had to go out of their way to set them up by building collaboration with mental health:

I'd say that's [having a plan in the system] the exception rather than the rule, and if there are plans, we either don't know about them or we don't know the details of them unless we specifically call someone to find out. So it's really good when there is a plan, you're like, oh great, tick, tick, tick, no (laughs). It's really good. That's really helpful for us. (CANT, Family Protection Officer 4)

Beyond mental health services, a growing frustration was occurring between frontline police officers and ambulance staff. Frontline police officers perceived they often needed to (inappropriately) fill a medical transport role because ambulances would take too long to respond or not respond:

Similarly, for... St. John's current staffing crisis means we're getting sent to jobs now that we would never have gotten sent to in the past. Where... we had an old man who had fallen over the other day, and he'd actually broken his leg. And they'd called an ambulance... requesting an ambulance, and the ambulance said, "We don't have anyone." So, we went instead and transported him in the first instance... when it's not a job for us, it's a job for Ambos. (CM, Frontline police officer 4)

More experienced frontline police officers provided examples of creating meaningful partnerships and collaborations with various agencies, including non-government agencies, to address the complex issues related to mental health (and connected issues of family harm). We illustrate this further in the next section of our report concerning police stakeholder perspectives.

A notable gap and desire for frontline police officers was enhanced access to the Māori Pacific Ethnic Services division as ethnic group liaison:

I will say that what I think could be super beneficial... which we don't have access to, is our Māori Pacific and Ethnic Services [MPESI] division... Who are our... essentially our liaisons with different ethnic communities. They're incredible like they're amazing, and they're like such a great resource, but if we could have them, at least like one or two people who represent each community, even not just on a... even if they were on an on-call basis, but after hours. (CM, Frontline police officer 4)

In the Canterbury case study, officers working in Neighbourhood Policing Teams (NPT) contributed perspectives. They highlighted examples of partnerships their workgroup had with other agencies. These partnerships were an embedded part of the NPT model and helped facilitate the goals of prevention and trust and confidence within the neighbourhood community:

We can alleviate, I think, some of the stresses that come into peoples' lives [...] even if it's not directly ourselves, it's through our partnerships with agencies whose job it is to support people in that [...] so that when that crisis rolls in, or when the next challenge in their life rolls in, that they are able to cope because some of those other needs are taken care of. (CANT, Neighbourhood Policing Officer 3)

Participants highlighted how each NPT aims to enhance trust and confidence in the police within their given community. They said key aspects of this were being consistently present in the community and following through with actions to humanise the police and show that they would provide help. NPT officers noted that their workgroup had the ability to have this focus because of their interagency partnerships and being able to dedicate more time to each response than frontline police officers:

When we've had time to be in those places, the feedback we have is that it actually makes a difference, even if it's just people's perception. It's a bit of trust and confidence in the police. It's seeing police regularly and knowing that we will be there and if there is an issue that, we will do something about it. And having a local cop rather than an anonymous number that may or may not get back to you, I think, is really important.

It's similar to rural policing, I think. Everyone knows their local rural cop, and you know that they'll follow it up. I think it's similar here. People get to know you, and they want to see you follow that up. (CANT, Neighbourhood Policing Officer 3)

Legal constraints, grey areas and creating harm

Legal constraints shaping police responses to whānau/citizens experiencing mental distress were discussed at length across the case studies. However, there were different challenges for different districts. For example, most police districts have a Memorandum of Understanding with mental health services not to detain whānau/citizens in police cells when they are experiencing mental distress but have not been arrested.

In some districts, even with the notion of a memorandum, whānau/citizens were still being detained in police cells. At the same time, they waited for a DAO to arrive for an assessment, often for the whole six hours they could legally detain someone under mental health legislation. Police reported concern about individuals with mental health issues being held in cells, which they saw as inadequate and potentially harmful environments. The burden of risk that fell on police when holding whānau/citizens in their cells was widely reported:

It is frustrating for us because we can't hold people or believe someone really needs to be assessed. For us, it's a huge risk, especially for people who are potentially suicidal or suffering from real mental health issues, could be smashing their heads on the wall and giving themselves... and then it all falls on us if that person gets seriously injured or worse. It is a huge risk for us to hold people with mental health issues within a cell. Realistically, it's a risk for anyone to be held in a cell.

So, we carry a heavy burden regarding that risk and the potential consequences of being in a risky situation for a long time. When it takes a while for people [DAOs] to turn up, I think we can sometimes vent that frustration. (BOP, Frontline police officer 22)

In other cases, someone who has been arrested for an offence and placed in a police cell but starts self-harming or explains they are suicidal leads to custody staff having to shift their focus intensely towards constant observations. A similar situation also occurs when someone is being detained for assessment, whereby a custody officer is required to sit outside a cell and prioritise observing the person inside it while using strategies to connect and reduce the escalation of distress:

Then probably another demand that we have is when somebody is in our custody, they've been arrested for an offence, and then they start expressing they're suicidal or self-harmed stuff because then that takes our custody staff out of their core role to then deal with that. And if they don't have sufficient staff numbers to deal with it in the cells, then another work group would have to supply somebody, and that would be primarily PST because we're one of the workgroups that work alongside them, so we go down to assist there regularly. So that would be something, you know, somebody attempts suicide in the cells or something like that, which is pretty common. (CANT, Snr Sgt 1)

In Canterbury, officers reported the usefulness of the mental health nurse situated in the watchhouse. The nurse on duty could help assess the needs of someone in mental distress whilst in custody. Additionally, they could aid frontline police who were at jobs and called up asking for information or advice about approaching a mental health-related event. The nurses also bridge an information-sharing gap because they can access Te Whatu Ora records:

Having a DAO in the watchhouse that we can ring is invaluable. If there's ever a concern regarding mental health, that's a phone call, and then they can look stuff up. We can get a picture of things and certainly ask them like this is what people are presenting at the moment, what follow-up is happening, or what are they scheduled for, and if they're not, can we see if we can schedule something? (CANT, Negotiations Officer 1)

Police reported situations where they lacked the legal power to do anything to help a person experiencing distress. For example, in the Canterbury case study, frontline police officers described facing situations where they felt it was necessary to transport someone in mental distress from a home to another location where they could receive a mental health assessment. This situation was difficult when the person would not willingly go with the police, and the police were unable to transport them under the Mental Health Act because the person was not in a public place. Frontline police officers reported often using arrest to get around the “grey zone” they faced in this situation, despite commenting that they don’t always think this is the right thing to do:

It's hard, too, if you're in a position where somebody is in distress, but you're really lacking in lawful powers beyond maybe an arrest. I've arrested people when I wouldn't, but I have a power there, and I'm lawfully all set to go as a means of getting them from an address to somewhere else. But that's a poor response for someone who's in mental distress, as the only lawful response from any government agency is to come and deal with their problem. (CANT, Negotiation Officer 1)

These set of circumstances added a different layer of risk for frontline police officers regarding potential scrutiny or liability:

Just on that line, to take them somewhere, it normally means you're going to arrest them. Because if you say, “look, can we take you to somewhere, like the mental health services”, they're like, “no, just leave me alone.” So, then you're faced with, okay, do I make a decision to arrest them to facilitate that, which potentially could be unlawful? Even though you're trying to do your best at the time, when it's investigated down the track, and people will criticise you for it, then it becomes a huge problem for us (laughs) and then effectively, you're justifying what you did, and then potentially you could be justifying your job. Even though it's easy for certain people just to say well, just arrest him, it doesn't work like that. (CANT, Community Services Officer 1)

Racism, bias, and discrimination

Discussions with frontline police officers explored racism, bias, and discrimination that may shape responses. This section reports begins with looking at understandings of equity, followed by the sub-themes of walking the fine line as a Māori officer, stigma and discrimination towards those experiencing mental distress, and general mistrust of the police.

Understandings of equity

Frontline police officers were generous in their discussions of complex social, cultural, and systemic issues, shedding light on the challenges faced by Māori communities and the need for understanding, support, and equitable treatment. Some frontline police officers described the long-lasting effects of colonisation on Māori communities, including intergenerational trauma, displacement, and cultural assimilation. They also described socioeconomic disparities between different communities and how they contribute to mental health disparities, limited access to resources, and unequal opportunities in education and sports. The following field note from the Counties Manukau case study provided insight into the broad scope of the police role. Police are not only called to mental health-related events but also to whānau who experience extreme social and economic deprivation and isolation.

At other times, there were clear limitations in understanding and experiences provided by frontline police officers of practices that exhibit racism, bias, and discrimination:

Sometimes, they will hear the whānau name and pre-judge that person and family, rather than appreciate the why behind the offending... “Oh, that whānau again”. Sometimes, having that background information can be just what they need to hear to approach it differently. Sometimes, you have to say, “Cut it out!” (BOP, Frontline police officer 13)

Such practices, limited acknowledgement and understanding of what underlays mistrust in police, such as traumatic experiences, particularly for Māori communities, is why police are making efforts to create better relationships with iwi:

Counties Manukau (CM) Area snapshot

Officers in CM are ethnically diverse and represent a broad cross-section of Aotearoa New Zealand society. Chinese, Korean, Pacifica, Tongan or Samoan, Māori, NZ European, Indian, and United Kingdom backgrounds. etc. Much conversation is had around the extent (or lack) of Māori cultural awareness. Mental health-related events are minimally addressed at police college, or strategies drawn from lived experience and from past professions, i.e., teacher of disabled children, family member's own mental distress experience. Officers are also reflective of their places of privilege and situation as officers often live outside of South Auckland, while others have grown up in the area they are now policing.

Our new police station that's being built is taking ten times longer than it should because, apparently, they're collaborating with iwi and stuff like that on every point of it, trying to make it more community-centric and stuff like that, which I don't necessarily agree with because I want to be relatable to my community to a certain point, but there's a cut off where it's like we need our building. We are police, we're not your friends, we're here to enforce the law and maintain public order. I like that iwi and community will have a little bit of an influence on it, but not to the point where they're saying we shouldn't even have jail cells in our building because that's aggressive or something, and it's like "bro...?" (BOP, Frontline police officer 10)

Also evident was the issue of tokenism in addressing Māori cultural needs and the need for genuine responsiveness to Māori values and practices. There was a clear lack of understanding of equitable practices, which may require differential responses for Māori and those who comprise our multicultural communities. The following police participant believed that the medical model of mental health approach to the treatment and management of whānau who experience mental distress was preferable to a hauora Māori culturally informed approach:

So where am I going with this? I guess. If those Māori how we call them... organisations were mental health professionals, certainly. I suppose that would be all right, but I think there might be a bit of a danger of having people who are trying to treat patients in the Māori way may not be necessarily treating that patient in a way that's suitable for their treatment. Yeah... the right people, the right activities, I learned are very important, and there's the drugs and... again, who helps them. There are a lot of parameters, and I think it'd be easy to think you've got the right answer for that person, perhaps because they're Māori, and I am speculating here completely, but they might not be right for the patient. (CM, Frontline police officer 2)

This officer's account not only revealed that the experience of being Māori was considered separately from the experience of mental distress but that they considered mental distress as a disease, along with the assumption that hauora services do not provide adequate support options. There is a true sense amongst police that Māori mental health concerns are the role of mental health professionals. If considered at all, there is an overall assumption that hauora Māori cultural perspectives and support should or would be initiated, not by police, but by mental health professionals alone.

Equal application of the law and police protocol was confused with practising to meet the needs of different whānau/citizens. One officer was very clear that their intention was not to treat whānau/citizens any differently:

But to me... At the end of the day, I am not that person who distinguishes someone just because of their culture; I think everyone deserves the best outcome and the best treatment that is possible, being that they are just human. (CM, Frontline police officer 3)

A displaced soul

This job file had been sitting in the police response system for longer than six hours. It was initially coded as a 1M (mental health) job. A mental health history is simply one aspect of a person's story. For some whānau, their lives and the lives of those around them are a complex pathway of trial and destitution. Some endure isolation and poverty, and their daily lives are intermingled with drug use, gangs, and criminal activity. As evident in the following story, some individuals are disconnected from their whānau, hapū, iwi, and whenua and rely on the government for everyday support.

At the centre of this story is a middle-aged wahine Māori who has been trespassed from her Kāinga Ora (KO) housing unit. 'Nerida' is fifty years old, yet she lacks the means to provide for herself and endures physical and psychological ill-health. There is an outstanding warrant for her arrest, yet the officers decided this was not an appropriate time to follow up. Nerida has been evicted from her KO unit for lighting fires. A social worker and mental health services visited earlier in the day. Police are now required to serve her a trespass order. It is after 10 pm, where is she to go?

The police are met by security in the housing block carpark and obtain the key code to enter the building. A couch but no toilet facility is at the far end of a well-lit entrance lobby. There is a pile of bedding and clothes in an overflowing cardboard box. Nerida rises from the couch and starts pacing around non-stop, talking, jumping from one subject to another. There are no signs of aggression. "Are you meant to be moving?" one officer asks. He shows Nerida the trespass letter and quickly confirms there is somewhere else for her to go. They will take her to another KO housing complex somewhere across the city. There are also security guards at the new premises which means that it is safe and suitable for high needs clients.

Nerida is concerned about taking her possessions and notifying her brother. The female officer immediately locates the brother's contact number on her police phone app and attempts to call him. The call does not connect. Meanwhile, the security officers acquired two shopping trolleys, and the constables started loading up her belongings. Disposable gloves are essential as the blankets and clothing are sodden. The officers quickly realise that the police car is not big enough to fit everything, so one returns to the Police station and returns with a police van. They proceeded to transfer the belongings into the boot and back seats of the vehicle.

Nerida insists on travelling with her belongings. The officer attempts to persuade her to ride in the accompanying police car, but in the end, he agrees she can sit in the front of the van next to him. Throughout the thirty-kilometre journey, Nerida talks nonstop; she likes that the male officer smiles, listens, and replies to her. If he loses focus, she demands his attention.

After arriving at the new location, the officers pile the belongings into more shopping trolleys and make multiple trips up a long access ramp. This KO building is identical to the one Nerida had been evicted from. The two big Pacific Island security guards are also similar in stature and attitude to those just left, and they decide that all of

Nerida's belongings will stay in the corner of the lobby tonight because the lift is not working. She will only need her bedding.

The security men sit behind the big desk in the starkly lit foyer, and Nerida starts sorting through her clothes and laying them out over the front counter.

Throughout the eviction and relocation, I wondered if Nerida was warm enough or if she needed to go to the bathroom and how strange it might feel to relocate to a foreign suburb and district without knowing or telling anyone. Despite feeling impressed by the officer's dedication and manner, no one said goodbye or bid Nerida well as we left. I felt a deep irony at Nerida's physical transfer from one government housing situation to another almost identical situation. I also felt that the police resourcing and effort to achieve this temporary solution went above and beyond.

Police participants focused on the fact that they were unbiased and would advocate for and protect anyone:

No different to interacting with anyone else, really. (BOP, Frontline police officer 15)

I know that statistically, Māori are overrepresented in mental health and things like that, but I kind of – to be honest, I don't look at them any differently. I just think, "Well, here's a person in mental distress; what can I do?" (CANT, Family Protection Officer 4)

Umm...umm...Yes. I don't think it's... It's not a conscious thought; it's more of an unconscious bias, perhaps. Yeah, so me personally, not necessarily to do with Māori um, but with some other cultures, you might, um, take things more seriously or less seriously, depending on what culture they're from. Unfortunately, we... from prior dealings. Some cultures from past experiences tend to be... 'dramatics' the wrong word again, but... just present differently I guess. (CM, Frontline police officer 5)

In Counties Manukau, the handover of care to mental health is seen as a symbolic act, but nowhere is Māori community support factored in. This text includes discussions around the limited opportunity to highlight culture/ethnicity in referring care to mental health services:

It becomes really difficult because when you give a call through to mental health, you only got the option of the person that answers the phone at the end. And we don't really have the latter of the choice of basically saying that they're of Māori culture, they'll prefer to speak to someone... along those lines that kind of understand it. I guess. (CM, Frontline police officer 3)

Walking the fine line as a Māori officer

Some frontline police officers spoke to the complexity of being Māori, standing strong in their cultural identity and walking between two worlds, particularly in the BOP where the proportion of te reo speaking and culturally connected Māori is higher than elsewhere in the country. Sometimes, being Māori and using te reo Māori could help them connect with whānau Māori, but sometimes, it became another reason to dislike the police.

I think for myself, being a Māori and introducing ourselves in Māori or just using Māori words every now and then throughout while we're talking to Māori, they then start to – something for you to relate to them. I've found there's some ups and downs like I've said kia ora and start talking to them in Māori and they're just like – say Māori words and that stuff, and they're just like don't talk to me in Māori, "you're a fake Māori", and then it's just like "well actually no, I'm not." So you're trying to relate to them, but most of the time, you get like, "oh kia ora", and they're happy to talk to you. (BOP, Frontline police officer 11)

Non-Māori Frontline police officers were aware of the negative public perception that may be generated by the police targeting Māori within the BOP. Unfortunately, the deprivations and disadvantages impacting the majority of the population in this region frequently put Māori on the receiving end of police responses:

What I've probably found quite difficult is, again, it's the balance of getting the job that's coming in, and you get there, and you make an assessment, and you decide on a course of action. I'd like to think that that's regardless of who they are, but then you might get a comment sort of, here you are to arrest another Māori or something like that. The statistics, they're all true, and it's terrible, but you've still got to go to this one instance of a job and react to that situation, and then the difficulty is in just finding that – well, you've got to do your job on that situation and it's uncomfortable... They might be Māori and homeless and all these, and I know the reasons, and I know the generational disadvantages, and I agree and despair for that, and they're all true, but they've just punched someone, you've got to arrest them. That's a difficult thing, and I don't see a solution. I'm just saying that's difficult. (BOP, Frontline police officer 12)

Māori frontline police officers described the fine line they walk. Being able to reflect on their biases in balancing their role as police officers with working with whānau Māori was key. Sometimes, having whakapapa linkages or local knowledge could carry a degree of mana with whānau, or conversely, some whānau have unreasonable expectations:

I think it's probably actually harder. I think it was easier with my whānau over in [location name removed], like going to jobs out my marae [name removed] and all that were easier because they knew me, and I knew them, and there was mutual respect... [but working in another region] because I'm not actually related to most of them, most of our whānau that I deal with, it can become more of a – it's more of a bargaining chip... It's almost like our whānau can sometimes expect to get away with more because I'm Māori, and I walk this real fine line of being fair to all people. So I walk a fine line, but then also I definitely would say I have unconscious biases towards my people which exists, and we all know it exists, so being aware of that. (BOP, Frontline police officer 21)

Māori frontline police officers carry a heavier burden of responsibility for their whānau/citizens; they want to help their own, but sometimes being Māori can be the factor that makes a situation worse:

I do get targeted just for being Māori. A lot of the time, it's because I guess they see me as a Māori and they go, "oh, what are you doing here, blah, blah, blah, you're supposed to be on our side", sort of thing, and then we get that whole side of things, and then that can also escalate situations as well. (BOP, Frontline police officer 7)

Non-Māori frontline police officers in the BOP were observed using greetings in te reo Māori as a natural way of diffusing a situation by getting to know someone and hear their stories; however, in some situations, this cultural tool was still not enough to deal with some citizens:

Recently, I had a fully conversant te reo-speaking constable, and I remember the last time we went to a big ruckus, it happened to be Māori people scrapping in the street. To me, it's just a whole heap of people in the street. It doesn't matter who they are. But his te reo was just pointless at that point, but sometimes it can be because sometimes you have to step back and go, right, I'm going to really try. He was in an argument face-to-face with someone who was already in handcuffs... But yeah, to stand there

and see my team member, it's not working, he's not responding to you any better. He actually responded better to me when I came and went. I'm the boss... I've decided. Just shush, you shut up. I was able to tell my colleague to stop and drag him [person handcuffed] away nicely (BOP, Frontline police officer 29)

Stigma and discrimination

Stigma and discrimination were exemplified in the pre-contextuality of whānau/citizens with mental health issues, which was something that many frontline police officers observed could cloud judgements and shape responses. Some frontline police officers mentioned how labelling someone as "1M" can lead to negative assumptions and biases, causing people to dismiss or disregard what others say. There was a need to continually keep an open mind and not judge individuals solely based on their mental health status:

I think the first thing that crosses my mind is 1M, even just labelling someone as 1M; it's such a broad spectrum of what that could mean that I need to actually remind myself to keep an open mind about it because as soon as you say 1M, even just within a team of police, many people are, "Oh they're 1M, don't listen to a thing they say." That's kind of the vibe that I get sometimes, and maybe that's because it's someone that we've dealt with over and over again, so is well known. (BOP, Frontline police officer 24)

Some frontline police officers needed to remind themselves of the need to respond without judging the event as 1M when it may be about another matter that they require police assistance with:

Flagging mental health, I think what we do sometimes is we'll get a call saying something has happened, and it might seem quite sane, or it might seem quite forgive the term 'crazy'. But if they've got a mental health flag on their dossier view, which we see, comms will, in quite a lot of instances, just code that a mental health-related job or use, even if what they're saying has happened. And that was something we at the CRT [Co Response Teams] saw... was a lot of distress from mental health patients that was basically ignored, because it just coded 1M and... oh they must be (again, forgive the term) 'crazy'. (CM, Frontline police officer 2)

As described in Section 5, the reported lack of proactive intervention and follow-up after the crisis often leads to repeated callouts to the same person. Pre-contextualisation of people ("frequent flyers") and places ("that whānau house") can then eventuate and was a factor senior police had to counteract continually:

The biggest challenge for me as a supervisor is to explain to the staff that "yes, it may be the 17th time you've been to that person, but sooner or later, they are probably going to get it right and actually harm themselves badly or kill themselves, so that's why we need to keep going back." Same with domestic violence. It's just a matter of whether it may be the fifth domestic for us for the day or the second or third suicidal person, but it could be the one that changes their thinking.

The good thing about it is that with negotiation, if you talk to people, be honest with them because it goes a long way when you have to deal with them a second time, "remember the last time you spoke to me? Did I lie to you?" That's what I say to the staff. It's just those simple tips that you teach staff, and it's the advantage of being in the position I've been in for so many years is that I can impart that knowledge to them. (BOP, Frontline police officer 35)

The following field note exemplifies this situation involving a rangatahi based in Tamariki Ora care who frequently threatens to self-harm. Considered by mental health services as having experiences of mental distress that are "behavioural" in nature, 'Tara' has established a pattern of contacting police frequently. The callouts always require lengthy communications involving delicate calming and distraction techniques on the part of the police. The officers on this occasion are wanting to avoid attending, yet a 1X threat requires their attendance:

Engage as normal

Many of the PST are on a well overdue meal break at the Counties Manukau station when there is a 1X self-harm call. The Lifeline informant has received permission from the victim to contact Police. 'Tara' is a teenager with over fifty previous flags and is well known to ALL frontline police at this station... i.e., everyone has interacted with her recently.

The officers discuss amongst themselves. Firstly, they are deciding whether to respond... they then acknowledge that there is a plan in place... and, "let's check it before we decide." The deliberating officers move to include their duty sergeant in the discussion, who orders them to "engage as normal!"

Mistrust in police

Frontline police officers accepted that for some citizens, their level of mistrust and fear in the police may have stemmed from previous negative police interactions that left them feeling powerless, criminalised, judged, labelled and shamed. Consequently, Frontline police officers acknowledged that dispelling their fears to build trust and confidence required a humanistic approach. However, this was not always possible when tensions were heightened.

Frontline police officers discussed how the police uniform symbolises a certain negative aspect to many whānau/citizens in the community and how this relates to a general mistrust of police. There was recognition that whānau/citizens may have an inherent fear of the police, which was important to consider in responding to 1M or 1X cases:

People will tell you straight up, they'll say "I don't trust the police, I don't want to talk to you", or they won't look at you, and they'll just head down, they just won't look at you... especially if they've had a lot of other experiences with police that maybe haven't been great. (BOP, Frontline police officer 24)

Some whānau Māori in Counties Manukau interpreted the mere presence of police to mean there was a criminal component to their situation, which in turn exacerbates mistrust in the police:

And his [distressed individual's] first question was, "What have I done? I'm not a criminal." And it's very hard to explain to someone like, "I know you're not a criminal." But they've called me because they've got concerns. Did I think these concerns were valid at the end of the day? I never saw what their concerns were. And I don't know if they were the case. And I find that often, police are used as a bodyguard for mental health, and it can look very negative to that person because now they think, "well, what have I done wrong? Why am I such a bad person?" (CM, Frontline police officer 5)

In this situation, where the individual felt criminalised, the officer was placed in a position where they had become more of a hindrance than a help. The police were required for the protection of mental health professionals, and yet police presence exacerbated the individual's level of distress.

Another officer referenced the South Auckland district as being significantly affected by high rates of negative police and whānau interactions:

I find in our community as well that a lot of these people have previously had such negative interactions with police, whether it's a criminal thing, family violence, or something like that, or they've just had an interaction with a cop that they didn't either like their attitude the way that they spoke to them. (CM, Frontline police officer 3)

Whānau Māori adverse reactions to police also reflected that there was a degree of stigma and shame associated with being involved with the law. Police from Counties Manukau agreed that their police identity was a significant barrier to being able to establish trust and confidence with whānau and suggested that other agencies may have better relations:

Rightly or wrongly, my perception is that they [Māori] would be more willing to engage with mental health coordinators, or people kind of from the healthcare world, as opposed to the New Zealand Police. It is just due to our... you know, the negative connotations that we have and our past dealings with that community. (CM, Frontline police officer 4)

Frontline police officers believed that positive interactions with police would inspire community trust and confidence and lead to more harmonious interactions in the future. Conversely, they acknowledged that negative interactions would damage trust and confidence and hinder the ability to have cooperative interactions:

I think again it probably comes back to that individual interaction, and talking to them, listening to them, showing them that you're not there to arrest them, despite what mental health might want (laughs), and just getting them to see that you're a person, another human, listening to another human. That way, they might think, "oh okay, well yes, he or she is police, but they did listen to me, and then I had a good interaction. They helped me, and it might lead to better interactions next time.". If the police do turn up, they might think well, last time they were kind, and they listened to me, so let's see where we can go with this. Whereas I know if the previous interaction was heightened or someone was unkind to them, they're much less likely to want to interact with you. It takes a lot more to build that relationship or that trust in that initial interaction. (CANT, Family Protection Officer 4)

Police in Counties Manukau understood that poor relations exist between Māori and police. As a direct consequence of the high level of distrust, whānau would not actively seek out nor invite police interaction. The level of situational acuity would often reach a crisis point before whānau do reach out for assistance:

I'd say we're not called until the situation is out of control in the caller's point of view. So, if it's a family with a family member that has mental health issues, or is diagnosed with some sort of condition, we won't be called until it's out of control and safety is at risk... to both the person themselves and the family that are around them. (CM, Frontline police officer 4)

Frontline police officers also perceived that people's negative experiences with other government agencies could generalise towards less trust and confidence in the police.

Frustration, disheartenment, and moral distress

Most frontline police officers expressed frustration and disheartenment regarding the current system's limitations in dealing with mental health incidents. Many feel unable to fulfil their duties as police officers and assist those in need when there are no services to refer whānau/citizens to. The strain on police officers' mental health due to the demands of the job and the inability to always provide the necessary help to individuals in crisis was evident, and this can be thought of in terms of moral distress. Moral distress refers to psychological distress experienced when a professional is constrained from carrying out what they believe to be the morally correct action (Lamiani, 2017; Williamson, 2020).

Frontline police officers gave examples of the devastating consequences when situations escalate and result in harm or death, emphasising the profound impact on the individuals involved, including police officers. One frontline police officer shared their experience after five months into his placement:

I think maybe I talked more about suicides, which to me is mental health, and I've gone to people threatening to do it. We've also gone to the other end. I've only been in, what, five months and I've been to two hangings already. Both men. One Pākehā, one Māori. The Māori boy was 22. It was heartbreaking, especially for the family he was with. His

history of – I obviously took statements from people and got a bit of his history, and he's been diagnosed with drug-induced psychosis and went to rehab for it when he was like 15, and he met his partner at rehab, and they've both got off drugs, got themselves a house, got a family. I sort of thought back to this other guy who was threatening, like if I could bring him almost and show him this and the effect it's going to have. We see that other side of it, and it's like, why wasn't... you could say why wasn't something done beforehand or start pointing fingers, but it's just sad because you can't stop someone from doing it. If they're going to do it, they're going to do it. Again, it's like, what else could there be to stop this? (BOP, Frontline police officer 20)

The following excerpt illustrates how a threat of self-harm has been significant enough to raise the concerns of wider whānau and police, yet mental health services decided that a response from them was unwarranted. This is challenging for frontline police officers to experience:

Being at a person's house that... them [whānau] saying, you know, they want to harm themselves, mental health team saying they're not at risk enough and then we've got to leave, and nothing gets done. (CM, Frontline police officer 5)

The moral distress of frontline police feeling powerless to act in people's best interests is exemplified here. These police likely anticipated being called to revisit the same whānau again.

Police officers often experience moral distress and face dilemmas when deciding between two (or more) conflicting requirements. For example, their duty of care and calming versus their duty of safety, protection, and restraint. The officer in the following excerpt describes how they feel when using coercion to manage situations:

You know, using force or having to be aggressive, and... and... or, or be talked to in an aggressive manner... is uncomfortable, and we don't like it. And you know, so we're... we'd be making our jobs harder if we fail to do that. (CM, Frontline Police 4)

Frontline police officers were aware that their actions could be experienced negatively by whānau/citizens in distress and had often had negative experiences with mental health services. Many examples of system inefficiencies contribute to further stress – for instance, whānau being passed from one service to the next:

It is hard. But I guess from... from our experiences, no one else is gonna come... The mental health team are really understaffed, under-resourced, and they'll tell people to call us, but you know all we're going to do is turn up and call them back [the mental health team], you know. (CM, Frontline police officer 5)

There were also many examples of whānau/citizens preferring the police over mental health professionals.

Sometimes they [whānau] just go, "I don't want to talk to mental health" and say, "Piss off." So, we'll call them [mental health] ... be like, "Hey, just to let you know, we've had this call for service, is this person known to you?" If not, "Here's their details..." and then we leave it up to mental health to contact their GP sort of thing. (CM, Frontline police officer 3)

However, this up-in-the-air resolution to a job is more symbolic than practical. Overall, frontline police officers' sharing of the reality of responding to increasing 1M/1X coded events challenges the sensationalised notion that police officers want to hurt whānau/citizens and expresses the emotional toll they experience.

Visions of alternative approaches

Frontline police officers widely reported the need for alternative approaches to mental health-related events. Ideas for solutions included creating dedicated health and social care spaces for assessment instead of using cells, implementing triage systems, or having mental health professionals co-respond with frontline police officers. Frontline police officers also reported ideas for training and ongoing

professional development. This section reports on each of these possible developments.

Safe health and social care spaces and triage systems

Some frontline police officers mentioned a vision for improved responses to mental health-related events that included creating a calm and supportive environment to transport whānau/citizens instead of placing individuals in police cells. This was particularly important for frontline police officers in the BOP case study, where the use of police cells was more common:

I think the only thing I want to see an improvement in is how we deal with people suffering from mental distress when we have to bring them back to the station. We need a proper facility if they have to come back here. I don't think we should have to bring them here. If they're a danger to themselves or others at the time, bring them here, but if they're not trying to get someone in for a DAO assessment, the DAOs will say we'll come and see them at the station. We don't want to bring them to the station. There needs to be something in place where we can take them to the hospital, and they are in a better environment. I think there needs to be some work done around that, including what their strategies are for dealing with that sort of thing, because they shouldn't be coming to a police station. (BOP, Frontline police officer 3)

In the Canterbury case study, the use of emergency departments as the place for initial assessment was reported as unsatisfactory. Frontline police officers were eager for a dedicated detoxification centre and for mental health assessments to take place at a dedicated space within a mental health facility rather than a public hospital:

When we're sitting there for three hours with somebody in A&E who's going through probably the lowest point of their life, with a queue of sick and bleeding people next to them, I think the whole hospital procedure is not fit for purpose. I think it's archaic, and I just think they don't prioritise the mental health at all. (CANT, Snr Sgt 1)

The idea of a triage service was also about reducing the extent of police time and resources drawn upon to respond to whānau/citizens experiencing mental distress, recognising that they are not the right people to be so extensively involved:

I think the challenge is our resourcing. We just don't have the capability to deal with all this kind of stuff. I think the frustration for the police comes when someone doesn't want to talk to the police because they don't understand why they should have to. When someone's in mental distress... I understand when they've mentioned harming themselves with a weapon we'll we have to go, but a lot of times, people are just having suicidal thoughts, and so us turning up aggravates the situation, which can then just get worse and worse, and we can't always let that happen. I think that's where a lot of frustration comes from for the police just. We often don't have the capability, and we're not mental health workers. We're not trained for this. We do a lot of training, but we're not social workers, and we're not mental health workers. (BOP, Frontline police officer 18)

A common thread across the case studies was a focus on police having a "referring" role. Police might be involved in the first response but then can easily transport whānau/citizens to a space where mental health professionals or navigators can provide a handover swiftly to release police to attend other callouts.

Police participants in South Auckland explored the importance of establishing better community support and prevention strategies:

I think they're [mental health services] very understaffed and under-resourced. I also think that while they need to triage who they do take in... because of their understaffing and under-resourcing... But I think there needs to be some sort of middle ground where maybe a DAO or mental health crisis team doesn't attend, but there's another option... rather than us being at a person's house that... them saying, you know, they want to harm themselves, mental health team saying they're not at risk enough and then we've got to leave, and

nothing gets done. There needs to be some other option or some other step that needs to be available, I think. (CM, Frontline police officer 5)

Positive attitude towards the co-response model

Despite acknowledging that one team cannot solve all the issues, there was a generally positive, albeit tentative, attitude towards a co-response model, indicating openness to collaboration between different agencies. Frontline police officers knew about piloting a co-response model in Wellington but were not sure how it operated. They had some sense of the usefulness of mental health professionals, inclusive of a DAO, attending events with police, who also had more in-depth training to work in a co-response manner:

But something like here, I reckon it would have to be about, I know, funding and all that, but sergeant and three constables that are well trained in mental health, and they work a certain roster, and they can actually go out similar to like our armed response teams. They go out to mental health jobs, and they are the ones that that is their portfolio is to deal with and liaise and work alongside crisis. (BOP, Frontline police officer 23)

I think it would probably be just the safety aspect rather than being the first to kind of go there. My head kind of goes to the teams that they're building in Wellington, I think, with the ambo officer, the mental health officer, and the police officer together going to these jobs. That's how I would kind of see it, having some kind of mental health resource attached to the police going to these jobs. Difficult to determine whether something's safe or not safe for them. Or having a specialised unit of some sort that is trained, that has more knowledge around mental health stuff.

You'd have to have a DAO, an ambo officer maybe, and a police officer there just dedicated to mental health stuff, and then you'd free your normal units off for any other priority jobs. (BOP, Frontline police officer 27)

Frontline police officers reflected that a co-response team would ideally see police taking a back seat in responses to mental health-related events. This was seen as preferable to police currently being the primary responder to these sorts of jobs, which they recognised could be traumatic for whānau/citizens in mental distress. They noted other benefits of a co-response model, such as enhanced information sharing:

So, if they had like a mobile unit, for example, in Wellington, then you've got the best of three wheels in there really, you know, you've got them providing- so you've got us providing safety, them providing expertise. And then you've got ambo, the medical side of things, addressing that. Um, yeah, I'd more than agree with that, that mobile side of things; it just makes a lot more sense. Cause that's the thing they could be solving that stuff out in the community, they might not necessarily bring it back to your hospital, or ED side of things. (CANT, Family Protection Officer 2)

To be in that state mentally and then see these blue uniforms charging up, it's like, "oh my god, what's happened? What have I done? What have I done wrong?" So again, that would be good if non-police could turn up out of uniform or in their paramedic uniforms and things and help. It would calm the situation a lot more, I think, because then, rather than us starting up here and having to work down, it might be starting here and then having to work down. So, that would be really beneficial. (CANT, Family Protection Officer 4)

Frontline police officers in Canterbury questioned whether it might be more practical, rather than implementing a co-response team, to give their watch-house mental health nurse a mobile capacity, where frontline police could pick them up from the station and bring them to jobs with them as required.

In the Bay of Plenty case study, it was clear that the family harm intervention team, which involves collaboration with various agencies, was working well, and senior police could see the potential of this

approach for mental health-related events.:

I've spoken to mental health lots about it. With family harm, we'll [PST] go to a family harm incident, and then the next day, the family harm team will make contact with everyone when everyone's calm. My thought is that should exactly be happening with mental health because 90% of the time, they say, no, they're affected by drugs or alcohol, which is fine, but the next day they're not, and the next day they're calmer, and we do nothing, and we let them wait until lunchtime to get on the piss again.

It's just this horrible cycle, and 50% of our day would be spent working with mental health. I don't know the exact number, but sometimes it feels like it's 90. So, in a nutshell, it's been quite hard, and probably mental health says the same about us because everyone's busy and trying to handle our relationship. That's why we'd really like to do something with the co-response team. But again, that's not going to – one team is not going to fix everything because they're not going to be able to attend everything. Sometimes, there are ten mental health jobs sitting in the system. (BOP, Frontline police officer 35)

In the Counties Manukau case study, officers were aware of the positive evaluation of the Wellington co-response trial. They pointed to limitations they saw in frontline teams still having to be the first responders, effectively not reducing the demand for them to respond to 1M/1X. But overall, there was a positive attitude towards the model. Many frontline police officers in this case study were unaware of the co-response team pilot that ran for three months in Counties Manukau (end of 2021-beginning 2022). One police participant had been part of the pilot and explained:

And so, I was part of that team [CRT], and the happy ending stories were when we had a social worker DAO, and a registered nurse DAO, and we went round there, and they were there... and basically the police just stepped back and said, "Well, there you go. This scene is safe", and then they spoke to that person and set their mind at ease. And those are the happy endings... they've seen the professional. Then they get the best result that could possibly be... is done there and then. We ensured a quick response, not to all but to as many as we could... patients as we could, and it was done and dusted there and then. (CM, Frontline police officer 2)

Mental health workers and/or navigators at the station

Some frontline police officers emphasised the importance of making services accessible to individuals seeking help. They discussed the role of navigators, which you see in court spaces, who connect whānau/citizens with relevant services and ensure they have the necessary information and support to access those services:

If we're going to be managing them, our facilities need to be a lot better than what they are, and that dream, so to speak, of having a crisis nurse in your custody area, probably won't happen as such here because we export a lot to [location removed], and that's where they supposedly have one over there or on call there or available there. It would be nice to have them here because sometimes we're probably expecting a little bit too much of, say, a new cop out of college who's thrust into this and expected to have some insight into mental illness and make good decisions about ongoing care and treatment of that person. We wear many hats, and sometimes it is our hat to wear, so to speak. If there were some means to work closer with them, yeah, that would be really good. (BOP, Frontline police officer 32)

It's not just I've referred you to this person, be at this place by nine o'clock tomorrow morning or whatever. They won't get there; otherwise, if they could do that, they would have done it a long time ago. They need someone to pick them up, hold their hand, take them there, and then take them to the next one. If they need addiction help, then they need someone to take them there and to stay there and to see it through. For most people, it's family or it's friends or whatever that helps them with that, but I think a lot of people simply don't have that, for whatever reason. Whether it's a society thing or what, those

connections are not there, so they need that navigator or that person from somewhere to hold their hand and do it. (CANT, Neighbourhood Policing Officer 3)

Training and education

Discussions with frontline police officers included their descriptions of training and ongoing in-service education and their ideas on whether there is room for improvement to support their responses during mental health-related events. They reported ongoing training needs regarding understanding different mental health conditions and their implications for shaping police interactions and responses. Other ideas were learning more about ways to respond and de-escalate situations from negotiators or learning about the histories of places they work from iwi perspectives:

We get a little bit. Not as much as we should, I think. I think that probably comes down to each section. We have the ability to have our negotiation team teach us those de-escalation skills, but I don't think we've used that as well as we could. To kind of use that within the section would be pretty smart, but we don't tend to, which is a bit silly. I suppose around just understanding, more training, continuous training around what someone in crisis looks like, all of that kind of – "is it behavioural, is it actually mental health, is it drug-related?" All that. "How does someone tell that?" I think continuous training around that kind of stuff would be beneficial as well, to give us a bit of insight into what we're dealing with or what's in front of us. Training's always good across the board. Someone's going to give you some information which will help, and that's always good. (BOP, Frontline police officer 27)

Frontline police reported that they learned skills for interacting with whānau/citizens in mental distress on the job more so than during their formal training at Royal New Zealand Police College. Participants also agreed that their receipt of other, more formal mental health-related training in the workplace was limited:

There's very kind of little [training]... that we're provided... We might get it brought up at the odd district training day if we're lucky, but it's not structured. (CM Frontline police officer 4)

But... to be honest, since graduating, we don't really get a lot of continued education in that kind of sector. You know, we get continued education when it comes to tactical stuff. If there's any updates to legislation, but as far as... that kind of continued education, it's not really provided or touched on. (CM Frontline police officer 5)

Police participants spoke about their dislike of completing online workplace learning modules:

Like I'm personally not a huge fan of E-learning. We do [them] because it's a... I think it's a box-ticking exercise, and a lot of people on the frontline treat it as such. [and] people do pay more attention when a new one [module] comes out. (CM Frontline police officer 4)

Trial and error and observing the examples of more experienced officers were the key ways of learning these skills. Police College was identified as a sterile environment, and the strategies taught there did not always reflect actual policing:

We're not taught how to communicate with people; we're just taught to communicate with people. (CANT, Neighbourhood Policing Officer 1)

I mean, they teach us AWOCA.³ So there is like a mental template that you can work through, but college is a very sterile environment, right? And yeah, sure, there are times and places where AWOCA would work, 100%, but there are many times and places where it doesn't work. (CANT, Frontline police officer 5)

3. AWOCA is the acronym used to describe the tactical communication technique. It includes ASKING or telling a person what to do, explaining WHY they must comply, giving the person OPTIONS, CONFIRMING that the person understands, and ACTING by taking action.

You're... in college, you're taught your AWOCA communication tool, ... but... that's quite limited... the tool guided their interactions with people, who are passively resistant and above, in order to gain compliance... not just [for] people with mental health issues, but you know anyone who doesn't... want you to be there... the tool was less effective with people with mental health issues, because of the nature of mental health. (CM Frontline police officer 4)

Since on-the-job learning was so foundational, there was a concern among some police in the Canterbury case study that most mental distress jobs were attended by PST officers, who were likely to be less experienced:

The front line is predominantly- it's where everybody starts, to learn how to police, so generally, there's a younger, less experienced workforce there. And I don't know what the figures are, but they're interacting with mental health persons probably more often than other work groups, so there's an interesting point there: they're asking our least experienced staff to deal with these problems. They may not have the most experience to deal with them. (CANT, Frontline police officer 2)

Police in the Canterbury case study reported a need for more training around communication skills. However, they noted a tension where upskilling police's ability to respond to mental health-related events might further embed the police's role as the main service responding to these events. In contrast, ideally, they wanted the police to have less of a role here:

We should take the opportunity [for more training] if it's there. But it's not given I don't think the priority [...] whether we should take it as a priority, because is it our role? I think there's a conflict there. (CANT, Frontline police officer 2)

Many frontline police officers acknowledged the need for options beyond armed responses. They highlighted the importance of ongoing in-service training in de-escalation techniques and non-lethal strategies in handling situations. Using the expertise of police negotiators was mentioned to learn how to resolve conflicts and crises, emphasising their passion for achieving peaceful resolutions without force. The discussion suggests expanding negotiation skills beyond being "specialised skills" to tools that could be generalised to all frontline police officers.

Counties Manukau Police described noticing the police organisation's progression and commitment towards being more responsive to Māori. The New Zealand Police PRIMED values (professionalism, respect, integrity, commitment to Māori and Te Tiriti, empathy, and valuing diversity) were apparent across all organisational messaging and emblazoned on walls and posters at Police Stations:

I feel confident in the way that... I feel like, as an organisation, we are trying to be better in this space with how the organisation interacts with Māori and tikanga, and I suppose it seems like there's more from when I first joined [6 years ago] to now. (CM, Frontline police officer 1)

It appeared that some frontline police had a rudimentary sense of Māori cultural awareness. However, there had been little formal education provided around the topic within the service. The absence of education necessitated reliance on other staff to learn about Māori culture and tikanga:

I would speak with] a couple of my colleagues... just talking to them about it. I mean, their kind of like worldview and perspectives... but it's not their job. (CM, Frontline police officer 4)

Counties Manukau Frontline police officer 1 identified as Māori and described his positioning in the workplace:

It's not, I wouldn't say, it's encouraged [contributing Māori cultural knowledge] to do so. But I do just pick up on that by myself.

Summary

This section summarises the key findings from three case studies of frontline policing conducted in various regions across the Bay of Plenty (BOP), Canterbury (CANT), and Counties Manukau (CM) police districts. The study identified ten key themes, which illustrated perceptions of frequent and substantial mental health callouts, approaches to mental health events, teamwork, diversity, and supervision, reactive measures, a high threshold for admission to mental health services, shaky collaboration among agencies, legal constraints, grey areas and creating harm, racism, bias, and discrimination, frustration, disheartenment, and moral distress, and alternative approaches. The next section provides an overview of the views of police officers across the country, which confirms many of the themes identified in the case study.

National police stakeholders

This section provides a summary of the opinions of senior police officers whom we engaged as key stakeholders (hereafter stakeholders) regarding effective practices and challenges encountered while dealing with mental health-related events and implementing Prevention First.

Method

We recruited a number of stakeholders from a sample of consenting police working in New Zealand's 12 police districts. Stakeholder interviews ran parallel as required throughout the time-line of the study whilst developing the emerging findings from the main study participants. The aim was to prioritise the views of stakeholders with experience in leadership in mental health and those working with Māori communities to gain insights into the broader experience of responses to mental distress and to help us understand how institutional, cultural and socio-political contexts shape police practices.

All interviews were transcribed. The stakeholder group comprised senior police officers from urban, provincial and rural police districts of Auckland City, Waikato, Bay of Plenty, Central, Canterbury, and Southern. The group included ranked and non-sworn officers responsible for strategic policy directions, supervision, or external liaison. This senior group were in roles such as supervisors of Public Safety Teams, custody sergeants, Police Negotiation Team officers, Iwi liaison officers, Mental Health liaison portfolio holders, Neighbourhood Policing Team officers, Prevention Managers, and District Commanders. We have not included a demographic breakdown in this section due to the possibility of identification, which would breach our ethical commitments to confidentiality.

The analytical focus was on how senior police understand the application of Prevention First; how that strategy shapes the way police interact and respond to whānau/citizens in mental distress; and what factors may place limits on their ability to achieve positive outcomes. We employed a thematic analysis approach to ensure familiarity with the data corpus, generate initial codes, and group codes into broader themes (Braun & Clarke, 2021). All quotes from the stakeholders are presented as a summary of their key points, followed by the participant's number.

Findings

Twenty-three officers in total were interviewed either individually or took part in a focus group discussion from 2019-2022. Four themes are presented generated through the interviews, these include: Preventative measures for mental distress, building relationships with iwi and external partners, boundary work with mental health services, and vision for improving the current system.

Preventative measures for mental distress

The stakeholders understood Prevention First as one of three core priorities alongside investigations and response. In this theme, we drew on stakeholders' descriptions of Prevention First in practice, providing examples of how mental distress permeates nearly every aspect of this police work. This theme highlights tensions and complexity in defining the scope of Prevention First regarding intervention responses to whānau/citizens experiencing mental distress.

Stakeholders reported that Prevention First relates to and can be operationalised in a wide variety of circumstances. They presented broad views of what Prevention First means in policing and explained how its application may be shaped depending on officers' rank, team and district. For example, as previously reported in case study findings, stakeholders explained that frontline police officers struggled to work preventatively and instead practised reactively to callouts across all districts:

Prevention First strategy – no capacity at the frontline. It's all reactive. We don't have the time; we don't have the resources to be able to do that. We're running from job to job. Yes, all reactive. You'd be lucky if our guys could do any proactive stuff in a rotation. Maybe on a night shift during the week, there might be time to go and do some kind of proactive stuff, but no. Last set, I don't think any of our guys at any point got back to the station to do any work on their computers. They just pack your car, put your food on it, and off you go. There's no capacity for it, unfortunately. (Stakeholder 2)

Frontline police officers saw preventative work as the role of community constables who have day-to-day relationships with members of their community:

We rely on our community constables for that, essentially, but they're only one person. ...Those are our community constables, and they do more work around with the community. (Stakeholder 2)

This work in the community by constables and neighbourhood police teams meant that action could be taken to prevent or intervene early in responses to citizens:

There's obviously the lower-end stuff that we still get like prevention officers or community officers getting involved in neighbourly disputes. There are people in the homeless sector who have very complex needs around mental health and addiction and the rest of it. [...] Officers in the prevention group may be asked to engage with such and such and check on the victim of a family harm matter. We may not have received a formal complaint, but we see the value in front-footing issues we come to know about. (Stakeholder 1)

Police officers' "front-footing issues" extended to groups of whānau/citizens and police engagement with multiple agencies. One stakeholder gave an example of the relocation of homeless people into an Auckland City hotel during the COVID-19 lockdowns required a cross-sector crime prevention response:

The other problem that presents is that then you get a big concentration of people who will feed off each other, who are low socio-economic and will go and commit offences, will do this, that and the other, [...] We had fire council regulatory services, MSD, the owners of the hotel, us, Lifewise, and Mission. I think a couple of other organisations sitting around discussing this. Discussing the issues that were happening there, talking about how we could empower the people that were running it, talking about – and then, for instance, going through our prosecutorial service to try and influence judges not to bail people there. I am trying to discuss with MSD about not housing them there. [...] There's a whole load of stuff that went on like that. It took time. We were going there a couple of times a shift, and we weren't going just in one car because we couldn't because it wasn't safe to do so. We changed that place quite considerably, but the owners still pulled the pin. So that stuff, yeah, prevention policy is not just a policy in isolation. It's what we do. (Stakeholder 12)

The scenario above provides an instance of police response in relation to COVID-19 restrictions in collaboration with government and non-government organisation (NGO) providers. Stakeholder 12 also demonstrated how prevention is perceived as "what we do." This implies that prevention in practice is a mindset or an approach to police problem-solving, encompassing core priorities of investigations and response despite not having full buy-in from community partners. The preventive mindset was exemplified from the point of view of a neighbourhood policing team, as follows:

Instead of racing around putting Band-Aids, as such, on stuff as it comes in on the radio, what we do is use a problem-solving process to go out and scan around looking for issues within our area. [...] So, there might be crime data, there might be talking to locals, there might be people that have come to us with issues. Anything that we can take all that information and distil it down to identify what the issues are, if they are an issue. If it's for police to seek out, if it's perhaps for another agency to work out, getting to the core of what this particular issue might be. Once we've identified it, then it's identifying what the appropriate response is. "Is it all police? Is it none of the police? Is it us coordinating with other agencies to fix it?" So, we have a response to that issue and then analyse it at the end and decide whether we have fixed it or set up systems that will fix it for us to go down the track. (Stakeholder 9)

The stakeholders described an approach to prevention that was intertwined with intervention, wherein the police identified a problem area and identified partner agencies to support a response, recognising that they cannot alone solve systemic issues. However, the limited capacity and resources of social

agencies and services to respond have an impact on the police, especially in rural areas:

Everybody's probably got a little bit of a different idea of what prevention is. Some people would say prevention is arresting people because then they go to prison, and then that prevents them from doing it, which, to a certain extent, is right. But I think as I've gone along, it's that stuff that we were looking at in NPT [Neighbourhood Policing Team] as delving deeper so that you identify what the issues are and then solve those so that you don't have to have the problem two or three stages down the track. That's the rub of the grain, like I say, because those issues are ultimately, I see as coming down to inequality somewhere in society, and that's why police can't fix inequality in society. We can help it, and our strategies probably have to be around what we can do within that, but it is an all-of-government thing to fix. (Stakeholder 9)

The stakeholders have reported that there is not enough investment to support the application of Prevention First and that preventative practices could be more supported across various teams. They strongly felt that the investment in Prevention First was inadequate to meet expectations and demands. For instance, the effectiveness of Neighbourhood Police Teams in targeting crime prevention is limited by police capacity for surveillance and the opportunity to address underlying issues, which has also been highlighted in the case study findings. Stakeholders suggested that there was inequitable investment in specialist teams between districts (e.g. NPT is not in every district) and relative to demand for other police services (e.g. road policing and mental health).

Echoing the case study findings, mental distress was reported by stakeholders to feature in nearly every aspect of police work. Frontline police officers are assigned a high volume of jobs through centralised communications, which can be relentless and overwhelming at times. Stakeholders have further observed that police work often intersects with alcohol and other drug issues and family harm incidents. The nature of these challenges ranges from low-level social disturbances to potentially life-threatening situations where time and limited information are critical factors in preventing harm to all parties involved:

People may think that police just focus on responding to crime. Often, we get called for help, and we are the most suited to deal with that issue, or we are the first of the three emergency services to get to that issue. In rural communities you might get fire going to health issues. End of the day, if it's a high-distress area where there's violence and concerns for people's health, including suicidal-type situations, the safest people to go are us, and depending on the circumstances, whether we need to go purely because we've got tactical equipment. We can deal with it, or we've got more staff that can deal with it. It depends on the situation. (Stakeholder 1)

Police involvement in mental health-related events was reported as no longer a last resort; rather, frontline police officers perceive themselves as filling the gaps created by a severely under-resourced mental health system:

We're picking up a lot of problems that other agencies either can't meet or just aren't – I won't say resourced. I know for us, like I said, nothing before 1 pm, like you're wasting your time in that space [...] most organisations, they knock off at three or four, so we're left sort of fixing that time period for them, so that's kind of when we'll get involved [...] we've really moved away from the fact that the police being involved in those incidences should've been last resort, not the nice to have or the means of doing it. (Stakeholder 5)

Stakeholders expressed their frustration about how the frequent need to respond to mental health crises prevented them from working on preventive measures and collaborating with external partners. It was also acknowledged that the limited resources of mental health services made it difficult for their partner agencies to work towards the vision of prevention instead of reacting to crises:

It's kind of an interesting conversation about mental health, isn't it? New Zealand police are focused on Prevention First, and yet many of our partner agencies haven't caught up. We have really good relationships, working relationships, with mental health, with Māori mental health, DHB [now Te Whatu Ora] and primary care. We get

on really well, although we're not all rowing in the same direction; that's the problem. That's what I talk about with Prevention First. [...] We should be doing a whole lot more at this end of the spectrum, not the acute end of the spectrum. If we all teamed up, we could actually have a 16/7, perhaps even a 24/7 service, because people shouldn't ring New Zealand Police for mental health. We're police officers. We make criminals of people, and we're making criminals of mental health people all the time. We're going really well; the only problem is as soon as you stop talking in a group, they all go back to their silos. [...] a lot of these primary care agencies are NGOs...These agencies are constantly fighting for money; they're constantly fighting for people, all for the same purpose. To me, that's crazy. (Stakeholder 6)

How Prevention First is being realised regarding mental health events becomes challenging when it does not fit the culture and policy of mental health services:

When the New Zealand Police Commissioner says, "We're going to be doing this", we try really hard to do what he or she wants. Ministry of Health will set up some edicts and expect the DHBs [now Te Whatu Ora] to pick it up, and then they go, nah, that's not how we do things. (Stakeholder 6)

I think from DHBs [now Te Whatu Ora] and some of those providers around, this is our business; we just do our business type thing. There's a culture of referral as well; just refer it off, done, I've done my thing, I don't have to worry about it anymore. Rather than actually taking some responsibility and helping people. At the end of the day, we have a very different culture, I think, because we just do whatever's required. I kind of like that culture, and most of the cops liked that culture because we are can-do people, but if we had more from our DHBs around that – and I know they've got funding issues and all sorts of stuff; we have funding issues as well – but they don't seem to have that 'can do' attitude or the ability to swim outside their lane a little bit to make sure that actually people are being dealt with properly or to work more closely with other parts of the DHB as well. They're quite siloed in many cases. (Stakeholder 5)

The above scenarios highlight how stakeholders made sense of the complexity of police working with mental health in terms of different organisational cultures of decision-making: one is underpinned by a predominantly hierarchical structure of command and control, and a predominantly professional autonomy underpins the other. The police culture of "do whatever's required" butted up against a healthy "culture of referral", and in practice, this was a source of frustration and tension for police officers who report lacking the expertise to handle certain situations and must therefore refer cases to other organisations.

One stakeholder reported how there needed to be a systematic transformation of the health system, in general, to provide seamless integration of service provision to support holistic wellbeing. This would then allow frontline police officers with a clear sense of direction as to how they can help people in the community:

If you're looking for some suggestions as to how we can improve mental health care, I think from my perspective and my experience, it would be about a collaborative approach across all health agencies, mental health agencies and health agencies from primary to acute care. It is about ensuring that we have the physical resources available to our area so that when our people do engage with people in crisis and detain them on Section 109, we can take them to a suitable location, and there is a quick handover. I don't want to be sitting for three hours waiting for somebody to come because they're busy doing something else. (Stakeholder 6)

To improve relationships, however, this same stakeholder suggested that the police need to create stronger policies and examples of what Prevention First means in practice. Then, work can be done to align their operational strategies with community agencies and push for different ways of responding:

I think getting our executives on the same page about Prevention First so that we're all swimming in the same direction, as opposed to at the moment some executives are

talking about it, but they actually don't – we're actually trying to do something, we're focused on it. If someone came to us and said, "Look, here's an idea about preventing crime, preventing mental health crisis attendance", we'd be saying, "Okay, what can we do?" My staff are thinking all the time about trying to do things differently, so what can we do to make something different? (Stakeholder 6)

Additionally, the practices of teams that aligned with preventive policing were reported as not sufficiently recognised across teams and the police hierarchy. For example, some stakeholders explained how the skills and practices of police negotiation teams could be used more widely and introduced to other teams as techniques for de-escalation, avoiding force, and restraint:

When I say untapped resources, I think we're untapped in terms of more of a holistic approach to make it better for people the next time they deal with the police. If we can give them a better experience when we have to do things like search warrants on their house, or warrants to find people, etc, then if we can have a different approach to what the AOS will do, which is far more dominant, it might be breaking doors down and stuff and if we can take or build in another component to that, then it would actually make that person's experience better for the next time and they might not elevate so much. (Stakeholder 8)

Stakeholder 1 explained that often, with a high level of scrutiny, "when we get it wrong", there is a de-emphasis on all the times "we get it right". They noted further that:

"We don't talk about the ones when it goes well, and that's a lot [that do]".

However, most stakeholders reported difficulty with determining the extent of police preventive measures in mental health-related incidents. As a result, the boundaries of police operations with external partners are often unclear, leading to confusion over who is responsible for what:

"Who's swimming in their lanes, and who's not?" In other words, how much are the police doing that they shouldn't be doing, or what are we not doing that we should? This happens and so we need to get better at that. For example, this is a mental health issue, this is Oranga Tamariki's, and this is a DHB issue [Te Whatu Ora]. So focused prevention is being quite clear of what partners and what agencies we work alongside for the overall betterment of the community. (Stakeholder 1)

Overall, this theme of preventative measures highlights the tensions in the idea of prevention as the first response to citizens experiencing mental distress. Day-to-day frontline police work involves reactive, rather than proactive, responses to situations in which whānau/citizens experience distress. Situational factors, such as what facts are known, influence decisions about the type and nature of intervention, including the use of tactics and specialist teams. The next theme explores Prevention First in more of a strategic sense, drawing on stakeholders' perceptions of how well police are working with iwi and external partners.

Building relationships with iwi and external partners

This theme emphasises the importance of relationships in building trust and understanding whilst working together. Trust and understanding form the basis for partnerships in focused prevention strategies between the government, iwi, hapū, whānau organisations, non-government organisations, and other partners. For successful partnerships, the police must establish and maintain community relationships. However, this takes time, and any changes can easily undo progress. In the context of the Crown and Māori partnership, this theme draws on iwi liaison perspectives of police responsiveness to Māori experiencing mental distress. Stakeholders also identified partners in the government for focused prevention strategies, including NGOs and other sectors, which are also considered towards the end of this section.

Various key stakeholders described the role of iwi liaison as having a broad role with a focus that varies across districts. Generally, they work wherever there are Māori and do what is right to support them. They

work to leverage iwi, hapū, whānau relationships and life experience and focus on things that matter to Māori while working with the police process as part of how they respond across the team of Iwi liaison. They also make sure to explain police processes in a way that whānau can easily understand:

Working across a broad spectrum of kaupapa, really, anything and everything to support whānau. [...] understanding and doing what we can to support whānau to address the underlying causes that lead them to become our offenders or our victims.
(Stakeholder 1)

A stakeholder described the many layers to the police's adoption of a culturally safe approach for whānau who experience mental distress. The values of Maoridom are still to be embedded in the current system so it cannot be taken for granted in police operations and ways of working as described below:

If I talk about that road trauma and the element that sits around that, it's quite a difficult thing. It's a small team trying to live those values of Māoridom and to bring them into an organisation which has been doing things in a particular way for a very long time. While you might have the support of the organisation or some managers of a particular area, it's not just a given that this is the way that we're going to do our business.

So, in that respect, it's quite difficult. It can be person-specific, down to the requester, as to whether we do something or don't do something...This is how we're going to approach it. That's really left up to the individuals. There's not a one-size-fits-all for it. When we do it, we do it really well, but it's not something that's just a course of business. (Stakeholder 1)

Here, one Iwi liaison officer described their opportunity for proactive problem-solving with whānau that is underpinned by the values of Te Ao Maori:

I've created a little mini booklet, so that the training is done off that little mini booklet. It's only a little fold out booklet where you can just put it in the back of your phone and stuff. [...] It's getting people back to gut feeling, just love, care, give a damn, that we have that – that skillset has been taken away from us because the system knows everything about all things.

I talk to them about that: anger is an emotion, depression is an emotion, suicidal thinking is an emotion, and emotions are okay. The only danger is if you stay in that emotion, it becomes dangerous. "If you stay depressed, it's dangerous for you. If you stay thinking about suicide, it's dangerous for you. If you laugh too much, you might end up in [an inpatient unit] anyway". It's just teaching people just simple – and then mental health systems have said it's an illness. It's not an illness. [...] When I say it's a grassroots approach and it's a cultural approach, everyone leaves me alone because I'm the expert now. (Stakeholder 4)

Stakeholder 4 further reflected on the systems approach in police contexts that looks to the experts in mental health. For example, if someone is in distress, police see them as needing expert help, even when they do not meet the access criteria of mental health services. This perspective does not align with a Māori worldview, which always prioritises offering wrap-around support to the person rather than only when they reach a certain acuity threshold:

From a Māori perspective, that assessment isn't necessarily right because when somebody is in distress, they need help. Just because we've ticked our boxes, we release our people, and we haven't given any assistance at all. Police have ticked their box, and the clinician has ticked theirs, and I'm just wondering what's the professionalism in there? That's why I don't want to be in those spaces because police have to go down that line of getting qualified professionals in because nobody wants to touch mental health. After all, we're not experts in it. Well, I think it's a load

of rubbish, personally. So, we have to get in the mental health experts to give an assessment like that, most likely not on record, that they say that they're bad, not mad. I hear it too often, and that's just not cool. It's any person, not just Māori. If anyone, whether they're Pākehā or otherwise, when they're in distress, they should get some support and the right support. Not good support, the right support. (Stakeholder 4)

Stakeholder 4 continued to describe in some detail how, in practice, a Māori perspective makes a difference for whānau in distress in the following extracts:

Instead of them being in our world, inside the cells. So definitely, that's where I go is community. On our system, you can see who's who and where there's the family harm, multiple dysfunctions, there's mental health issues, so you go to that, you step into their world, and not under that reactive way where there's something wrong with you, that's why we're here, is that there's something wrong with you and we have to do an assessment. When I go there, it's just talking naturally like this, and there is no assessment, and yet there is. It's being more natural and away from our system way. (Stakeholder 4)

A Māori perspective was described in holistic terms, as being about what whānau wants and needs, and not about what services define as their needs, or what services can provide:

As soon as you get professionals involved, they've got their paper out, and that's not the way to work with Māori. It's just treating them with respect and with honour and what support do you think you need, not what a system tells them that they need. That's what I prefer. I am not necessarily looking at the flags or waiting for people to be assigned to me; it's just being in the community, and when people need support, we respond, or I respond to them. That's the main thing. There might be some flags coming up in the family harm space, or the boss might have somebody that comes up, and he might ask me about them, but I think just having your ear to the ground. There are so many people who need support; it's easy to just step into their world and help. (Stakeholder 4)

Stepping into the world of whānau also meant meeting whānau where they are at, not pushing or rushing to fill a silence, but listening deeply:

I said to him, "What help do you need?" I said to him, "and I'm talking about in your heart what's happening for you" and he looked at me and said "Yes, I was just thinking about that." and I said, "Well, you don't even have to answer that question because I heard you in your silence; there are things going on for you", but he heard a different approach. (Stakeholder 4)

A different approach that changes relationships and responses could be as simple as changes in language used with whānau:

Even the words that we, as police, call people offenders; well, that's not helpful either. How you name people is how you'll deal with them, and if it's an offender, you will be punitive because that's what the word says that you should deliver something punitive. But if you called that person whanaunga or whānau, if he had that word there, you would be responsive, you'd have a responsive approach. Wording inside of systems can be your biggest mistake. Even if you changed the language, you would change your approach. (Stakeholder 4)

During the focus group, a number of stakeholders below discussed the importance of the role of Whānau Ora navigators in proactively addressing prevention measures. They noted that the navigators can act as a "foot in the door" with the family, regardless of how the referral is made. For instance, it could be a roadside referral from a police officer who sees someone in need, a call to a family harm event, or even a missing person's report. No pre-formed criteria for the referrals enabled flexibility and openness in terms of what options for support could be provided. Stakeholders from a focus group explain:

Navigators have a wide network of support agencies, both Māori and Pākehā iwi affiliated throughout [location removed]. They're pretty well connected. (Stakeholder 4)

That's their role is to present a number of options to understand what's going on. (Stakeholder 1)

We're really lucky here; we've got the Whānau Ora alliance here. I'd say we're probably leading the country in terms of our response and what's happening there. Police have partnered, we've been partnered with them for a very, very long time, very long time. In fact, a lot of our work streams fall out of different Whānau Ora-based tables and governance boards and things that we sit on. If there's an issue, a community issue, then any one of the partners at the table – and we're talking the heads of state of everyone; there's education, there's social investment agency, there's anyone who's anyone is sitting at that table. If there's a need from the community, then we discuss it, put a team together, work that out, go out and deliver it, evaluate it, and then scale it. (Stakeholder 4)

We get the opportunity to engage with people when they're not in crisis which is good. (Stakeholder 3)

However, the focus group discussion continued to indicate a perception that if mental health is a space for experts that means further training and support would be required for navigators to support whānau experiencing mental distress:

For mental health? No. I would be reluctant to have our navigators or our teams do that because it's not something we are trained to do and I think it's actually, in my opinion, that's a mental health service. (Stakeholder 3)

Government criteria for funding can restrict how partners work with whānau: Because systems have infiltrated even Māori service providers, and so you can't work how you need to work because funding criteria stop that. If you don't do it my way, we'll pull your funding. It's as simple as that. (Stakeholder 4)

Building cultural capacity within the police was also a core aim for some stakeholders involved in iwi liaison. One key stakeholder suggested that police responsiveness to Māori must be tailored for local areas with kaumātua involvement, as well as Māori leadership within police centrally:

A plan [...] was to get iwi, a liaison officer and then our police and the local marae and then we have a bit of a talk about the history and maybe help in understanding that it's not a case of getting over it, the past, that it's our history and a big part of our background. And then problem-solving in ways to actually physically and practically do better working together with iwi. They're bringing some training in that will be compulsory that apparently is very interactive and so forth. There's the Wall Walk [...] it brings people to areas where there's been land wars or other historical significance, where this is what actually happened, and here you are in the place it happened, and it really hits people. (Stakeholder 1)

This stakeholder reported that it is crucial for the police to understand that the impacts of colonisation continue across generations and that the past is still relevant today. Moreover, the following stakeholder in focus group 1 reiterates how important it is for officers to comprehend their commitments under Te Tiriti o Waitangi, and apply them to police practice:

I think there's probably perhaps a little bit of a lack of understanding of what the value of commitment to the Treaty and commitment to Māori actually means. Doing a karakia and our waiata and all that sort of stuff is a great way forward. But I think when we talk about some of our whānau that are in those positions where they're in conflict with whatever it might be, the mindset of our team is really, really important.

In order to support better outcomes, we have to understand that there was some stuff that happened in the past, and therefore, because of some of that stuff, what we see are the symptoms of that. I don't think across the organisation we look deep enough at that. Some are just like - I've heard it before, Māori just need to get over themselves and stop blaming this and that, but well, actually, it's far bigger than that.

A few years back, we developed a cultural confidence kind of a programme here in [location removed], and we've just finished rolling that across the district, and that was based on what our staff needed and wanted. Not so much what our kaumātua and kuia that support us need and want from us, but what our people need from us. I think it's been quite a success, and a lot of it is about addressing the 'why' that sits behind why Māori do this and why it's important to do this. That's been a pretty big journey, but I've definitely seen, there's been a big culture change in the last five, six, ten years. We're still a long way to go but we're definitely on the right track. (Stakeholder 1)

Police are being trained to interact with Māori communities in ways that respect their cultural values and not disrespect their dignity. Although progress has been made, Stakeholders have emphasised that more work is needed to improve cultural capability training. This includes not assuming that only Māori staff, regardless of rank, have a role to play in protocol and engagement with Māori and "It is important to get the basics right, such as tikanga and protocol, at all levels of seniority within the police force" (Stakeholder 14). Leadership was therefore described as very important: the small steps on a journey, including pākehā.

Cultural safety is also important for the police's own well-being:

I think for our teams; I've got them on a bit of a journey at the moment in terms of not only their team culture but their cultural response, I suppose. Whilst those teams are predominately dealing with whānau experiencing violence or with young people experiencing addictions, it really does come down to who's managing those teams, their attitude, and how their attitude changes. Police have been on quite an arduous journey, probably the last 10 or 15 years, to change the culture of policing. I think we've definitely come a long way, and I actually think we're probably one of the best government organisations in bringing our people along that journey, but there's still a lot of mahi to do. For our people and leading that, that's about actually it's the small things at the moment. Things like for our teams in the morning, we've started to do karakia. It's the way you approach that with your staff. The majority of my staff are Pākehā, and that picture is slowly changing with our new recruitment model, but the majority of my staff are Pākehā. For them, it's been scary jumping on that journey, and we're only doing small things. So karakia in the morning to keep ourselves safe and to keep our whānau safe. (Stakeholder 3)

Karakia was an important aspect in looking after each other and opening up discussions around keeping well, protecting whānau and having the ability to do the best to respond to their communities:

The work that they do, actually, they take on a lot of mental distress themselves; they take on some of the trauma that they see and talk about. So, for us to do a karakia, it's about actually one protecting themselves and their own whānau, but also having the strength to and the motivation to work with whānau experiencing distress, whether that's addiction, mental health or family harm. (Stakeholder 3)

External partnerships with mainstream services were also important for enhancing Māori responsiveness. Stakeholders also reported applying a police-focused prevention strategy with Government partners, using examples of Prevention of Family and Sexual Violence, Oranga Tamariki, Education (schools), and Kāinga Ora. Engagement with whānau at the 'frontline' generated referrals to social support and service providers, but not primary mental health care, as described below:

If we're dealing with people out in the street, we can refer them to all of those partners, nothing else. That's kind of it at our level. We've got addiction services partners, budgeting partners, age concern partners, youth partners, mental health partners,

family well-being, accommodation partners and partners for if we're serving police safety orders on someone. License stuff. That's pretty much all the groups. Sexual health stuff. That's in each of the areas. [...] The mental health ones I tend to use if a family member has contacted police, so I'd give them their details. But I don't generally refer people directly; I'd rather them go and see the crisis team. (Stakeholder 2)

During prevention-first policing and responding to whānau/citizens in mental distress, local government and non-government social support organisations were mentioned. Council bylaws also play a role in shaping how police interact with homeless individuals:

For the most part, we get involved in those because of someone's criminal offending, and you can't separate the two from an individual in the middle of a crisis. We'll deal with the first one to stop that happening or we'll deal with the safety aspects to them, to the public. The second half of that normally comes down to the fact that we can't just go, "okay, we've solved that, and now you can go." We won't normally do that. We'll then try and get other agencies involved. (Stakeholder 12)

Building on theme one of the preventative measures, the stakeholders concluded that partner services linked with the government could impact the ability of police to achieve a Preventive First strategy:

It is reactive. Prevention First is a Disneyland movie, I think. It sounds good, but in reality, because of the type of work it is, police can't do anything on its own, so you've got the justice system, you have corrections, education. They're all one and the same thing; they're all linked. Police can do what it does, but then it can be eroded by the Ministry of Justice or Corrections or whatever or advocates. If you're going to get the proper change, it's got to be widespread across all... I think the police have responded to Māori better than other statutory agencies, but this is my own personal opinion. ... we have a head in Wellington, and it all flows right across the nation, and our comms, all that sort of thing, are pretty cool when it comes to a Māori approach. We've still got to find better ways of dealing with it. (Stakeholder 4)

To summarise, the stakeholders emphasised how iwi and government agency partners are essential in prevention strategy relationships. However, there is less clarity regarding mental health partner relationships at a strategic level. While there has been an improvement in being responsive to Māori, there is still much to be done. Understanding partner roles and approaches is crucial, and an example of this is the police being part of the whānau ora alliance by utilising the skills of navigators to build and maintain community relationships. The next theme explores the specific interaction with mental health services in relation to mental health liaison.

Boundary work with mental health services

This theme revolves around the perceptions of stakeholders regarding the relationship between police and mental health services. The police mental health liaison is a portfolio responsible for managing the interface between the police and the local mental health services. In some cases, this may be a dedicated position. This includes working with Duty Authorised Officers who coordinate using the Mental Health (Compulsory Assessment and Treatment) Act of 1992. The relationship between police and mental health services is fluid and influenced by various situational factors, as well as how mental health events are categorised as 1M or 1X. This theme focuses on how police liaisons foster positive relationships with mental health services and whether they have the necessary support to be effective.

One stakeholder described the main role of a mental health police liaison as "keeping the wheels spinning" with mental health services. The role also provides opportunities for proactive problem-solving with mental health service/crisis teams regarding recurring call-outs:

Effectively, my role is obviously liaison, but we also look at our higher-risk mental health patients that we need to work with and in relation to that liaison with the hospital. Unfortunately, a lot of the stuff that has happened here is a conflict between the Mental Health Act, the health board [Te Whatu Ora], and their resourcing, particularly resourcing around crisis teams. So, I guess my main role is to liaise

with them and keep the wheels spinning as we can around trying to work within an area which, in my view, is particularly under-resourced from a health point of view. (Stakeholder 2)

However, the geographical boundaries of health services do not map onto policing districts, complicating the relationship:

The DHB lines don't align with our lines. It's really, really tricky. [...] We just drive them here and take them over this imaginary line, and then we might get some service. (Stakeholder 5)

Stakeholder 22 reflected on their concerns that in rural areas, where there are no mobile 24/7 mental health services, there is a particular strain on police. Frontline police officers can be called for police assistance to transport whānau/citizens, even with little risk, resulting in potential misuse of the Mental Health Act.

The inequity of resourcing mental health liaisons within the police, compared, for example, to road policing, was raised to highlight the need for dedicated roles to focus on mental health demand. There was a sense that top levels of leadership having more information about trends would lead to more dedicated resources to reduce demand:

With our leadership team, telling them what the trends and data is. I kept [my boss] up to date, and she'd impart it up here, but whether they actually understand – 'they' meaning the mothership in Wellington – because there hasn't been a lot of emphasis put on mental health, one of our demands of crime. (Stakeholder 7)

The mental health liaison role used to be about relationships and knowing who to contact, but not working in partnership for constructive change. The practice of moving police between temporary positions in portfolios was seen as disadvantageous to building and maintaining relationships over a longer term, especially in mental health liaison. Success in roles was characterised by what's going to work in this situation and practical results from acting, not 'just meetings':

There's a lot of issues around one, having a portfolio because there's one in each district, so there's 12 liaison holders around New Zealand, and just probably what we're actually achieving, we do actually have a list of things you had to deliver on or things to work on, so it was a lot of self-led. (Stakeholder 5)

Day-to-day work in the role included connecting monthly with crisis teams and hospital management to talk through cases and explore what could have been the better solution. This problem-solving together aimed to achieve reductions in the average number of whānau/citizens brought into custody and detained in cells by police. Developing working relationships based on trust requires reciprocity. It was important to give as much as you received in order to build and maintain mutual trust. For example, giving the police a 'set of eyes' over mental health inpatient procedures for reporting assaults on staff:

One problem with police relationships is that cops walk in and say "I want this, I want this, I want this, I want this", and people often get their backs up. I always work on the theory if you try and develop a working relationship or partnership with people, you want to do something for them first, develop that trust, and that way, they know straightaway it's a two-way because lots of people complain. (Stakeholder 5)

For one stakeholder, the mental liaison role had a crossover with the custody role, monitoring police action and surveillance of the person in custody. This suggested a key purpose of the role is focused on the examination of ethical and legal issues of the dangerous detainment of very unwell whānau/citizens in not-fit-for-purpose cells:

When I first took that over, probably one of the main concerns for this district was the number of people that were in our cells, in custody, that were having mental health issues or were having a mental health episode or had done something else, and there

was a mental health background to it. It was getting close to one person a day, and they're quite high risk, particularly around the potential for suicide. Most of the people in cells are sort of 20, 30-plus years old. They're not really fit for purpose anymore. They were designed to stop people from getting out, not to stop people from hurting themselves. (Stakeholder 5)

Stakeholder 5 reported how there was very little decision-making of frontline police officers being recorded correctly in the documentation to show why they were bringing whānau/citizens to the cells in distress:

My worst-case scenario in that job was someone committing suicide in the cells. (1) because there's a dead person, (2) there's also a massive investigation (IPCA) that comes with that, which is just like – you just don't need that work.

The importance of documentation was described not only in the context of external scrutiny of tragic events. Documentation was important in risk prevention to bring attention to police systems to support and improve frontline decision-making. The example given was police officers attending family harm incidents with pre-formatted decision-making tools:

When you have formatted paperwork, your decision-making is headed towards, right, I need to –? If you go to a family harm and there's kids there, you're obliged to take the kids' names, and if you don't fill that in in the paperwork, the machine will say "no, do it again". That means you're going there and it's not just about getting their names; it's going, "right, who's affected by this family harm?" All sorts of things like that and that determines your decision-making when you go there because you know what you're going to be held for account for your reporting. (Stakeholder 5)

Another stakeholder described the development and use of a "flowchart" as a decision-making support tool for frontline police officers to help them with risk prevention:

A flowchart on when you pick someone up, this is what you need to do, this is who you need to ring. Can't get any more basic than that. It's actually on their app on their phones. It helps because you don't have to think. Or, if you're not sure. But also, that empowers them with some knowledge. That is really, really important for all our troops. If you're unsure, I'd much rather someone make a decision and stuff up than not make a decision and stuff up worse. That's really, really helpful. (Stakeholder 7)

Stakeholder 5 further reports that they had reduced risk by encouraging better processes by ensuring whānau/citizens were taken directly to the hospital to be assessed when experiencing mental distress. They worked hard on "changing mindsets" within police decision-making but also "pushed back" on mental health (DAO) requests for police assistance:

But in terms of the other partnership stuff, the problem for the DHB [now Te Whatu Ora] and mental health services, other than the moral thing of having people assessed in the right place, the fact that those people were in our cells to such a high number... It was actually taking work and stress off them. For us to change that balancing with people getting assessed in the right places based on their individual needs, that probably pushed a bit more stress onto them [...], but that was only because the managers saw this is what the legislation says, this is what the people need, but it's actually changed some of the behaviour of our staff.

I'm actually quite proud of that change we made because we were one of the worst districts, and now we're just about probably the best in that space, and that is not an overnight thing. That's not a send everyone an email; "hey, can you do it this way from now on?" That's changing practices that people have done since they walked into the police or since they walked into the CAT team and probably some real mindset stuff. I found that quite effective. (Stakeholder 5)

The above statement highlights the sustained effort required to shift practices and ways of working between police and mental health services from an entrenched culture that has developed around the Mental Health (Compulsory Assessment and Treatment Act (1992)). Mental health liaison stakeholders characterised their success in terms of their ongoing relational work within the police (e.g., custody, frontline, communications) and with health services (e.g., mental health crisis, acute units, ED).

Another example of mental health liaison self-led initiatives was the potential application of a prevention mindset to the problem of high mental health demand – identify the people and target deployment as suggested below:

So one thing that we haven't done in the Prevention First space is actually analyse who those people are and actually task it out. We had a burglar that was burgling two houses a week. A cop would be told "you're going to go catch this guy, and you're going to arrest him and put him in court." Well, we have mental health people doing the same amount of demand, but no one ever gets told right that you're going to own this person and work with their caregiver or check up on them. We don't use that same prevention mindset, and no one seems interested in actually getting involved in that. That is one of the key parts of prevention. First is actually seeing where we can have the greatest effect with our limited resources, who's actually in most need and target it with some targeted effort, and we have not done that in the mental health space. (Stakeholder 5)

One key stakeholder described how the development of a "spreadsheet" enabled tracking and surveillance of coded mental health events to identify persons involved in recurring police call-outs. This self-led initiative, in conjunction with mental health service, achieved the implementation of 'intervention plans' to guide frontline police and communications decision-making, illustrated in the following extracts from stakeholder 7:

For example, what I did every day I started – I look at the 1X, 1M, so that's the attempted suicides and the mentally impaired. I started a spreadsheet because after a few days, the same names kept popping up, and I was sitting there thinking, "hang on, let me, I'll check them... and I thought, no, we've got to make this easier." So, I started a spreadsheet where I'd do file number, name, ethnicity, and gender.

After a few days, you started looking at your repeats. Say we had 'Katie' who came through, and we've had. Actually, there's some stuff here, so then I'd get hold of the manager of specialist mental health. "Have you got a caseworker for her?" Because I'm very much about everyone swimming in their own lanes because we can't keep up with this mental health load that we've got. It works both ways, too. We had pretty much daily contact, or if they had an issue with someone, they would come to me. Things like if we had a high rate, once they presented the third time, I want an intervention plan. I want to know what we can do better so if we do pick up 'Katie' in the frontline, "what's the plan?"

What I sort of got into place was you either ring the mental health crisis line to find out whether they have a plan for Katie, and that plan could be close the door and walk away, and that is very, very hard for police to do that, but that's what we need to entrench in them, we're not mental health workers, we're not making that decision. [...] That plan would be to either leave her, call this case worker, or do whatever. (Stakeholder 7)

Further to the data and trends analyses generated from police systems, this key stakeholder illustrated how feedback loops played an important part in shifting practice at the frontline and in communications:

I liaise very closely - in comms, I said, "you've got this triage line, but you're not using it; you need to start using this because that affects our frontline." I've worked with him a lot, so I could be a little bit bolshy. And they did, and it really made a difference, but every few months, once again, they just needed that reminder or that validation that you're doing really, really well; always room for improvement, but I've noticed that there's been a decline, whichever it is, with that. That at the comms level is the number one thing they should be doing. (Stakeholder 7)

The key role of mental health liaison is to 'keep the wheels spinning' with mental health services capturing the image of machinery moving whānau/citizens through these systems. Mental health liaison dedicated roles pay attention to reducing demand and risk for police in the system by working to maintain clear pathways and 'demarcation lines' between police and mental health services.

The idea is that we don't bring mentally impaired people into the cells area. That's the last resort. Obviously, if there's an offending component and we've arrested them, that's where they go, but the first thing is a doctor's surgery, ED or hospital, a mental health facility. [...] Unless there's an offending component or we're charging someone, we don't need to bring them to our cells. We might do that in a detox. Any form of intoxication is not good enough for them [DAOs] to say, "No, we can't assess because they're drunk", but that's something we're working on with that. That's what it says in our Memorandum of Understanding. In that case, we would bring them to the cells for a detox. (Stakeholder 7)

As one stakeholder described it,

Sometimes we are the advocate.. [because] it's actually our job to go and deal with these whānau/citizens in times of crisis, [but a] mental health call to uplift - that's not our job". (Stakeholder 10)

Stakeholder 12 was a strong advocate for the limited use of police in responding to mental health-related events:

I just don't think the police should be – I don't think it's best for anybody concerned for police to be involved in mental health services. The only reason that we should be doing that is safeguarding life and property on a very, very short-term basis until those other services can get behind it and take over. It's not something that any of the people who are mentally disaffected want. They don't want to see us. (Stakeholder 12)

During discussions with stakeholders, it was highlighted that there are certain boundaries that the police must adhere to when responding to individuals experiencing mental distress. They argued that mental health professionals are trained in assessment and care, while frontline police officers use "common sense" understandings. Some illustrative extracts are provided to better explain this point.

When you're in crisis, and everything's going wrong, and you're massively stressed, the police turning up is just going to stress you more. What you need is a professional who knows how to talk to you and deal with you, how to calm you down and how to get you to square again, or understand the medication needs that you have if you have medication needs and things like that... Actually, we're bound by the legislation that says you have to get a DAO to come and see them or a doctor to assess them and those sorts of things. The first and foremost is the legislation that says that that's where and how it should happen. I'm going to throw this out there - the police are not a social service. We shouldn't be dealing with mentally disordered people other than to make sure that people are safe and to deal with those safety aspects, but we shouldn't be dealing with that otherwise. We're not trained for it. We're not the best for it. It doesn't do the best for their wellness. (Stakeholder 12)

I don't want my police officers trained in mental health. It's about dealing with people compassionately and empathetically and showing them respect. I rely more on those three attributes than I would on trying to train them for mental health. We've got doctors who are trained in mental health, and they can't assess everything. Getting some bloody policeman trying to do it, it's never going to work. (Stakeholder 6)

Stakeholders spoke to their frustration when 'clinical' criteria placed limitations on police being able to hand over care and responsibility of a person to mental health services, who then became perceived as a 'problem' for police. The following extract from a key stakeholder focus group illustrates the frustration this creates for frontline police officers, confirming the findings in the case studies:

"They're not in psychosis. It's behavioural." It would be kind of nice if you just dealt with them as opposed to leaving it with us or making it our problem. (Stakeholder 6)

And we don't understand that attitude either around not my problem, because everything's our problem. Any sort of problem. We do whatever's required at the time of any sort of crisis or emergency. That's what we do. (Stakeholder 5)

We walk into a room, and people expect us to solve their problems. That's what it is. We've got a problem; you can solve it. "How am I going to do that?" (Stakeholder 6)

They think we've got all the answers, eh? As you've found out today, we don't have any of them. We have no idea. We just play it by ear and make it up as we go along. (Stakeholder 5)

You just think about the people, and you think about what you need to achieve to get the best outcome for everybody and you try and make it happen. (Stakeholder 6)

Stakeholders involved in mental health liaison have tried to understand how to better support whānau/ citizens experiencing distress but often find specialist assessment skills narrow parameters for compulsory assessment and admission for those deemed "mentally disordered", which is also bound by the Mental Health (Compulsory Assessment and Treatment) Act (1992)'s legal definitions for compulsory care:

They have said to me before - that just because someone is suicidal, that doesn't automatically mean that we can call them mentally disordered. There have, at times, been very difficult conversations between custody sergeants and staff and emergency psychiatric services who would say, and we would say inappropriately, made a call that they're not going to come and assess someone. Or that because alcohol is involved, then that precludes them from making an assessment, or whatever it might be or that something is behaviour or whatever it might be. (Stakeholder 11)

In some districts, stakeholders reported different interpretations of mental health legislation, creating tension between police and mental health services:

Sometimes, there is combativeness between mental health staff and police staff. Mental health staff are leaning on the Act, saying this is how we see it, and actually, we see the Act a different way. We think we're right, and they think that they're right, and that can lead to some quite robust discussions at times. (Stakeholder 4)

In some cases, stakeholders explained that mental health professionals were using the Act in ways that were not intended, causing issues to arise. There was a perception that mental health services do not respond as early as they could within 6 hour timeframe to assess people detained by police. Another example was calling for police assistance to transport 'patients' on Community Treatment Orders to hospitals for injections. As previously mentioned, stakeholders considered police mental health liaison meetings to be crucial in problem-solving and resolving individual situations that may arise in practice:

That's one of the points of friction for me, though, because they're in our care, they provide them a lower priority because we're looking after them. It's not our job to look after them, and it takes a lot of my people to look after one person. Our role must still solely be what the Mental Health Act was, I think, intended for. One, the person who's absolutely in crisis in the public, so in a plaza now, and someone just rings up and says, right, this guy is just off his nut, you better come. So, we go there, and we pick that person up, and we take them to the service that's provided. Or the occasion where the health worker goes out to Ross's home because Ross needs his medication or Ross needs to be assessed for whatever, and Ross refuses to answer, or Ross won't let them in, okay, then they ask for the police to come along. Or they get there, and Ross has got to come, and they need someone to help get Ross. Our role is not to care. We care, but we're not carers if that makes sense. (Stakeholder 6)

As reported in the case study section, police will sometimes be frustrated in the context of competing priorities and a queue of assigned jobs, and police experience waiting for up to 6 hours for a DAO to arrive:

The times when that will become an area of tension is when there's high demand for other policing services and so we don't get there quickly. So that's an area of tension, and when we perceive that that might be abused, around "oh we don't want to put them in our car or we don't have other transport to get us there, we don't want to get a taxi, so why don't we just call the police and get them to come to do that?" There probably is a little bit of that that happens, but again, we'll raise that at the meeting. That's the whole idea behind that meeting. (Stakeholder 12)

There was a strong opposition to holding whānau/citizens in custody. A fundamental area of risk highlighted by stakeholders was police resourcing in the context of whānau/citizens in distress detained in custody. If police are constantly observing persons in cells, that is one less officer out in the community:

If they've come in and made genuine attempts to hurt themselves or commit suicide, they'll be on constant monitoring, so someone will be sitting on the other side of the glass watching them 24/7. Depending on which officer comes into do that depends on how that interaction goes, but you're generally just trying to talk to them and remove any issues that they have just by talking to them. That's kind of our only option, really, until the crisis team gets here. (Stakeholder 2)

While most stakeholders agreed that cells were not the right places for whānau/citizens in mental distress, some considered cells had to be used in the absence of alternative options:

No, police cells just aren't the place for them. They never should be the place for them. It doesn't do anything for their wellness. The only thing it does is secure safety for the community and for their victims or the person they're obsessed with or the person they've just been trying to assault or the ethnic minority that they target or things like that, that type of thing. But otherwise, no, I don't think at any time someone should be in the cells without having had some intervention from mental health services. (Stakeholder 12)

Frustration was expressed often when speaking about the use of cells, which largely revolved around the resourcing of police to do a job they do not think is theirs to do and that this is not the right place for whānau/citizens with health issues:

Stakeholder 22, noted that other health staff were reported to be misinformed about the law and have occasionally asked officers to hold whānau/citizens down for an injection of a sedative, and newer frontline police officers did not know that this was the incorrect use of force. Issues were also described by stakeholders regarding the context of mental health services use of police under the Act to enforce treatment for whānau/citizens under community compulsory treatment orders:

Effectively, they're managed by the community mental health team. Some of them have to have their [medication] once a week, fortnightly, monthly. Out of that 80, we've got about 11 that are generally non-compliant, and they won't turn up for appointments, so the mental health unit has to get warrants. Those warrants come to us, and then we go and play taxi and pick those people up nine times out of ten and take them back to the unit so that they get their injection. There's a lot of work around that. (Stakeholders 2)

As suggested in the first theme of preventative measures, this involved constant boundary work and strong views on where prevention starts and ends in mental health-related events. Various factors were described as impacting how police respond to events involving whānau/citizens needing mental health assessment. These include responsiveness of mental health services, different interpretations of legislation, and availability of appropriate places for mental health assessment.

Vision for improving the current system

Under this final theme, we bring together the suggestions by stakeholders to improve the role of police in responding to mental health-related events. Some of what is reported here builds on the above presentation, so we briefly summarise suggestions below to avoid repetition. Overall, this theme illustrates stakeholders' views on strengthening Prevention First practices to support police and citizens.

- Resourcing facilities and workforce in mental health and addiction systems. Many of the solutions stakeholders suggested are outside of the control of New Zealand Police. Often, discussions revolved around resources, such as mental health services across primary, community and secondary care. The need for a preventative focus across sectors was also reported as a core solution. If this vision could be achieved, police would see less of a role in responding to mental health events:

We're never going to have enough beds because of the way we're continuing to deal with mental health. We need to actually go back into the primary care and start dealing with 'Ross' when he's starting to escalate when the families ring and say he's changed. "Oh, he'll be all right. Just take his medication." That's not enough. It's got to be back here at primary care where we can do something for "Ross and get him into whatever you want to call it. Get him just to manage himself. (Stakeholder 6)

- Acknowledgement police bring their personal background and life experiences. Stakeholders reported that aligning their values to their police service/roles was described as a strength in several ways. It was suggested that there could be more acknowledgement of strengths made visible by police, bringing to the fore support that exists in belonging to a community (geographic and cultural). Acknowledgement is closely related to recruitment - the sense that people entering the police force with 'life experience' can bring and translate skills from previous jobs or training. This range of experiences is recognised, even sought after, by police. This includes police being Māori or female as well as growing up and living in the community they serve:

Being from here has helped immeasurably, actually. I think it probably stopped me from getting hurt a few times because people recognise you. People probably tell me that they wouldn't normally talk to the police sometimes, too. I suppose you feel a bit more affinity to a place, so this is home. Some people in police bounce around quite a lot. ...I've only ever really been here, which in some ways confines my way of thinking, but in other ways... There was a sort of theory once upon a time that they didn't want you to police where you grew up in case you had too many conflicts of interest, but I suppose it's how you operate. Anyone who knew me knew I was never going to break any rules for anybody else, so I never had a problem back there, really. ... It used to be they wanted people with life experience; now they say they want empty vessels, but really it's to do with pay. You can pay a 20-year-old not very much. It's very different. (Stakeholder 5)

- Recruitment messages and College training reflect the reality of the work. According to stakeholders, frontline policing involves dealing with a high volume of family harm and violence related to mental health emergencies. This contrasts with what some newcomers may expect, such as chasing burglars and cars. Some stakeholders believe that more emphasis should be placed on the reality of police work, particularly at the frontline. Most people join the police force to help others and want to solve problems with a 'can-do' attitude, including preventing harm to people and property by catching criminals. While this view aligned with a strong sense of moral duty of care, for most, it stopped short of extending the police role beyond crisis/mental health events, as in "We care, but we're not carers" (Stakeholder 5).
- Strategies and techniques for good interpersonal interactions – listening is more important than talking. Stakeholders described strategies that could be shared as examples of good personal interactions for frontline police officers. Examples shared with us included finding something to comment on (e.g., comparing tattoos) and starting a conversation to relate and connect with the person. Just speaking calmly with whānau/citizens as normal "human beings" and meeting them at their level. One participant gave an example of when in the role of police negotiation using a small crane to be hoisted up to a girl on the roof of a building to engage at the same level (stakeholder 6).

Stakeholders emphasised police communication skills, empathy for whānau/citizens (spoken of as not unique to policing) and listening as more important than talking:

I just talk to him like a normal human being. Sometimes that decreases his attitude and behaviours. [...] I kind of realised that neither of us would benefit from me getting angry with them because they're often in a place where they can't understand why they're there, and they can't reason to get back to normality. For me, it's being really calm with them and just talking to them normally. That's kind of how I approach things. (Stakeholder 2)

- Essential negotiation skills training. Negotiation skills and strategy were urged as the basis for a structured nationwide training programme across all localities for up to 10,000 "frontline police as part of the tactical response model" (stakeholder 13). The other aspect of negotiation skills training was an emphasis on the integration of these practices into day-to-day problem-solving and in the operations of frontline teams and communications teams. Stakeholder 13 argued that this would reduce the domination of tactical options (use or force/show of force) in crisis responses escalated to specialist teams:

It would be good if everyone could do that rather than the 100 negotiators there are throughout the country because inevitably, as with AOS, we're never in the right place. We just come afterwards and support cops that have to deal with it for a start. One of the things we're looking at is increasing everyone's skill level. (Stakeholder 13)

- Education and/or training on pre-contextualisation of situations, unconscious bias and racism. While frontline police officers learn by osmosis, adapting their strategies and techniques based on these on-the-job experiences, this should not limit appropriate 1M and 1X attitudes and responses. Feedback data to identify trends or patterns in police responses at a systemic level provided further opportunities for exploring ways to improve strategies:

I think another part of that is when you go into... it doesn't take very long, a few months, to experience quite a wide range of experiences in terms of mental health, family harm, burglars, armed offenders, car chases, whatever the case might be, disorder, on the frontline. Within a year or two, people do develop stereotypes, either the culture of what they'll walk into in terms of that team or what they start to perceive. A job comes in, it's a 1X job or 1M job, and it may straight be put in a box as to what we encounter. It's just human nature. It's very hard to go, right? I'm not going to make any judgment here; "I'll just go to the job, and I'll see what happens because you would have been told it relates to mental health." You should be told that, too, because you need to be situationally aware as to how you're going to deal with that problem or the issue. The sad thing is that maybe there may be some of us that put people into stereotypes, and therefore, maybe the compassion of seeing the person as a person is lost at times... There's been some training that is going to come out as a package on unconscious bias. That will be very helpful in understanding the reasons why we may act the way we do. There's the statistic may be that non-Māori receive more warnings than Māori, so we need to dig a bit deeper to see what is actually occurring for this to happen. (Stakeholder 1)

- Education and/or training on mental distress and responses. Stakeholders reported benefits of in-service education or workshop sessions between police and mental health service teams, aimed to foster understanding about common interests and objectives and constraints, and how to achieve better outcomes for whānau/citizens. However, these kinds of education/training sessions were ad-hoc. A "big area" for education and training was knowledge related to ways of approaching, engaging, or dealing with whānau/citizens police encountered in public who appeared to be 'unwell'. The language of "mental health issue" was used as an umbrella term for substance and/or addiction or myriad of disorderly behaviours:

[Police] College don't realise how often you're dealing with people who have got mental health issues out on the street. It's probably –some days it would be 50, 60% of our job dealing with people who have got some kind of mental health issue. (Stakeholder 2)

The two suggestions above on education/training intersected, with implications that education/training could source holistic Te Ao Māori values, lived experience expertise and knowledge as well as traditional medical/psychological framings to create meanings of mental health and wellbeing.

- Digital access to plans and tools is useful to help frontline police decision-making. Stakeholders commented on the usefulness of 'plans' developed by/in conjunction with mental health services to support police dealing with recurring incidents involving whānau/citizens who are known to mental health and addiction services for specific behaviours (although this was a shorthand characterisation of 'attention seeking behaviour' which is stigmatising language in the context of incidents where police were advised not to respond to repeated requests for police engagement). Access to digital tools on the 'frontline' that provide a wide range of information about social services and communication tips was described as essential for supporting frontline staff, such as the Check Point App and the AHWI App used across districts. Stakeholders responsible for the supervision of frontline teams also spoke of devices set up with e-documents that enable 'paperwork' submission only once required fields in forms are completed. Pre-formatted documentation used for family harm and road policing events would also be useful for mental health events. The value to stakeholders was that these kinds of plans and tools seemed to provide assurance police are doing the right thing for whānau/citizens while minimising risk in police exercising judgment calls. These comments are incongruous with other attempts by frontline police officers to not predetermine a response based on information. This suggests an operational tension between responding to the volume of intake of calls and, at the same time, supporting frontline police to make good decisions under pressure.
- Supporting the mental wellbeing of police. Stakeholders described providing support to colleagues through talking together informally. Access to the police welfare team, a self-referral, for psychology support, was more actively encouraged to staff by some supervisors than others. More structured support was offered in the form of "hot debriefs" straight after a firearms or fatal incident response. There was a sense that these mandatory, routine referrals for psychological support following incidents were recognised as important for the police's own mental well-being and carried little negative connotations or stigma. However, the cumulative negative impact on police witnessing harm over time is suggested as an area for more attention:

I think we're probably quite poor in looking after our own mental health [...] it's very "you'll be right, mate, just go and have some days off, you'll be fine." [...] I don't think it's even those really big things. It's just the little stuff that we're accumulatively going to and have no ability to deal with because we're seeing shit that actually we shouldn't be, and we're having to deal with it. That just builds up, and then boom. (Stakeholder 2)

Leading by example was seen to be important. Stakeholders with supervision responsibilities spoke of showing how they look after their own mental health, such as an example of a supervisor encouraging an officer to have a session with a psychologist in a glass-walled office so openly modelling this type of support to their peers. Other examples were making express acknowledgement in shift meetings that police have their own stressors and pressures (e.g. COVID context and consequences) and frequent, general reminders about where to get internal support. Hence, stakeholders overall spoke of feeling well-supported by senior leadership in their roles, who understood the stressors.

- Localised solutions for partnerships with mental health and social services. Stakeholders had conflicting opinions on co-response police, mental health, and ambulance teams in different regions. The extracts below suggested the need for tailored solutions and arrangements between police and mental health across districts:

Wellington's great because it's so central and it's very metropolitan, but most of New Zealand is actually like farmland, massive distances. Co-response? – nothing. (Stakeholder 5)

For us, if I had a choice between the co-response and the DAO, I'd stick with the DAO in the custody suite because that's their expertise... If I had a choice, I'd like both, but if I had a choice, definitely keep the DAOs. (Stakeholder 7)

Look, I think that's probably the best thing since sliced bread from what I've seen from a police officer, ambo and mental health response point of view. I've got all the stuff around

that, and we've had discussions with my boss up here and the CEO of [location removed] District Health Board [now Te Whatu Ora]. They're keen on it, but to be fair, I see that as a way forward, certainly around that crisis response through 1X, 1M that we're getting called to, which will take a hell of a lot of pressure off our frontline staff. I think it'll also pipeline people who need help better into the mental health system. (Stakeholder 2)

In contrast, another stakeholder expressed scepticism about whether police would want to work within a co-response model because some officers see mental health as not part of their role:

The first reaction to that is a lot of our staff aren't here because they want to deal with mental health issues all the time. [...] That will be quite difficult, I think, because you'd have the team go somewhere, and the police will be going, "yeah, let's just get on, chuck them in and let's get going", and the clinician or whoever it is that's in there will be saying, "well hang on, we've got family here, let's sit down and discuss this and try and understand." I think there'll be some difficulties... I don't know if the mental health workers would feel the same as us, but I think some of our staff would be; "I don't want to do that. That's not something I want to do. I don't want to be dealing with this all the time, and if I'm going to be working with other people, I want them to be cops." I would suggest that mental health services would probably have quite a similar view; "we don't want to work with cops; they're all thugs." (Stakeholder 12)

Summary

In this section, we have summarised the viewpoints of police stakeholders on effective practices and challenges encountered while dealing with mental health-related events and implementing Prevention First. The section was divided into four themes: measures to prevent mental distress, building relationships with Māori and external partners, boundary work with mental health services and visions for improving the current system. Overall, this section has shown how police across Aotearoa New Zealand understand the application of Prevention First during mental health-related events and has highlighted the structural factors that limit their ability to achieve positive outcomes.

Part 4 | Bringing it together

In this final section of the report, we aim to summarise the findings from the whānau/citizen and police experience parts of this project. We highlight the similarities and differences between the experiences of whānau/citizens and police officers. We focus on the issue of trauma and suggest that the New Zealand Police must adopt a trauma-informed approach across their organisation and how they respond to the community. The section concludes with a set of critical actions to improve police responses to mental health-related events while also emphasising the ultimate goal of shifting to mental health and social-led responses.

The significance of trauma

Through the stories shared by whānau/citizens, it became evident that they attributed their experiences of mental distress to trauma. Trauma was described as the result of multiple, severe, and sustained traumatic events, circumstances, or experiences that occurred from childhood through to adulthood. It was important for the police to recognise the value of trauma-informed approaches that focus on acknowledging what has happened to someone rather than trying to identify what is wrong with someone.

Remember that when you are talking to someone in distress, you are talking to all their trauma. The trauma of their parents, of their ancestors. In particular, Māori are still experiencing the impacts of colonisation and their inter-generational trauma. Shift from asking what is wrong with this person, to what has happened to this person. In doing that, you remove the judgement and allow this person to express their hurt. — Ana

We also heard stories of intergenerational and collective experiences of trauma, which are often overlooked in Westernised trauma-informed approaches (Pihama & Smith, 2023). For Māori, a trauma-informed approach considers the importance of the wider community, including whānau, hapū, iwi, and hāpori. It also acknowledges intergenerational and historical trauma and interlocking impacts of ongoing colonisation. It incorporates a te ao Māori worldview and Māori healing concepts and practices (Abuse in State Care & Royal Commission of Inquiry, 2023).

Trauma-informed care is a compassionate approach that aims to help individuals thrive. It prioritises treating whānau/citizens with kindness, humanity, compassion, dignity, respect, and generosity whilst upholding their mana. The relationship between whānau/citizens and those supporting them is critical for whānau healing. These relationships can foster safety, security, hope, and trust. Trauma-informed care also respects the autonomy of whānau. It creates opportunities for them to feel empowered to make their own decisions about their lives and livelihoods (Abuse in State Care & Royal Commission of Inquiry, 2023).

A humanistic response

The study found that when frontline police officers took a humanistic approach, it resulted in a positive experience for many participants. Many officers described their approaches to mental health-related events as similar to the humanism participants found helpful. Therefore, the study provides examples from both police and whānau/citizens about what a humanistic response may look like and the consequences when this approach does not happen. This research found the following fundamental principles were imperative for frontline police officers to follow while interacting with whānau/citizens:

- 1. Connection:** including connection existing by history, family, friends, ethnicity, age, and gender; attempts by police to make connections with whānau/citizens; and whānau/citizens having an opportunity to speak and police actively listening to that. Barriers to connection include the power imbalance and uniform (“padded up; all their gear”), boundaries, lack of communication, whānau/citizens being ignored, and lack of engagement.
- 2. Respect and genuine concern:** including respect for human dignity – an overarching theme whānau/citizens express regarding how they should be treated during humanistic engagement. Whānau/

citizens believed they had the fundamental right to be treated with respect and dignity. This related to the total engagement process from when the interaction commenced to when it ended. This value placed on respect and dignity was best reflected in descriptions of interactions when whānau/citizens felt humiliated. In these situations, the feeling of being made fun of was prominent. This theme also included genuine concern – responding and resolving situations in a positive and empowering manner for the whānau/citizens involved. This was often observed when the police went out of their way (beyond the call of duty) to assist. In contrast, a lack of genuine concern leaves whānau/citizens with no control over their situation and highly vulnerable, leading to the blame being put back on them.

3. Information provision: Police officers should communicate clearly with whānau/citizens about what will happen during the interaction and keep them updated throughout the process. They should provide information about where to access help and inform citizens about what they will do and when they have done it.

We have used the term humanistic engagement, an applicable concept grounded in everyday language and the voices of both whānau/citizens and police officers. We also acknowledge strong connections to procedural justice (which could have been equally used). These humanistic principles are specific, tangible concepts. However, not all frontline police officers felt their humanistic responses were adequate for mental health-related events. Instead, they described the need for better training or for other specialised clinicians to lead responses. While the findings support both these propositions, based on the whānau/citizen stories, frontline police officers should be encouraged to respond according to the fundamental principles of a humanistic response.

I had a big male police officer on either side of me, holding me by my arms. Now they're walking me down to an observation room, and it was the absolute lowest moment of my life. And they said, "This is your moment", as if we were walking down, you know, a red carpet to the Oscars. The officers' comment, made in apparent jest, affected me profoundly. — Kelly

Default responders

Content analysis of calls showed that police are being used as a primary and/or default mental health and social support service. Many calls, however, were assessed by the research team as not necessarily requiring police attendance and, instead, could have been led by a health or social service. The Earlier Mental Health Triage line did not appear to be used in any calls and warrants further exploration.

In the case studies, frontline police officers confirmed that they were often relied upon as the primary or default mental health and social support service. They expressed frustration with systematic issues, such as the chronic underfunding of mental health services and being forced to fill the gaps. They described a self-fulfilling prophecy, where police officers feel a moral obligation to attend events always, therefore, perpetuating the demand cycle.

*I think as police, we're go-getters. We like being out there, we like going to jobs, we like helping people. So, in some respects, we may do ourselves a disservice because we know that no one else is there to help them. Because that's our personality trait, we want to help... We probably do ourselves a disservice at times by filling that gap.
(CANT, Frontline police officer 5)*

While sympathetic to the resource constraints of mental health and more comprehensive community services, senior officers interviewed nationally described challenges in effective collaboration with mental health services.

Bias, racism and criminalisation

Content analysis of calls indicated that many calls coded 1M have a mental health component. Still, it is often incidental to the call's primary purpose, which is often a social issue. In these instances, it was unclear why the call was coded 1M. Frontline police officers also spoke about the wide range of events that are coded 1M and the need to refrain from pre-judgement continually.

However, there were examples of biased, racist and discriminatory pre-judgements (pre-textuality), of whānau/citizen, which then shaped how frontline police officers responded. A diverse police service was considered as one way to reduce pre-judgements. Diversity was also regarded as key to supporting connections between police and citizens, emphasising the importance of this as a core value for New Zealand Police. Some frontline police officers expressed conflict between the concepts of treating whānau/citizens equally and responding in equitable ways based on individual needs. Treating whānau/citizens equally applies to not acting unfairly e.g. nobody should be treated unfairly. However, to treat whānau/citizens responsively in an equitable way, there may be a need to treat whānau/citizens differently, and part of that is being responsive to connecting with whānau/citizens through diversity.

Sometimes, they will hear the whānau name and pre-judge that person and family, rather than appreciate the why behind the offending... "Oh, that whānau again." Sometimes, having that background information can be just what they need to hear to approach it differently. Sometimes, you have to say, "Cut it out!" (BOP, Frontline police officer 13)

As the number of calls coded 1M/1X has increased, there appears to be immense frustration among frontline police officers. This frustration may contribute to bias and is particularly evident when officers receive repeated callouts to the same individuals, sometimes derogatorily referred to as 'frequent fliers'. Frontline police officers described these individuals as stuck in repeating cycles due to a lack of follow-up or regular engagement with mental health or social services. Frontline police officers have explained that many of these whānau/citizens have been diagnosed by mental health professionals as having "behavioural issues" that do not require a clinical or, sometimes, police response. The multiple instances of engagement were precious in terms of whānau/citizens being able to compare and contrast different experiences that they had had.

The fact that most participants have recovered (however that may be defined by them) reflects that recovery is not only possible - it is probable. Appreciating the importance of responding to whānau/citizens each time they call because of the risk of harm is essential, but it is also about promoting recovery. Each positive and supportive engagement can contribute to a person's recovery.

The topic of criminalisation emerged as a dominant theme during the research. This included the use of police cars, handcuffs, cells, and dogs, which whānau/citizens felt should not be used on individuals who are unwell and have not committed any illegal activity. This theme was so strong that it was decided to separate it out as an individual theme. Whānau/citizens were concerned about how they would be perceived if they were treated in such a manner by the police. For many, experiencing mental distress while encountering police is an emotional and life-altering experience. Even though it happened in the past, treating whānau/citizens in an impersonal way or criminalising their distress can worsen their trauma and further harm their trust and confidence in the police.

After a negative encounter with the police, whānau/citizens have expressed their fear of future engagements not only when experiencing mental distress but also in other situations, such as reporting a crime. This fear originates from the belief that they may face similar negative experiences in the future. This is a concerning issue, particularly considering that individuals who experience mental distress are especially vulnerable to being victimised. To address this, a proactive approach to restoring a person's mana using hohou te rongo or restorative practices in a calm and respectful way so that people in mental distress can, in that moment, feel seen and heard and therefore validated. Using these approaches can increase trust and rapport and strengthen ongoing engagement or future interactions without further

traumatising the whānau/citizen. Such approaches are growing in healthcare settings when things go wrong (see <https://www.hqsc.govt.nz/our-work/system-safety/healing-learning-and-improving-from-harm-policy/restorative-practice-and-hohou-te-rongo/>).

Frontline police officers have expressed their concerns about the potential criminalisation and harm that may arise from their use of cells for detainment and their police powers in mental health-related events. Many officers acknowledge that they are not always the right people to respond to such situations and that their actions may create harmful experiences. They also explained that they often find themselves working in a 'grey zone' where they are faced with either 'arresting' or 'doing nothing', even though they know neither option is the right thing to do. The police talked about their frustration, disheartenment, and moral distress. Some of them experienced disheartenment regarding the current system-wide limitations in dealing with mental health incidents and feeling unable to fulfil their duties as police officers and provide the necessary assistance to those in need.

When officers use a humanistic approach, they can minimise experiences of discrimination and criminalisation and reduce further traumatisation.

The lady talked to me, and she asked me what happened. We sat and talked. I felt as if I was a person. It wasn't like I was a criminal. Or a non-person, they treated me like a person. And not even a person who was unwell. They just treated me like a person. — Annie

Alternative ways of working

We received feedback from police officers across the country that when agencies collaborate and cooperate, it can lead to positive outcomes for the community and the police, provided they are well-resourced. Some examples of such collaboration include sharing information, creating health-led safety plans, making referrals easy, maintaining regular communication, and building meaningful partnerships with health and community providers. Officers have also suggested alternative approaches and defined the role of police in responding to mental health-related events. Many of these solutions may lie outside of New Zealand Police and sit with mental health and/or social agencies.

The range of Ideas from police officers included:

- Co-response models such as that trialled in Wellington, particularly for 1X (threatens/attempts suicide) coded call-outs that may require a police presence to ensure safety.
- Increased community policing initiatives, such as the Neighbourhood Policing Team in Canterbury or Family Violence Intervention teams, to enhance prevention.
- Development of 24/7 safe health triaging spaces to take whānau/citizens to as an alternative to specialist mental services. This idea connected strongly with the concept of police as referrers only, with less involvement in continued responding.
- Enhanced promotion and professional development of de-escalation, conflict resolution and non-lethal strategies among all police districts.
- More opportunities for health and police professionals to train and learn together.
- The introduction of a mental health worker or peer navigator embedded within the police station.

With each of these ideas, there are risks to consider when reflecting on the whānau/citizen stories and broader literature. The criminalisation experienced by whānau/citizens in this study may be exacerbated when mental health/social support approaches are integrated into police spaces, or if police are a routine part of multiagency responses. Most studies have also indicated the requirement for careful consideration of alternative approaches or models, with robust research as to their effectiveness for all parties (see context section p. xx). We also observed the benefits of not imposing blanket nationwide initiatives, with our research findings suggesting the need to consider partnering with community organisations to prioritise localised solutions.

Recommendations

We recommend that the New Zealand Police proactively work to transition from police-led responses to mental health/social-led responses to both 1M and 1X events. This would require re-thinking emergency responses to mental health-related crisis events, as well as the common occurrence of welfare checks related to 1M coded events. Acknowledging this will require significant planning, resource distribution and cross-sector cultural change, we propose the following immediate improvements for police responses:

1. Consider adopting a trauma-informed model to support frontline police officers to engage and respond to whānau/citizens with experience of mental distress and, more generally.
2. Reaffirm a trauma-informed humanistic response at a policy level, given that it correlates with Prevention First and New Zealand Police values (PRIMED) and aligns with whānau/citizens' needs.
3. Conduct focused research to determine why the Earlier Mental Health Response triage line is not working and consider if 111 Communications could implement a direct mental health option.
4. Consider increasing the visibility of Prevention First approaches to mental health events at different levels of police, from recruitment to The Royal New Zealand Police College's training and ongoing district work programmes. This should include real-world exemplars of strategies and techniques that illustrate 'good' personal interaction in alignment with a trauma-informed humanistic response.
5. Endorsement and investment from the national level to further support district-led initiatives with partners and iwi, including:
 - Advocacy to bolster investment in community-based services (e.g. Kaupapa Māori and/or NGO community providers) to improve district capacity and options for social support of whānau/citizens.
 - Consider rethinking the rotation policy: rather, create permanent leadership roles in Mental Health Liaison and Prevention Management to strengthen consistent and sustainable partnerships.
6. Emphasise and reassure frontline police officers that humanistic responses are of value and assistance to whānau/citizens
7. Proactively counter bias, racism, and discrimination and amplify trauma-informed humanistic approaches through the implementation at The Royal New Zealand Police College's initial training and nationwide through continuous training in police districts focused on:
 - Te Ao Māori and tikanga, including space to build stronger community relationships and partnerships.
 - Racism, stereotyping, and bias to assist frontline police officers in supporting diverse whānau/citizens who may or may not experience mental distress.
 - Practical negotiation skills and trauma-informed humanistic approaches, including through a Te Ao Māori worldview.
 - A humanistic response to distress (including the avoidance of criminalisation and pre-textualisation).
8. Continue to diversify the police service, emphasising various lived experiences, genders, sexuality and cultural backgrounds to contribute positive connections and understanding.
9. Consider proactively applying a restorative approach to debriefing processes when things go wrong during a police and whānau/ citizen/community interaction.
10. Consider cultural and professional supervision and compassion fatigue training to support the mental well-being of police.

Abbreviations and Te Reo Māori Glossary

105	Non-emergency call number in Aotearoa New Zealand
111	Emergency calls in Aotearoa New Zealand are made by calling 111
1M	Police event code - mental health
1X	Police event code - threatens/attempts suicide
A&E	Accident and Emergency
AOD	Alcohol and Other Drug
AOS	Armed Offenders Squad
AWHI	Alternative Ways for Help Interventions
AWOCA	Police communication tool: Asking, Why, Options, Confirming, Acting
BHERD	Behavioural Health Emergency Response Division program
BOP	Bay of Plenty Police District
CAHOOTS	Crisis Assistance Helping Out On The Streets
CALL	Community Assistance and Life Liaison model
CANT	Canterbury Police District
CAT	Community Assessment Team
CEO	Chief Executive Officer
CIT	Crisis Intervention Team
CIMD	Citizen in mental distress
CM	Counties Manukau Police District
CRT	Co-response Team
CRU	Crisis Response Unit
DAO	Duly Authorised Officer
DHB	District Health Board
ED	Emergency Department
EMHT	Earlier Mental Health Triage
GP	General Practitioner
IPCA	Independent Police Conduct Authority
MoU	Memorandum of Understanding
MPES	Māori, Pacific and Ethnic Services
MSD	Ministry of Social Development
NGO	Non-Government Organisation
NPT	Neighbourhood Policing Team
PST	Police Safety Team
PRIMED	Police values: Professionalism, Respect, Integrity, Māori and Te Tiriti o Waitangi, Empathy, and Diversity
SCRT	Street Crisis Response Team
UK	United Kingdom
US	United States
WINZ	Work and Income New Zealand

Te Reo Māori (Māori language)

Aotearoa	New Zealand, first used for the North Island only, usually translated as 'the land of the long white cloud'
Hapori	community
hapū	kinship group, sub-tribe, to be pregnant
hauora	health, wellbeing, vigour, the breath of the spirit of life

iwi extended kinship group, tribe, nation, the largest socio-political units in NZ Māori society, bone
 Kāinga Ora Homes and Communities, Government agency
 kanohi ki te kanohi face to face, in person
 karakia incantations and prayer used to invoke spiritual guidance and protection
 karakia whakamutunga closing prayer
 kaumātua Māori elder of either gender, respected for their tribal knowledge and experience
 kaupapa principles and ideas used as a basis for action, central purpose, initiative, issue
 kia ora hello, be well
 kōrero speak, talk, a meeting to discuss something
 Koro an elderly Māori man
 Ko wai koe? Nō hea koe? Who are you? Where do you come from?
 Kuia an elderly Māori woman
 Mahi work
 mana prestige, status, authority, control
 manaakitanga show respect, kindness, hospitality, support
 Māori Indigenous peoples of Aotearoa New Zealand
 Māoritanga Māori culture, traditions, and way of life
 marae a sacred place in Māori culture, the marae refers to the whole complex
 Oranga Tamariki Ministry for Children
 Pākehā non-Māori European, white New Zealander
 Pono be true, valid, honest
 rangatahi to be young, youth, younger generation
 tāne male, man, husband
 tangihanga the enduring Māori ceremony for mourning someone who has died
 taonga treasured possession, cultural item, anything precious
 te ao Māori Māori worldviews that acknowledge the interconnectedness and interrelationship of all
 living and non-living things
 Te Pae Oranga Iwi Community panels, to talk, listen and become well
 te reo the Māori language
 Te Tiriti o Waitangi The founding document between Māori and the Crown signed in 1840
 Te Whatu Ora Health New Zealand, Government agency
 tika to be correct, right
 tikanga protocol, the customary system of values and practices
 tūpuna ancestors
 urupā a cemetery or burial site
 wahine woman
 wāhine women
 waiata song
 whakapapa genealogy, lineage, layers of descent
 Whakarongorau Aotearoa New Zealand Telehealth Services
 whakawhanaungatanga process of establishing relationships
 whanaunga relatives, blood relations
 whanaungatanga relationship, a sense of family connection
 Whānau ora A culturally grounded approach to improving the wellbeing of Māori families while
 addressing individual needs
 whāngai to nourish, the Māori tradition of children being raised by someone other than their birth
 parents, usually a relative
 whenua land, placenta

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Appendix One: Summary of overall analysis of calls to the Police Emergency Communications Centres

Table 1. Call location, day of week and time of day

Location	1M coded calls (n=35)		1X coded calls (n=35)	
	<i>n</i>	%	<i>n</i>	%
Auckland City	8	23	5	14
Bay of Plenty	5	14	4	11
Canterbury	4	11	5	14
Central	2	6	6	17
Eastern	0	0	2	6
Northland	2	6	3	9
Southern	1	3	0	0
Tasman	5	14	1	3
Waikato	4	11	3	9
Waitemata	2	6	2	6
Wellington	2	6	4	11
Day of week				
	<i>n</i>	%	<i>n</i>	%
Monday	6	17	8	23
Tuesday	5	14	2	6
Wednesday	5	14	5	14
Thursday	2	6	6	17
Friday	2	6	6	17
Saturday	5	14	2	6
Sunday	10	29	6	17
Time of the day				
	<i>n</i>	%	<i>n</i>	%
Morning AM (0600-1200)	9	26	6	17
Afternoon PM (1201-1800)	11	31	13	37
Evening PM (1801-1200)	11	31	8	23
Night AM (1201-0600)	4	11	8	23
Duration of call				
	<i>n</i>	%	<i>n</i>	%
< 1 minute	1	3	1	3
1-3 minutes	4	11	0	0
3.1-5 minutes	15	43	9	26
5.1-7 minutes	2	6	6	17
7.1-9 minutes	6	17	6	17
9.1-11 minutes	1	3	5	14
11.1-13 minutes	3	9	2	6
13-15 minutes	0	0	3	9
15.1-17	1	3	1	3
> 17.1	2	6	2	6

Table 2. Details of the caller

	1M (n=35)		1X (n=35)	
	<i>n</i>	%	<i>n</i>	%
Who is the caller?				
The caller is at the centre of the incident	21	60	5	14
Professional	5	14	13	37
Whānau, family, friend	8	23	17	49
Member of public	1	3	0	0

Table 3. Verbalised indications of drug use, addiction, medical or mental health issues

	Drug use	Addiction	Medical	Mental health
1M	6	1	3	22
1X	6	3	5	31

Table 4. Verbalised indications of history with services, presence of weapons/violence and expressions of self-harm or suicidality

	1M (n=35)		1X (n=35)	
	<i>n</i>	%	<i>n</i>	%
History with services				
With police	9	26	6	17
With mental health services	9	26	17	49
Presence of violence and weapons				
Violence	12	34	2	6
Weapons	2	6	2	6
Presence of self-harm or suicidality				
Self-harm	1	3	11	31
Suicidality	1	3	28	80

Table 5. Verbalised indications of clear steps for police action

	1M (n=35)		1X (n=35)	
	<i>n</i>	%	<i>n</i>	%
Police action				
Provided advice/instructions	3	9	0	0
Local police to be informed	2	6	1	3
Call taker to ring victim	0	0	3	9
Transferred to Earlier Mental Health triage	1	4	1	3
Police to attend	14	40	21	60
Ambulance to attend	0	0	1	3
Caller hung up	0	0	3	9
No clear steps/unclear	15	43	5	14

Table 6. Descriptions of variables

Variable	Variable description
Location	The location of the caller or incident
Duration	How long the call lasted
Time of day	The time the call was
Day	The day of the week the call took place
The caller	The relationship between the caller and the person at the centre of the incident
Drug use	Verbalisations that indicate that alcohol or other drugs have recently been used by the person at the centre of the incident (i.e. have possibly contributed to the current incident).
Addiction	Verbalisations that indicate that the person at the centre of the incident has a known addiction issue (note: the addiction may be historical).
Medical issues	Verbalisations that indicate that the person at the centre of the incident has medical issues, not specified as mental distress
Mental health	Verbalisations that indicate the person at the centre of the incident experience mental distress and/or has had a previous diagnosis.
History 1 (mental health services)	Verbalisations that indicate there is an existing history of receiving a specialist mental health service (inpatient or community)
History 2 (NZ Police)	Verbalisations that indicate there is an existing history with police
Weapons	Verbalisation of weapons present.
Violence	Verbalisation of violence involved in the incident
Self-harm	Verbalisation of self-harming occurring
Suicidality	Verbalisation of suicidal thoughts or behaviour
Resolution	Verbalisations that indicate clear steps for police action
The decision rules and how we applied them to the calls	
<i>Researchers agreed to a call being coded 1M if it included the following.</i>	<ol style="list-style-type: none"> 1. The case had to include a direct reference to mental health issues. 2. Violence and aggressive behaviour alone could not be the basis for a 1M classification. 3. The mental health issues needed to be something needing police-led response.
<i>Researchers agreed to a call being coded 1X if it included the following.</i>	<ol style="list-style-type: none"> 1. The call had to include a reference to self-harm. 2. The self-harm had to be direct rather than indirect. 3. The self-harm had to necessitate a police response. 4. The call had to be intended for the police, not accidentally referred to the police.





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