COPS: Calling Out Police to Suicide: Exploring how New Zealand police are perceived as first responders to suicide by those experiencing callouts

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed____

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Abstract

Suicide is a serious issue across the globe. With police often being called as first responders to suicidal individuals, it is important to explore whether they are the best option for these types of callouts, especially when those with the highest rates of suicide are also those with the highest level of distrust in police. Through thematically analysed, semi-structured interviews, this study sought to determine if police were indeed the best first responders to suicide attempt callouts. Interviewees either had previously received a callout by police for a suicide attempt or were family members who had been involved in such a police callout. Five key research findings emerged. Firstly, the research found those who received a callout experienced poor police communication, both verbally and non-verbally. Secondly, police officers who respond to suicide callouts require improved training. Thirdly, police are not the ideal first responders unless the use of force is required. Fourthly, ideally, a team of health workers are the preferred first responders. Lastly, because using health workers only is currently not feasible, co-response teams are preferred over police-only callouts. While these findings are novel in the New Zealand context, they align with much of the overseas mental health literature. It is clear from both this study and prior research, that police are not the ideal responder for suicide callouts. Their poor use of communication including invalidating language, lack of training in mental health and suicide, and lack of procedural justice principles show that they can negatively impact suicide callouts. Instead, the co-response teams which are currently being trialled in New Zealand should become the new normal, with a plan to eventually move to a health-based callout system using police only in cases where the use of force is necessary.

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Introduction

One in every hundred deaths is a result of suicide, with over 700,000 global deaths per year. While its rate has been on the decline over the last 20-odd years, except in the Americas, it remains the fourth leading cause of death in 15 to 29-year-olds, after road injury, tuberculosis, and interpersonal violence (World Health Organisation, 2021). In the period between July 2018 and June 2019, a suspected 685 people in New Zealand took their own lives (Coronial Services of New Zealand, 2020). During that same period, the New Zealand Police (NZP) were called out to 24,662 suspected suicides, averaging over 67 callouts per day (NZP, 2019). While official statistics are only available up to 2018, the estimated figures have shown a downward trend over the COVID-19 period, with the suspected number of suicides in 2022 being 538 (Coronial Services of New Zealand, 2022). While police have not specified the number of suicide attempts they were called to in the 2022 period, they stated that the number of general mental health calls was 73,006, a significant increase from 57,656 callouts in 2019 (NZP, 2019, 2022). If suicide attempt callouts made up the same percentage of mental health callouts as the 2019 year, this would translate to an average of 85 callouts per day by police to attempted or threatened suicides. These numbers demonstrate that while the suicide rate is decreasing, the call to aid for suspected or attempted suicide has been on the rise. New Zealand's overall suicide rates are by no means the highest globally, sitting in the upper middle of the OECD countries (OECD, 2023). However, for over two decades, New Zealand has experienced one of the highest levels of teen suicide rates amongst industrialised countries, currently holding the number two position in the OECD rates after a long run at number one (Drummond, 1997; Fleming et al., 2022; Mental Health Foundation of New Zealand, 2022).

Amongst Māori youth, the suicide rates are even higher than the general youth rates in New Zealand. Data show that, for as long as suicide statistics have been collected, those at greatest risk and experiencing the highest rates of suicide in New Zealand are those aged between 15-24, Māori, male, and those facing socio-economic disadvantage (Coronial Services of New Zealand, 2020; Ministry of Health, 2016). According to the most recent official suicide statistics, young Māori men were 1.6 times more likely to take their lives than their non-Māori counterparts. While women's

suicide rates are much lower compared to men's, Māori women were 1.9 times more likely to take their lives than non-Māori women (Coronial Services of New Zealand, 2022). However, young Māori men (and women) are not the only minority with increased rates of suicidal ideation, i.e., ideas and thoughts around suicide and death. While official New Zealand suicide statistics fail to differentiate gender identity beyond the male/female dichotomy or take sexual orientation into account, many studies point out that LGBTQI+ individuals have higher rates of suicide and suicidal ideation than their non-queer peers (Figueiredo & Abreu, 2015; Schimanski & Treharne, 2019). Transgender individuals specifically are five times more likely to attempt suicide than their cisgender counterparts (Clarke et al., 2014; Schimanski & Treharne, 2019).

In New Zealand, when an individual in mental distress reaches out for help or is suspected of a suicide attempt, the first face-to-face port of call is the police. Whether the individual is standing at the edge of a bridge ready to jump or has called a suicide hotline, it is the police who are called in to talk the individual down and take them to trained professionals. NZP (2022) self-report being insufficiently trained to be first responders in mental health crises:

> *It is important to note that Police are not the lead agency for mental health in New Zealand. Our officers are not trained mental health specialists and dealing with these events that can be very time consuming. However, our people act with compassion and professionalism while trying to link those in distress with the support they need, where these services are available.* (p. 8)

While there has recently been an increase in police mental health education (Gordon et al., 2018), their training in dealing with suicidal individuals appears still less than ideal. Currently, police recruits receive a total of eight hours of mental health education and all staff receive a refresher course every two years. It is important to note that these eight hours cover every type of mental health intervention an officer may encounter, including a small section on suicide (Reid, 2020). While most mental health professionals spend years training before interacting with a suicidal individual,

the police train for a fraction of that time and are thrust into front-line action. The police are, therefore, seen almost as a 'band-aid' solution in a possible triage situation. As Gordon et al. (2018) note, the police's job in these cases is "to facilitate prompt access to appropriate services" (p. 2).

A major cause of concern regarding police as the first port of call in suicides is that those with the highest suicide rates are also those with the greatest distrust of the police. According to a 1998 study commissioned by NZP (Te Whaiti & Roguski, 1998), there was a clear distrust of police amongst Māori. While the police have stated they want to curb that distrust (NZP, 2019, 2020, 2022), the high levels of Māori incarceration and racialized police practices continue to create mistrust between Māori and police (Cunneen & Tauri, 2016; Norris & Tauri, 2021). This lack of movement is demonstrated in the NZP's (2020) annual report, showing only 65% of Māori have 'full or quite a lot' of trust in the police (compared with the overall 77%). Additionally, Miles-Johnson and Death (2019) highlight a multitude of studies that show a clear distrust between police and members of the LGBTQI+ community. While this distrust has eased over the last few decades, it still permeates the queer community to this day (Dario et al., 2019). Since the data indicate that individuals with the highest rates of suicide and suicidal ideation are those with the greatest distrust of the police, the fact that police officers are the first to attend a suicide callout seems to disconnect from the safety concerns for these individuals. While arguments can be made for why police officers are useful in these situations, such as their ability to use physical force if the individual cannot be talked down or the legal ability to enforce the *Mental Health (Compulsory Assessment and Treatment) Act 2012*, it does not necessarily mean that they are the best option in these cases, just that they are currently the *only* option.

Using an advocacy worldview and procedural justice lens, this study sought to gain insight into the experiences and perceptions of previous suicide attempters who received a NZP intervention and family members who have been involved in such callouts. In semi-structured, one-on-one interviews, both attempters and their family members were asked whether they consider NZP the ideal first responders to suicide callouts and what alternatives they would suggest. Through thematic analysis, the study arrived at five key findings. These were:

1. Poor police communication;
2. The need for improved police training;
3. Police are not the ideal first responders unless the callout requires use of force;
4. Health workers as responders;
5. and Co-response teams as a callout model

These findings align with the current international mental health literature that examines the role of police as first responders. The study contributes to this larger body of literature by specifically speaking to suicide callouts in the New Zealand context. As the following literature review demonstrates, the international suicide literature in this area is sparse.

Literature Review

The literature around suicide is vast and found within numerous academic disciplines, in both the social and hard sciences. Particularly, the demographics of suicide are widely discussed. Similarly, the risk and protective factors that cause these demographic variances and their impact on suicide reduction are well covered by the literature on suicidality. A growing body of literature concerns itself with police conduct during mental health callouts, as police conduct may impact the mental well-being of those experiencing mental distress. Due to the potential impact of police conduct and how training can affect this conduct, the literature on police training in mental health continues to grow. A newly forming body of research has emerged around the use of co-response teams as a callout model, using both police and health professionals to conduct mental health callouts. However, the literature on perceptions of police as first responders, especially regarding police-only callouts to attempted or threatened suicide, is sparse.

The Demographics of Suicide

A vast body of empirical literature on suicide investigates the phenomenon along demographic lines, such as gender and age, pointing towards an intersecting pattern. One of the most widely known demographic facts is that suicide rates are higher for men than women. This is because men tend to use more lethal means of suicide, meaning they are less likely to be stopped or able to change their minds once plans are

put into action (Chidgey et al., 2019; Khazaei et al., 2017). However, the differences between suicide rates in men and women are not always consistent. Region, religion, education levels, economic positioning, and the Human Development Index, among other factors, all impact the variance between male and female suicide rates. For example, in countries with higher education levels, women are less likely to die from suicide due to increased opportunities and inclusion in society, meaning a higher male-to-female ratio. Also, countries which are majority Christian have the highest male-to-female ratio followed by Muslim and unaffiliated countries, Buddhist, and lastly Hindu countries (Alothman & Fogarty, 2020; Khazaei et al., 2017). It is important, however, to consider Emile Durkheim's work on suicide and religion, or more specifically the criticisms of his theory. As current literature points out, Durkheim's ideas about a correlation between different religions and suicide rates are flawed due to unreliable statistics. Durkheim found lower suicide rates among Catholics compared to Protestants, explaining the difference with relative normlessness (anomie) among the latter. However, he failed to consider alternative explanations which include a higher motivation for Catholic families to conceal suicide because of its stigmatisation as a sin (Hassan, 1998). Because current suicide studies rely on official statistics, they too are limited to the reported levels of suicide ignoring religious barriers around the reporting and recording of suicides. It is also important to note that some majority Christian countries have a history of colonialism. The long-term impact of colonialism on Indigenous people (Cunneen & Tauri, 2016) may also affect suicide rates.

In countries where the Indigenous population is a minority, rates of suicide for Indigenous peoples are significantly higher than the majority population. While this has been linked to the forced disconnection of Indigenous peoples from their culture (Hatcher, 2016), it is not the main driver of these high rates. Indigenous scholars argue that colonialism has a long-term impact on the socioeconomic status of Indigenous minorities (Cunneen & Tauri, 2016; Kingi, 2013), and the most economically deprived strata of society experience the highest rates of suicide (Curtis et al., 2013). Alongside this, the mental health impact of systemic racism on Indigenous people needs to be taken into consideration (Mendez et al., 2021).

Age is also a major topic in suicide research. Child suicide rates have, over the last two decades, been on the rise, with children belonging to ethnic or Indigenous

minorities experiencing the highest rates of increased suicide. Currently, in low-to-middle-income European countries, suicide is the number one cause of death amongst 10 to 19-year-olds and number two in high-income countries (Junuzovic et al., 2022; Price & Khubchandani, 2022a; 2022b). Currently, an estimated 70% of youth within the criminal justice system are dealing with some sort of mental health issue (Muller et al., 2021). However, while youth rates are widely studied, they are not the age group with the highest suicide rates. As age increases so too does the rate of suicide, with those who are in the eldest age brackets taking their lives at the highest rate (Pires et al., 2022). While those over 65 made up only 5.7% of the global population in 2017, they accounted for 15% of the global suicides, figures which may be understated due to the underreporting of suicide in this age bracket (He, et al., 2021; Novilla-Surette et al, 2022).

Police officers are also a widely studied topic regarding suicide and mental health, as law enforcement personnel are more likely to die from suicide than in the line of duty (Christopher et al., 2016). A significant amount of research over the last few decades has looked at police suicide (Violanti et al., 2019). For the most part, police suicide rates are significantly higher than in the general population, with figures higher among minority and female officers. When compared to firefighters, police take their lives around four times more often (Kyron et al., 2020; Violanti, 2010). The small number of studies that found police taking their lives at the same rate as the general public, point toward a variance between regions and police departmental structuring, where more supportive structures result in lower suicide rates. Some research also points toward methodological flaws in the study of police suicide, where short time periods studying these rates may not reflect the real scope of the problem (Loo, 2003).

Suicide Reduction

From the suicide reduction literature, two main themes emerge – suicide prevention through reducing suicide risk and suicide prevention through increasing resiliency. The World Health Organization has tasked governments worldwide with targeting suicide reduction and enhancing prevention programmes to reduce global suicide rates. They have pointed out a need for a systematic approach to achieving this goal (Arensman et al., 2020). However, some researchers discourage a 'one size fits all'

approach in favour of a more tailored approach, co-designed with the help of those who need the service. They argue that this approach would give voice to those experiencing suicidal ideation and improve overall engagement with prevention programmes (Hanlon et al., 2022). It is often stated that the best way to prevent suicide is to remove risk factors or provide support when they cannot be removed (Charalambous et al., 2020; Claveria, 2022; Milligan, 2022; Olfson et al., 2022; Shaw, 2022; Smith et al, 2022).

According to the suicide risk literature, risk factors include previous suicide attempts, substance abuse, mental and physical illness and their diagnoses, and economic pressures, as well as societal factors such as living alone or not having children and even the stigma surrounding suicide attempts can increase the risk of further attempts (Canning et al., 2017; Curtis & Curtis, 2011; Mayer et al., 2020). But, risk factors are not the same for all. For youth, risk factors include bullying especially with the increase in cyberbullying, academic pressures, and relational issues (Kim & Leventhal, 2008; Stubbing & Gibson, 2019). The impact of both substance use and sexual behaviour has been found to double young people's risk of suicide over the following 12 months (Jacobs et al., 2023; Smith et al., 2020), although these could be symptoms of suicidality rather than the triggers.

Within New Zealand youth, there is a serious issue around poor mental health and the risky behaviours it can cause, including suicide attempts. Over the last two decades, there has been a negative shift in some of these behaviours. While many risky behaviours, such as smoking, drug use, and dangerous driving, have decreased over the years, there was a clear increase in poorer mental well-being including depressive symptoms, suicidal thoughts, and suicide attempts (Fleming et al., 2022). This contrasts the decline in suicide rates over the last two decades, showing that while the rates of suicide are going down, the risk of suicide, through higher suicidal thoughts and attempts, is possibly increasing (Muller et al., 2021).

It has been found that providing neighbourhood support and local activities for youth decreased their risks of suicide and depression (Canning et al., 2017). Older adults, however, tend to have lower, and different, protective factors when it comes to suicide risk. Ageism, undiagnosed depression, lower levels of social connection, and

decreased physical health all add to the increased risks of suicide in those over 65 (de Mendonça Lima et al., 2021).

The key risk factors in police suicide rates include increased stress, trauma experienced from the job, and relationship problems caused by being an officer (Chae & Boyle, 2013), as well as easy access to firearms, continuous exposure to death and severe injury, shift work, social strain including the negative image of police in society, and inconsistencies in the criminal justice system (Loo, 2003; Violanti et al., 1996).

The resiliency literature revolves around increasing the levels of psychological resilience within the population rather than focusing on decreasing risk factors. "Psychological resilience is the ability to cope properly with stressors and difficulties" (Çaper & Çuhadar, 2021, p. 1446) through strengthened mental well-being. Some researchers favour resiliency over risk reduction because higher levels of resilience have been linked to decreased suicide rates as well as higher self-esteem. This can be achieved through promoting positive mental health and well-being, strengthening interpersonal connections, and creating spaces for leisure activities for all, at the youngest age possible (Çaper & Çuhadar, 2021; Ivbijaro et al, 2019; Malak-Akgün et al., 2022). Increased resilience is one of the reasons why women have lower rates of suicide, through having stronger social connections and being better at complying with prescribed mental health treatments (He et al., 2021; Vijayakumer, 2015). A large portion of individuals who are subject to police callouts have a history of mental health and prescribed medications (Chidgey et al., 2019; Khazaei et al., 2017), indicating the importance of taking prescribed medication in suicide prevention. The biggest issue with police seeking help for their mental health issues and suicidal ideation is the long-standing culture within the police which stops many officers from seeking help. Often this culture leads officers to fear that their jobs or career advancement will be at stake if they seek help for these issues or that their peers will think they are weak, which in a job which is all about strength creates a major barrier (Richards et al., 2021). Through the means of mindfulness, training, and mental health support, among other tools, studies have managed to curb police suicide rates, resulting not only in fewer officers taking their lives, but in reduced sleep disturbance, anger, fatigue, burn-out, and stress as well as increased mental and physical well-being (Christopher et al., 2016; Mishara & Martin, 2012; Mishara & Fortin, 2022).

While risk and resilience research approach suicide prevention from different angles, many of their suggested prevention strategies overlap. This shows that these ideas are not independent of each other but rather interconnected. For example, women attempt to take their lives at around twice the rate of men, but men die by suicide at two to four times the rate of women. This is due to variations in both the risk and resiliency levels of men and women. Women are twice as likely to suffer from depression, a major risk factor, but have stronger resilience as they are more likely to ask for help when in mental distress. Alongside using less lethal means, which means a higher likelihood of surviving, this results in more women seeking help after an attempt than men (Vijayakumar, 2015). Men being less amenable to seeking help interplays with the fact that previous attempts and any stigma around these are risk factors for future attempts. Therefore, in this case, risk reduction strategies may suggest programmes which encourage men to seek help for suicidal ideation, reducing the risks associated with lower social connections. Resilience research would suggest increasing social bonds in order to increase an individual's resilience, as greater social bonds increase resilience. In this case, both sides would result in the same method of suicide reduction, increased social bonds, despite seeing it from differing angles.

Police conduct during mental health callouts

A substantial body of literature has investigated how police conduct themselves when dealing with individuals with mental health issues or suicidality. In studying the use of force on individuals experiencing mental distress, research points toward excessive use of force especially when dealing with minorities, an issue that has been linked to a lack of training and inbuilt implicit biases. Those with mental health issues are more likely to be shot and killed by police, more likely to be unarmed when shot, and more likely to be at the end of excessive physical use of force in general, especially if they are a person of colour. It is estimated that in the United States of America (USA), persons with mental health issues are between seven and 16 times more likely to be killed by police, with one-quarter of all police shootings in the USA being linked to a mental health incident. Black Americans have the highest death rate from police interactions, and when accounting for mental health they are ten times more likely to die by police than non-Hispanic Whites. Additionally, those with mental health issues

have the highest rate of incarceration, with the rate of those with serious mental health conditions in prison estimated to be as much as four times that in the general population (Bailey et al., 2022; Balfour et al., 2022; Rohrer, 2021). This racially biased treatment can lead to mental health issues, even in those not experiencing mental health at the time, such as depression and suicidal ideation (Dennison & Finkldey, 2021; Fleming et al., 2021). However, while Black Americans and non-white Hispanics in America are more likely to face unnecessary use of force or unfair treatment by police and both groups showed heightened levels of mental health distress due to police treatment, White (non-Hispanic) Americans were more likely to feel depressed or suicidal after unfair police treatment. It has been theorised that this is due to the normalisation of unfair treatment by police of non-white Americans. Black and Hispanic Americans, especially those living in disadvantaged communities, are so used to poor treatment by police that they have normalised this behaviour (Dennison & Finkeldey, 2021). This normalisation of police as unfair, violent, and unsafe seems to be adding to the ongoing perspective change amongst Black Americans, who now fear the police more than they fear crime itself (Pickett et al., 2022).

In Australia, 'Project Beacon' succeeded in reducing the overall number of fatal police shootings, but not when it came to people experiencing mental distress. In the period before the project commenced, those experiencing mental distress made up 40.6% (N=13) of fatal shootings. In the same-length period after the project, they made up 81.3% (N=13). This showed that while officers managed to better distinguish when a situation required the highest level of physical force, this did not extend to those experiencing mental distress (Kesic et al., 2010). Within New Zealand, those in mental distress are more likely to be subject to police weapon use, more likely to die from this use, and most likely to be of Māori or Pacific descent (Hallett et al., 2021; O'Brien et al., 2011, 2021). In contrast to this, a study in the Waikato observed no difference between the use of force on Māori over others, despite being more likely to be the subject of a police mental health callout. However, it was found that use of force was used in a large proportion of the cases studied, which had been linked to a greater distrust of police (Holman et al., 2018).

According to Jones et al. (2021), the American public is aware of this use-of-force issue. Americans tend to accept police use of force when drugs are involved in

the callout but do not tolerate the use of force on those in mental distress, and they do not see police as the appropriate responders to mental health callouts. Only after using appropriate Crisis Intervention Team (CIT) methods, such as de-escalation and communication, was the use of force by police seen as legitimate (Jones et al., 2021). The American public also feels that law enforcement need better training to remove the stigmatising beliefs that the police hold, as these beliefs affect police handling of mental health sufferers in their day-to-day practices (Yasuhara et al, 2019). Some studies confirm a correlation between police contact and suicide, especially when the suicidal individual is not a perpetrator of a crime. This is not to say that the police triggered the suicide, but that a need for police intervention is a strong suicide warning sign and that police may be able to stop suicides by noticing the warning signs and taking the necessary steps to get individuals aid (Chidgey et al, 2022; Walton et al., 2017).

Police Training in Mental Health

The training police receive and the impact of this training is a continually growing field of research. As those dealing with mental illness are three times more likely to come into contact with the American police than those who are not (Bailey et al., 2022), it is important that police know how to conduct themselves in these situations. This is where police training becomes key, as limited police training in mental health can relate to increased fatalities for those experiencing mental distress (Richmond & Gibbs, 2021). The most used form of additional training in the USA, outside of standard police training, is Crisis Intervention Team (CIT) training. This 40-hour, scenario-based training model gives officers the tools to identify individuals experiencing mental distress, de-escalate the situation, and get the individual to necessary health providers, rather than a jail cell (Balfour et al., 2022). One of the main outcomes of CIT training is the increase in police officers' feelings of confidence in their handling of mental health callouts (Booty et al., 2020; Fiske et al., 2021). Some studies found that training in CIT programmes significantly decreased the use of force, as well as increased mental health referrals and a better general understanding of mental health. As research has shown, if an officer holds an implicit bias toward a specific person or group, they are more likely to use force on them. Furthermore, if

officers fear such individuals, this fear can lead to negatively impacted cognitive capacity, which is, in turn, linked to a higher likelihood of shooting. CIT training can, therefore, remove some of this bias and reduce use-of-force rates. It does not, however, result in a decrease in arrest rates (Balfour et al., 2022; Rohrer, 2021; Wittman et al., 2021b). Conversely, Fiske et al. (2021) found that CIT reduced neither the use of force nor the levels of fatal police shootings. In this case, it may have been that while the officers undertaking the CIT training gained a better understanding of mental health, this knowledge did not translate into better handling of mental health situations. This aligns with Tartaro et al.'s (2021) findings, that while officers who received CIT training felt better prepared to handle mental health callouts, they also tended to hold more stigma toward the mental health community than those who did not receive the training. Some officers saw CIT skills as being able to increase the safety of the community, whilst also increasing an officer's injury risk and the risk of use of force. Mental health experts argue that for CIT to be a successful strategy, only officers who specialise in responding to mental health callouts should be trained in it, not the general police force (Pelfrey Jr & Young, 2020).

Other forms of police training in the USA have yielded similar results. While training together, police and ambulance officers can learn from each other. This allows those of different, yet intersecting, emergency services to share knowledge of their own experiences, widening both groups' understanding of mental health (Fisher et al., 2020). Within New Zealand, there have been attempts to increase police awareness and training in the areas of mental health to decrease the stigmatization of individuals in mental distress. Officers who completed a full series of training showed a short-term decrease in stigmatisation and increased positive attitudes toward mental health-based interactions. The researchers pointed out, however, that there is no way to know if those changes would be long-term; without some form of longitudinal study (Gordon et al., 2018).

Co-Response Teams

A growing body of literature attends to the recent phenomenon of police and mental health workers and/or paramedics operating together to attend suicide callouts. These teams were created to increase interdepartmental communication and respect, create

better avenues for accessing support, and decrease police emergency department delays (Hollander et al., 2012). The use of co-response teams in Australia, the USA, and Canada was found to often result in lower arrest rates, increased mental health referrals, increased sharing of knowledge, increased feelings of safety among clinical staff, and reduced pressure on the criminal justice system (McKenna et al., 2015; Rohrer, 2021; Shapiro et al., 2015). These teams have also resulted in less need for hospitalisation and more ability for the community to provide needed support directly (Lee et al., 2015). While these types of callouts tended to be longer, they resulted in better outcomes for recipients and greater communication with police and health staff (Kisely et al., 2010).

Multiple international studies revealed that the use-of-force and injury rates of those experiencing mental distress when co-response is used are relatively unchanged from when it is only police attending the callout (Bailey et al. 2022; Marcus & Stergiopoulos, 2022). Conversely, other studies found that co-response teams resulted in less use of force and a lower likelihood of the callout resulting in transportation against the individual's will than police alone (Blais & Brisebois, 2021).

Since March 2020, New Zealand has been trialling its first co-response teams, made up of a police officer, a paramedic, and a mental health clinician. Much like their overseas counterparts, these teams have been found to a) be more efficient at resolving a mental health crisis, b) increase the likelihood of a crisis being resolved in the community, and c) reduce hospital admissions, when compared to police responding alone (Every-Palmer et al., 2022).

Australian police find these co-response teams to be highly beneficial because they free them up to do other tasks and provide better outcomes for the 'consumers', being those receiving the callout, as well as creating a better working connection with the Crisis Assessment Team (CAT). CATs themselves are not necessarily as enthusiastic about teaming up with police, as whilst they liked the increased communication with police, there is concern about the improper use of their teams and unsafe conditions to complete assessments (Lee et al., 2015). The communication between police and CATs is crucial to have an efficient and effective response to mental health callouts which are led by empathy (Hollander et al., 2012). Australian 'consumers', who reported both positive and negative experiences with co-response

teams, ultimately preferred that family or friends were the ones that helped during a crisis and, if necessary, the combined team was significantly preferred over police alone (Boscarato et al., 2014). However, with co-response units being relatively new, there has been limited time to study the true effect of their impact and therefore there is limited research in this area (Balfour et al., 2022). Nevertheless, several scholars argue that mental health professionals have an important role to play in callouts as they add to their quality and result in a better outcome for the individual receiving the callout (Balfour et al., 2022; Mckenna et al., 2015; Marcus & Stergiopoulos, 2022).

Views on police as first responders

There is a scarcity of literature that focuses on police as first responders to suicide callouts. In general, police believe that mental health callouts take up too much of their time, divert them from other tasks, and are not an enjoyable part of the job, with officers often perceiving mental health callouts as babysitting for the unwell. Further, police often feel under-resourced, under-supported by their administration teams, and that they lack adequate relationships with mental health service providers due to opposing philosophies, and, therefore, feel they should not be the ones attending mental health callouts. They often believe specialist mental health teams should be sent out rather than themselves (Fry et al., 2002; Kuehl et al., 2023; Wood et al., 2021). However, when specially trained officers are used, these feelings change. Specialist suicide officers from Scotland, who focus mainly on suicide callouts, found their work was both very important and rewarding. The standard officers who worked alongside these specialists, however, felt the same as officers in other studies; they did not like nor feel equipped to be first responders to suicide (Spence & Millot, 2016).

Noticeably absent from this body of literature are the views of those who are on the receiving end of police callouts. The few studies that have been conducted on 'consumer' views on police callouts demonstrated mixed findings. While some individuals remembered the police fondly, others found the police added to their trauma. While personal experiences were mixed, the consensus was that all aspects of a callout needed to be handled with respect, individuals experiencing mental distress needed to be given autonomy, and the use of physical restraint needed to be reduced. This is important, as police callouts to mental distress have been referred to as

traumatic and distressing with a lack of understanding of those experiencing mental distress. Police conduct in mental health callouts can also impact trust in police, affecting any future callouts. While some of these callouts were positive, the distrust in police often remained after such encounters. Hence, one negative experience with the police may significantly outweigh multiple positive ones. In general, police were not considered the preferred group that those experiencing mental distress wanted to attend to them (Allen et al., 2003; McKenna et al., 2015; Watson et al., 2008). However, when using anti-stigmatisation techniques to reduce the stereotypes, social distance, and negative feelings toward the police, respondents had a more positive outlook on their police callouts and were more willing for police to be involved (Wittman et al., 2021a).

Research Questions

The literature review has shown that we know a lot about what can impact suicide rates, from gender roles to the risks associated with stressful work environments. Much work has been completed around the conduct of police at mental health callouts finding that the excessive use of force that is often used, especially on minority individuals, negatively impacts the very mental health police are being called upon to aid. One way in which on-the-job training can occur is through the incorporation of other services, such as mental health workers and paramedics. The newly forming research area around co-response teams shows that working together increases the understanding of all parties involved. Co-response teams also tend to result in better outcomes for those receiving a callout, but not necessarily a more positive experience. Both the research into co-response teams and police-only callouts show that there is a mix of positive and negative encounters. However, police-only callouts are by far the least preferred by those in mental distress.

The majority of studies focus on mental health in general, sometimes briefly discussing suicide or the percentage of cases which included suicide-related callouts. Because not all mental health issues are the same and suicide is not always caused by mental health issues, it is important to talk about these topics separately (Brent et al., 1999; Fry et al., 2002; Stubbing & Gibson, 2019). The lack of suicide-specific research shows there is a significant gap in the literature both globally and in New Zealand.

Hence, the current study seeks to explore whether suicide attempters and their families perceive New Zealand Police as appropriate first responders to suicide attempts and what alternatives they might suggest. To do so, this study asks the following research questions:

1. What are the experiences and perceptions of previous suicide attempters who received NZP intervention and what are the experiences and perceptions of their family members who have been involved in such callouts?
2. According to these two social groups, are NZP the ideal first responders to be called out to suspected suicide attempts?
3. If NZP are not the ideal first responders, what alternatives do these two groups suggest?

Research Design

This study adopted an advocacy worldview because its goal is to explore who might be *best* positioned to act as a first responder in suicide intervention situations. Many other worldviews do not go far enough in advocating on behalf of or are not appropriate for marginalised groups (Creswell, 2007). The idea of advocacy research is to bring about improvements in people's lives (Padgett, 2008). While the final findings ultimately may not be implemented, this research seeks to provide those with the ability to make change appropriate ways forward for suicide callouts and suicide reduction. Because this research is dealing with suicide, it is important to centre the voices of those who have experienced suicidal ideation. This is especially true when police have been given lawful power and authority over them in most cases, but especially when dealing with possibly suicidal individuals; through the *Mental Health (Compulsory Assessment and Treatment) Act 1992.* Hence, the study was approached from a qualitative perspective as qualitative research allows for a deeper understanding of individuals' thoughts, feelings, and perspectives (Bryman, 2016).

Because the research seeks to understand a small group of individuals' lived personal experiences and worldviews, the study is both phenomenological and exploratory (Rossman & Rallis, 2017). Phenomenological research is, in its most basic form, the study of the human experience. It seeks to allow the researcher to understand the world around them – not objectively but subjectively through shared human

experience (Gallagher, 2012). Therefore, this research seeks to tell the stories of those interviewed and how their experiences impact their perceptions of police as first responders to suicide callouts. Due to the lack of previous research on this topic, and the small group studied, this study is consequentially exploratory. Because this is exploratory research, the findings can give glimpses of insight into the topic and thus lay some of the groundwork for future studies, however, without claiming to be able to make any generalizations (Stebbins, 2001). So, while this research will make some suggestions based on the findings, these only seek to inspire hypotheses for further research before social and structural changes can be implemented.

Theoretical Perspective

Police are given a certain level of legal power over those they are sworn to protect. Because of this, they must behave in a way that is appropriate for this power. Misuse of this legal authority can create distrust of police by the general public. This distrust can then bring into question how legitimate of an authority the police are. The legitimacy of the police has been brought into question in the last few years, significantly impacted by the shootings of innocent Black individuals in the USA. Instances such as the killing of George Floyd have thrown doubts not only on police in the USA but has forced other countries to question the biases their officers hold (Tyler, 2017). With the police holding stigmatising beliefs toward certain groups of people, be those beliefs implicit or explicit, their actions must be held to account. Within New Zealand, police are more likely to stop, arrest, and prosecute Māori than any other ethnic group (Webb, 2013). It is, therefore, understandable that Māori have a higher distrust of police due to the racial prejudice within the NZP. While this racial bias permeates the entire criminal legal system, with Māori making up 52% of the prison population as of June 2023 (Ara Poutama Aotearoa Department of Corrections, 2023), police remain the gatekeepers and physical enforcers of this racially-biased system. Hence, interrogating their actions and biases becomes particularly important. Due to the stigma they face, persons with mental illness are also a marginalised group, with a significant overrepresentation of people with ill mental health in prisons (Fazel et al., 2016). Māori individuals with mental health issues are especially marginalised, due to the convergence of racial and mental health bias shown by police. As those who

have the highest distrust of police are also those with the highest rates of suicide, it is important to take the markers of perceived police legitimacy into account. As part of a marginalised group, individuals with mental illness or in mental distress, are more sensitive to the principles of procedural justice than the general public (Jones & Thomas, 2019; Watson & Angell, 2007). The higher sensitivity to these principles explains why those in mental distress have been found to respond better to callouts by the police when they were procedurally just (Morgan, 2021). Therefore, this study applies a procedural justice theory lens to its findings.

Procedural justice touts that the legitimacy of any judicial process, police or otherwise, can be impacted by the perceived fairness of the conduct based on certain aspects of the interaction (Vermunt & Strrnsma, 2016). There are four key aspects which form the procedural justice theory. If these four principles are met, the interaction is seen by the public as fair and the authority legitimate. However, if these factors are not met, the interaction is seen as unjust and the authority's legitimacy is diminished. These four principles are (1) respect, meaning that an individual feels they are being treated with respect in their interaction with the authority and during any decision-making processes; (2) trustworthiness, meaning that the individual perceives the authority can be trusted to act fairly toward them in any decision-making processes and future interactions; (3) neutrality, meaning that the authority is impartial and without bias for any personal reason or due to the individual's characteristics, such as gender, ethnicity, sexuality, or religious affiliation; (4) voice, meaning that the individual feels they have been given the opportunity to participate in the decision-making process, that their voice is heard (Meyerson et al., 2020; Murphy & Tyler, 2017; Tyler, 2017). In short, procedural justice theory posits that if the police act toward members of the public with respect, trustworthiness, and neutrality whilst giving individuals the chance for their voices to be heard, they will be seen as legitimate authority figures. However, failing to meet even one of these, can result in police being seen as unjust, illegitimate authority figures. The procedural justice model has been applied to previous research on police callouts to mental health incidents (see, for example, Jones & Thomas, 2019; Watson et al., 2008), as well as both Indigenous and queer research (see, for example, Dario et al., 2019; Wook, 2019). Also, part of advocacy research is about giving a voice to the research participants, making

procedural justice important for the research's worldview. This shows that procedural justice theory is an appropriate lens through which to explore police callouts to suicides.

A procedural justice framework can help decipher how individuals experiencing suicidal ideation interact with and respond to police and how those interactions impact not only the individual's perception of police but also their likelihood of reaching out for aid in the future. As suicide attempts are often not a one-time occurrence (Forman et al., 2004; Rudd et al., 1996), it is important that if the police are the ones conducting these callouts, they are seen as a legitimate authority. Otherwise, individuals may not reach out for help when attempting suicide again because they know that the police will attend. Reduced police legitimacy due to a negatively perceived callout impacts not only the future callouts for suicide but all police interactions. If police are not seen as a legitimate authority, it can impact whether an individual will reach out for aid in other circumstances. This means reduced legitimacy in police reduces overall police usefulness, as if people do not trust police to do their job why would they reach out to them or provide aid to police when requested? Procedural justice theory also posits that if the general public perceives the police as fair and legitimate, they are more likely to obey the law. Adherence to the law is ultimately a voluntary action, with legal compliance depending on individuals choosing not to break the law. Procedural justice theory states that if legal processes are seen as fair, people will then choose to obey the law (Tyler & Lind, 2001). This means procedural justice and police legitimacy are not just important for future suicide callouts, but the willingness of individuals to aid police and to legally conform.

Research methods

Data was collected via semi-structured interviews of up to 60 minutes in length. While each interviewee was asked a standard set of questions, the semi-structured interview allowed for flexibility in the order in which questions were asked as well as the ability to add further prompts as needed (Dawson, 2007). This was important, as each individual's experience was different, and so further questions were sometimes needed to understand the situation more clearly. Semi-structured interviews also aligned with the phenomenological aspect of the research, as certain questions needed to be asked

but the rigidity of structured interviews would not have allowed for a deeper dive into each individual's lived experience. Interviews were conducted either face-to-face or via video call according to the interviewee's preference, including their judgment of the COVID-19 risks involved at the time. All interviews were audio recorded and later transcribed. Audio recording not only allowed for easy transcription of the full interviews but meant no notes needed to be kept during the interview, allowing for a better connection and flow of the interview.

After transcription with the help of an online tool (otter.ai) and manual adjustments made through listening over the recordings multiple times, to ensure accuracy, the data was thematically analysed. The goal of thematic analysis is to find themes or patterns of ideas within the studied text that relate to the research questions. These ideas are identified via coding (Bryman, 2016). This study's thematic analysis followed the general process discussed by Braun and Clarke (2006). While transcribing and reading, the researcher familiarised herself with the text, highlighting points of interest in the process. This included looking for keywords of interest, emotional cues, points related specifically to procedural justice principles, and specific question answers. Then all the transcripts were printed out and further highlighting occurred with a series of multi-coloured highlighters, each colour for a different code. The highlighted sections of all transcripts were individually cut out and placed on the floor; a large surface that allowed for a clear overview. The highlighted cutouts were then categorised into general concepts by moving the physical text around into different groupings. Through the continued reading of the highlighted texts as well as further reading of the bulk text for missed points of interest, and adding more physical cutouts to the mix, the concepts were then expanded into general themes. These themes were then organised according to how they aligned with the research questions and theoretical perspective, with any superfluous themes removed, such as the impact of COVID-19 on mental health. After further refining, five themes were left, which then became the key discussion points in the findings section of the write-up. The physical paper versions of these themes were bundled up with a paperclip after being entered into the findings section. This allowed for easier access to each theme's text as needed through the writeup process.

Participants

Participants of this study were either individuals who have been the subject of police suicide callouts or family members of those who have experienced callouts for a loved one. For safety, all previous attempters needed to be out of suicidal ideation for at least six months. Several potential participants were therefore unable to participate as their safety needed to come first.

Participants were invited through a poster that was distributed via social media, in Auckland University of Technology's postgraduate study rooms and classroom e-boards, and it was also emailed to mental health professional bodies and groups such as St Johns New Zealand. Interested individuals contacted the researcher directly via email or phone.

Researcher Positionality Statement

Suicide research is sensitive and arguably requires a high level of trust and rapport between the researcher and participants to obtain in-depth quality data. Such rapport can be established through shared experiences. Hence, I disclosed to all interviewees that I have personally received two police callouts for suicide attempts and have been put under the *Mental Health (Compulsory Assessment and Treatment) Act 2012* on one of these occasions. At my first police intervention, one of the police officers made me feel heard and seen in a way even the mental health professionals in attendance could not. It was only her second week on the job. The second experience, however, had the opposite effect. After spending an hour and a half on a call to a suicide hotline, two male police officers turned up. The main officer was rude, disinterested, and clearly did not want to be there, and in five minutes had nearly undone all the progress made on the phone. These two contrasting experiences led to the desire to explore the experiences and views of others who had been in similar positions. I also belong to the LGBTQI+ community, one of the groups with a high level of suicidal ideation (Clarke et al., 2014), and have seen the impacts of suicide on my fellow queer community members. The fact that many of the rainbow community have or will attempt suicide or will suffer from suicidal ideation during their lives is something I am keenly aware of.

Ethics

Ethical approval for this study was given by the Auckland University of Technology Ethics Committee (AUTEC) on 12 January 2022, under application number 21/438.

Limitations

One of the biggest challenges was the recruitment of participants, reflecting the stigma that still surrounds the topic of suicide. Since the safeguarding of participants required that individuals had to be six months without suicidal ideation, this ruled out anyone with very recent experiences with police callouts and thus limited the pool of potential participants significantly. Additionally, for ethical reasons, participants needed to be 18 or older, ruling out the ability to interview anyone who fell under the age restriction. Another major issue that has impacted recruitment is COVID-19. While much of the research was undertaken at the latter end of the pandemic, there was still a lingering fear of COVID.

A major limitation of this study is the limited number of participants interviewed. With only five participants in total, only a very small portion of the general population who meet the research criteria have been interviewed. This is especially the case for those who have the highest rates of suicide, specifically Māori, Pacific peoples, queer individuals, and men, as a majority of participants identified as female and/or Pākehā or European; with only one respondent identifying as New Zealand European/Māori. This means that the research does not truly speak to those who fall into the highest risk category or who have the highest distrust of police. However, as the following research findings will show, even though some respondents expressed that they have high trust in the police, they still did not think that, ideally, police should be the ones conducting first-contact callouts to suicides.

Findings

In the end, five individuals participated in the study; three individuals who had received callouts for themselves (henceforth: attempters) and two unrelated parents of under 18-year-olds who had received callouts (henceforth: family members). Also, one of the interviewed family members relayed her daughter's (attempter) experience from conversations they had about the callout as her daughter was too young to participate

in the research herself but wanted to share her thoughts on the topic after she heard her mother had agreed to an interview. Her experience was not requested by the researcher, but offered at the time of the interview. Because voice is an important aspect of procedural justice, and this should be applied to the research itself and not just the police, her voice is honoured in the research findings as a "quasi-participant". Pseudonyms are used when referring to individual interviewees to maintain confidentiality. All ethnicity data is expressed as self-identified by the respondent, as this best aligns with the advocacy worldview.

Table 1

Participant information

Name	Preferred Pronouns	Age Bracket	Ethnicity	Group
Holly	She/Her	30s	Pākehā	Attempter
Erena	She/Her	40s	European/Māori	Attempter
Celeste	She/Her	30s	Indonesian/Kiwi	Attempter
George	He/Him	40s	Pākehā	Family Member
Sarah	She/Her	30s	European	Family Member
Sophie*	She/Her	Teen	European	Attempter

* Sophie was not interviewed but her mother Sarah relayed her experience.

From the thematic analysis of the transcribed interviews, five key themes emerged. These were:

1) poor police communication,
2) the need for improved police training,
3) police are not the ideal first responders unless the callout requires the use of force,
4) health workers as ideal first responders, and
5) co-response teams as an alternative callout model.

Poor police communication

A major theme that permeated the interviews was how police communicated with those experiencing callouts. The use of communication significantly impacted how the interaction was perceived. Good communication resulted in both the interaction and

the officers being perceived as positive. Poor communication, however, resulted in a negative view of both the callout and the officers involved. The quality of the police communication was a key reason why one of the attempters perceived their interaction with police positively and one attempter and both family members perceived their interactions with police as negative. The final attempter had, due to the substances she had ingested, no explicit recollection of the communication with police during her callout.

Attempter Holly, for example, explains that her experience was a positive one because the police helped her through a difficult situation with casual banter and a calm temperament. For Holly, the way officers communicated with her aided the situation, showing that positive language and attitude can result in a positive interaction.

> *They were really relaxed. And that helped I think they were in quite a good mood. As I said, it would have been a quiet night and they were just like, they were chatting to me the whole time. And in retrospect, I can see why they were doing that it wasn't just for the banter, but they were keeping it quite like a relatively light-hearted chat. And I remember […] I said something like 'sorry about that' and they […] [said] something along those lines of like 'this is one of the parts of the job we enjoy', a sentence like that. Whatever it was, which I can imagine for some people they might feel like 'oh, I'm just a job to you' but for me that was the right thing to say in that moment, I think. (Holly, 30s, Pākehā)*

In Holly's experience, the casual banter set her at ease, resulting in a positive recollection of her police interaction. As Holly herself pointed out, this casual banter was not just to fill the silence but used as a distraction from the dark thoughts she was experiencing. Notably, the officers used positively geared language, when saying they "enjoyed" this part of the job. The use of positive language is important for mental well-being, as it improves an individual's mood, self-perception, and environment, which are all vital when an individual is experiencing suicidal ideation. Holly's

experience with the police shows that the use of positive communication increases the likelihood of the overall interaction being perceived as positive.

While much of the specific conversation with the police was very hazy for Erena (attempter), she too recalled that the police left her with a positive feeling. For her, the way that the officers treated her resulted in a positive recollection of events. This was especially important for Erena, as she had opened the door of her apartment unclothed.

> *I don't remember a lot of the interaction with them per se, but I remember having a really good feeling from them. So, I'm pretty sure they handled it really well. (Erena, attempter, 40s, NZ European/Māori)*

Holly and Erena's experiences resulted in a positive interaction with the police, despite the difficult situation. In both these cases, the interaction with the police resulted in a sustained positive outlook on the police. Erena pointed out, however, that while her experience was a positive one, this may not be the same for everyone, which was confirmed by the remaining three study participants.

One attempter and both family members felt that police did not handle their callouts as well as they could have. Their interactions resulted in negative feelings including shame, embarrassment, fear, and heightened depression. Participants attributed these negative experiences to poor police communication during the callout. For attempter Celeste, the language and demeanour of police during her callout amplified the feelings of depression she was already experiencing:

> *[The police] just didn't seem to care and were almost acting as if I was dramatizing things. And it was like, hey, you know, you just knock some sense back into yourself, you know. And then one officer said, "You're not going to do anything". And I was just like, oh, so [...] should I prove it then? [...] I just remember that really clearly, that they just didn't care, and I didn't find that helpful. It did amplify my feelings of depression and things, because I just felt like, ok, this is what someone official has treated me like [...] the moment*

someone says your selfish or you weren't gonna do it anyway, it just makes, it almost pushes you more into the direction of 'OK, fine then I will'. (Celeste, attempter, 30s, Indonesian/Kiwi)

The use of trivializing, uncaring, and invalidating language such as 'you're not going to do anything' and that she needed to 'knock some sense back into herself' dismissed Celeste's feelings and showed that the police officers did not take her attempt seriously. While Celeste did not give an example of what she would have liked to hear at that moment, it is imagined that something along the lines of "It sounds like you are going through a really hard time. I may not fully understand, but just know I am here to support you. Is there anything I can do to help?" could have enhanced Celeste's callout experience and made her feel safer around the officers in attendance. This suggests that if the police had used more validating language, the interaction would have been perceived more positively. Instead, the use of dismissive language resulted in Celeste's emotional state worsening. This shows that poor communication may push individuals further into suicidal ideation, which undermines the purpose of why police were brought in.

Family member Sarah looked back on both her and her teenage daughter Sophie's (attempter) experiences with police. She reminisced on the conversations she had with Sophie about the experienced callout. After a solo male police officer turned up to the woods where Sophie was, she explained to the officer that she had taken pills because she had been bullied. However, the officer simply stated that "that was not a good enough reason" to take her life and then sat there in silence.

I feel like him invalidating her and telling her that nothing is that bad that she should feel like she needs to do that because it is literally saying to someone your feelings aren't valid and you're overreacting. And that is possibly the worst thing you can say to someone when they're not coping. It just adds to feelings of shame and embarrassment. And like, their problems don't matter or by someone else's standards aren't justifiable, you know, aren't justified in response. I feel like perhaps if he had been more understanding,

and compassionate and less judgmental, and had some way of keeping communication going, that will keep her calm, even if it was distraction, not sitting there in total silence in the dark in the middle of the bush and feeling like he didn't know what to say. He clearly didn't know what to do. And for someone that's relying on a police officer or someone to support them, you can easily pick up on when someone doesn't know what they're doing. And that scares you, because all of a sudden, the security in that person is gone. Because you sort of feel like well, they don't even know how to deal with me, I don't know how to deal with me, and it just sort of makes them feel very insecure, which makes it all worse [...] there was one point where she just sort of thought, I just want to go home, I don't wanna be here, and I want to get away and it actually made her feel more stressed and more upset. And at that point, she had started reacting a bit to what she'd taken and she was getting quite scared [...] he didn't really do much to make her feel calm (Sarah, family member, 30s, European)

Much like Celeste's experience, the officer's communication with Sophie was dismissive and invalidated her feelings and experiences. Saying bullying is not a good enough reason for suicide, dismissed and belittled Sophie's emotions. This invalidation may not have been a conscious one. The officer may have been attempting to ease the mental distress by trying to change Sophie's perspective on her situation, unaware that his language and behaviour were an invalidation of her feelings. After this invalidation, the officer then sat in near-total silence. When left only to one's thoughts, sudden and prolonged awkward silence can make someone feel as if they have said the wrong thing, leaving the individual feeling judged, rejected and alone. This is opposite to Holly's (attempter) experience, where the casual banter allowed for a distraction from the thoughts whilst also creating a social connection. Here, the officer could have started a light-hearted conversation with Sophie, to help distract her from the fears which were building inside. Instead, the combination of dismissive

communication alongside extended periods of no verbal communication increased the adverse feelings she was experiencing.

Sarah (family member) also discussed her own experience with this police callout. She was at home at the time and received a phone call from the officer at the scene. From the start of her call, the officer gave her very little information on what was going on.

> *The whole concept behind his call was 'Sophie's very afraid that you're going to be very angry with her and I need you to keep calm' and it was a little bit, I felt a bit accusatory like, immediately jump to conclusions thinking that I was gonna flip out […] He didn't make me feel calm. He freaked me out, basically. And when I said, "Is she going to be okay? Like, is she okay?" He didn't clarify that she was conscious, that she was breathing, she was anything, it was just "We've got Sophie she's taken a whole bunch of painkillers, she's very afraid you're going to be upset with her. She's really, really concerned that you're going to be angry. I really need you to be calm and be gentle with her" and all this stuff. And then I said 'Is she is she, okay?' 'She's safe with us' is what he says and I'm like that's not telling me the status, it's not giving me any heads up about if she's like, is she conscious still like what's happening? [...] And saying that in front of her while she was being loaded into an ambulance, 'Sophie's very concerned, you're going to be angry, please be calm'. She thought that I was flipping out on the phone and getting upset when I wasn't, I wasn't at all […] So, I arrived at the hospital an absolute mess because I didn't know what I was walking into, basically. (Sarah, family member, 30s, European)*

For her as a parent, the lack of communication resulted in Sarah not knowing what was going on with her daughter. Because the officer refused to give her any real details on how her daughter was doing, Sarah drove to the hospital not knowing if her daughter was dead or alive. Had the officer simply communicated Sophie's state,

Sarah’s fears and anxieties could have been eased. Instead, due to this deficient communication, Sarah’s interaction with the officer left her feeling very scared and panicked. On top of that, the communication she did receive from the officer also suggested invalidation. By repetitively telling Sarah that Sophie was afraid she was going to be angry and to ‘keep calm’, he invalidated her very justified fears. The constant repetition to ‘keep calm’ also increased Sophie’s fear as she believed her mother was ‘freaking out’, while she was, in fact, relatively calm. The interactions with this officer left both Sarah and her teenage daughter Sophie feeling scared, confused, and in a poorer mental state.

Family member George also discussed his experience as a parent of an attempter after two officers turned up at his door. They failed to let him know why they were there and only after talking to his son alone for 20 to 30 minutes, informed George that his son had tried to take his life the night before. This lack of communication left George feeling very confused and disoriented.

> *Initially, it was a shock, I didn't know why they were there and I didn't know why they wanted to talk to my son. They were not wanting to divulge why they were there. They just said, we would like to talk to your son. And then it felt like from my perspective, that when the constable told me, it was just very matter of fact, and with no thought given to how that information would impact on the person being told, particularly as a parent. It was just almost like a ‘Oh yeah, your son's attempted suicide. Can you gather him and your daughter up, and we’ll take you to the hospital?’ Without the sense of this is a huge thing for a parent who's probably unaware of what's going on. And so, no thought of how this might impact on the person being told, and also the family dynamic. (George, 40s, Pākehā)*

For George, the lack of verbal communication while the officers spoke to his son outside not only left him feeling stressed but also very confused and shocked when they finally filled him in on why they were there. Whilst George, having no prior knowledge of his son’s emotional state, would still have been shocked, had the officers

let him know what was going on promptly, using empathetic language, the overall impact would have been significantly lessened. Much like Sarah's experience, the poor communication resulted in significant distress for George, which could have been easily lessened through positive and comprehensive communication.

From both the positive and negative experiences, it is clear that the use of communication is critical in how the overall interaction with police is perceived in suicide callouts. The findings suggest that validating language and comprehensive, relaxed communication are more likely to result in a positive outcome for those involved in suicide callouts and a positive longer-term perception of police. On the reverse, the use of dismissive, invalidating, or scarce verbal communication can result in negative emotions and distrust of police, both of which can increase the likelihood of poor outcomes in the future. Some may argue that female police officers may be better at communicating, but the gender of the officers who attended the discussed callouts showed no obvious effect in this study. There were both male and female officers present at both positive and negative callouts. Therefore, poor communication may simply be a result of the officer having a bad day, not liking this particular aspect of the job, or not having the skills to use appropriate communication techniques. This shows that the way police communicate during a suicide callout has a significant impact on how they are perceived as first responders. With both positive and negative communication experienced, it is clear that, as Erena (attempter) described it, communication with police can be very "hit and miss".

But it is not just the verbal communication or the lack thereof that is important. Police are visibly very recognizable with their uniforms and marked vehicles. The very act of turning up in front of someone's house is itself a form of non-verbal communication that can cause feelings of shame and embarrassment, as family member Sarah pointed out:

> *I also think [Sophie] doesn't like the drama associated with the police callout you know, police car being at our house or the police being where she is. It's not a very discreet way of being dealt with. You know, if you're even in a house, it's still a police car outside your house, all of your neighbours see. If someone's having mental*

distress, you should be in an unmarked car, shouldn't be something that alerts everyone on the street something's going on there [...] And I think for her she felt really embarrassed (Sarah, family member, 30s, European)

Simply wearing a police uniform communicates to everyone around, ‘I am the police, and something untoward is going on here’, a very different reaction than the one of concern that is often elicited upon seeing an ambulance or firefighter uniform. With Sophie (attempter) being in a very vulnerable state suddenly having someone show up and sit beside her in a police uniform, announcing to all who could see them that something was going on, made her very embarrassed. The added stress that this non-verbal communication elicited only added to the pre-existing mental distress. Had the officer turned up in plain clothes, there would not be the added stress of strangers staring at Sophie, wondering what was going on, while she waited for the ambulance.

Despite the overall callout being perceived as positive, Erena (attempter) was quite taken aback by the officers suddenly standing outside her door.

*[It should be] Plain clothes first, not cop clothes. Because part of what freaked me out was the whole, you know, because it’s quite a lot. They've got the vests on and they come and stand like this *puts fists up by collar bones* […] when you're in that real state, that kind of, so the whole uniform is intimidating (Erena, 40s, NZ European/Māori)*

As Erena pointed out, the visual communication of the police can be quite an intimidating one; from the way they are trained to stand, to the gear they wear. While Erena’s callout resulted in a positive view of both the interaction and the police, others who do not have high levels of trust in police may not perceive their interaction as positive due to the uniform alone. Hence, the police’s nonverbal communication, as expressed through body language and uniform, may cause those who do not hold a positive view of the police to react poorly to police intervention. Therefore, it is important the nonverbal part of a police callout be taken into consideration for delicate situations such as suicides. In these cases, as both Sarah and Erena point out, the

officers should be in plain clothes and unmarked vehicles, whilst using less intimidating body language. The use of unidentifiable equipment can set mentally distressed individuals at ease, making them more appropriate for suicide callouts.

Overall, those who had positive interactions found police bettered their experiences, resulting in calming and positive vibes. Whereas those who experienced negative interactions were left feeling invalidated, confused, and frightened. Overall, they felt their mental state had worsened due to interaction with the police. Therefore, police must be correctly trained in communicating with those experiencing a callout, be it as an attempter or family member. Further, the findings suggest that, if possible, police should attend callouts in plain clothes and unmarked vehicles, as the very nature of police gear can nonverbally communicate intimidation and negatively impact a suicidal individual's mental state.

The need for improved police training

The idea that police needed to be better trained to conduct suicide callouts was something that all respondents pointed out, regardless of whether their experience was positive or negative. While there was no clear consensus as to exactly what this training should consist of, it was clear that increased levels of training were needed for all officers regarding suicide callouts. For example, Celeste (attempter, *30s, Indonesian/Kiwi*) noted that

> *If [police] are to be the first people, they definitely need training.*

This point was reverberated by the other respondents.

Drawing on the aforementioned theme of poor communication by police, Sarah (family member) pinpointed the need for better communication techniques as well as understanding of suicide in general to be learned:

> *[Police need] better training and better understanding of how people are feeling when they're in distress. And just, even if they all just sort of had, you know, a script that they know psychologists have ticked off to say this is how you deal with it and these are the way you react to this kind of issue. If they're really highly strung, this is*

> *a de-escalation technique that you can use, that doesn't involve violence, or physical force, or anything like that. (Sarah, family member, 30s, European)*

Sarah proposed the idea of having some sort of set of communication points that have been signed off by a mental health professional. These communication points could help to alleviate the issues that she and her daughter Sophie (attempter) experienced when the officer attending to her clearly did not know what to say. This could include general talking points to try and start a conversation, to lighten the mood, steering away from invalidating language or long periods of silence. While scripts may not be the best option for all police officers, as they may come off as inauthentic, the use of psychologist scripts or talking points would give officers a better idea of what is and is not appropriate to discuss at a suicide callout.

George, also coming from a parental perspective, similarly discussed the need for increased training in how to communicate and support not only those experiencing mental distress but also their loved ones in the situation.

> *At a bare minimum, every single frontline police officer needs to go through some form of training to help them recognise [suicidal ideation] to help them know how to support the person going through that [...] that the police have the tools and the training to recognise that and support people through that, and also support the loved ones. Because I feel that as a parent and guardian to just go 'Yeah, your son attempted suicide last night please come to the hospital', the way that was handled was not the best way. And yeah, it was scary. But I don't think that the police had the skills to understand the impact of that on everyone around that situation. So, I think the minimum they need some form of skills and training [...] from my experience, knowing a few people that have gone through Police College, that's an intense period of time of training. And eight hours on mental health and suicide ideation is not enough and I'm sensing it needs to be readdressed. Maybe you give the basics over*

a day. But once you've got on to the job there needs to be something that happens six months down the track, that they are paired up with someone who is experienced that has been through this. That every year there is a reminder course, a refresher course, because mental health, like everything, changes. The understanding of the brain, how the brain works, changes. So, an eight-hour course done when they do training, which might have been five years ago. The information they have after that eight hours was completely out of date. And it's irresponsible to say that's enough. (George, 40s, Pākehā)

By not letting George know what was going on and leaving him in the dark for more than 20 minutes, only to be told 'Your son attempted suicide last night, please come to the hospital' shows a lack of effective communication from the police. Therefore, police need to be trained in how to communicate with not just the individual experiencing distress, but loved ones who are present for the callout. George also discussed the need for police to be trained through interaction with someone who has experienced suicidal ideation in the past. This would then allow for a greater understanding of what someone may be feeling at that moment. It would also allow police to discuss with a previous attempter what they needed from police at that moment. He also discussed that this training needs to be ongoing, as with most things, our understanding of mental health continues to grow. We, therefore, cannot expect the police to automatically know what best practice is if best practice is constantly changing. Yearly refresher courses, would allow police officers to train their mental health and suicide-based skills over time. While the skill level would still not be as ideal as having fully trained psychologists onboard, continual training would at least give officers a better grasp on the complex issues they come face-to-face with daily.

For Erena (attempter), though her experience was positive, she recognised the need for improved police training regarding communication and mental health in general. She believed that there should not only be more training, but specialised training given to select officers. This training could then be used to create a specific

team within the police who knew how to effectively conduct mental health and suicide-related callouts.

> *We've all seen programmes where there's someone who's quite aggressive or whatever, and the cops just rak them up, you know, because they're not trained properly to deal with that [...] they're aggressive because they don't feel they're being listened to. So, if you've got a cop who can deal with it and knows the right words to say, that can make a huge difference. So, I think definitely having a 24/7 team, in the cops of committed people who are properly trained to deal with all things mental health, and then maybe have sub-trainers who deal with suicide and self-harm. (Erena, 40s, NZ European/Māori)*

Erena's idea to have a specially trained set of officers who attend to these callouts would allow for a more specialised system of callouts. While each participant had a different idea of exactly what this increased training should look like, they all agreed that more of it was needed. Increased training of officers would give police better tools to handle suicide callouts and should enhance the experienced callouts for those with suicidal ideation and their loved ones. However, Celeste (attempter) stated that even an increase in training would not make her feel comfortable with police being the first responders to suicide callouts.

Police are not the ideal first responders unless the callout requires use of force

One of the ways in which it became clear that police were not the best option for suicide callouts, came from the respondents' reluctance to call police for any future suicidal ideation. Of the five participants interviewed, four stated that if they were in a similar situation, they would not call the police for aid. Only Erena stated she would call the police if she or a loved one were in a similar situation if it was the only number she could remember. The very fact that police would be involved was something that the respondents said could put them off from seeking help in the future if found in a similar situation. If police are the ones who will be attending gives an individual

experiencing suicidal ideation pause to reach out for aid, it shows they are not the right people for the job. Celeste (attempter) stated if she had known the police would be the ones who attended callouts, she would have been put off seeking aid. She stated that:

> *I haven't had great experiences with the police in general [...] I've had more bad interactions with them than I have had good, and I used to work with them [...] so, I was just amongst that cynical, misogynistic kind of environment for too long I feel. (Celeste, attempter, 30s, Indonesian/Kiwi)*

Even if police had the training to better their skills, Celeste still thinks the experience she had with the police would have stopped her from reaching out for help:

> *I would have more peace of mind if I knew that there were a bit more trained up, but it would still put me off.*

This shows that those who do not have a good relationship with or view of police, may not reach out for help if experiencing suicidal ideation if they know the police will be the ones who respond. The simple fact that it is the police who will attend to the callout, appears to be a barrier to reaching out for help. This contradicts the very act of sending police out to help, as the act of helping is stopping some from asking for help. George (family member) noted that for him, it may have not been an issue in the past because he has a high trust in the police. However, he was well aware of the fact that this may not be the case for everyone.

> *I mean, I have a reasonably high trust of police from my personal experience. But I am aware and very mindful of the way police actions have negatively impacted on the perception of the police by other parts of society. And for me, that would be people who are more vulnerable, people who are Māori, Pacifica, poorer communities, there is a large distrust and I understand that, and their distrust is rightfully so. The police actions in the past, they've shown that they have not been the best. So even for me, as someone who has a high trust, I still was scared of the fact that the police*

[were] involved. The police only turn up when, even for me the thinking is, the police only turn up when something bad has happened [...] as someone who has a higher trust of the police and was raised to trust the police, there was that natural instinct of what's wrong? And why are they here? I haven't done anything wrong. As far as I know, my kids haven't done anything wrong, so why the police here? So naturally, that puts me at a distrust just in that situation. (George, 40s, Pākehā)

George realised that his son's callout could be very different if his history with the police was not a positive one. This points out the fact there will be individuals who are experiencing suicidal ideation who may not reach out for help if they know police are the ones who will attend, because of their personal history with police. Additionally, if an individual does have a negative history with police and police are the first responders, there is also a higher likelihood that the individual may become hostile or violent. Most people do not see police as those who are attending to suicide, but as those who are implementing legal enforcement. So, even with his high trust in the police, simply having police turn up at the door put George in a place of distrust, as usually police only show up when someone has done something wrong.

After recalling her experience with her callout, attempter Holly discussed how she had not called the police directly in the past for help but a friend who worked in the industry instead. Though it had not crossed her mind at the time, police being first responders may have been a factor in the way she reached out for help. The call to her friend was not how Holly's callout with the police occurred but for previous suicidal ideation. Her choice to call her health worker friend was partly because his knowledge of her meant it would be easier to explain what was going on, but also because this knowledge would mean he would reach out to her husband rather than the police. Whereas if she called a helpline, they would have to call the police.

I wouldn't call the police directly but [...] knowing that if I were to call a helpline or some kind of line that they were going to call the police? I think I'd always assume that was the case like if you call

Healthline you know that they might call an ambulance for you and if you call any third party you know they might get someone else involved, and that they kind of have to. So, now that I think about it that's probably why I didn't call actual [helpline], I called my friend who volunteered for [helpline]. It was partly because he was a friend and I knew he knew lots about my life so it wouldn't be like you know going in from scratch. But also, I think it was because of the safety of like, he doesn't have to call someone else, [if he did] he'd call my husband. And he wouldn't do it without my permission, so if I really refused, he wouldn't do it. So, I think, in retrospect, [that police would be called out] probably had stopped me calling a third party. It hasn't stopped me calling for help, it has stopped me calling a [helpline]. (Holly, 30s, Pākehā)

While Holly's motivations for not wanting police involvement were different than Celeste's, the result of not wanting police to be involved was the same. Holly's resistance to police was not to do with trust levels, she even stated she had a high level of trust in police at the time, but instead, it was the fear of 'wasting' police resources that made her hesitant. As Holly exclaimed at one point *"Oh God! The public resources!"*, correlating her concern for the 'wasted' resources to her Presbyterian upbringing. Therefore, it is not just about distrust in the police that stops individuals from wanting police involvement, but also how the individual may see their callout as a strain on police resources. Holly's experience shows that even those with a positive view of police before a callout may still be hindered from reaching out to police when experiencing suicidal ideation. Sarah (family member) brought up that the drama associated with police turning up may also create a barrier to seeking help. Marked cars and police uniforms are not very subtle and allow for the prying eyes of neighbours to know something is going on.

[Sophie] would not call the police again, she has called Kari centre emergency line. That's who she calls now. So, I don't know whether it's because of her interaction with the police. I think it partially has

something to do with it. But I also think she doesn't like the drama associated with the police callout you know, police car being at our house or the police being where she is. It's not a very discreet way of being dealt with [...] And I think for her she felt really embarrassed. She was in a park, it was late at night, but there were still people around and she felt very embarrassed. (Sarah, family member, 30s, European)

For Sophie (attempter, teen, European), the impact of the nonverbal police communication involved in the callout, was a hindrance for possible future callouts. Police showing up in their uniforms is indeed 'not a very discreet way of being dealt with' and may make individuals too embarrassed to reach out for help. This sentiment was also echoed by Erena (attempter), who found the police suddenly at her door to be a massive shock and led her to initially believe she had done something wrong, as that is when police tend to turn up. However, for her, knowing that it is the police that would turn up would not stop her from reaching out for help in the future.

[Police as first responders] wouldn't stop me calling them. But it totally would, I think for a lot of people, it would, because people don't know that cops come to those situations […] I think that's quite scary, though. Yeah, but it definitely wouldn't stop me at the end of the day (Erena, 40s, NZ European/Māori)

These responses show that there are multiple reasons why people may be put off seeking help when police are involved; for some, it is the distrust they already have in police, and for others the drama associated with a police callout. Ultimately, the respondents showed that having police be the first contact for suicide will cause some individuals not to reach out for help, simply because it is the police who will turn up at their door. This shows that police are not the best first responders for suicide attempts, as people's lives are at stake.

None of the participants in this study thought that police were the ideal first responders in suicide callouts. This was echoed by all respondents, regardless of whether their callout was positive or negative.

No. No. […] I don’t think so. (*Sarah, family member, 30s, European*)

In the ideal situation, Holly would rather see trained counsellors as the first point of call. However, due to her personal history with St. John’s, she also was not keen on them conducting callouts either. When asked if she thought police should be the ones conducting first contact callouts, she stated:

In an ideal world no - it would be trained counsellors. In the current world though it’s probably preferable over St. John’s or other first responders”. (Holly, 30s, Pākehā)

Holly’s personal experience with other groups within the emergency services shows that while police are not seen as the best first responders, some people may see other groups as equally inappropriate. Only one respondent thought police could be the ones conducting suicide callouts. However, this was qualified with two conditions – that police are trained better and are best accompanying health professionals as a backup.

[Police] can be [first responders], if they're trained properly. I think the idea of having a mix team is probably heaps better, [but] they can be there for safety. […] So I don't think it matters whether they're just cops or not, it matters about that the training that they've got. I don't think it's super appropriate for just normal everyday cops who haven't had a lot of mental health training to be doing it. Because like we found out it's hit and miss (Erena, attempter, 40s, NZ European/Māori)

Participants recognized that whether police should be attending suicide callouts was not a simple black-and-white decision because they also acknowledged that police had one decisive advantage over any alternative responders – that they are legally permitted and trained to use physical force if necessary and can implement the *Mental Health (Compulsory Assessment and Treatment) Act 2012.* As family member Sarah pointed out, there will be times when a police officer may add necessary value to a callout team.

If it's someone who may have a weapon and is an immediate danger to other people, and will require restraining of some kind or a real critical de-escalation then perhaps, but again, alongside a mental health worker. But, yeah no, […] I think that there should always be some kind of mental health worker involved in some capacity. (*Sarah, family member, 30s, European*)

Whilst Sarah did not think that police should be conducting suicide callouts alone, she did believe that they could be involved when there was a physical danger, such as a weapon. The police would then be able to step in and de-escalate the situation. Much like Sarah, Erena spoke on the legal powers that the police have which other groups may not. The use of police would speed up the de-escalation of a violent situation through the legal facilities that police have. At this point, other groups do not have the training or sufficient knowledge to handle cases when an individual may be a harm to themselves or others.

I know there's all the section fives [power of police to detain a mentally disordered person] and all that that they can force people in. But most of the time, we're going to end up needing the cops to do that anyway, especially if the person is absolutely refusing, "I'm not going to go". So there's all that extra time and stress that person is going to go through whereas the cops can just deal with you take you away or get the ambulance there. That's all done and dusted." (Erena, attempter, 40s, NZ European/Māori)

George (family member) also echoed this sentiment, especially given the thought most people will have to ask for police when they call for an emergency when someone is showing signs of violent or hostile behaviour.

I understand, particularly if there's violence or something, they are a first responder. So, I understand that, you know, when you call 111 it's fire, ambulance, or police and I think for most people, their

> *instinct is to ask for police. So, I understand that they are likely to be first responders. (George, 40s, Pākehā)*

These three responses show, that there are valid reasons for police to be in attendance at suicide callouts. This means that if an individual is presenting themselves in a violent manner, whether they are violent toward police, others, or themselves, officers can step in with the legal power they have been given and their training to subdue violent individuals. However, as the respondents, and earlier literature, have pointed out, the current police training may not be suitable, in its current state, for those experiencing suicidal ideation. Therefore, according to the respondents, even in situations that require the use of force police should always be accompanied by a health professional and never be the sole responder, and, for the most part, police should not be conducting these callouts. Most of the respondents said that police attending to callouts would give them pause when reaching out for help, even those with high trust in police. Therefore, there is a major issue with police as first responders to suicide attempts, as knowing the police may be the ones attending could stop people from reaching out for help.

Health workers as ideal first responders

All respondents were asked what their ideal situation would be like if all barriers were removed, such as financing. For the most part, there was a desire for a specialist mental or physical health service to respond to suicide callouts. All but one participant thought that some form of health worker should, in the ideal, be the first point of contact in suicide-related callouts. For those four respondents, police would not be involved unless absolutely necessary. For example, when asked about what the ideal callout looked like, family member Sarah wanted specialist mental health workers to be the first responders.

> *Oh, you would not have police going to those callouts. You would have very highly trained specialised mental health workers. And you'd have someone that was for the person and for their family. You know, you have two people involved to manage a situation, at critical*

> *level and at support level. That would be ideal.* (Sarah, family member, 30s, European)

Rather than having the police as the first responders, Sarah wanted the first point of contact to be with a specialist team of mental health workers. This team would be there for those experiencing suicidal ideation and for those around them. Also having someone there for those around them can help to keep the situation under control, if a loved one is panicking, it only going to make the situation worse. If there is someone there who can read the dynamics of the callout, which police do not have the training to do for suicides, the callout can be handled in a much more proficient manner. Family member George, on the other hand, thought ambulance officers should be the ones that conduct callouts, as mental health and physical health are interconnected.

> *I think ideally, because I see mental health as being something that is a mental version of physical health, and so, the police are not the right agency to deal with it at all. That in an ideal world, our ambulance service would be fully funded by the government and at a decent rate, and that there would be an aspect of the ambulance service that will be there for mental health services. So, like, an ambulance getting sent to an accident and they are dealing with triage trauma, or trauma triage, where there's blood or broken bones. That there is an aspect of the ambulance service that is designed to do the same thing, but for people who are mentally in trauma, who need that mental triage to help them. So, in an ideal world, it would be an aspect of the ambulance service that would be fully funded, focused solely on mental health stuff. (George, 40s, Pākehā)*

George sees mental health as an extension of physical health, therefore, he believed that ambulance officers are the ones who should be attending to these callouts as they would attend to a car accident. Also, much like Sarah, he believed that there should also be something in place for loved ones who were involved. At first, Holly

(attempter) discussed her thoughts on the ideal situation but then realised the ideal situation would look a little different than she first thought. She realised that a 'crack team of therapists' would be the best option.

> *I mean who else is on call? A crack squad of therapists would be amazing […] It's interesting because when you ask that question, I started running through like, okay [...] Who do you want police, fire, ambulance? Like, I want the crack squad of therapists. Yeah, the Therapy squad, with their uniform of beads and a loose jumper […] Because we expect so much on police and fire and ambulance […] And how can police be expected to be therapists, and enforcers, and deescalate, and traffic cops? It's too broad, for any one department.* (Holly, 30s, Pākehā)

Holly brought up an interesting point, that police are already dealing with so many other tasks, so why are we expecting them to be makeshift therapists as well? Creating a 'crack squad of therapists' would free up resources for police, giving them time for other aspects of policing. Celeste (attempter), on the other hand, had some specific ideas as to who she thought should attend the callouts.

> *I think a psychologist or someone well versed in this in particular. Yeah, I mean, I like the sound of psychologists as well, having worked with a few I just think they are grounded. Even a counsellor […] Counsellors are quite validating of your experience. So I think anyone in that sort of field to immediately come and then I think something to do with DBT therapy […] Maybe a breath work person… maybe an option for something with physical touch like massage or something […] I know some people [are] really anti touch but having that as an option for people that just do wanna cuddle.* (Celeste, attempter, 30s, Indonesian/Kiwi)

Celeste's ideas could be incorporated into one team of specialists which go out specifically for suicide callouts. Trained professionals with the skills to be able to read

what a person needs at the moment and provide this on call. While these teams would be highly specialised, with upwards of 80 callouts per day, a number consistently on the rise, creating specialist teams would, as Holly alluded to, free up police for other aspects of policing.

These four responses show that most respondents thought that police should not be the ones conducting callouts in the ideal situation. Instead, these should be conducted by some form of mental or physical health professional team. These teams would then allow for a more specialised callout with team members who have a good understanding of mental health issues and suicidal ideation. Further, these teams would allow police to focus on other issues, whilst still offering support as needed. Erena (attempter), however, was concerned that the issues that police cause may still be caused if other agencies conduct these callouts; specifically, that even a trained mental health professional can have an off day or poor mindset when attending to a callout.

> *I've been through a lot of the mental health system, and there's a lot of people who are psychologists, psychiatrists, blah, blah, blah, community workers, and just as many of them have the blasé attitude or the I don't want to be here attitude as the cops do. So, would I want to say people who are only trained and they're not cops? I think I don't think it matters a huge amount if they are plain clothes, to me personally it was seeing the uniform. (Erena, attempter, 40s, NZ European/Māori)*

Erena's experience shows that even when trained professionals are involved, the interaction can result in a negative one, and as she pointed out, they are only human, and humans have bad days. For her, it was more about the police showing up in their uniform that made her uncomfortable than the fact they were police. However, as the other respondents pointed out, police are not going to be the best option for everyone. Therefore, the preference of the respondents was to have some form of health professional involved.

Co-response teams as an alternative callout model

There was also a lot of discussion around the need for better collaboration between police and supporting agencies, ranging from having support services ride along with police to having them available by phone during a callout. These collaborative services would then allow for a more specialised service for those experiencing suicidal ideation. Whilst it was not the ideal, co-response teams were seen as an acceptable alternative, for now. Sarah (family member) not only pointed out the use of other agencies in callouts, but better systems within the police procedure. That these two things used in tandem could significantly enhance how callouts for suicide attempts are handled.

> *Maybe having a support person along with a police officer. A mental health worker, you know, that would be a great option. I mean, obviously, there's funding involved with that. But even having someone on the phone who is a mental health worker, you know, if they feel they're not able to manage it. Having two people instead of one, so that you've got two minds and if someone can see that the other person is not managing very well, they can step in. Or you might find that that person might respond better to a male or a female or a certain ethnicity or something like that, but having that option as well.* (Sarah, family member, 30s, European)

It is clear that Sarah thought mental health workers should be riding along with police, however, given the finances that may be required for this, she pointed out that even a phone call with mental health workers would enhance the current system. Smaller changes to policing systems could, in Sarah's eyes, improve the current callout model. Sophie only had one officer at her callout, and adding another could have allowed for better communication between the three of them. Also, as a young woman, it is slightly inappropriate to send a solo male officer out when there is no knowledge of the individual's history. As Erena at one point pointed out, a large number of individuals who end up in the mental health system and attempt to take their lives have a history of sexual assault, and it would simply be inappropriate to send a single male

officer to such a callout. Therefore, it is better to have at least one female officer on all suicide callout teams, so that the gender of the officers is not impacting upon the suicidality of the individual.

George (family member) elaborated on the need for some sort of secondary response team of professionals that can help the individual experiencing suicidal ideation as well as those around them. He pointed out, that the police may not have the skills to see things the way a professional counsellor or therapist may be able to, with the individual experiencing suicidal ideation as well as those around them. This would then allow for a team effort of police dealing with any issue that may arise which may need section fives or de-escalation, while therapists would allow for counselling of the issues involved.

> *I think that there should be a second tier where there is some form of counselling, crisis counselling that can come in quickly. Because I think that a crisis counsellor is more attuned and more skilled and tooled to recognise and support not just anyone going through suicide ideation, but also the people around them that need that support in order to help that person.* (George*, 40s, Pākehā*)

Because the police or mental health worker cannot be with that person after the callout, those who are around them must be given the support to help. As George has pointed out, police do not necessarily have the tools to guide those support people through a callout. A mental health worker is more attuned to the individual needing the callout as well as those around. Additionally, if one of the individuals in attendance is making the callout worse, mental health workers are more attuned to notice when others in attendance may be exacerbating the situation, be that support people or police themselves. While Erena (attempter) thought police could be involved in callouts, and at times should be, she preferred the idea of co-response teams. The use of both police, as well as some sort of mental health worker, would allow for better safety measures for all involved.

"So [police] can be [first responders], if they're trained properly. I think the idea of having a mix team is probably heaps better. [Police] can be there for safety" (Erena, 40s, NZ European/Māori)

Overall, the respondents felt that at a minimum, police needed to be supported by other agencies, such as mental health professionals. The use of these professionals would allow for a better outcome for those experiencing suicidal ideation as well as those around them who may need support. While a purely health-based team was preferred over all other options, the use of co-response teams was a clear second.

These five findings show that negative encounters with police make those experiencing suicidal ideation feel embarrassed, unsafe, and ashamed. Those interviewed did not think police should be conducting callouts, even when their experience was positive, but instead specialised health professionals. At the very least, respondents thought police needed more training and better collaboration with other agencies, especially now that the impact of COVID-19 has decreased the mental well-being of the country. These findings are not unexpected as they align with much of the current literature in the general mental health domain as demonstrated in the following chapter.

Discussion

Through the thematically analysed one-on-one interviews, five key findings emerged. These were: (1) poor police communication, both verbal and nonverbal; (2) the need for improved police training; (3) that police are not the ideal first responders unless the callout requires the use of force; (4) a preference for health workers as respondents; and (5) a secondary preference for co-response teams as a callout model. These findings help to answer the three research questions posed.

Responding to Research Question 1

Firstly, this study sought to explore the experiences and perceptions of previous suicide attempters who received an NZP intervention and family members who have been involved in such callouts. This research found a mixture of both positively and

negatively experienced police callouts. The findings were slightly more negatively geared, with two respondents expressing that police made their experience better and the other three perceiving their interactions as negative. Thus, the findings confirm the mixed emotions that Watson et al. (2008) found in their US-based study on police as first responders to individuals in mental distress. Unlike Watson et al., this study found no outright abusive or disrespectful behaviour by police. However, invalidation of feelings can arguably be considered a form of disrespect. While no participant explicitly said that they felt disrespected by the police officers involved, research shows that invalidating people's feelings and experiences, especially those of adolescents who are still forming their sense of identity, can result in feelings of shame, the individual disconnecting from the relationship or interaction, decreased positive emotions, and reduced likelihood of the individual reaching out for help in the future (Wasson Simpson et al., 2021; Zielinski et al., 2023). It is argued that the invalidation of this study's participants' feelings constitutes a failure by the police to respect their emotions. Ultimately, the invalidation dismisses their voices. Most participants felt like they had no or very little power in the situation. They had no say in how they were being treated. In fact, no one was asked what they needed in their respective situations.

As Murphy and Tyler (2017) point out "police communicate trustworthy motives when they listen to people's accounts and explain or justify their actions in ways that show an awareness and sensitivity to people's needs and concerns" (p. 287). The reported lack of awareness and sensitivity as expressed through poor communication that the police officers showed in several of the interactions, resulted in a lack of trust as most study participants said they would not call the police again in a similar situation. This demonstrates that police failed to effectively implement the trustworthiness principle of procedural justice.

In sum, poor police communication resulted in interactions that were perceived as disrespectful and silencing, which resulted in participants becoming unwilling to call NZP for suicide callouts in future. The police officers thus violated three critical elements of procedural justice, resulting in negative perceptions of police during and after the callout. These negative perceptions are likely to be exacerbated when NZP communicate poorly in encounters with individuals who have high distrust in police, who also happen to be the individuals with the highest rates of suicide. As only one

individual in this study self-identified as Māori, further research is required on how police communication in suicide callouts affects individuals who belong to this high-risk population. It can be argued that if the police do not increase their legitimacy through the removal of institutional and individual bias, they will never be the right agency to conduct suicide callouts. This cannot happen overnight, as Tyler (2017) pointed out, one positive interaction with police is not going to change the views an individual has accumulated over a lifetime.

One respondent of this study, however, felt that police made her experience easier, with comforting banter and an overall calm demeanour, with another remembering police giving her 'good vibes', confirming the positive responses seen in Watson et al. (2008). However, unlike this study, their participants pointed out that sometimes all that was needed for them to say it was a positive experience was that police did not physically assault them – a very low bar indeed. For Holly, the officers moved the conversation away from her suicidality and onto general casual banter using positively geared language. Therefore, all the officers needed to do for a positive communication interaction in her case was to *not* invalidate her feelings and keep the discussion light-hearted and upbeat. This shows that if officers do not know what to say or are uncomfortable discussing how the individual is doing, simply changing the topic and using positively charged words may be enough to keep the individual calm and improve their mental state. Casual banter removes awkward silence and diverts the conversation so that there is less chance of invalidating the individual's feelings and creating distrust and disrespect between police and attempter. While ideally there would be conversations around how the individual was feeling, to help guide them through their suicidality, the police are often a stopgap until health responders can step in. Therefore, if keeping the individual who is in mental distress calm until a professional can arrive is all police need to do, then the use of distracting casual banter is appropriate. Since Holly and Erena experienced no disrespectful language or police actions which may constitute distrust or express bias, they experienced their callouts as positive. This research has shown that the positive responses experienced by Holly and Erena did not impact on their likelihood of calling the police for help in the future. Though Holly did say that she would not call the police if in a similar situation again, this was not connected to police legitimacy but her concerns about police resource use,

which existed before the callout. Therefore, a positive experience with police can result in individuals reaching out for help again as needed, as long as there is no prior distrust of police due to other negative interactions.

The findings of this research show that is not just verbal communication by police that caused issues but non-verbal communication as well, which is reiterated in the existing literature. As Otu (2015) pointed out in their study on the impact of uniforms on the general public, an officer's non-verbal communication, such as facial expressions, clothing, and posture, can negatively impact the interaction, even if the verbal communication is positive. While police uniforms give the general public a sense of safety and security, they also are seen as more intimidating and aggressive compared to civilian clothing (Simpson, 2017; Simpson & Sargeant; 2022). When an individual has prior negative interactions or perceptions of police, uniforms make the officers appear less friendly or respectful than those not in uniform (Simpson, 2017). Suicidal individuals are already in mental distress before police arrive, and because someone in mental distress is more sensitive to the elements of procedural justice, their chance of a poorer interaction is more enhanced than it is for the general public. This means that the effects of a police officer's uniform are going to negatively impact an individual in mental distress more than the general public. Because police officers are identified as authority figures through the nonverbal communication of their uniforms and marked cars, it is important that they follow the four key components of procedural justice as an individual officer's actions can impact the public's views on all others wearing that same uniform. If an individual had past experiences with police which negatively impacted their perception of anyone wearing the police uniform, this may impact future interactions with police. This can be seen in Celeste's response, as she already had a negative perception of the police, which was enhanced by the invalidating and insensitive callout she experienced. Both her prior interactions with the police and the suicide callout meant Celeste would refrain from getting help in the future because the police would be the ones who would attend the callout. Officers are unaware when they are arriving at a suicide callout what prior experience the individual has had with police and how the non-verbal communication of the uniform may impact the callout. Therefore, the safest option for all involved is for police to attend suicide callouts in plain clothes and unmarked vehicles.

The respondents in the current study perceived that there was a need for increased police training if they are to continue conducting suicide callouts, echoing the findings of overseas mental health research. The need for increased training revolved specifically around better communication with individuals experiencing mental distress and their loved ones. After all, how are police expected to know how to talk to individuals in mental distress if they have not been taught to do so? As the overseas literature posits, this mental health-based training should build officers' empathy and anxiety-reducing skills (Allen et al., 2003). Findings from this study suggest that if police wish to be perceived as a legitimate responders to suicide callouts, this training should be based on the four pillars of procedural justice: respect, trust, neutrality, and voice. Previous findings also imply that even a 40-hour specialised training programme may not be sufficient time for mental health training (Boscarato et al., 2014). However, as family member George pointed out, mental health is still a relatively new field of study and our understanding of mental health is constantly evolving. Therefore, it is not just a matter of the number of training hours, but also of training regularity. George suggested including individuals who have experienced a suicide callout in an interactive police training, allowing police to learn firsthand from those who have experienced suicidal ideation or their family members, giving a face to the concept of suicidal ideation (Gordon et al., 2018). Erena, on the other hand, suggested choosing specific officers to undergo more intensive training to create specialised mental health police teams. These teams could then go out to all mental health-based callouts, with even more specialised teams for suicidal ideation, much like those found in Scotland (Spence & Millot, 2016).

This increase in training for police can also lead to decreased rates of police suicides (Mishara & Fortin, 2022). With police suicide being of great concern in academia, and amongst police agencies themselves, the increased training can then act as a double protective measure, for police as well as the individuals they are attending to. Training, such as that conducted by Gordon et al. (2018) and suggested by George, could reduce the stigmatisation of those experiencing not only suicidal ideation but mental health issues in general and the stigmatisation within the police, in turn reducing police suicide risk. However, this training would need to be reiterated over time, as there is no guarantee that the impact of one-off training would result in long-

term effects. From both this research and past research, it is clear that police need to be better trained regarding mental health, especially regarding suicide.

Responding to Research Question 2

Next, this study asked whether NZP are the ideal first responders to suspected suicide attempts from the perspective of previous attempters and their family members. The findings showed that only one participant would personally call the police if they or a loved one were experiencing suicidal ideation, given it was the only number they could remember, which mostly aligns with the findings of Boscarato et al. (2014). They stated that "Participants unanimously reported that they would never call on the police to resolve their crisis" (p. 291). This shows that having police as first responders can result in individuals not reaching out for help, especially if they already have a negative view of police. Procedural justice theory explains that this is often due to the negative perceptions that individuals either already had or were created during a negatively experienced suicide callout with police. Both this study and prior research have shown that a single negative experience with police can stop someone from reaching out for help if the police are the responders. Because seeking help is a major part of suicide reduction strategies, both risk and resilience, it is clear police are hindering suicide reduction. It is, therefore, important that the powers that be give voice to the concerns of previous attempters if they wish to implement appropriate suicide reduction strategies. While there are other reduction strategies which also need to be dealt with, such as the serious stigma held by the New Zealand public around mental health and suicide, it does not make these issues any less important.

The reasoning behind why individuals would not call the police varied and was not always due to procedural justice failures. As in Holly's case, the of fear the police resources being 'wasted' may stop some from seeking aid from the police. Holly equated her concern for resource use to her Presbyterian upbringing, but her reaction does bring up concern for those who may have low self-esteem. As suicidal individuals tend to have low self-esteem (Chatard et al., 2009), it is important to realise they may see their callouts as a 'drain' on police resources. Therefore, it is not just the distrust of police that can cause stop someone from seeking aid for suicidal ideation. Whilst moving the task of attending to suicide callouts away from police would not change

the self-esteem levels of suicidal individuals, it is much easier to justify seeking help from a specialist team than the police, who have other jobs on top of suicide callouts to attend to.

The fact that only one participant thought that police should, or could, be the first contact to suicide callouts, and certainly not without some form of mental health worker, was confirmed by the existing mental health literature. There has not been any previous research specifically into whether NZP should be the first contact in the case of suicide from the perspective of those who have been the subject of these callouts. Hence, the current study makes, despite its exploratory nature, a novel contribution to the literature. Much like the current study, research looking into general mental health callouts aligned with this study's findings, that those experiencing mental distress did not favour the police as first responders (Boscarato et al., 2014; Watson et al., 2008). The distrust, disrespect, and lack of giving voice displayed by the police drove home the main reasons why police were not seen as the best responders. Additionally, several respondents noted that while they may have high trust in police, or at least did before their callout, others whom police have shown a clear bias toward may not share this level of trust. However, when there was a need for the use of force, several of the respondents found it reasonable for police to step into a callout for the safety of all involved (Boscarato et al. 2014). Therefore, there are legitimate reasons why police may attend suicide callouts. This does not mean, however, that they are the ideal callout but can act as support when needed for the safety of those attending the callout, bystanders, or the suicidal individual themselves.

Even police have shown that they do not want to be the ones conducting callouts and think that mental health workers are the ones that should be attending to suicides (Fry et al., 2002; Kuehl et al., 2023; Spence & Millot, 2016; Wood et al., 2021). Since police are the most common first responders to suicide in New Zealand, it is important to ask them their views on conducting suicide callouts, which future research should address. As Every-Palmer et al. (2022) point out, "Having police operate as a de facto mental health crisis service reportedly has negative consequences for service users, staff and providers" (p. 2). Police often, but not always, have a high rate of suicide themselves (Mishara & Fortin, 2022). Procuring their point of view on callouts could give insight into not only the callouts and what is needed but the impact

of those callouts on the police officers themselves. After all, as stated in their 2022 report, NZP have said that they are neither the lead agency for mental health nor sufficiently trained to deal with mental health callouts (NZP, 2022). With an estimate of over 80 callouts per day to attempted suicides, moving this task away from the police would increase their ability to focus on other aspects of policing, rather than something which is clearly in the realm of mental health. Also, it could be argued that if academic research wants to be perceived as legitimate, the principles of procedural justice should also be extended to academic research, which requires the voice of police to be heard in a respectful, unbiased and trustworthy manner. If the police do not feel they are being heard on this subject, it may cause a bias toward a part of the job they do not want to be doing, impacting upon the neutrality they bring to callouts and in turn impacting those they are sent to help.

Responding to Research Question 3

Finally, this study questioned if the NZP are not the ideal responders, what alternatives do previous suicide attempters and their families suggest? The most common finding for the 'ideal' callout was the use of professionals either mental health workers, for example, a 'crack team' of therapists, as Holly put it, or physical health professionals, such as paramedics; as mental health is still a health issue. The desire to have some form of specialist mental health professionals conduct callouts aligns with findings from research looking at police themselves. Police officers wanted mental health callouts to be conducted by specialist mental health clinicians and not them. This is because it frees the officers up to conduct other aspects of their job, which they are more interested in doing (Wood et al., 2021). If police are disconnected from mental health and suicide callouts, this may explain why some officers lack the procedural justice principles needed to result in positive callouts. Because this research is quite novel, there is not really any literature to align with regarding mental health workers from the point of view of those who have been the subject of a callout or their family members. The lack of literature in this field is most likely because, for the most part, mental health professionals are not the ones conducting these first contact callouts; though they are often the ones dealing with the aftereffects of them. However, these ideals put forward by the respondents are not, in the current New Zealand climate,

sustainable. At the moment, we are seeing that ambulance services, and hospitals, are overwhelmed with the number of callouts they receive per day, and the current mental health systems are not able to sustain the workload they already have (Davison, 2023). If New Zealand were to make dramatic changes to suicide callouts, increased funding would be required including an increase in human resources in the health sector. However, taking suicide callouts off the police's agenda would free them up to do other jobs and allow for better allocation of police resources.

A key element that came through the interviews was a need for better inter-agency collaboration, which is echoed in previous literature. The majority of respondents in this research expressed that one of the main realistic changes that could be made to improve police callouts was a better collaboration with agencies like ambulance officers, hospitals, and mental health personnel. Changing to a co-response unit is seen as the best way forward from a police-only system (Boscarato et al., 2014), as completely changing the system over to a mental health-only unit can be a jarring and messy process, for all involved. While the combination of police and mental health professionals has drawbacks, such as a disconnect caused by the two group's differing philosophies, they result in better outcomes for those in mental distress and better communication between the two services, among other positives, than police alone (Kisely et al., 2010; Lee et al., 2015; & McKenna et al., 2015; Shapiro et al., 2015). Co-response also provides mental health clinicians with protection, through police and their ability to physically de-escalate violent encounters, giving them a sense of safety (Shapiro et al., 2015). New Zealand has begun to implement a co-response to mental health callouts with mental health professionals coming on board (Every-Palmer et al., 2022). However, this is not what this study was specifically looking at, so none of the respondents had experienced these co-response teams. It is currently unclear what the long-term impact of the New Zealand co-response teams is, as they were only implemented in the last few years. Therefore, it is still possible that they will find issues with these callouts in the long run. This is because overseas studies have found that while including mental health professionals in the callouts reduces hospitalisations and pressure on the criminal justice system whilst increasing mental health referrals, community-based support, and providing better outcomes for 'consumers' of the services (Every-Palmer et al., 2022; Kisely et al., 2010; Lee et al., 2025; McKenna et

al., 2015; Rohrer, 2021; Shapiro et al., 2015), it does not necessarily decrease use of force or injury (Bailey et al. 2022; Marcus & Stergiopoulos, 2022) or result in a more positive experience for 'consumers' (Boscarato et al., 2014). Therefore, the element of the police may still cause a disconnect with the best outcome for the individual in mental distress. Again, this can be linked to the misuse of procedural justice principles, as simply adding mental health professionals does not negate the distrust those in the highest suicide bracket already have toward police.

One participant in this study alluded to the fact that some attempters may feel most comfortable with friends or family being the first responders, a reiteration of Boscarato et al.'s (2014) research. Holly's initial response was to call a friend rather than a mental health team and, if needed, she would rather have her husband be the one who was called than the police. She did point out, however, that she wanted a follow-up by health professionals after being taken home. Holly also reminisced on how her experience would have been very different if she had not been married. She realised if her parents had been the ones being contacted, as next of kin, her mental health could have suffered due to the relationship she had at the time with her mother. She pointed out that contacting family when this is not desired by the individual in distress may "make a lot of people unsafe". This can also tie to the issue of stigma increasing the risk of future suicide attempts (Mayer et al., 2020). If the wrong people are called to a suicide attempt, this could impact the likelihood of future attempts. If it were the case that family were to be called when an individual has expressed that they do not have a good relationship with their family, this would invalidate the individual's voice and trust they may have in those they have reached out to for aid. Listening to and, as appropriate, honouring the wants of those experiencing mental distress is important in achieving positive long and short-term outcomes for the individual (Allen et al., 2003). Therefore, while part of Holly's response aligns with Boscarato et al.'s (2014) research, for the most part, the research findings do not support Boscarato et al.'s argument for family and friends over mental health teams. The difference in findings may be due to Boscarato et al. looking at general mental health versus suicide alone. While suicide falls under the general bracket of mental health, it is its own unique subject.

As per the limitations, this study has a dearth of respondents who fall into the highest distrust and highest suicide levels. For this reason, further research should be completed looking at those who have had callouts with police and fall into these categories. With the new trial of police and mental health professionals, a qualitative study of those who have experienced these callouts compared to police-only callouts could be of great use; especially when paired with quantitative research such as Every-Palmer et al.'s (2022) quasi-experimental study. But it is not just the 'consumers' point of view which is important. With mental health professionals often seeing the impact of police as first-contact callouts, their viewpoints would significantly add to this research topic.

Conclusion

This research has explored the appropriateness of police as the first contact for suicide attempters. Because those with the highest distrust of police have the highest suicide rates, it is extremely important to know if they are the right agency for this job. Answering the question of whether police should conduct first contact callouts is not necessarily as easy as just saying 'no'. While in an ideal world, police would not be the first contact, there are other factors to consider. As the respondents of this research point out, there are elements such as financing, the possibility of violence, and the availability of resources that impact who can conduct these callouts.

This study has shown that a negative interaction with police can result in shame, increased depression, and further suicidal thoughts as well as shock and confusion for loved ones. Communication, be it verbal or nonverbal, plays a vital role in how the callout is perceived. How police conduct callouts to mental distress mattered for the individual's overall mental well-being and the perceptions of police in general. This means, how police conduct these callouts can not only impact the individual's mental well-being but also their levels of trust in the police. The poor communication with attempters and family members can be linked to the misuse of procedural justice principles. It is therefore important that police communication skills are appropriate for suicide callouts, with procedural justice at its core. Police language used should be validating and calm. Validating language is important in the realm of mental health but is not necessarily taught to police in their training. After all, you do

not need to use validating language when pulling someone over for speeding or arresting someone for selling illegal substances. Additionally, if police do conduct suicide callouts, they should be wearing plain clothes, turn up in unmarked vehicles, and use relaxed body language.

As those who are experiencing suicidal ideation are in a critical mental state, callouts must be conducted in a way which prevents future harm. Because of how the callouts discussed in this study were conducted, all participants felt police needed better training on how to conduct suicide callouts, especially concerning communication. This training should be based on the four principles of procedural justice, as a lack of procedural justice results in negatively perceived callouts and poorer outcomes for suicidal individuals. The training should also involve stakeholders, such as previously suicidal individuals who have had callouts from police, so officers can learn firsthand from those who have experienced mental distress. This training should also be conducted regularly, as mental health is an ever-evolving subject. An increase in police training in general mental health with the integration of suicide, would create a safer environment for not only those experiencing suicidal ideation but anyone in mental distress. It would also reduce the risk factors for police, as prior research has shown that increased training of police reduces their stigmatisation of mental health and those experiencing mental distress. As stigmatisation is a risk factor for suicide and the police have long held stigmatising beliefs around suicide and mental health, and getting help for these issues, the increase in training may decrease the risk of police suicide. Therefore, the increase in mental health training for police has the possibility of aiding not only those who receive callouts but those implementing them.

It was clear that only one of the respondents would call the police if they or someone else were experiencing suicidal ideation. This means, that if an individual is aware of police being the ones who will come to their aid, this may stop them from reaching out for help. Police attending attempted suicide callouts is of course not the only thing stopping the call for aid, but at least removing them as first responders would remove a possible barrier. Also, only one of the participants thought that police should, or could, be the ones conducting suicide callouts. Even those who had had positive experiences with police did not think they were the ones to be going to

callouts. If the police were to continue these callouts alone, research suggests that incorporating procedural justice into administrative police policy can be the most appropriate way to curb police behaviour toward more effective and ethical callouts, especially for individuals in mental distress. This is due to these policies creating the standards and philosophies of the agency, therefore guiding officers toward decision-making in line with procedural justice theory (Morgan, 2021). Therefore, policy changes can impact how people experiencing mental distress are treated by police. Further, this policy change would impact not only those experiencing mental distress but all callouts, as procedural justice is linked to better outcomes for all, including reductions in crime rates (Murphy & Tyler, 2017; Tyler, 2017; Tyler & Lind, 2001).

Even increasing police training does not remove the issues surrounding them as first-contact callouts. Therefore, it is not surprising that for the most part, the ideal situation for those who have experienced or witnessed a callout for a suicide attempt did not include the police. Instead, respondents wanted some form of health or mental health professional team to conduct these callouts. This is the ideal situation and not necessarily something that can be implemented, as currently, New Zealand does not have the infrastructure to implement it. Even in the ideal situation, there is still a possibility for police involvement. With several of the respondents, and previous literature, discussing the possibility of needing police regarding violent behaviour, it may be good to have police on call. This way, if there is a situation that may involve violence, police can be dispatched to aid. However, in the ideal, the majority of callouts would be conducted by a specialist health team.

While a specialist team of health workers were ideal, the respondents realised this is not necessarily able to be put in place at this time. Therefore, the best option for now was the use of co-response teams as a callout method. The fact that New Zealand is currently implementing a co-response team for mental health callouts, shows that the country is moving in the right direction. However, the use of these teams needs to become the standard practice. At this point, the resources are not available to make this the standard callout, so more resources need to be provided to enhance not just suicide callouts but all mental health callouts.

This research shows that in an ideal world, we would not have police conducting callouts to suicide attempts. While this is not practical at this stage, it is

something we should be working toward. Instead of a police force, already burdened by high suicide risk and large workloads, a specialist team should be put together, made up of professional mental health care workers. The police can then be called upon as needed when a situation may require them to step in. In the meantime, however, the police need to be better trained to deal with suicidal individuals, to make sure they are not causing more harm than good. They also need to be supported by secondary agencies, such as mental health professionals, to enhance these callouts. As other research has shown, working together with mental health professionals increases police understanding of the situations they attend, a sort of on-the-job training. Therefore, police working with mental health professionals enhances the results for those experiencing suicidal ideation as well as the results for the police. At this point, the best course of action is to increase the use of co-response teams, making them the standard practice, with the ultimate goal being a specialist team for suicide.

References

Allen, M. H., Carpenter, D., Sheets, J. L., Miccio, S., & Ross, R. (2003). What do consumers say they want and need during a psychiatric emergency? *Journal of Psychiatric Practice, 9(1),* 39-58. http://doi.org/10.1097/00131746-20031000-00005

Alothman, D., & Fogarty, A. (2020). Global differences in geography, religion, and other societal factors are associated with sex differences in mortality from suicide: An ecological study of 182 countries. *Journal of Affective Disorders, 260*, 67-72. http://doi.org/10.1016/j.jad.2019.08.093

Ara Poutama Aotearoa Department of Corrections. (2023). *Prison facts and statistics: June 2023*. https://www.corrections.govt.nz/resources/statistics/quarterly_prison_statistics/prison_stats_june_2023

Arensman, E., Scott, V., de Leo, D., & Pirkis, J. (2020). Suicide and suicide prevention from a global perspective. *Crisis, 41*(1), 3-7. http://doi.org/10.1027/0227-5910/a000664

Bailey, R. K., Barker, C. H., & Grover, A. (2022). Confluence of law enforcement, mental health, and care. *Behavioural Science & the Law, 40*(4), 532-539. http://doi.org/10.1002/bsl.2567

Balfour, M. E., Stephenson, A. H., Delany-Brumsey, A., Winsky, J., & Goldman, M. L. (2022). Cops, clinicians, or both?: Collaborative approaches to responding to behavioural health emergencies. *Psychiatric Services, 73*(6), 658-669. http://doi.org/10.1176/appi.ps.202000721

Blais, E. B., & Brisebois, D. (2021). Improving police response to suicide-related emergencies: New evidence on the effectiveness of co-response police-mental health programs. *Suicide and Life Threatening Behaviour, 51*, 1095-1105. http://doi.org/10.1111/sltb.12792

Booty, M. D., Williams, R. G., & Crifasi, C. K. (2020). Evaluation of a crisis intervention team pilot program: Results from Baltimore, MD. *Community Mental Health Journal, 56*, 251-257. http://doi.org/10.1007/s10597-019-00474-w

Boscarato, K., Lee, S., Kroschel, J., Hollander, Y., Brennan, A., & Warren, N. (2014). Consumer experience of formal crisis-response services and preferred methods of crisis intervention. *International Journal of Mental Health Nursing, 23*(4), 287-295. http://doi.org/10.1111/inm.12059

Braun, V., & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. http://doi.org/10.1191/1478088706qp063oa

Brent, D. A., Baugher, M., Bridge, J., Chen, T., & Chiappetta, L. (1999). Age and sex-related risk factors for adolescent suicide. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(12), 1497-1505.

Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.

Canning, J., Denny, S., Bullen, P. Clark, T., & Rossen, F. (2017). Influence of positive development opportunities on student well-being, depression and suicide risk: The New Zealand youth health and well-being survey 2012. *Kōtuitui: New Zealand Journal of Social Sciences Online, 12*(2), 119-133. http://doi.org/10.1080/1177083X.2017.1300924

Çaper, A., & Çuhadar, D. (2021). Correlation between psychological resilience and suicide probability in patients with psychiatric disorder. *Perspectives in Psychiatric Care, 58*, 1442-1448. http://doi.org/10.1111/ppc.12948

Chae, M. H., & Boyle, D. J. (2013). Police suicide: Prevalence, risk, and protective factors. *Policing, 36*(1), 91-118. http://doi.org/10.1108/1363951131132498

Charalambous, C., Asimakopoulou, E., Dimitrakopoulos, I., Argyriadi, A., Krepia, V., Sapountzi-Krepia, D., & Argyriadis, A. (2020). Financial crises: What is the impact on suicidality rates? *International Journal of Caring Sciences, 13*(2), 1111-1122.

Chatard, A., Selimbegović, L., & N'dri Konan, P. (2009). Self-esteem and suicide rates in 55 nations. *European Journal of Personality, 23*, 19-32. http://doi.org/10.1002/per.701

Chidgey, K., Procter, N., Baker, A., & Grech, C. (2019). Police response to individuals displaying suicidal or self-harming behaviours: An integrative review. *Health and Social Care in the Community, 27*, 112-124. http://doi.org/10.1111/hsc.12668

Chidgey, K., Procter, N., Baker, A., & Grech, C. (2022). Suicide deaths following police contact: A review of coronial inquest findings. *Death Studies, 46*(3), 675-683. http://doi.org/10.1080/07481187.2020.1758243

Christopher, M. S., Goerling, R. J., Rodgers, B. S., Hunsinger, M., Baron, G., Bergman, A. L. & Zava, D. T. (2016). A pilot study evaluating the effectiveness of a mindfulness-based intervention on cortisol awakening response and health outcomes among law enforcement officers. *Journal of Police and Criminal Psychology, 31*(1), 15-28. http://doi.org/10.1007/s11896-015-9161x

Clarke, T. C., Lucassen, M. F. G., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., & Rossen, F. V. (2014). The health and well-being of transgender high school students: Results from the New Zealand adolescent health survey (youth '12). *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 55*(1), 93-99.

Claveria, O. (2022). Global economic uncertainty and suicide: Worldwide evidence. *Social Science & Medicine, 305*, 1-9. http://doi.org/10.1016/j.socscimed.2022.115041

Coronial Services of New Zealand. (2020). *Annual provisional suicide statistics for deaths reported to the coroner between 1 July 2007 and 30 June 2020.*

Coronial Services of New Zealand. (2022). *Suicide web tool: Key findings for confirmed suicide data*. Retrieved 4 March, 2023, from https://tewhatuora.shinyapps.io/suicide-web-tool/

Creswell, J. W. (2007*). Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Sage Publications.

Cunneen, C., & Tauri, J. (2016). *Indigenous Criminology*. Policy Press.

Curtis, C., & Curtis, B. (2011). The origins of a New Zealand suicide cohort: 1970-2007. *Heath Sociology Review, 20*(2), 219-228.

Curtis, B., Curtis, C., & Fleet, R. W. (2013). Socio-economic factors and suicide: The importance of inequality. *New Zealand Sociology, 28*(2), 77-92.

Dario, L.M., Fradella, H.F., Verhagen, M., & Parry, M. M. (2019). Assessing LGBT peoples perceptions of police legitimacy. *Journal of Homosexuality, 67*(7), 885-915. http://doi.org/10.1080/00918369.2018.156027

Davison, I. (2023). Emergency departments under pressure: Ambulances diverted from Auckland City Hospital as ED full, patient beds placed in overflow room. *The New Zealand Herald.* https://www.nzherald.co.nz/nz/emergency-departments-under-pressure-ambulance-staff-called-in-to-help-patient-beds-overflow-into-hospital-I/YK5D2XBGBBGE3CQMRUBAUXTMGE/

Dawson, C. (2007). *A practical guide to research methods: A user-friendly manual for mastering research techniques and projects* (3rd ed.). How To Content.

de Mendonça Lima, C.A., De Leo, D., Ivbijaro, G., & Svab, I. (2021). Suicide prevention in older adults. *Asia-Pacific Psychiatry, 13*, 1-12. https://doi.org/10.appy.12473

Dennison, C. R., & Finkeldey, J. G. (2021). Self-reported experiences and consequences of unfair treatment by police. *American Society of Criminology, 59*, 254-290. https://doi.org/10.1111/1745-9125-12269.

Drummond, W.J. (1997). Adolescents at risk: Causes of youth suicide in New Zealand. *Adolescence, 32*(128), 925.

Every-Palmer, S., Kim, A. H. M., Cloutmen, L., & Kuehl, S. (2022). Police, ambulance and psychiatric co-response versus usual care for mental health and suicide emergency callouts: A quasi-experimental study. *Australian & New Zealand Journal of Psychiatry, 1*(11), 1-11. https://doi.org/10.1117/00048674221109131

Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). Mental health of prisoners: Prevalence, adverse outcomes, and interventions. *Lancet Psychiatry, 3*(9), 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0

Figueiredo, A. R., & Abreu, T. (2015). Suicide among Lgbt individuals. *European Psychiatry, 30*(1), 1815.

Fisher, M., Vishwas, A., Cross, S., & Attoe, C. (2020). Simulation training for police and ambulance services: Improving care for people with mental health needs. *BMJ Simulation and Technology Enhanced Learning, 6*(2), 121-122. http://doi.org/10.1136/bmjstel-2018-000423

Fiske, Z. R., Songer, D. M., & Schriver, J. L. (2021). A national survey of police mental health training. *Journal of Police and Criminal Psychology, 36*, 236-242. https://doi.org/10.1007/s11896-020-09402-1

Fleming, P. J., Lopez, W. D., Spolum, M., Anderson, R. E., Reyes, A. G., & Schulz, A. J. (2021). Policing is a public health issue: The important role of health educators. *Health Education & Behaviour, 48*(5), 553-558. https://doi.org/10.1177/10901081211001010

Fleming, T., Ball, J., Bavin, L., Rivera-Rodriguez, C., Peiris-John, R., Crengle, S., Sutcliffe, K., Lewycka, S., Archer, D., & Clark, T. C. (2022). Mixed progress in adolescent health and wellbeing in Aotearoa New Zealand 2001-2019: A population overview from the Youth2000 survey series. *Journal of the Royal Society of New Zealand, 52*(4), 426-449. https://doi.org/10.1080/03036758.2022.2072349

Forman, E. M., Berk, M. S., Henriques, G. R., Brown, G. K., & Beck, A. T. (2004). History of multiple suicide attempts as a behavioural marker of severe

psychopathology. *The American Journal of Psychiatry, 161*(3), 437-443. https://doi.org/10.1176/appi.ajp.161.3.437

Fry, A. J., O'Riordan, D. P., & Geanellos, R. (2002). Social control agents or front-line carers for people with mental health problems: Police and mental health services in Sydney, Australia. *Health and Social Care in the Community, 10*(4), 277-286.

Gallagher, S. (2012). *Phenomenology*. Palgrave Macmillan UK.

Gordon, S., Davey, S., & Tester, R. (2018). *Evaluation of mental health e-Learning modules for New Zealand Police*. Wellington Health Promotion Agency. https://www.hpa.org.nz/research-library/research-publications/evaluation-of-mental-health-e-learning-modules-for-new-zealand-police-report

Hallett, N., Duxbury, J., McKee, T., Harrison, N., Haines, A., Craig, E.,'& O'Brien, A. J. (2021). Taser use on individuals experiencing mental distress: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing, 28*, 56–71. https://doi.org/10.1111/jpm.12594

Hanlon, C. A., McIlroy, D., Poole, H., Chopra, J., & Saini, P. (2022). Evaluating the role and effectiveness of co-produced community-based mental health interventions that aim to reduce suicide among adults: A systematic review. *Health Expectations, 26*, 64-86. http://doi.org/10.1111/hex.13661

Hassan, R. (1998). One hundred years of Emile Durkheim's suicide: A study in sociology. *Australian and New Zealand Journal of Psychiatry, 32*(2), 168-171. http://doi.org/10.3109/00048679809062725

Hatcher, S. (2016). Indigenous suicide: A global perspective with a New Zealand focus. *The Canadian Journal of Psychiatry, 61*(11), 684-687. http://doi.org/10.1177/0706743716644147

He, J., Ouyang, F., Qiu, D., Li, L., Li, Y., & Xiao, S. (2021). Time trends and predictions of suicide mortality for people aged 70 years and over from 1990 to 2023 based on the Global Burden of Disease Study 2017. *Frontiers in Psychiatry, 12*, 1-15. http://doi.org/10.3389/fpsyt.2021.721343

Hollander, Y., Lee, S. J., Tahtalian, S., Young, D., Kulkarni, J. (2012). Challenges relating to the interface between crisis mental health clinicians and police when

emgaging with people with mental illness. *Psychiatry, Psychology and Law, 19*(3), 402-411. http://doi.org/10.1080/13218719.2011.585131

Holman, G., O'Brien, A.J., & Thom, K. (2018). Police and mental health responses to mental health crisis in the Waikato region of New Zealand. *International Journal of Mental Health Nursing, 27*(5), 1411-1419. http://doi.org/10.1111.inm.12440

Ivbijaro, G., Kolkiewicz, L., Goldberg, D., Riba, M.B, N'jie, I.N.S., Geller, J., Kallivayalil, R., Javed, A., Svab, I., Summergrad, P., Laher, S., & Enum, Y. (2019). Preventing suicide, promoting resilience: Is this achievable from a global perspective? *Asia-Pacific Psychiatry, 11*, 1-10. http://doi.org/10.1111/appy.12371

Jacobs, W., Orozco, G., Villanueva, G., & Merianos, A.L. (2023). E-cigarette and cannabis use patterns, depression, and suicide behaviours among US youth: Analysis of 2019 youth risk behaviour survey data. *American Journal of Health Promotion, 37*(1), 77-83.

Jones, A. M., Vaughan, A. D., Roche, S. P., & Hewitt, A. N. (2021). Policing persons in behavioural crisis: An experimental test of bystander perceptions of procedural justice. *Journal of Experimental Criminology, 18*, 581-605. https://doi.org/10.1007/s11292-021-09462-1

Jones, L. B., & Thomas, S. D. M. (2019). A pilot study exploring mental health consumers' experiences with the police. *Psychiatry, Psychology and Law, 26*(2), 235-251. https://doi.org/10.1080/13218719.2018.1504240

Junuzovic, M., Lind, K. M. T., & Jakobsson, U. (2022). Child suicides in Sweeden, 2000-2018. *European Journal of Pediatrics, 181*, 599-607. http://doi.org/10.1007/s00431-021-04240-7

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2010). Mental illness among police fatalities in Victoria 1982-2007: Case linkage study. *Australian and New Zealand Journal of Psychiatry, 44*, 463-468.

Khazaei, S., Armanmehr, V., Nematollahi, S., Rezaeian, S., & Khazaei, S. (2017). Suicide rate in relation to the Human Development Index and other health related factors: A global ecological study from 91 countries. *Journal of*

Epidemiology and Global Health, 7, 131-134. http://doi.org/10.j.jegh.2016.12.002

Kim, Y. S. & Leventhal, B. (2008). Bullying and suicide: A review. *International Journal of Adolescent Medicine and Health, 20*(2), 133-154.

Kingi, T. K. R. (2013). Māori mental health: Past, present and future. In T. McIntosh & T. Mulholland (Eds.), *Māori and social issues* (pp. 77-91). Huia Publishers.

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *The Canadian Journal of Psychiatry, 55*(10), 662-668. http://doi.org/10.1177/070674371005501005

Kuehl, S., Kim., A. H. M., & Every-Palmer, S. (2023). 'An accident waiting to happen' experiences of police officers, paramedics, and mental health clinicians involved in 911-mental health crises: A cross-sectional survey. *Journal of Psychiatric and Mental Health Nursing, 0*(0), 1-14. http://doi.org/10.1111/jpm.12916

Kyron, M. J., Rikkers, W., Page, A. C., O'Brien, P., Bartlett, J., LaMontagne, A., & Lawrence, D. (2020). Prevalence and predictors of suicidal thoughts and behaviours among Australian police and emergency service employees. *Australian & New Zealand Journal of Psychiatry, 55*(2), 180-195. http://doi.org/10.1177/0004867420937774

Lee, S. J., Thomas, P., Doulis, C., Bowles, D., Henderson, K., Keppich-Arnald, S., Perez, E., & Stafrace, S. (2015). Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. *International Journal of Mental Health Nursing, 24*, 538-546. http://doi.org/10.1111/inm.12153

Loo, R. (2003). A meta-analysis of police suicide rates: Findings and issues. *Suicide and Life-Threatening Behaviour, 33*(3), 313-325. http://doi.org/10.1521/suli.33.3.313.23209

Malak-Akgün, B., Üzar-Özçetin, Y. S., & Aydin, A. (2022). Association between resilience, self-esteem and suicide probability among university students in

Turkey. *Perspectives in Psychiatric Care, 58*, 2524-2533. http://doi.org/10.1111/ppc.13089

Marcus, N., & Stergiopoulos, V. (2022). Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. *Health & social care in the community, 30*(5), 1665–1679. https://doi.org/10.1111/hsc.13731

Mayer, L., Rüsch, N., Frey, L. M., Nadorff, M. R., Drapeau, C. W., Sheehan, L., & Oexle, N. (2020). Anticipated suicide stigma, secrecy, and suicidality among suicide survivors. *Suicide and Life-Threatening Behaviours, 50*(3), 706-713. http://doi.org/10.1111/sltb.12617

McKenna, B., Furness, T., Oakes, J., & Brown, S. (2015). Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *International Journal of Mental Health Nursing, 24*, 386-393. http://doi.org/10.1111/inm.12140

Mendez, D. D., Scott, J., Adodoadji, L., Toval, C., McNeil, M., & Sindu, M. (2021). Racism as public health crisis: Assessment and review of municipal declarations and resolutions across the United States. *Frontiers in Public Health, 9.* http://doi.org/10.3389/fpubh.2021.686807

Mental Health Foundation of New Zealand. (2022). *Statistics on suicide in New Zealand.* Retrieved March 4, 2020, from https://mentalhealth.org.nz/suicide-prevention/statistics-on-suicide-in-new-zealand

Meyerson, D., Mackenzie, C., & MacDermott, T. (2020). *Procedural justice and relational theory: Empirical, philosophical, and legal perspectives*. Taylor & Francis Group

Miles-Johnson, T., & Death, J. (2019). Compensating for sexual identity: How LGB and heterosexual Australian police officers perceive policing of LGBTIQ+ people. *Journal of Contemporary Criminal Justice, 36*(2), 251-273.

Milligan, F. (2022). Suicide and women: Living with and beyond a breast cancer diagnosis. *British Journal of Nursing, 31*(18), 954-960.

Ministry of Health. (2016). *Suicide facts: Deaths and intentional self-harm hospitalisations 2013*. https://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2013

Mishara, B. L., & Fortin, L. F. (2022). Long-term effects of a comprehensive police suicide prevention program. *Crisis, 43*(3), 183-189. https://doi.org/10.1027/0227-5910/a000774

Mishara, B. L., & Martin, N. (2012). Effects of a comprehensive police suicide prevention program. *Crisis, 33*(3), 162-168. https://doi.org/10.1027/0277-5910/a000125

Morgan, M. (2021). Police responses to persons with mental illness: The policy and procedures manual of one Australian police agency and 'procedural justice policy'. *Social Sciences, 10*(42), 1-16. https://doi.org/10.3390/socsci10020042

Muller, R., Morabito, M. S., & Green, J. G. (2021). Police and mental health in elementary and secondary schools: A systematic review of the literature and implications for nursing. *Psychiatric and Mental Health Nursing, 28*(1), 72-78. http://doi.org/10.1111/jpm.12704

Murphy, K., & Tyler, T. R. (2017). Experimenting with procedural justice policing. *Journal of Experimental Criminology, 13*, 287-292. http://doi.org/10.1007/s11292-017-9300-8

New Zealand Police. (2019). *Annual Report 2018/19.* https://www.police.govt.nz/about-us/publication/annual-report-2019

New Zealand Police. (2020). *Annual report 2019/2020.* https://www.police.govt.nz/about-us/publication/annual-report-2020

New Zealand Police. (2022). *Annual Report 2021/22*. https://www.police.govt.nz/about-us/publication/annual-report-2022

Norris, A. N., & Tauri, J. (2021). Racialized surveillance in New Zealand: From the Tūhoe raids to extralegal photographing of Indigenous youth. *Race and Justice, 0*(0), 1-19. https://doi.org/10.1177/21533687211063581

Novilla-Surette, E. M. P., Shariff, S. Z., Le, B., & Booth, R. G. (2022). Trends and factors associated with suicide deaths in older adults in Ontario, Canada. *Canadian Geriatrics Journal, 25*(2), 134-161. http://doi.org/10.5770/cgj.25.541

O'Brien, A. J., McKenna, B. G., Thom, K., Diesfeld, K., & Simpson, A. I. F. (2011). Use of tasers on people with mental illness: A New Zealand database study.

International Journal of Law and Psychiatry, 34(1), 39-43. http://doi.org/10.1016/j.ijlp.2010.006

O'Brien, A. J., Thom, K., Gordon, S., McKenna, B., Kidd, J., Quince, K., & Exeter, D. (2021). The nature of police shootings in New Zealand: A comparison of mental health and non-mental health events. *International Journal of Law and Psychiatry, 74*, 101648. http://doi.org/10.1016/j.ijlp.2020.101648

OECD. (2023). *Suicide rates (indicator).* https://doi.org/10.1787/a82f3459-en

Olfson, M., Cosgrove, C. M., Altekruse, S. F., Wall, M. W., & Blanco, C. (2022). Living alone and suicide risk in the United States, 2008-2019. *American Journal of Public Health: Research and Analysis, 112*(12), 1774-1782. http://doi.org/10.2105/ajph.2022.307080

Otu, N. (2015). Decoding nonverbal communication in law enforcement: *Salus Journal, 3*(2), 1-16. https://doi/10.3316/informit.264350093655814

Padgett, D. (2008). Advocacy research. In L. M. Given (Eds), *The SAGE encyclopaedia of qualitative research methods* (pp. 8-11). SAGE Publications Inc.

Pelfrey Jr., W. V., & Young, A. (2020). Police crisis intervention teams: Understanding implementation variations and officer-level impacts. *Journal of Police and Criminal Psychology, 35*, 1-12. http://doi.org/10.1007/s11896-019-9314-4

Pickett, J. T., Graham, A., & Cullen, F. T. (2022). The American racial divide in fear of the police. *Criminology, 60*, 291-320. http://doi.org/10.1111/1745-9125.12298

Pires, A. M., Reis, J. G. M., Garcia, F. M., Veloso, G. A., Melo, A. P. S., Naghavi, M., & de Azeredo Passos, V. M. (2022). Suicide mortality among older adults in Brazil between 2000 and 2019: Estimates from the global burden of disease study 2019. *Journal of the Brazilian Society of Tropical Medicine, 55*(1), 1-8. http://doi.org/10.1590/0037-8682-0322-2021

Price, J. H., & Khubchandani, J. (2022a). Childhood suicide trends in the United States, 2010-2019. *Journal of Community Health, 47*, 232-236. http://doi.org/10.1007/s10900-021-01040-w

Price, J. H., & Khubchandani, J. (2022b). Hispanic child suicide in the United States, 2010-2019. *Journal of Community Health, 47*, 311-315. http://doi.org/10.1007/s10900-021-01054-4

Reid, J. (2020). Mental health: Role play and real life. *Ten One Magazine*. https://www.police.govt.nz/news/ten-one-magazine/mental-health-role-play-and-real-life

Richards, N. K., Suarez, E. B., & Arocha, J. F. (2021). Law enforcement officers' barriers to seeking mental health services: A scoping review. *Journal of Police and Criminal Psychology, 36*, 351-359. http://doi.org/10.1007/s11896-021-09454-x

Richmond, M., & Gibbs, J. C. (2021). Police perceptions of training on interactions with persons with mental illness. *Journal of Police and Criminal Psychology, 38,* 268-275. http://doi.org/10.1007/s11896-020-09409-8

Rohrer, A. J. (2021). Law enforcement and persons with mental illness: Responding responsibly. *Journal of Police and Criminal Psychology, 36*, 342-349. http://doi.org/10.1007/s11896-021-09441-2

Rossman, G., & Rallis, S. (2017). *An introduction to qualitative research*. SAGE Publications. http://doi.org/10.4135/9781071802694

Rudd, M. D., Joiner, T., & Rajab, M. H. (1996). Relationships among suicide ideators, attempters, and multiple suicide attempters in a young-adult sample. *Journal of Abnormal Psychology, 105*(4), 541-550.

Schimanski, I. D., & Treharne, G. J. (2019). "Extra marginalisation within the community": Queer individuals' perspectives on suicidality, discrimination and gay pride events. *Psychology & Sexuality, 10*(1), 31-44.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2015). Co-responding police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health Services Research, 42*, 606-620. http://doi.org/10.1007/s10488-014-0594-9

Shaw, R. J. (2022). Living alone and suicide risk: A complex problem requiring a whole population approach. *American Journal of Public Health: Opinions, Ideas, & Practice, 112*(12), 1699-1701.

Simpson, R. (2017). The police officer perception project (popp): An experimental evaluation of factors that impact perceptions of the police. *Journal of Experimental Criminology, 13*, 393–415. http://doi.org/10.1007/s11292-017-9292-4

Simpson, R., & Sargeant, E. (2022). Exploring the perceptual effects of uniforms and accoutrements among a sample of police officers: The locker room as a site of transformation. *Policing: A Journal of Policy and Practice, 16*(4), 663–675. https://doi.org/10.1093/police/paac002

Smith, A., Breazeale, S., Goulet, J. L., Vlahov, D., Justice, A. C., & Womack, J. A. (2022). A systematic review of risk factors for suicide among persons living with HIV (1996-2020). *AIDS and Behaviour, 26*, 2559-2573. http://doi.org/10.1007/s10461-022-03591-y

Smith, L., Jackson, S. E., Vancampford, D., Jacob, L., Firth, J., Grabovac, I., McDermott, D., Yang, L., López-Sánchez, G. F., Niederkrotenthaler, T., Veronese, N., & Koyanagi, A. (2020). Sexual behaviour and suicide attempts among adolescents aged 12-15 years from 38 countries: A global perspective. *Psychiatry Research, 287*, 1-7. http://doi.org/10.1016/j.psychres.2019.112564

Spence, W., & Millott, J. (2016). An exploration of attitudes and support needs of police officer negotiations involved in suicide negotiation. *Police Practice and Research, 17*(1), 5-21.

Stebbins, R. A. (2001). *Exploratory research in the social sciences*. SAGE Publications, Inc. https://doi.org/10.4135/9781412984249

Stubbing, J., & Gibson, K. (2019) Young people's explanations for youth suicide in New Zealand: A thematic analysis. *Journal of Youth Studies*, 22(4), 520-532.

Tartaro, C., Bonnan-White, J., Mastrangelo, M. A., & Mulvihill, R. (2021). Police officers' attitudes toward mental health and crisis intervention: Understanding preparedness to respond to community members in crisis. *Journal of Police and Criminal Psychology, 36,* 579-591. http://doi.org/10.1007/s11896-020-09459-6

Te Whaiti, P., & Roguski, M. (1998). *Māori perceptions of the police.* He Pārekereke. https://www.police.govt.nz/sites/default/files/publications/maori-perceptions-of-police.pdf

Tyler, T. (2017). Procedural justice and policing: A rush to judgement? *Annual Review of Law and Social Science, 13*, 29-53. http://doi.org/10.1146/annurev-lawsocsci-110316-113318

Tyler, T. R., & Lind, E. A. (2001). Procedural justice. In J. Sanders & V. L. Hamilton (Eds.), *Handbook of justice research in law* (65-92). Kluwer Academic Press.

Vermunt, R. & Steensma, H. (2016). Procedural justice. In C. Sabbagh & M. Schmitt (Eds.), *Handbook of social justice theory and research* (pp.219-236). Springer New York. http://doi.org/10.1007/978-1-4939-3216-0

Vijayakumar, L. (2015). Suicide in women. *Indian Journal of Psychiatry, 57*(2), 233-238. http://doi.org/10.4103/0019-5545.161484

Violanti, J. M. (2010). Police suicide: A national comparison with fire-fighter and military personnel. *Policing, 33*(2), 270-286. http://doi.org/10.1108/13639511011044885

Violanti, J. M., Vena, J. E., & Marshall, J. R. (1996). Suicides, homicides, and accidental death: A comparative risk assessment of police officers and municipal workers. *American Journal of Industrial Medicine, 30*, 99-104.

Violanti, J. M., Owens, S. L., McCanlies, E., Fekedulegn, D., & Andrew, M. E. (2019). Law enforcement suicide: A review. *Policing, 43*(2), 141-164. http://doi.org/10.1108/PIJPSM-05-2017-0061

Walton, D., Li, J., Barnes, S., & Newcombe, R. (2017). Does prior contact with police reduce the likelihood of suicide? Examining the predictive ability of different incident types and the interaction effects. *International Journal of Police Science & Management, 19*(3), 148-158. http://doi.org/10.1177/1461355717717997

Wasson Simpson, K. S., Gallagherm A., Ronis, S. T., Miller, D. A. A. & Tilleczek, K. C. (2021). Youths' perceived impact of invalidation and validation on their mental health treatment journey. *Administration and Policy in Mental Health and Mental Health Services Research, 49*, 476-489. http://doi.org/10.1007/s10488-021-01177-9

Watson, A. C., & Angell, B. (2007). Applying procedural justice theory to law enforcement's response to persons with mental illness. *Psychiatric Services, 58*(6), 787-793. http://doi.org/10.1176/ps.2007.58.6.787

Watson, A. C., Angell, B., Morabito, M. S., & Robinson, N. (2008). Defying negative expectations: Dimensions of fair and respectful treatment by police officers by people with mental illness. *Administration and Policy in Mental Health and Mental Health Services Research, 35,* 449-457. http://doi.org/10.1007/510488-008-0188-5

Webb, R. (2013). Incarceration. In T. McIntosh & M. Mulholland (Eds.), *Māori and social issues* (pp. 202-212). Huia Publishers.

Wittman, L., Groen, G., Ogorka, J., Jörns-Presentati, A. (2021a). "I didn't know what they wanted from me": The perspective of individuals with mental disorders on police interventions. *Journal of Police and Criminal Psychology, 36,* 537-542. http://doi.org/10.1007/s11896-021-09449-8

Wittman, L., Jörns-Presentati, A., & Groen, G. (2021b). How do police officers experience interactions with people with mental illness. *Journal of Police and Criminal Psychology, 36,* 220-226. https://doi.org/10.1007/s11896-020-09398-8

Wood, J. D., Watson, A. C., & Barber, C. (2021). What can we expect of police in the face of deficient mental health systems?: Qualitative insights from Chicago police officers. *Journal of Psychiatric and Mental Health Nursing, 28*(1), 28-42. http://doi.org/10.jpm.12691

Wook, I. (2019). Addressing the rights of Indigenous people to resources in Malaysia: A procedural justice approach. *International Journal on Minority and Group Rights, 26*(1), 40-66. http://doi.org/10.1163/15718115-02601003

World Health Organization. (2021). *One in 100 deaths is by suicide: WHO guidance to heal the world reach the target of reducing suicide rate by 1/3 by 2023*. Retrieved 21 February, 2023, from https://www.who.int/news/item/17-06-2021-one-in-100-deaths-is-by-suicide

Yasuhara, K., Forman, D. L., Phillips, S., & Yenne, E. M. (2019). Development of a measure of mental health stigma including police behaviours. *Psychiatry, Psychology, and Law, 26*(4), 520-529. http://doi.org/10.1080/13218719.2018.1507845

Zielinski, M. J., Veilleux, J. C., Fradley, M. F., & Skinner, K. D. (2023). Perceived emotional invalidation predicts daily affect and stressors. *Anxiety, Stress, & Coping, 36*(2), 214-228. http://doi.org/10.1080/10615806.2022.2033973