An insight into New Zealand Police officers' work and interactions with those in mental distress:

A grounded theory study

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Abstract

The New Zealand Police directive is that officers are to accompany all persons they suspect are mentally distressed to the hospital emergency department for assessment by mental health professionals.

How frontline police officers work and interact in the hospital emergency department when accompanying persons suspected of being in mental distress, is not clearly understood. There is a paucity of knowledge of what officers do and how they interpret their role in this setting.

Using a social constructivist grounded theory approach to address this knowledge gap, a two-fold question was asked:

1. What do New Zealand Police officers do in the hospital emergency department when accompanying persons in mental distress?

2. How do New Zealand Police officers manage these situations?

The theory of *doing your best* was developed from interviewing 23 frontline police officers at three police stations in the North Island of New Zealand. When developing the theory, the core elements of grounded theory of simultaneous data collection and analysis, constructing codes and categories from data, constant comparative analysis, memoing and theoretical sampling were employed. However, this constructivist approach also included reflexivity and acknowledged the interpretive co-construction of the findings.

Doing your best emerged as the central process that police officers use when working in the community and hospital emergency department with those in mental distress. *Doing your best* involves officers *navigating* between *meeting obligations* and *negotiating challenges* they confront when keeping all safe.

Several notable findings emerged from this study. These are that an officer's initial interaction with the mentally distressed individual is an influencing factor, and impacts how officers work with the person later in the hospital emergency department. Officers with personal experience (family or friend) with mental illness engage with the mentally distressed person more effectively than officers who lack this experience, or who have become desensitised. Challenges for officers when working with those in mental distress emanate from their interactions with their interagency partners, not the mentally distressed individual. Officers want change to occur at an organisational level as to how they currently respond to a person suspected of being in mental distress, and how they work with their interagency partners.

Key challenges that officers encountered were: *doing their best* to *meet their obligations* (personal, professional, societal), *making the right call* and *negotiating and navigating challenges* in the emergency department.

This study has given a voice, understanding and new knowledge of how New Zealand Police officers work and interact with the mentally distressed in the community and within the hospital emergency department. It has identified the challenges encountered by officers in both settings, and provides potential recommendations for New Zealand Police and their interagency partners.

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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.

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List of Abbreviations and Glossary

AUTEC: Auckland University of Technology Ethics Committee.

CATT: Crisis and Assessment Treatment Team.

CIT: Crisis Intervention Team police-based response model to those in mental distress.

COAST: Crisis Outreach and Support Team.

Comms: A term used by police for the Police Communication Centre.

CPN: Community Psychiatric Nurse.

DAMHS: Directors of Area Mental Health Services.

DAO: A duly authorised officer is a health professional competent in dealing with those in mental distress and is appointed by Directors of Area Mental Health Services.

DHB: District Health Board.

ED: refers to hospital Emergency Department.

MHIT: Mental Health Intervention Team.

MoU: Memorandum of understanding.

NPACER: Northern Police and Clinician Emergency Response.

PACER: Police, Ambulance and Crisis Emergency Response.

PCSO: Police Community Support Officers.

TEMPO: Training and Education about Mental Illness for Police Organisations.

WHN: Watch-house Nurse.

SLA: Service level agreement.

Deinstitutionalisation: A government policy in the 1970s that moved those in psychiatric institutions back to their families, or into community-based homes.

Mental distress: A term used by mental health practitioners and users of mental health services to describe a range of symptoms and experiences that affect the way a person thinks, feels and behaves.

Personality disorder: A person who has a way of thinking, feeling and behaving in a manner that deviates from the expectations of their culture. These characteristics are enduring, cause distress to the person and they are unable to function properly. However, it is not due to substance use or other medical conditions.

Psychiatry Liaison Team: Consists of psychiatrists and mental health nurses who provide mental health assessments and care to people being treated for physical health conditions in a general hospital. At times this team is called to mentally distressed people in the emergency department.

Service users: People who have the lived experience of mental distress and use mental health services.

Chapter 1: Introduction

By default, New Zealand frontline police officers have become first responders to the increasing number of persons in the community suffering from mental distress. In this default role, an officer's perception is that they are functioning as public safety officers, social workers, triage decision makers, counsellors, providers of transport for the person to hospital and acting as security officers once in the hospital emergency department (ED). New Zealand Police are now recognised by the public as the most responsive service for those in mental distress (University of Otago, 2019). This is despite police officers' limited training in mental health and often little support from mental health services. As a consequence, frontline police officers are presented with many challenges.

The directive from New Zealand Police and District Health Board Mental Health Services is that police officers transport all those who they suspect to be in mental distress to a hospital ED. Here, officers must wait until the individual has been assessed by mental health professionals. Police stations are used only as a last resort for assessing mentally distressed individuals. This would occur if the person was displaying violent behaviours (District Health Board Mental Health Services & New Zealand Police, 2015). However, little is known about how this current directive is working, understood or interpreted by officers in their everyday working with persons in mental distress in the hospital ED.

In this study, mental illness is mainly referred to as mental distress. This is a more appropriate term as it is "more relatable, does not discriminate and encompasses various different causes" (Davey, Gordon, & Tester, 2019, p. 8). Mental distress manifests itself in the way a person thinks, talks, feels or behaves that affects their normal functioning and results in other people, including police officers, becoming worried about them. This situation presents frontline police officers with many challenges when working with those in mental distress. Throughout this study, the terms of 'a person in mental distress, a mentally distressed person, a mentally distressed individual(s), a person suspected of being in mental distress' are used interchangeably.

Why This Topic

My journey of interest in this topic began as a clinical lecturer working with students in local hospital EDs. It was here that I constantly observed police officers waiting with individuals in the reception area. On many occasions it became obvious that these were individuals in mental distress. However, I was unaware at this stage as to why police officers would be in this setting with these individuals. I wondered if they had hurt themselves or committed a crime.

Often I observed that members of the public in the reception area gave the officers and person accompanying them 'a wide berth'. From time to time, one officer would go outside and talk to someone calling them on their police radio. Several hours would go by, and as I passed the reception area again, often the officers and person accompanying them were still sitting there. Body language indicated both parties were getting restless. I was curious as to why mental health professionals had by now not relieved the officers. I had the notion that police officers worked with persons who had committed a crime, and mental health professionals with those persons in mental distress. However, I discovered this was not the case.

It was through questioning a member of my family in the New Zealand Police that I found the answer. I was informed of the directive from New Zealand Police that officers transport those they suspected of being in mental distress to the hospital ED. I pondered about how this arrangement was impacting the EDs' and officers' core duties. It started my questioning what frontline police officers knew about mental illness. Moreover, how did they construct working with persons in mental distress as part of their role? I was interested to find out about the role responsibility and involvement New Zealand frontline police officers had with those in mental distress. It was then I discovered that in New Zealand and internationally, police involvement with mentally distressed individuals can largely be traced back to the advent of deinstitutionalisation in the 1970s.

Historical Overview: Police Involvement with Mentally Distressed Persons

Deinstitutionalisation in the Western world resulted in an influx of those with mental illness living in the community. Prior to deinstitutionalisation, police officers had minimal dealings with these individuals. Those suffering from mental illness were usually in large psychiatric institutions for long periods of time (Wells & Schafer, 2006; Wood, Swanson, Burris, & Gilbert, 2011). The movement of people from psychiatric institutions into the community saw a dramatic increase in the interactions police had with these people when they became mentally distressed (Chappell & O'Brien, 2014; Watson & Angell, 2007). This brought about decades of changes to mental health delivery (Lamb, Weinberger, Walter, & DeCuir, 2002; Schulenberg, 2016). Rapidly, the role of police changed as they became increasingly responsible for overseeing a population with specific and complex needs (Barillas, 2012; Chappell & O'Brien, 2014). A lack of community-based health systems, social services, inpatient beds (rigid admission thresholds) stretched police capabilities in actually how to manage mentally distressed persons (Clifford, 2010; McLean & Marshall 2010; Tamsin, McDonald, Luebbers, Ogloff, & Thomas, 2014; Wells & Schafer, 2006).

Fakhoury and Priebe (2002) believe that New Zealand lagged behind other Western countries in successfully implementing deinstitutionalisation. These authors suggest the retention of inpatient units attached to general hospitals, poorly developed community-based services and a lack of trained mental health professionals contributed to this. O'Brien (2006) proposes that in New Zealand, deinstitutionalisation simply meant closing psychiatric institutions. He asserts that the limited transition planning gave little thought as to the impact on the mentally ill, society or the police. Joseph and Kearns (1999) remarked that it proved easier to close large psychiatric institutions, than to set up an effective treatment community-based care system for those with mental health issues.

There is much international and national anecdotal evidence and conjecture highlighting the deficiencies in countries following the neoliberal trend of placing the mentally ill in the community (Clifford, 2010; Kelsey, 1997; Rowe, 2001). The idea that the civil rights of those with mental illness could now be better supported with the emphasis on personal responsibility and the involvement of non-governmental agencies was admirable. However, worldwide systemic shortfalls in mental health services placed an increasing burden on police officers to be first responders to persons in mental distress. With the growing number of those with mental illness now in the community, new mental health legislation was required. The new mental health legislation impacted how police officers responded and how they were to work with mentally distressed persons. This legislation embraced the police officers expanded public health role in the community with those who were mentally unwell (Wood & Watson, 2017).

An overview of the variations in mental health law internationally and in New Zealand is included in this introduction. This enables the reader to have a basic understanding of the impact of this legislation for police officers, which dictates the role they have when responding and working with individuals in mental distress.

Mental Health Legislation Impacting Police Officers

From a legal perspective, mental health law encompasses a variety of statutes, cases and administrative decisions that affect mentally distressed individuals (Carney, 2003). There is some controversy as to whether mental health law is separate from public health law. However, both are embedded in “common legal principles which apply equally to general public health issues” (Wood et al., 2011, p. 6). The rationale for police involvement with the mentally ill is based both internationally and nationally on two common law principles. The first principle is the given power and responsibility of police to protect the safety and welfare of the public. The second principle is *parens patriae*. The latter term refers to when an

individual is unable to make decisions on their own, or is at risk to themselves or others due to mental illness. In this situation, the State intervenes accordingly (McKenna, Simpson, & Coverdale, 2000; Teplin, 2000; Wood et al., 2011).

Both criminal and mental health laws are used to manage a variety of situations, behaviours and circumstances that guide police encounters and responses to those in mental distress (Wood et al., 2011). However, the roles and choices police have when interacting with the individual in this situation is one that determines whether they facilitate the individuals access to mental health services, or the criminal justice system (Watson, Swartz, Bohram, & Draine, 2014).

Worldwide, police encounter mentally distressed individuals in a range of settings. These settings may be the community, at the scene of a public disturbance, a homeless encampment, park or a hospital ED. The broader role of contemporary policing has seen police officers refer to their role with the mentally distressed person as a "street corner psychiatrists"(Teplin & Pruett, 1992, p. 139). However, the acquired social welfare role that has evolved for police does not mean they deviate from their core business of enforcing the law and protecting society (Wood et al., 2011). Nevertheless, how officers work with mentally distressed persons can vary in keeping with the mental health law of their particular country.

International mental health law variations governing police responses

There is variation in international mental health law in the United States of America (USA), Canada, United Kingdom (UK) and Australia that affects how police work with those in mental distress. The legal criteria for detaining, involuntary admissions and treating the mentally distressed individual in the above countries have similarities, but differ within these common parameters (Wood et al., 2011).

Mental health law in the USA and Canada authorises police officers to detain and transport persons in mental distress who they consider pose a risk to themselves or others, to a hospital ED or a mental health facility (Wood et al., 2011).

In the UK, national legislation outlining the role of police officers in responding to people in mental health distress is the Police and Criminal Act (1984) (PACE) and the Mental Health Act (1983) updated in 2007 (Moore, 2010). The Mental Health Act refers to an Act in law that can be applied to the assessment, treatment and care or support of persons experiencing mental distress. Amendments to the UK Mental Health Act (2007) extended the definition for mental disorder as 'any disorder or disability of the mind' and thereby including those with a personality disorder (Apakama, 2012). Under PACE, police can arrest a person they deem to be

mentally distressed. Section 136 of the Mental Health Act (1983) gives police officers the authority to transport a mentally distressed individual to a 'place of safety'. The place of safety could be a police station, a community or inpatient mental health facility, or a hospital ED. There has been much controversy by psychiatrists, nurses and police officers as to whether the use of police cells and the hospital ED are appropriate places to assess a mentally distressed person (Moore, 2010; Watson et al., 2014; Wood et al., 2011).

In Australia, mental health law is instituted at state and territorial levels (Wood et al., 2011). Each jurisdiction in Australia has its own mental health legislation and is state specific. However, there are similarities across these Australian jurisdictions as to the authority given to police officers when responding with those in mental distress (Clifford, 2010). For example, in New South Wales (NSW), one of the six states in Australia, their Mental Health Act (NSW) 2007 provides legislative framework of how police are to respond to those in mental distress (Herrington & Pope, 2014). Within Section 22 of this Act, police are given the power to detain and transport the person they deem to be in mental distress for an assessment. Similarly, in the State of Victoria, Section 10 of the Mental Health Act (1986) gives police the power to detain an individual they deem to be mentally distressed who may be a risk to themselves or others. The purpose of detaining the person is to facilitate access to have these individuals assessed by mental health professionals (Wood et al., 2011). The hospital ED is usually the place of choice for an assessment in order to avoid using legal channels for these individuals (Herrington & Pope, 2014).

New Zealand mental health law governing police responses

Since the introduction of the Mental Health Compulsory Assessment and Treatment Act (1992) in New Zealand, responding to incidences in the community that involve mentally distressed individuals is now a practice role for all contemporary police (Stenning & Shearing, 2005). The Mental Health Act (1992) replaced the Mental Health Act (1969). The Act (1992) moved away from totally relying on medical authorities about the compulsory assessment and treatment of mentally distressed people. Other health professionals were delegated to undertake some of the statuary roles in the process of compulsory assessment and treatment of an individual (McKenna, Thom, O'Brien, Crene, & Simpson, 2009). The duly authorised officer (DAO) was one such role.

Duly authorised officers are appointed by Directors of Area Mental Health Services (DAMHS) under Section 93 of the Mental Health Act (1992). Duly authorised officers are the frontline statutory officers of the Mental Health Act (1992) and are designated health professionals (often registered nurses). They are trained and experienced to respond to concerns about

persons in mental distress and often work in the Crisis and Assessment Treatment Team (CATT) (Ministry of Health, 2012). However, some DAOs also work in psychiatry liaison teams within the hospital and ED. The role of the DAO is to respond to concerns about a person's mental health and arrange for an assessment of the individual. If necessary, the DAO can direct police to take the person to a specific place for an assessment (Ministry of Health, 2012). At present, the place of assessment for the mentally distressed person is usually the hospital ED (District Health Board Mental Health Services & New Zealand Police, 2015).

Currently, New Zealand police have a legal duty covered under Section 109(1) (a) and (b) of the Mental Health Act (1992) to respond to mental health emergencies in the community (District Health Board Mental Health Services & New Zealand Police, 2015; Ministry of Health, 2012). Under this section, officers may detain persons they perceive to be mentally distressed for up to 6 hours, or until they have been assessed. However, under Section 41 of the Mental Health Act (1992), police officers have no power to enter or detain an individual they suspect is mentally disordered in a private property unless requested to assist by a DAO. Section 41 applies if no crime has been committed, the person is not under a compulsory treatment order and absent without leave, or there is no immediate risk to the individual or others (Ministry of Health, 2012).

There are four main situations in the Mental Health Act (1992) where police officers interact with a person experiencing mental distress. The first area is when there are concerns about a person's behaviour in a public place. In this instance, police officers may take the person to a suitable location and arrange for the person to be assessed. The suitable location is now considered to be a hospital ED. A police station is only used if the person is displaying violent behaviour. The second situation is if a DAO requires assistance when assessing a person under the Act. Police officers may then be required to transport the individual to a place for assessment and be in attendance if required. With the current directive between New Zealand Police and the Ministry of Health, the assessment will usually take place in the hospital ED. The third situation is when police officers may be required to assist a medical practitioner to administer medication during the initial stages of implementing the Mental Health Act (1992). In such a case, this is under the request from the medical practitioner, and officers may enter a person's property to detain or transport them to a suitable venue for this to occur. The fourth situation is when police officers have the authority to return patients to hospital if they self-discharge or do not come back from approved leave (Ministry of Health, 2012).

The legislative framework of the Mental Health Act (1992) requires police to work in a somewhat supportive, peripheral role to the DAOs or medical practitioners who have

requested police assistance. Within the framework of the Mental Health Act (1992), there is the expectation that those designated as DAOs are expected to be first responders to those who are mentally distressed (Li, Newcombe, Hendy, & Walton, 2018). However, in order to meet their statutory obligations to protect society, New Zealand Police have now included responding to persons in mental distress as part of an officer's core policing duties (New Zealand Police, 2017a). As a consequence of their legal responsibilities under the Mental Health Act (1992) and core policing duties, police are often the interface between the criminal justice system and mental health services as first responders. Unlike the UK, the New Zealand Mental Health Act (1992) does not specify that persons with personality disorders are subject to the Act (Law Commission, 1994). A person who has a personality disorder has a way of thinking, feeling and behaving in a manner that deviates from the expectations of their culture. These characteristics are enduring, cause distress to the person and they are unable to function properly. However, it is not due to substance use or other medical conditions.[1] Furthermore, in the Mental Health Act (1992) there is no age requirement. If children meet the criteria for a mental disorder, they can also be placed under the Act.

Background to the Research

Political, legal influences and societal expectations have constructed how police officers respond and work with mentally distressed persons in the community and hospital ED. The process of deinstitutionalisation has resulted in officers now becoming increasingly responsible for overseeing a population with multifaceted needs. Nationally and internationally contemporary health care systems, social programmes and policing models have been designed in such a way that contact between those in mental distress and the police is now inevitable (Livingston, 2016).

In 2017, New Zealand Police officers attended 35,803 mental health related events (Davey et al., 2019). Mental health related attendance refers to officers responding to persons who are in mental distress or any suicidal related incidences. This equates to 98 events every 24 hours and that number is steadily growing (University of Otago, 2019). By the end of 2020, this number is forecasted to grow to approximately 120 mental health incidences a day that police will attend. In the vast majority of these call outs, police will be the only agency attending.

While the role of police in responding to mental health emergencies is not new, it is becoming more apparent and visible with a lack of available mental health services (Holman, O'Brien, & Thom, 2018; Marsden, Nigram, Lemetyinen, & Edge, 2020). However, as police are not trained

[1] For further information, refer to the *DSM-5, The Diagnostic and Statistical Manual of Mental Disorders*.

mental health professionals, there are advantages in their working collaboratively with those who do have that expertise. Undeniably, working with the mentally distressed in the community and hospital ED can only be effective when police officers and mental health professionals work together collaboratively.

Literature indicates that nationally and internationally there are a range of different collaborative interagency approaches and initiatives that have been developed. These have been developed to assist in reducing police officers interactions with those in mental distress and to provide a better outcome for these people (Li et al., 2018). However, in order to improve police responses to mentally distressed persons, there is a need to first gain a sound understanding of how police officers interpret their encounters with these individuals. The growing literature concentrating on models of how to improve police responses to the mentally distressed should "take a step back to better understand these calls from the perspective of police officers" (Watson et al., 2014, p. 357). In light of this, more research is also required on not only how police construct their encounters with this group of people, but also what social factors may influence this.

Thus, with changes in mental health policies and interagency collaboration models with police and mental health services, there still appears to be a lack of research examining the social processes police use in their interactions with those who are mentally distressed. The paucity of research is particularly evident in the hospital ED when police officers are accompanying these individuals.

Despite changes in mental health policies and interagency collaboration models with police and mental health services, there still appears to be a contradiction as to what is considered the least restrictive environment to take the mentally ill person to in times of crisis. In some countries the hospital ED has become the preferred place for police to transport an individual displaying mental distress. In other countries, the direction has been to divert the mentally ill person away from the ED into other appropriate services.

In New Zealand, police officers are now directed to transport people in mental distress to the hospital ED. However, little is known about New Zealand Police officers' involvement in the hospital ED with individuals in mental health distress, or how they interpret their expanding role in this setting. This original research will shed some light on what New Zealand Police officers do and how they manage in the hospital ED when accompanying individuals in mental distress.

Aim and Purpose of Study

The aim of this research is to generate theoretical concepts and understanding by addressing the identified knowledge gap of how and what New Zealand frontline police officers do when working in the hospital ED with individuals suspected of being in mental distress.

The purpose of this research is to provide practical knowledge that will inform the development of supportive practices in the field. Having this knowledge will assist in future training programmes and policy development for frontline police officers when working with persons in mental distress they have transported to the hospital ED.

Methodological Overview

A social constructivist grounded theory approach to this chosen topic implies there is no one fixed truth, but multiple realities and systems of knowledge that are specific to New Zealand Police. This grounded theory methodological approach will enable an in-depth interpretive co-construction of meaning and understanding of the social processes that influence interactions and actions between New Zealand Police officers and individuals experiencing mental distress. Officers' interactions with these individuals occur in the community and within the hospital ED.

A grounded theory approach informed by Charmaz (2014a) was chosen as the appropriate research design. This constructivist approach gives authenticity, understanding and voice to New Zealand frontline officers' views of their realities when working with persons in mental distress in this setting.

Overview of the Study

This thesis is presented in eight chapters each of which has a concluding summary.

Chapter 1 set the scene regarding the current situation for New Zealand frontline police working with persons in mental distress in the hospital ED. My interest in this topic is explained followed by a brief historical overview of why police are now involved with those in mental distress. International and national variations in mental health law were then identified before background information on this topic was presented. The aim, purpose, significance of this study and choice of methodology were articulated.

Chapter 2 examines the position of a literature review in a constructivist grounded theory before locating literature sources used in this research. This is followed by an overview of the different interagency police response models used in the USA, Canada, the UK and Australia. The New Zealand Police response and initiatives to working with those in mental distress are

discussed before examining global changes in policing practices. This chapter concludes with the challenges police confront in the hospital ED.

Chapter 3 presents the methodology used in the study. The evolution of classic grounded theory, as influenced by the Charmazian constructivist grounded theory, is explained. The key philosophical epistemology underpinning the evolution of the constructivist approach is examined. Grounded theory core principles and the different interpretations of these by Charmaz are then discussed.

Chapter 4 explains the research method. This includes ethical issues, data collection and analysis and how rigour for the study was obtained through story-lining.

Chapters 5, 6 and 7 present the findings of this study. Chapter 5 begins with an overview of the theory followed by contextual understandings of the theory and the core category of *doing your best*. In Chapters 6 and 7, the theoretical categories of *meeting obligations* and *negotiating challenges* underlying the theory of *doing your best* are explained.

Chapter 8 discusses the key challenges that New Zealand Police officers articulated and their significance in the context of existing knowledge. These challenges are *doing their best* in *meeting obligations* (micro, meso and macro)[2] by *making the right call* and *negotiating and navigating challenges* in the hospital ED. The discussion concludes with potential suggestions for how officers may be able to improve on *doing their best*, followed by a summary. The limitations of the study are acknowledged before ending with recommendations and a concluding statement.

[2] Micro (personal), meso (professional) and macro (societal/governmental) are the three levels of meeting obligations for police officers.

Chapter 2: Literature Review

Introduction

Charmaz (2014a) defines a literature review as where the researcher "claims, locates, evaluates and defends their position" (p. 305) on the decision to accept or dispute earlier ideas and evidences on the topic under study. The purpose of this review is to situate the literature and identify the potential gap in what is known internationally and in New Zealand about research relevant to this topic.

The chapter begins with the constructivist grounded theory position of a literature review, followed by how literature for this study was located. Next is a review of existing knowledge internationally (USA, Canada, UK and Australia) of police response models used in these countries when working with persons in mental distress. This is followed by a examining the New Zealand Police response model and recent implemented initiatives. Changes to policing practices are then discussed before exploring how police are currently being trained. Known challenges that confront police officers when accompanying mentally distressed persons to the hospital ED are then examined before the concluding summary.

The position of a literature review using grounded theory

In grounded theory, the place of a literature review is frequently debated and misinterpreted (Charmaz, 2006). Different philosophical frameworks in grounded theory (classic, Straussian and constructivist) have resulted in divergent stances taken on literature reviews (Kenny & Fourie, 2015). Glaser (1998) as the classic grounded theorist, advocated suspending any pre-existing knowledge and personal/professional experiences from the literature until completion of the data analysis. Glaser (1998) asserted that in so doing, the researcher would have an open free mind and avoid contaminating data with their pre-existing ideas or experiences.

However, the constructive grounded theory approach developed by Charmaz considered the researcher was not a "*tabula rasa*" (blank slate) (Charmaz, 2009a, p. 165). As with other grounded theorists (Clarke, 2009; Thornberg, 2012), Charmaz proposed it was virtually impossible for a researcher to claim a veneer of objectivity and neutrality when writing a literature review. A literature review should be relevant to your grounded theory and demonstrate why you "favour certain arguments and evidence" (Charmaz, 2014a, p. 305). Moreover, in grounded theory, Charmaz (2014a) contends that the constant comparative method used for analysis of data can direct the critique of existing literature and enable comparisons to be made in relation to this. Rather than avoiding pre-existing literature,

Charmaz (2014a) advocates for the researcher designing the final literature review to fit the specific purpose and argument of their study.

Charmaz (2014a) recommends a preliminary literature review be undertaken leading into the study, and that this material be put aside until the analysis of the data has been completed. When a substantive theory has been generated, Charmaz suggests the literature should then be revisited. This method enables the researcher a place to locate, evaluate and defend their emergent theory (Bryant & Charmaz, 2007). During this process, the data, codes, categories and memos written during the study assist to validate or reject literature irrelevant to the study (Ramalho, Adams, Huggard, & Hoare, 2015). Moreover, existing knowledge should not be disregarded, but be viewed critically (Thornberg, 2012).

Following the Charmaz (2014a) constructivist approach to a literature review, a pre-literature review was conducted prior to analysing the data and developing a substantive theory. On returning to the existing literature, I was then able to further locate, evaluate and support the emergent theory of *doing your best* as generated from the analysis of the data collected.

Locating the Literature

In order to understand what is known about this subject nationally and internationally, a literature search was conducted using a diverse number of electronic library databases. These were MEDLINE, CINNAHL, Scopus, EBSCO, ProQuest Nursing, Allied Health Source and Google Scholar. The initial search strategy used a combination of the following keywords (limited to English): Police, New Zealand Police, mentally ill, mental*[3], mental health services, legislation, culture, emergency department, responses, interactions, discretionary power, stereotyping, stigma and interagency collaboration. This broad search provided background information which was later refined to: police, mental*, interagency models, challenges, role shifts, training and hospital emergency department. The focus was primarily on articles less than 10 years old and relevant to this research. However, due to the paucity of literature, older articles were also included. Of particular interest were studies conducted in New Zealand and Australia. However, other international literature also provided relevant information.

[3] * This symbol is a truncation. This technique is used when one knows the term has several endings, but these fundamentally represent the same meaning.

International police response models (United States of America, Canada, United Kingdom and Australia)

Background information

Literature in the field of collaborative practice in responding to those in mental distress is relatively new (Winters, Magalhaes, & Kinsella, 2015). Internationally, much of the research on the interagency response models with police and mental health services focuses on how the various models work when responding to people in mental distress. The different response models broadly fall into two categories. The first is a police-based response model. This is where a select group of police officers receive specialised training of how to respond and link the mentally distressed individual into the mental health system. The second is a co-response model, whereby police officers and mental health clinicians respond jointly to a mental health related incident (Coleman & Cotton, 2010; Wood et al., 2011). There are variations on these two main response models. Nevertheless, all variations aim at improving the interface between police, mental health services and subsequently, those in mental distress (Ogloff et al., 2012).

There is a difference globally in service provision, legislation and local policies. However, little is known how police officers view mental health services and the recommendations to work in a partnership to assist those in mental distress (McLean & Marshall 2010). In the reviewed literature there is also a contradiction as to what is considered the 'least restrictive environment' for police to transport mentally distressed individuals to, in order to get assistance for them. In some countries, the hospital ED has become the preferred place and is considered the 'least restrictive environment' (Clifford, 2010; Huppert & Griffiths, 2015; Independent Police Conduct Authority, April 2015; Wise, 2014). In other countries, police response models have been created deliberately to divert these individuals away from the ED. This has been achieved by enabling direct admission to inpatient units or other mental health services (Knott, Pleban, Taylor, & Castle, 2007; Llewellin, Arendts, Weeden, & Pethebridge, 2011; McKenna et al., 2015a; Meehan, Brack, Mansfield, & Stedman, 2019).

In the USA, Canada, the UK, Australia and New Zealand, police response models/approaches have been adapted to accommodate the requirements of a particular district or region. One model does not necessarily suit all locations (Fisher & Grudzinskas, 2010; Ogloff et al., 2012).

United States of America response models

The predominant model in the USA for police officers responding to individuals in mental distress is the Crisis Intervention Team (CIT). This police-based approach is sometimes referred to as the Memphis (Tennessee) model and is considered by Ellis (2014) to be ground-breaking.

The Crisis Intervention Team takes a problem solving approach (Watson, Morabito, Draine, & Ottati, 2008), transforming mental health treatment for individuals who have for many decades been the victims of social stigma and neglect (Ellis, 2014).

The CIT model is a collaborative approach between police, mental health services and those experiencing mental distress in the community (Compton, Bahora, Watson, & Oliva, 2008). The goals of this model are to keep the person in mental distress safe, link them with the appropriate services and divert these individuals from the criminal justice system (Watson & Fulambarker, 2013). This model is a systemic organisational intervention that signifies the contemporary role shift for police officers as to how they are now to work with those in mental distress (Watson et al., 2008). Thomas and Watson (2017) suggest that the CIT approach entails much more than just training or law enforcement; rather they view it as a "community programme" (p. 95).

When responding to a mental health related incident, the CIT model requires that the selected police officers have specialised skills of how to intervene with the person and liaise with the mental health system (Coleman & Cotton, 2014). The required specialised skill set includes officers having the knowledge and ability to assess for the presence of a mental disorder; being able to communicate effectively with the person and mental health providers; and being able to complete an emergency assessment application (Thomas & Watson, 2017). Officers who volunteer to be part of the CIT gain these skills through specialised training (Ellis, 2014; Thomas & Watson, 2017; Wood et al., 2011).

The initial CIT training for officers involves 40 hours with annual refresher training thereafter. In the 40 hours of specialised training officers learn the signs and symptoms of mental illness and associated co-morbidities; local resources, policies and processes when transporting an individual for a mental health assessment; and de-escalation strategies for mentally distressed persons (Coleman & Cotton, 2010; Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006; Thomas & Watson, 2017; Watson & Fulambarker, 2013). The CIT training also involves interagency collaboration with officers and hearing from those with the lived experience of mental illness. Officers also collaborate with mental health providers and visit local mental health agencies (Thomas & Watson, 2017; Watson & Fulambarker, 2013).

Adaptions to the CIT model across the USA are based on the actual needs and availability of resources at specific localities. One frequent adaption is that of a centralised drop off centre where police can transport the mentally distressed individual (Watson et al., 2008). In some locations a centralised drop off centre is not practical (Watson et al., 2008; Wood & Watson, 2017). Therefore, adaptions to the CIT model include community agreements with police to

fast track the mentally distressed person through the ED, or use of the mobile crisis team to transport the individual to a facility to receive treatment. Other communities have centralised registries to help CIT officers find available hospital beds for mentally distressed persons (Watson et al., 2008).

Steadman, Williams Dean, Borum, and Morrisset (2000) compared three different models of police responses to those in mental distress at three study sites (Birmingham Alabama; Memphis Tennessee; Knoxville, Tennessee). Memphis Tennessee was the only city that used the CIT model. These authors examined records of police dispatch calls and incident reports for a comparative cross-site descriptive study of the three models. The study had two aims: to uncover the frequency of calls and the extent to which specialised professionals responded, and to establish how often these incidences were resolved without an arrest occurring.

Findings revealed the highest response rate was 95% in Memphis (CIT). This was the only city to have a 'no refusal' triage drop off centre where police officers could transport an individual in mental distress. Moreover, arrest rates across the three cities were also lowest in Memphis (2%). Steadman et al. (2000) concluded that the collaboration between police and mental health services, consumer services and a centralised triage centre for police referrals, lowered the rate of imprisonment for the mentally distressed individual. Furthermore, the availability of the triage centre in Memphis reduced the officers' downtime waiting in the ED.

Despite there being limited evidence about the effectiveness of the CIT model, 400 programmes are operating in medium and large cities in the USA (Watson et al., 2008). Police organisations throughout the USA have embraced this model as a sound approach to improving police responses to those in mental distress. There is a fundamental assumption that CIT training will enhance police officers' partnership with mental health services, reduce arrest rates and assist in connecting the mentally distressed individual to mental health services. However, this assumption remains untested. It would appear having readily available treatment facilities that police could transport the mentally distressed person to was the essential component in achieving the desired objectives of this model (Steadman et al., 2000; Watson et al., 2008).

A later study by Watson et al. (2010) found the arrest rate of those in mental distress by CIT officers was similar to that of non-CIT officers. One of the moderating variables of this study, "officers familiarity with mental illness" (Watson et al., 2010, p. 306), increased the likelihood of the individual being directed into the mental health system. The term 'officer familiarity with mental illness' referred to CIT officers who had personally experienced a family member or friend with mental illness. Limitations of this study were the small sample size, the interview

instrument was adapted from unknown existing measures (not stated) and responses were based on officers' perceptions (Likert scales)[4] of variables relating to the mentally ill and the CIT programme.

Fisher and Grudzinskas (2010) looked at alternative models to CIT and research that could be employed to validate the widely acclaimed success of this model. These authors argued there was a lack of data and credible systematic studies conducted to validate the success of the CIT model. They proposed that the goals of CIT could be achieved by improved crisis management training for police officers and guaranteeing "the availability of a mental health services portal" (Fisher & Grudzinskas, 2010, p. 68). Whether CIT is the best option for all situations pertaining to persons in mental distress is queried by Fisher and Grudzinskas (2010). However, there is much evidence in an increasing body of research that suggests CIT is an effective model that "has established itself as a prototype of law enforcement mental health collaboration" (Compton et al., 2008, p. 47) in many states in the USA.

Watson and Wood (2017) utilised data from a 5-year mixed method study of the Chicago Police Department's CIT programme. The study examined police officers' responses to incidents involving persons in mental distress. The aim of this study was to examine how officers understood the complexities of encounters with mentally distressed persons. Furthermore, how officers chose between the limited interventions available to them including what alternative choices they viewed were needed, was also examined.

Findings from the call resolution data of this study (Watson & Wood, 2017) revealed that most CIT and non-CIT trained officers chose to resolve the call out to the person in mental distress by transporting the person to the hospital ED. There was a conscious effort by all officers to avoid using the criminal justice system. Moreover, the quantitative data revealed that officers often chose to resolve mental health incidences at the scene through informal methods. Supporting this finding is the qualitative data gathered from in-depth interviews of 21 officers, 10 of whom were CIT-trained. These interviews revealed officers tendency to choose informal and de-escalation techniques over formal or strong-armed tactics (Watson & Wood, 2017). However, Wood and Watson (2017) recommended there was a need for better collaboration between police, ED and mental health staff. These authors asserted that to assist the mentally distressed person, all three parties must understand the protocols and constraints that dictate emergency care (Watson & Wood, 2017).

[4] A Likert scale is a rating scale often used in survey research to assess people's opinions, attitudes or behaviours.

Currently, CIT programmes in the USA are working in partnership with community mental health services. The aim of this partnership is to avoid arresting or using hospital EDs for individuals in mental distress. The rationale for this is that both these options are considered expensive. Furthermore, the ED is now deemed as an unsuitable environment for such persons according to Wise (2014). Alternatives being offered are "crisis triage centres, respite beds and co-responder linkage teams" (Wood & Watson, 2017, p. 292).

Canada's response models

The original framework of the CIT model needed modification in Canada and different versions have emerged. This was due to Canada's diversity of police organisations, mental health systems, geographical and demographic factors. Subsequently, this resulted in a variety of different adapted CIT models and co-response strategies used by police when working with mentally distressed persons (Cotton & Coleman, 2010). Of interest, was that in Canada, the police-based CIT model has proven to be economically expensive and seen to work better in smaller police departments (Watson et al., 2008). Moreover, a number of cities needed to adapt the CIT model "to reflect jurisdictional needs" (Coleman & Cotton, 2014, p. 327).

In Ontario for example, the police-based CIT model was modified to 20 hours of training for 25% of its staff. The Ontario Provincial Police utilise this response model to mental health related incidents. When a CIT-trained officer is available they attend the incident. If they are unavailable, a non-CIT officer will attend, and if necessary, may ask for assistance from a CIT officer (Wood et al., 2011).

The Advanced Patrol Model is used by police in Toronto and Belleville (Ontario). This is still a police-based response model; however, annually all frontline police officers receive extra training in mental health. Police in these two cities also use designated mental health officers who assist to case manage and liaise with mental health services (Coleman & Cotton, 2010; Wood et al., 2011). This model has proven useful in smaller and rural policing districts (Cotton & Coleman, 2010).

A further model called TEMPO (Training and education about mental illness for police organisations) has been developed under the auspices of the Mental Health Commission of Canada and builds upon the existing police-based models (Coleman & Cotton, 2014). The major difference between the CIT and the TEMPO model is that all police officers receive initial and ongoing training in the TEMPO model of how to respond to mentally distressed persons. Core elements of CIT such as interagency partnerships remain however, as does a focus on police community involvement (Wood et al., 2011). The aim of TEMPO has been to divert

persons in mental distress from the criminal justice system and retrain police officers' "basic assumptions and attitudes about mental illness" (Coleman & Cotton, 2014, p. 333).

However, throughout Canada, the co-response Mobile Crisis Team is the predominant model. This model has a mental health worker (nurse, social worker or mental health professional) accompanying a police officer when responding to a mental health related incident (Cotton & Coleman, 2010; Watson et al., 2010). Calls to attend the incident come from either a police call centre or directly from other first responders. Once at the scene, the police officer ensures all are kept safe whilst the mental health worker assesses and facilitates admission into the mental health system. Many larger urban centres in Canada use this model.

Hamilton City, also in the province of Ontario, uses a slightly different co-response model. This is the Crisis Outreach and Support Team (COAST) implemented in 2001. The COAST teams comprise of plain clothed police officers, mental health and social workers, nurses and youth crisis workers. A 24 hour, 7 day a week telephone triage and initial assessment system is managed by a mental health clinician. These clinicians either mobilise the COAST team or provide telephone support to the mentally distressed person. In addition, COAST provides support to officers by providing them with alerts about a given client when agencies who normally work with the client are closed (Wood et al., 2011).

In Vancouver, British Columbia's co-response model of partnership between police and their mental health emergency services includes hospital ED personnel (Coleman & Cotton, 2014; Wood et al., 2011). Police and a mental health worker arrive jointly to a mental health incident where together they use their respective skills. The aim is to divert the person into the mental health system, thereby reducing the need to use the hospital ED or criminal justice system (Morabito, Savage, Sneider, & Wallace, 2018).

Even with the many interagency approaches between Canadian Police and mental health services in their response to those in mental distress in the community, "scientific evidence on their effectiveness is limited" (Cotton & Coleman, 2010, p. 311). Shapiro et al. (2015) contends that with the lack of research and literature available on evaluating the co-response model, its success is questionable. Canadian Police are keen to provide anecdotal support for the success of their police/mental health partnership. However, Cotton and Coleman (2010) maintain there is a lack of robust research to validate such a claim.

Challenges in the co-response model are identified as relating to the delineation of roles between health professionals and police officers (Morabito et al., 2018). Confusion existed as to "who should take the lead" (White & Weisburd, 2017, p. 3). However, a review of literature

of the co-response model found that the use of this model enabled the police to develop links with community mental health services. Additionally, it was found to reduce the time officers spent waiting in the hospital ED (Shapiro et al., 2015). Borum et al. (1998) considered that reducing the time officers spent in the ED improved efficiency and morale for officers. Waiting was considered by officers as an ineffective use of their time.

Over the years, police-based and co-response teams in Canada have not been the only models developed. Some police organisations have developed stand-alone programmes tailored to meet the special needs of their area. According to Coleman and Cotton (2016), these stand-alone programmes often lack a strategic approach to working with mentally distressed persons. Moreover, frequently stand-alone programmes are not well integrated into larger police services. Nevertheless, as noted by Steadman et al. (2000) and Morabito et al. (2018), the availability of access to mental health services is a key component to any effective police-based or co-responder model. This can avoid the hospital ED becoming the default option (Wise, 2014).

United Kingdom (England, Northern Ireland, Scotland, Wales) response models

In the UK, all policing arrangements are overseen by the Home Office. The Home Office places great importance on interagency partnerships to look after those in mental distress (Moore, 2010; Wood et al., 2011). The co-response model is used mainly for police mental health triage in the UK (Puntis et al., 2018). In England and Wales, a secondary specialist police service has been established in the form of Police Community Support Officers (PCSOs). The job of the PCSOs is to engage with the community, be visible and available to the public, and tend to public disorder and minor offences (Wood et al., 2011). Police Community Support Officers work in conjunction with community mental health teams consisting of nurses, doctors and social workers.

The Police Custody Liaison Scheme is a further example of co-response interagency partnerships. This scheme operates in Central London and covers three police stations in Westminster-Charing Cross, West End Central and Marylebone. When police in these locations arrest a person suspected of being in mental distress, a community psychiatric nurse (CPN) working for the Police Liaison Service gathers information on the individual's mental health history. A mental health assessment is then conducted by the CPN. It is the CPN who determines if the person is referred to community mental health service facilities, or taken to a hospital ED (Moore, 2010; Wood et al., 2011). The CPNs in this service are linked to community mental health and social service teams. The aim of this scheme is to keep minor mental health

offenders out of custody and placed into appropriate care. A similar scheme has worked well in Birmingham UK, and Belfast, Ireland (James, 2000; McGilloway & Donnelly, 2004).

Two new initiatives have been implemented in the UK. One is the Mental Health Crisis Care Concordat[5]; the second is a triage scheme. The Concordat is a national agreement between all relevant services that is tasked at fast tracking the assessment process if a police cell is used for a mentally distressed individual. With input from mental health services, the individual is moved to a more appropriate facility. There is an expectation that this approach will decrease the use of police cells and ensure local services respond quickly to those in mental distress (Wood et al., 2011).

The second initiative is the setting up of a street triage scheme in West Midland and in Coventry. The triage scheme involves police officers in these regions teaming up with mental health nurses and paramedics. When the Police Call Centre receives the initial request concerning an individual in mental distress, the Street Triage Team will respond to the incident. At the scene, the team assess the individual and usually transport them to a safe healthcare facility, namely the hospital ED. This co-response model has seen police stations being used less for mentally distressed individuals (Independent Police Conduct Authority, April 2015). The Street Triage Team also provides telephone support for their police colleagues when necessary. However, Puntis et al. (2018) assert that more research needs to be conducted about the street triage approach to consider the funding, interagency working and the effectiveness of this model.

A systematic review of literature by Puntis et al. (2018) found that co-response models did reduce arrest rates of persons in mental distress. Furthermore, these individuals found their interactions with police in the Street Triage Team less distressing. However, there were marked variations on how these co-response models operated. Differences identified were the times and days this model was operating, whether the response units arrived together or separately, whether police and mental health workers were co-located and the type of transport used to attend an incident (Puntis et al., 2018). These authors found many unanswered questions and a lack of evidence of the effectiveness of co-response models. This was despite considerable investment of resources to both police and mental health services. Marsden et al. (2020) concur with the findings by Puntis et al. (2018), and agree that more research is needed to be conducted about the street triage approach to consider the funding, interagency function and the effectiveness of this model.

[5] For further information refer: www.crisiscareconcordat.org.uk

Australia's response models

In Australia, due to the State or Territory structure, each police organisation must provide, and be responsible for, the appropriate service to those in mental distress (Wood et al., 2011). A number of interagency approaches have developed between police and mental health services to improve their responses to these individuals. Several adaptions to the CIT approach have proved successful and popular. One of reasons for the popularity of the CIT model is due to the role for police as "enforcers of social control" (Clifford, 2010, p. 503). The CIT model effectively allows police and mental health services to work separately and still retain their designated roles (Shapiro et al., 2015). Nevertheless, the adaptions of CIT have enhanced the skills of police to efficiently handover a mentally distressed person to health professionals in an ED (Clifford, 2010). With these acquired handover skills, Clifford (2010) suggests this may assist in reducing the unnecessary waiting for police with those they have transported to the ED for an assessment.

Initially run as a pilot programme, police partnered with the New South Wales (NSW) Department of Health in 2008 and implemented the Mental Health Intervention Team (MHIT). The MHIT modelled itself along the CIT programme developed in Memphis (Huppert & Griffiths, 2015). The MHIT programme provided special mental health training to 20% of frontline police officers in three designated police districts. These specialist officers were called on in mental health related incidences. However, these officers also performed regular patrol duties when not involved in mental health incidents. The goals of MHIT were to enhance frontline police skills in working with those in mental distress, enable interagency co-operation, and reduce police time spent in dealing with mentally distressed persons in the community and ED (Herrington & Pope, 2014).

Herrington and Pope (2014) used a multi-phased, mixed method study to evaluate the effectiveness of MHIT. Their findings found the MHIT model to be effective and assisted in improving relationships between police and health care staff. However, the qualitative findings of this study reported ongoing difficulties with interagency co-operation. These difficulties derived largely from a lack of mental health service resources, and this service relying on police to be substitutes for the gap in security and transportation (Herrington & Pope, 2014). A recommendation from this study was the importance for all police officers in remote rural areas to have MHIT training. Herrington and Pope (2014) argue that in remote rural areas, individual police officers need to know how to de-escalate situations when assistance is not readily available. Rural police officers are often on their own when responding to a mentally distressed person.

Crisis Assessment Treatment Teams (CATTs) in Victoria is another response model staffed by doctors, nurses, social workers and psychologists. This is not a mobile emergency response service. However, it offers an alternative to hospitalisation for persons in mental distress by providing intensive support in their homes (Wood et al., 2011). The CATT is also responsible for on-site support to some hospital EDs and works with police when an individual requires assessment at a police station. There is an understanding that CATTs are expected to prioritise referrals from police (Wood et al., 2011).

However, Huppert and Griffiths (2015) found that CATTs were often unable to assist police in the community with a mentally distressed individual after their normal working hours. This was due to limited staffing. Research indicates that it is after CATT services normal working hours their services are most required by police (Lee, Brunero, & Cowan, 2008). The result of this situation is that police officers transport the person through to the closest ED. Here, police are often required to wait and remain if there is a significant risk of violence (Huppert & Griffiths, 2015). This is a source of frustration for police who have competing work demands in the community (Clifford, 2010; Hunter, Murphy, Grealish, Casey, & Keady, 2011; Huppert & Griffiths, 2015; Lee et al., 2008; Teplin, 2000). To rectify this situation the following co-response model was developed.

In Australia, the co-response model consisting of police, ambulance and crisis emergency response (PACER) is now the predominant model. The PACER model was designed to enhance the collaborative response between Victoria Police, CATT and ambulance services to persons in mental distress. Police, ambulance and crisis emergency response (PACER) acts as a second response team for individuals detained by police under Section 10 of the Mental Health Act (1986). Ambulance and police units call PACER for various forms of assistance. These could vary from an on-site clinical assessment, recommendation of appropriate referral options, guidance by phone on the best means of transport, and de-escalation advice (Wood et al., 2011). Police, ambulance and crisis emergency response mental health clinicians travelling with police manage and assess mentally distressed individuals in the community. The task of the police officers in the PACER team is to contain the situation, keep all safe and gather relevant information (Huppert & Griffiths, 2015).

The aim of the PACER model was to hasten the assessment time for mentally distressed individuals, and divert them away from the hospital EDs. When transportation of an individual to the ED is needed, PACER contact local ED staff and give their evaluation of the situation. When admission of the individual to an inpatient mental health unit is required, direct admission occurs (Huppert & Griffiths, 2015).

A three-month trial of PACER in Melbourne was implemented and evaluated (Huppert & Griffiths, 2015). A quantitative dataset of 235 events that included 171 'attended jobs' and 64 instances of 'phone advice' comprised the data collected by Huppert and Griffiths (2015). The findings revealed an improved mental health services and police partnership. Moreover, there was a reduction in assessment time and numbers of mentally distressed persons being processed through EDs. A further benefit of PACER was that police officers gained specific mental health training by working closely with mental health clinicians (Huppert & Griffiths, 2015). In Australia, since the initial trial of the PACER model, there have been several replications with few modifications to it.

One such replication model established in 2012 was the Northern Police and Clinician Emergency Response team (NPACER) (Furness, Maguire, Brown, & McKenna, 2016). The NPACER team comprised a senior mental health clinician and police officer who respond to calls from frontline police to attend incidents involving those suspected of being mentally distressed. Once at the scene, the team assessed the individual. A decision was then made whether direct admission to an inpatient unit was required, or that the individual be diverted to community mental health services. The aim of the NPACER team was to keep the mentally distressed individual calm, improve service utilisation and divert these persons from presenting at the hospital ED**.**

Using a qualitative exploratory research design with a purposive sampling method, McKenna, Furness, Oakes, and Brown (2015b) described the perceptions of 17 key stakeholders in Melbourne on the benefits of the NPACER model for the mentally distressed person. Stakeholders included "consumer advisors, carer advisors, mental health staff, emergency department staff, police and ambulance officers" (McKenna et al., 2015b, p. 387).

Findings revealed that stakeholders perceived the NPACER model to be a sound solution to a stand-alone police response (Huppert & Griffiths, 2015; McKenna et al., 2015b).

Stakeholders felt this model met several criteria. These criteria included diversion of the mentally distressed from the ED to more appropriate services and assisting direct access to inpatient mental health services. Consequently, police officers could promptly return to their other duties in the community. The NPACER also resulted in a greater level of interagency co-operation and knowledge being shared by team members. Moreover, the use of this model lessened the chance of an undesirable incident occurring (McKenna et al., 2015b). These authors acknowledged the limitations of this study as being a small pre-selected sample and that data may have been contaminated by peer group communication. Thus, the findings of

this study may not be necessarily generalisable to other response teams and models of care elsewhere.

However, by using retrospective comparisons of electronic records, an evaluation of NPACER was conducted. Trends and service utilisation pre and post NPACER implementation were compared (McKenna et al., 2015a). The NPACER operated 7 days a week, from 15:00–23:30 hours. Over a six month period, during these hours, 16% of people in mental distress went through the ED. This was compared with 100% at all other times of the day over this six month period. Furthermore, NPACER enabled assessments at police stations and in the community that facilitated direct admission to mental health inpatient units. Direct admission did not occur outside NPACER operational hours (McKenna et al., 2015a). Limitations of the study were the use of retrospective data that included selection bias due to case duplication occurrences treated as single events. Furthermore, the data was time limited due to the study design and cannot be extrapolated to other jurisdictions.

There is strong evidence internationally and in Australia that co-responder models assist in avoiding ED presentations and hospital admission for persons in mental distress (Meehan et al., 2019). A mixed method study by Meehan et al. (2019) set out to assess the outcomes for persons considered to be in mental distress following interventions by a co-responder team. Individuals who had contact with the co-responder team were monitored for two weeks. This was to observe if there were subsequent ED or inpatient admissions. The co-responder team consisted of police and a mental health nurse working alongside each other from Thursday through to Monday (1400–2200hours). Initially, on-site triaging from a safety perspective was conducted by the police officer. This was followed by the mental health co-responder assessing the type of mental distress and risk posed. If the individual met criteria for more a comprehensive assessment, they were transported by ambulance to the ED.

Over a 16 week trial of the co-responder programme, findings were: of the 122 individuals who had direct contact with the co-responder team, 82 remained in their own home, 35 were transported to the ED and 5 taken into custody by police; over the two week period of the 82 that remained at home, 10 presented to the ED and 3 were admitted to an inpatient unit. Interestingly, as the first responder, police officers were asked how they had initially intended to resolve the situation for the 122 individuals. All officers stated their intent would have been to transport 100 of these individuals to the hospital ED. Meehan et al. (2019) concluded that police-mental health co-responder teams are effective and do assist in diverting many of those in mental distress from presenting at EDs. These authors understood this to be “in keeping with least restrictive models of care” (Meehan et al., 2019, p. 20).

It would appear that through co-responder teams providing timely and effective care to those in mental distress in the community, the number of these individuals presenting at hospital EDs is reduced. Boscarato et al. (2014) viewed the co-response approach as offering an improved outcome and experience for the mentally distressed person. There was a recurrent theme throughout much of the literature on interagency models of police and mental health services responses to those in mental distress. This theme identified the importance of diverting those in mental distress into mental health community services, rather than using the hospital ED.

Internationally and nationally, police officers and health sector personnel are required to work collaboratively in a range of capacities when responding to those in mental distress. This is due to legislative requirements and the nature of their work. However, the response model in New Zealand between police and mental health services to those in mental distress is somewhat different than in the USA, Canada, the UK and Australia.

New Zealand response model

Ostensibly, New Zealand Police officers operate, as Boscarato et al. (2014) would term, a 'separate response team' to those in mental distress. It is the Community Assessment and Treatment Team (CATT) who are considered the "front-line service to address the assessment needs of any member of the public appearing to be mentally unwell" (Wison, Carryer, & Brannelly, 2016, p. 203). Theoretically, police should attend a mental health related incident only in response to a call from a Duly Authorised Officer (DAO). In such an instance, the DAO may ask police to transport the person to the hospital ED for an assessment (Independent Police Conduct Authority, April 2015). There is an expectation that a DAO working in a mobile CATT will be the first point of contact for the individual in acute mental distress (Li et al., 2018).

However, consistent with international trends, New Zealand Police have seen a rapid growth in the number of mental health related events they attend as first responders. This situation is due to a mental health system struggling to keep up with demand for their services (Li et al., 2018). Consequently, today, New Zealand Police have an established position as part of a group of organisations required to provide help and assistance to those in mental distress in the community.

New Zealand Police officers refer being called out to individuals in mental distress as being dispatched to a '1M'. Calls that are specifically suicidal related are referred to as a '1X'. In 2017, there were 98 mental health related incidences every 24 hours that police officers responded to. In 77% of the 1M calls attended, police officers were the first and sole

responders at the incident. This percentage does not include suicide related attendances (1X) by police alone response (University of Otago, 2019).

Currently, the New Zealand Police officers' directive is to transport the individual they suspect of being in mental distress to the hospital ED to be assessed (Independent Police Conduct Authority, April 2015). International findings are that this 'police alone response' usually results in over half of those in mental distress transported to the ED, being discharged. (Al-Khafaji, Loy, & Kelly, 2014). The reason for this is that the individual failed to meet the criteria threshold for admission. Similar results were found in New Zealand, as seen in a quantitative descriptive cross sectional design study by Holman et al. (2018).

Holman et al. (2018) investigated the clinical, legal and social characteristics of mentally distressed individuals subjected to the police alone response in the Waikato region in New Zealand. Also described by Holman et al. (2018), was the police use of force with these individuals. Data was collected from three sites using a structured data collection form. From the 96 forms returned, 86 were analysed. The 10 that were not analysed did not meet the inclusion criteria. Findings revealed that over half of those detained by police were released following a mental health assessment at the hospital ED. Furthermore, Māori were more often the subject of a police response but "no more likely than Europeans to be subject to police use of force" (Holman et al., 2018, p. 1415).

Of interest was that use of force by police occurred more in rural areas and in the evening when mental health services were less available. Holman et al. (2018) suggest that a co-response model focusing on after hours responses may be a helpful model to employ when responding to the mentally distressed in the community. Employing a co-response model, Holman et al. (2018) contend could reduce police use of force and the number of persons in mental distress being transported by officers to the hospital ED. Nationally and internationally it would seem that a police alone response is fraught, owing to police being unable to differentiate between mental illness and complex societal/psychological problems (Holman et al., 2018; Maharaj, O'Brien, Gillies, & Andrew, 2013; McLean & Marshall 2010). In New Zealand, these challenges associated with the police alone response to those in mental distress have been addressed through several initiatives.

Initiatives to support NZ 'police alone response' to those in mental distress

As first responders frequently to those in mental distress, it is important frontline police have a close working relationship with all health care providers, including mental health services. This

ensures all parties contribute to provide the best outcome for individuals in mental health distress.

Currently there is a national memorandum of understanding (MoU) between the Ministry of Health and the New Zealand Police which accompanies the Mental Health Act (1992). The MoU sets out national standards of the services to be delivered between District Health Board (DHB) mental health services and the New Zealand Police. These national standards cover police responses to mentally distressed persons in the community and within public hospitals (District Health Board Mental Health Services & New Zealand Police, 2015). The MoU is an evolving agreement that is responsive to the changing climate of the increasing numbers of mentally distressed individuals requiring police involvement and hospital ED admissions. There are local and regional variations to the MoUs.

Concern in one New Zealand Police district over the increasing numbers of mental health assessments still taking place in police stations resulted in police collaborating with a local DHB. With work by both organisations, the result was a comprehensive MoU that spelt out the roles, responsibilities and expectations with each party, whilst acknowledging each other's perspectives, powers and responsibilities (Independent Police Conduct Authority, April 2015). This DHB's partnership with the local policing district has significantly reduced the number of assessments conducted at police stations. It would appear that this model of working collaboratively between police and DHBs is being replicated in other regions in New Zealand (Tait, 2015).

However, well before the use of the hospital ED as the place for police to transport persons in mental distress, some other interagency collaborative initiatives had been trialled. One was the placing of qualified mental health nurses in four police watch-houses. These nurses were to assist police improve the management of risk to detainees who displayed mental distress. The 'Watch-house Nurse' (WHN) initiative began in Christchurch and Counties Manukau in 2008 and is now also operational in Rotorua and Hamilton (Independent Police Conduct Authority, April 2015).

The aim of this arrangement was for the WHN to assess and clinically manage individuals in police cells experiencing drug, alcohol and mental health issues. These nurses also liaised with, and arranged for, appropriate referrals for these individuals. A further benefit was the WHN being able to informally educate police on the identification of mental health and addiction issues (Paulin & Carswell, 2010). The WHN initiative has allowed police to focus on other duties and has sped up police processes in the police watch-houses. Outcomes from this trial have

been positive, with increased access to appropriate mental health services for the mentally distressed in police custody (Independent Police Conduct Authority, April 2015).

Paulin and Carswell (2010) conducted an evaluation of the WHN initiative at Christchurch Central and Counties Manukau Police stations over an 18 month period. Assessments carried out by the WHNs totalled 5,836 detainees in police custody at these two sites. The findings revealed that having a WHN increased the identification of mental distress in many of the detainees. A further benefit was that the WHNs could assist persons with alcohol and drug issues by giving advice, information and referrals. Moreover, having a WHN in a police station allowed for quicker triaging of detainees suspected of being mentally distressed. The result of this was that if appropriate, individuals were released from police custody or reconnected to mental health services (Independent Police Conduct Authority, April 2015; Paulin & Carswell, 2010). Feedback from police officers was that they felt more supported by having immediate access to a WHN. Furthermore, officers considered that having a WHN present reduced risk to themselves and detainees. Police officers credited this to the WHNs clinical knowledge and assessment skills (Paulin & Carswell, 2010).

It is interesting to note that whilst this initiative has seemingly been successful for police in reducing waiting times for mental health assessments (Holman et al., 2018), there has been no national 'roll out' of such a scheme. One explanation may be in the national standards of service delivery between DHB mental health services and New Zealand Police. This document states that a police station is to be used only as a last resort for the assessment of a mentally distressed person. The preferred setting for the assessment is that it be conducted in a community mental health facility or in a hospital ED (District Health Board Mental Health Services & New Zealand Police, 2015). The rationale given is that a person in mental distress may have their condition further exacerbated in a police watch-house environment. Furthermore, using the police station for those in mental distress could be seen as "criminalising and stigmatising the persons condition" (Independent Police Conduct Authority, April 2015, p. 19).

This approach is also in keeping with the World Health Organization's comprehensive *Mental Health Action Plan 2013–2020*[6]. The World Health Organization aims to see that persons affected by mental disorders have access to high quality, culturally appropriate health and social care. Moreover, the care of these individuals must be free from discrimination and stigmatisation and provided in the least restrictive environment (Saxena & Setoya, 2014).

[6] For further information refer: www.who.int>action plan 2013>

A further initiative on 1 July 2014 was the establishment at Police National Headquarters (Wellington) of a Police Mental Health Team. The brief of the team was to identify ways New Zealand Police could work more collaboratively with the relevant services and respond more effectively to those in mental distress (Independent Police Conduct Authority, April 2015). Part of the role of the Mental Health Team at Police National Headquarters has been to improve outcomes for people experiencing mental distress, manage the increasing demand and risk associated with mental health related calls for frontline officers, and work in partnership to improve the multi-agency response to people in mental health distress.[7]

In 2017, New Zealand Police included mental health for the first time as one of the six official core 'drivers of demand'. The addition of mental health as a sixth demand driver was alongside the five other drivers of demand, namely alcohol, youth, families, roads and organised crime and drugs. However, mental health is also at the centre of the Police "Prevention First" operating strategy (New Zealand Police, 2017a). The aim of the Prevention First policy is to prevent harm before it happens in the community (Cook, 2017). The inclusion of mental health in this national operating model was in response to increasing mental health related calls to police (New Zealand Police, 2017a).

Changes in policing practices

In the past decades, the role of the police has been centred on law enforcement. However, due to socio-economic developments, that role has changed and now includes the provision of social support (Andoh, 1998). Traditional reactive policing practices have changed to a more pro-active contemporary policing model when responding to those in mental distress (Coleman & Cotton, 2010). Contemporary policing involves more than arresting and detaining people. Today, police need to see themselves as being involved in the social welfare aspects of those in mental distress, not just law enforcement (A. Fry, O'Riordan, & Geanellos, 2002).

Changes in policing practices mean the police 'force' has become a police 'service' that provides a service to governments and their communities (Stenning & Shearing, 2005). With the focus now on community policing, this has necessitated a radical change and challenge requiring police officers to have a different relationship with the communities in which they work. These changes include practices not always associated with traditional policing (Buerger, Petrosino, & Petrosino, 1999; Rahr & Rice, 2015). Today, police officers may spend minimal

[7] For further information, refer https://www.stuff.co.nz/national/hwwwealth/118657922/the-new-beat-the-1x-attempted

time doing what the public perceive as ‘real police work’. Indeed, much of police work today has little to do with criminal behaviours (Carroll, 2005).

Arguably, the journey of police transformation and the drive for re-imaging and reshaping police culture and practices to incorporate a role in public health has been as a result of deinstitutionalisation (Stenning & Shearing, 2005). The result of deinstitutionalisation was an influx of those in mental distress living in the community without appropriate facilities to cope with their requirements (O’Brien, 2006; Rahr & Rice, 2015; Wood & Watson, 2017). Police organisations were forced to embrace and actively manage these people. The extent to which police were able to manage this unasked for role, is sometimes questionable (Wood et al., 2011). Nowadays, the guardian public health role that police play in responding to persons in mental distress has become more transparent (Wood & Watson, 2017). This transparency can be seen in the predominance and acceptance of the CIT model, where a select group of police officers act as the “mental health interventionists” (Wood & Watson, 2017, p. 96).

There has seemingly been concerted effort by police organisations to change their culture and improve their interactions with those in mental distress. Police culture is defined by Schulenberg (2016) as “consisting of values and attitudes held by officers which are made visible through interactions, practices and the direct and indirect pressures to conform to norms of behaviour” (p. 464). This is an example of an occupational culture that has been generated through socialisation with colleagues and includes concepts of loyalty and camaraderie (Wood, Sorg, Groff, Ratcliffe, & Taylor, 2014). Nevertheless, the changing of policing practices is challenging for officers, as departmental directives and philosophies fluctuate with political changes (Schulenberg, 2016). However, “culture, does not stand on its own; it is reinforced at an organisational level through reward structures, and in particular, pressures to generate activity” (Wood et al., 2014, p. 372).

Godfredson, Thomas, Ogloff, and Luebbers (2011) suggest that there still exists an underlying police culture that measures and rewards ‘real police work’ such as catching criminals. However, this may fail to officially recognise the contemporary broader, supportive and vital role police perform daily working with the mentally distressed in the community and EDs. The challenge for police officers is that they may consistently have to balance their work practices whilst navigating between what they feel they should be doing, and what they are rewarded for. This is especially so when directives from management carry expectations of fulfilling crime quotas (Godfredson et al., 2011). Wood and Watson (2017) make the observation that much of the welfare role that police officer undertake is usually out of public view, usually not valued, misunderstood by policy makers and largely undocumented, or acknowledged.

The cultural tension police officers face between their traditional law enforcement duties and their supportive role to those in mental distress is a research focus. Field observations by Wood et al. (2014) involving foot patrol police officers in Philadelphia confirmed the conundrum that police officers experience in the duality of their role. The aim was to capture police officers' perceptions and experiences with their 'on the beat' street patrol work during shifts. Findings similar to those of Godfredson et al. (2011) reveal that officers constantly felt a cultural tension between what they felt they should be doing, and what they would be rewarded for doing by their police organisation. Schulenberg (2016) believes there is a need to re-examine performance evaluation criteria used by police organisations. This would better reflect the nature and activities of the growing proportion of police work that is involved with persons in mental distress.

Globally, there is an acknowledgement from police organisations of the need to re-image themselves and change their culture to be seen as "guardians rather than warriors" (Wood & Watson, 2017, p. 289) when carrying out their many tasks. There is a need for police to re-image themselves as protectors of society and assist those they serve. In some countries, police officers' engagement with those in mental distress has been under scrutiny as it has sometimes resulted in fatalities (Teplin, 2000). However, Rahr and Rice (2015) argue that this situation can be rectified with commitment to foster a 'guardian mind-set' in the police culture. This mind-set would assist police in creating stronger relationships and engagement in the communities they work in. In turn, this could lead to improved public safety and result in a more effective policing style (Rahr & Rice, 2015).

Working with people who are in mental distress is now part of contemporary policing. Policing practices in working with these individuals have adopted the broader concept of security, harm reduction and prevention (Godfredson et al., 2011; Stenning & Shearing, 2005). Community policing has a large social welfare role for officers, and 'real police work' now involves interacting with individuals experiencing mental health crises. This role is now larger, more complex and places additional pressure on police resources and funding (Clifford, 2010).

Nevertheless, what has not changed is the public paranoia of people feeling unsafe with the mentally ill now living in the community. This paranoia has placed a new focus on police involvement and practices in the everyday life of those in mental distress (Cotton & Coleman, 2017). When an individual is perceived by the public to be 'acting a little out of the ordinary', police are called despite no criminal activity necessarily having taken place (Brookbanks, 2002; Dew & Badger, 1999; Lamb et al., 2002; Rowe, 2001). Police interactions with those in mental distress and the mental health system have increased. Similar scenarios are occurring globally,

and police officers appear to be carrying the responsibility of managing those in mental distress (Clifford, 2010; Kalucy, Thomas, & King 2005; Klein, 2010; Martin & Thomas, 2015; Schulenberg, 2016). Much of this increase has been as a result of shifts in legislation, social policies and changes in policing philosophy (Coleman & Cotton, 2010).

Changes in policing practices when working within the mental health context are now focused on practices being protective and not punitive for those in mental distress. Nevertheless, police are also legally responsible for public safety. However, like other groups in the community, police are influenced not only by societal perceptions of those in mental distress or by models of service provision, but also by the training provided (Chappell & O'Brien, 2014).

How Police are Currently Being Trained

Consistent with the basic principles of contemporary policing, many police organisations have worked to improve their response to situations involving persons in mental distress. Two predominant initiatives have been the education and training of police officers about mental health, the mental health system and specialised police responses (Cotton, 2004). As police are frequently first responders to a mentally distressed person, the training received is key to a successful outcome for both parties (Borum et al., 1998; Moore, 2010). A review of the literature has identified a wide range of mental health training options for frontline police officers (Thomas & Watson, 2017).

Lamb, Weinberger, and Gross (2004) recommend the need for increased mental health training for all police officers. This recommendation comes as the result of officers recognising their training in this field as inadequate, and feeling ill-equipped to deal with mentally distressed individuals (Marsden et al., 2020; Wells & Schafer, 2006). At times, officers attributed this feeling of inadequacy stemming from their limited scope of practice. Officers scope of practice often prevented them going beyond legal obligations set under mental health legislation (Godfredson et al., 2011; Marsden et al., 2020). However, there were specific areas that officers wanted further training in. These specific areas were training about how to recognise if a person is mentally distressed; what to do if they present as violent or suicidal; how to access community resources; and when to get assistance from a mobile mental health team (Lamb et al., 2004). Currently, these specific areas are covered in many police training programmes (Coleman & Cotton, 2014; Thomas & Watson, 2017).

However, in a New Zealand study by Dew and Badger (1999), officers stated that their real education came from working with those in mental distress, not from any formal training. Officers believed they had the ability to determine if a person was mentally unwell. They

determined this by relying on their own experiences, intuition and by observing the individual's behaviour. Some officers claimed that no amount of formal training could prepare them for situations they attended involving mentally distressed individuals (Dew & Badger, 1999).

Similarly, in Victoria, Australia, a survey of 3,534 police officers found that most officers constructed their understanding of how to work with the mentally distressed as coming from "on-the-job training and experience" (Godfredson et al., 2011, p. 190) and not formal training. These authors compared this type of training to the 'apprenticeship type model'. This model is where new officers are partnered with more experienced officers to learn the skills required of working with those in mental distress. As this model of training is not necessarily best practice, Godfredson et al. (2011) recommend that in future, police training should incorporate a multi-module approach. This approach would utilise mental health experts in the design and delivery of the training module to police.

Regardless, in ensuring training for officers is effective, it needs to be presented in a style that captures the realities of the everyday work for police with those in mental distress. When this does not occur, Wainwright and Mojtahedi (2020) report that police use their own experiences and personal judgements when identifying and responding to the mentally distressed individual, rather than referring to official training that they do not find relevant.

Recently in the UK, Marsden et al. (2020) reported officers viewed much of their training at Police College of how to work with persons in mental distress as irrelevant. The decision making processes that training recruits were encouraged to apply to those in mental distress was perceived as too general. As such, these processes were unable to be applied in many situations. Subsequently, officers in this study considered 'on the job training' as being more useful than formal training. These officers wanted a more practical approach to their training. Moreover, officers felt if their training was updated to reflect legislative changes and amendments, it would be more effective and acceptable (Marsden et al., 2020). Coleman and Cotton (2014) added that including those with the lived experiences of mental illness in training police how to work with those in mental distress is also invaluable.

Nonetheless, Thomas and Watson (2017) assert that the Crisis intervention Team (CIT) is the most acknowledged specialist training and response model for police. The CIT model of training has been found to positively impact officers' knowledge, attitudes and skills in responding to those in mental distress (Compton et al., 2014; Steadman et al., 2000; Teller, Munetz, Gil, & Ritter, 2006). The core element of this model involves 40 hours of specialised training for a select group of volunteer police officers. However, Thomas and Watson (2017)

allege that the whole philosophy of this CIT model is not simply focused on training. Rather, the focus is on a collaborative approach when delivering the training. Support for police with their training involves mental health and social services, non-government agencies and persons living with experiences of mental illness. Using a multi-module approach to CIT training highlights that collaboration with other services is central to the programme. Additionally, all those involved in the training can learn and gain an understanding of each other's expertise and the challenges each service faces (Thomas & Watson, 2017).

In Australia, the MHIT programme, discussed previously in this chapter, has a similar training approach to that of the CIT model. The MHIT consists of a select group of frontline officers trained to be specialists to respond to mental health related calls (Herrington & Pope, 2014). The development and delivery of training to police officers in the MHIT programme involves a central project team (Herrington & Pope, 2014). It was found that the enhanced training in mental health these officers received gave them more confidence in dealing with individuals in mental distress. Furthermore, with this training, handovers between MHIT police officers and staff at EDs and mental health care facilities were significantly improved.

However, since the development of the CIT model 30 years ago, Petersen, Densley, and Erickson (2019) assert that its focus on the medical understanding of what constitutes mental illness, is no longer appropriate. CIT training should incorporate the contemporary view on mental illness which includes "trauma, stress and other environmental factors beyond someone's unique diagnosis" (Petersen et al., 2019, p. 3).

Yet, there is still limited evidence of the best and most effective type of mental health training for police officers (Watson & Fulambarker, 2013). Thomas and Watson (2017) acknowledge that it remains unknown what part of mental health training for police actually makes a difference to how officers interact with those in mental distress. Regardless, it must be acknowledged that mental health training is only one part, albeit an important one, of the pre-service and ongoing in-service officers have to undertake (Thomas & Watson, 2017).

With this in mind, and in response to the increased mental health related calls, New Zealand Police have re-examined their existing mental health training programmes. Contrasting with the previous strong bio-medical psychopathology training for officers, New Zealand Police have taken a contemporary approach to officer training to counter discrimination and effect behaviour change.

New Zealand Police commissioned the University of Otago with the development, delivery and evaluation of three service-user led and interpersonal contact/education based mental health

e-Learning modules (Davey et al., 2019). Davey et al. (2019) examined if these e-Learning programmes could assist and maintain positive changes in police behaviours when working with persons in mental distress. Three half-hour e-Learning modules were developed by a working group and academics who themselves had lived experiences of mental distress. The modules focused on the recognition of mental distress, engaging and responding to these individuals and how to assess for the risk of suicide. All modules included "written tests, practical exercises (fictional and non-fictional) and the use of audio-visual recordings" (Davey et al., 2019, p. 5).

Of the 1,200 police officers invited to take part in the e-Learning modules, 300 participated. On completion of the training, the Police Education Team recruited 24 staff who had previously participated. Those recruited included constables, sergeants, detectives and communication staff who had completed the e-Learning modules and had responded to mental health related incidences in the past six months. Participant contact details were forwarded to the Otago University's research team. This team collected the qualitative data using semi-structured telephone interviews which was then thematically analysed.

Findings revealed that the 24 selected participants felt that the e-Learning modules were invaluable in countering discrimination and effecting behaviour changes in their practice when working with those in mental distress. Resonating with all participants was that these training modules were created and drew on the lived experiences of those with mental illness. Some participants felt this type of mental health training would be more effective if supplemented or delivered with a face to face approach. Furthermore, across the full range of police roles, all participants wanted more extensive training and regular refresher courses.

However, there were barriers also identified in this research that e-Learning could not address. These were the institutional and societal barriers that police officers frequently encountered when responding to mental health related incidences. The institutional barriers were identified as limited time, resources and challenges associated with working collaboratively with other relevant health services. The societal barriers were socio-economic barriers that were linked to social and drug problems. Nevertheless, evidence from the findings of this qualitative study suggests that in future, e-Learning for training police in working with those in mental distress offers an effective alternative approach (Davey et al., 2019).

Yet, in order to evaluate the effectiveness of any mental health training for police officers, it is necessary to take into account the context, and especially the availability of mental health services. Knott et al. (2007) contend that it is not the lack of knowledge, training or resources that presented the challenges police encountered when working with those in mental distress.

The main challenges encountered were the social and organisational context in which police interact and work with these individuals (Knott et al., 2007). Undeniably, gaining access to mental health services for those in mental distress was a major concern for officers (Fisher & Grudzinskas, 2010; Godfredson, Ogloff, Thomas, & Luebbers, 2010; Martin & Thomas, 2015; Wells & Schafer, 2006). Officers reported access to mental health services in the hospital ED for those they suspected of being mentally distressed was particularly difficult (Martin & Thomas, 2015). This was especially so for those with personality disorders. A person who has a personality disorder, as defined previously, has a way of thinking, feeling and behaving in a manner that deviates from the expectations of their culture. These characteristics are enduring, cause distress to the person and they are unable to function properly[8].

Known Challenges Confronting Police in the Hospital Emergency Department

In many countries, the hospital ED has become the interface between community-based and inpatient care mental health services (Tankel, Di Palma, Kramer, & van der Swan, 2011). However, after transporting the mentally distressed individual to the hospital ED, usually under mental health legislation, police officers are presented with several challenges (Knott et al., 2007).

One specific challenge for police in the ED is the delay in handing over care of the mentally distressed person to mental health professionals (Hollander, Stuart, Tahalian, Young, & Kulkarni, 2012). In this setting, police often must wait for the mental health team to arrive and assess the individual (Clifford, 2010). Police officers consistently voiced their concern about spending time waiting in the ED only for the mentally distressed individual to be discharged once assessed (Clifford, 2010; Livingston, 2016; Tamsin et al., 2014). Generally, police considered this waiting as a waste of police time and resources (Bradley, 2010; Godfredson et al., 2011; McKenna et al., 2015b; Schulenberg, 2016; Wood et al., 2011).

Klein (2010) claims anticipated time delays in the ED made officers reluctant to detain mentally distressed individuals. Police from rural areas found delays in waiting times with the mentally distressed person in the ED particularly stressful and unproductive (Bradbury, Hutchinson, Hurely, & Stasa, 2017). Moreover, officers found long waiting times often compounded the individual's distress and escalated behaviours that police were left to manage.

However, McLean and Marshall (2010) assert that it is the lack of collaboration between police with ED and mental health staff that results in officers spending hours waiting in this setting.

[8] For further information, refer to https://www.mentalhealth.org.nz

Hoffman, Hirdes, Brown, Dubin, and Barbaree (2016) argue that this lack of collaboration is an unavoidable consequence of the different role functions of police and emergency staff. Police officers' focus is on protecting the public and personal safety. Emergency department staff focus is on how long the individual could safely remain in the department before being assessed by mental health professionals. Hoffman et al. (2016) explain that maintaining safety is the reason why ED staff insist police remain until the person is assessed by mental health professionals.

Furthermore, on occasions, hospital ED staff misunderstood police powers and expected officers to act unlawfully with the mentally distressed individual (McLean & Marshall 2010). This presented a challenging situation for the officers. On the one hand, they wanted to be seen to be working collaboratively with ED staff. On the other hand, as police officers, they also had a legal and moral obligation to those in mental distress (Marsden et al., 2020). The dilemma for officers was that sometimes either choice may result in "negative repercussions for the officers from their superiors" (Marsden et al., 2020, p. 6). Police were often put in a position of 'walking the tight rope' balancing their obligations for public safety issues, whilst looking after the welfare of the person in mental distress (Lamb et al., 2002). In this ED setting there were also a number of contextual risk challenges police needed to consider (Tamsin et al., 2014).

Some of these challenges began when the officers arrived at the ED. Emergency and mental health staff often questioned the officer's judgement in transporting the individual to the department (Knott et al., 2007). Moreover, sometimes the individuals who police suspected to be mentally unwell and whose behaviours presented as a clear problem to the community, were refused a hospital admission, or admitted briefly and discharged (Knott et al., 2007; Lamb et al., 2004). Martin and Thomas (2015) reported this scenario was a common occurrence for police as a result of encounters in the community with persons diagnosed with personality/behavioural disorders.

A lack of policy, guidelines or legislation specifically related to persons experiencing personality disorder presents an on ongoing challenge for police (Klein, 2010; Martin & Thomas, 2015). Police are often informed by mental health professionals in the ED that there is nothing they can do for the person with this disorder. The challenge for police then is how to deal with the person and situation (Martin & Thomas, 2015). Frontline police found this particularly frustrating and viewed the situation as the "vicious cycle leading to the process being compared to a revolving door " (Marsden et al., 2020, p. 4). In order to prevent this situation,

Klein (2010) advocates caution is required in EDs where there is often pressure to discharge such individuals prematurely.

Nevertheless, Meehan et al. (2019) contend that unnecessary transporting by police of those in mental distress to the ED is costly in time for police and health staff. Whilst waiting in the ED, officers are unable to attend to other policing duties (Knott et al., 2007). Waiting can also prove distressing for individuals experiencing a mental health crisis. In many instances, police realised they would be 'clogging up' an already busy ED by transporting the mentally distressed individuals there (Knott et al., 2007; McKenna et al., 2015b). Sometimes, this resulted in police receiving a less than welcoming reception by emergency staff (Hollander et al., 2012). However, police maintain they are always aware of a hospital's workload and took this into account before transporting a mentally distressed individual there. Klein (2010) purports police use the hospital ED not only to get assistance for a mentally distressed individual, but also as a means of containing the person. Steadman et al. (2001) concurs with this, and alleges EDs have always served as a containment resource for police when dealing with persons in acute mental distress.

However, in Melbourne, Australia, transporting an individual in mental distress to the ED is identified as the "default local practice of the stand-alone police response" (McKenna et al., 2015b, p. 388). Klein (2010) believes this occurs as police are simply desperate to help these individuals and often have no other solution of how to assist. Concurring with these authors, Wise (2014) claims that in the UK, EDs are still used by police and other services as a "holding pen" (p. 1).

A further challenge confronting police officers, as noted by Lee et al. (2008), was the physical layout of hospital EDs. In general, hospital EDs are not designed for mentally distressed individuals. In some instances, this may lead to the care of these individuals being comprised (M. Fry & Brunero, 2004)**.** When those in mental distress are at risk of self-harm, harming others or self-discharging**,** most hospital EDs are not secure enough environments to cope. This is frequently the reason police are being used as security guards in this environment (Knott et al., 2007).

In Victoria, Australia, Godfredson et al. (2011) surveyed 3,534 police officers examining challenges confronting police officers in the hospital ED. Using a grounded theory thematic analysis, challenges identified included having to 'baby sit' persons in distress whilst waiting for them to be assessed; individuals being discharged only to re-present to police shortly after; officers lacking knowledge of how to communicate, gain trust and what approach to take with the distressed individual; and keeping the individual calm and co-operative. Yet, notably the

overarching challenge for police officers was knowing how to get support for the mentally distressed individual from hospital ED staff and mental health professionals (Godfredson et al., 2011).

Globally, police officers recognise that responding to mental health emergencies is often necessary, yet pose complex challenges (Thomas & Watson, 2017; Wells & Schafer, 2006). The everyday reality of different operational models, MoUs and organisational directives can prove contentious between police and their interagency partners in the ED. This is frequently due to each having differing ideologies, organisational priorities and availability of resources (Skinns, 2008).

Summary

The constructivist grounded theory methodology was adhered to throughout this literature review. This entailed setting aside the preliminary literature review undertaken until the analysis of the data was completed and a substantive grounded theory was generated. The preliminary literature was then revisited in order to compare and contrast with the emergent theory and resulting discussion.

This chapter has presented an overview of international and national literature on how frontline police officers respond to those in mental distress. Topics covered were interagency responses to those in mental distress, changes to policing practices, current training and challenges officers confront in the hospital ED. Evident from the literature reviewed was that the implementation of working interagency models between police, the mentally distressed person and mental health services is a systems approach to a complex social relationship. The role for police has changed. Today, police are required to be involved in the social welfare aspects of those in mental distress, not just law enforcement. This has presented challenges as contemporary training for police emphasises the importance of improving their interactions with those in mental distress. Although, there are many different types of mental health training, officers predominantly valued ‘on the job training’.

Internationally, many of the different interagency models have been designed to divert persons in mental distress away from the ED and into community care. However, currently the national directive from New Zealand Police requires officers to transport all persons in mental distress to the hospital ED. This national directive may require officers to work in a new and different way when accompanying the individual. The aim of this study is to develop a deeper appreciation and understanding of New Zealand Police officers’ roles in relation to this national directive.

There is paucity of knowledge of how Police officers interpret their expanding role in this setting. To address this gap in current literature a two-fold question was asked:

- What do New Zealand Police officers do in the hospital ED when accompanying persons in mental distress?
- How do New Zealand Police officers manage the situation?

Constructivist grounded theory (Charmaz, 2014a) will be used as the theoretical framework to capture New Zealand Police officers social, organisational and individual processes that influence their interactions in this setting with the mentally distressed. Only by establishing how people construct meaning and actions can one understand why they act as they do. Meanings and actions are often "embedded in larger and often hidden positions, networks, situations and relationships" (Charmaz, 2009a, p. 130).

Chapter 3: Methodology

Introduction

A methodology is defined as "a set of principles and ideas that inform the design of the research study" (Birks & Mills 2015; p. 4). However, all methodological approaches are underpinned by a philosophical/epistemological base. Constructivist grounded theory, as articulated by Charmaz, is no exception. A constructivist grounded theory methodological approach was used in this study to explore and gain understanding of how New Zealand Police officers work with persons in mental distress within the hospital ED.

This chapter begins with an historical overview of grounded theory methodology. The evolution of grounded theory is then examined along with the emergence of the constructivist grounded theory by Charmaz. The constructivism epistemology and its underpinnings of pragmatism and symbolic interactionism are explained. Next, the debate relevant to this study between the use of the terms 'constructivist/ism' and 'constructionist/ism' is discussed. Following on, under the heading methodology, the research design and its core elements that work with the epistemology of constructivist grounded theory are presented. The method is presented in Chapter 4. Finally, the rationale for choice of this constructivist grounded theory is discussed before concluding with a summary.

Historical overview: Grounded theory and emergence of constructivist grounded theory

The appearance of grounded theory was at a time when qualitative research was being denigrated. Qualitative research was simply being taught orally to would-be researchers (Charmaz, 2000). Grounded theory represented a shift from the dominance of positivism to constructivism, and has played a major role in generating, advancing and broadening qualitative research from the 1960s through to today (Charmaz & Bryant, 2010).

In 1967, Glaser and Strauss presented a grounded theory methodology in which the researcher could develop a substantive theory from empirical data. Glaser and Strauss (1967) established this alternative approach to research at a time when positivist research was the dominant methodology. The positivist approach was about testing established theories, not generating new ones. Both Barney Glaser, a sociologist, and Anselm Strauss, a social psychologist, sought to use grounded theory as a research design to discover underlying theory from the systematic analysis of data (Holloway & Brown, 2012; Kenny & Fourie, 2014). These authors changed qualitative research methods of analysis and developed systematic methodological strategies that researchers could use for many topics (Charmaz, 2014a). This classic form of grounded

theory was underpinned by the principle that natural emergence of a theory would appear from the collected data (Kenny & Fourie, 2014).

Grounded theory has its roots in both positivism and pragmatism. Glaser and Strauss brought together two different philosophical and methodological ways of approaching research (Gardner, McCutcheon, & Fedoruk, 2012). One was the positivist tradition emphasising the scientific method. The other was the pragmatic tradition that viewed reality as being fluid and having multiple perspectives that arise from people's actions to resolve situations in their worlds (Morse et al., 2009). Both Glaser and Strauss were committed to researching basic social processes within a setting or a particular experience (Charmaz, 2009a). They were convinced that by systematically analysing and offering abstract ideas about data that was truly grounded in that data, theory could be generated. This, they believed, would enable researchers to make a significant contribution to qualitative research (Charmaz & Bryant, 2010).

Glaser and Strauss were asked to explain how they conducted grounded theory. The result of this inquiry was their book titled *The Discovery of Grounded Theory* (Glaser & Strauss, 1967). The title of this book clearly shows an epistemological leaning that reality is discovered, explored and understood (Bryant & Charmaz, 2007). These two men are known as the first generation of grounded theorists (Birks & Mills 2015). Glaser brought most of the language, systematic methods, logic and a "concept indicator model to grounded theory" (Charmaz & Bryant, 2010, p. 407) from his quantitative training at Columbia University. Strauss brought his University of Chicago traditions of pragmatism and symbolic interactionist perspectives (Charmaz, 2009a).

A number of years later as these two men continued to develop grounded theory, a professional and methodological separation occurred. Each saw grounded theory from different points of view (Gardner et al., 2012). On the one hand, Glaser insisted on allowing the theory to emerge from the data. Strauss, on the other hand, looked at the data in a broader context embracing symbolic interactionism and the examining of many different aspects that could relate to the data, but, were not overtly there (Morse, 1994; Strauss, 1993). Glaser stayed closely associated to the original approach he and Strauss had developed which is now termed classical, or Glaserian grounded theory. This approach saw the researcher as interacting with those being studied and sought to explain their social worlds (Stern, 2009). It was considered to be a more objective approach to generating theory which reflected Glaser's positivist background (Gardner et al., 2012; Stern & Porr, 2011). Glaser saw grounded theory

as a method of discovery whereby categories emerged from the data and basic social processes were analysed (Charmaz, 2009a).

In contrast to Glaser, Strauss contended that symbolic interactionism should guide grounded theory research and joined in co-authoring books with Juliet Corbin, a fellow symbolic interactionist. Whilst the seminal works by Glaser and Strauss (1967) had links to pragmatism, Strauss and Corbin (1998) focused on the symbolic interactionist perspective in their research that explored how people make meaning out of their everyday actions (Kenny & Fourie, 2014). Both these authors refined some of the features of the seminal grounded theory. Strauss and Corbin (1998) had concluded that grounded theory described only the various strategies and techniques (methods), but lacked a methodological basis (Birks & Mills 2015). Together Strauss and Corbin revised a new framework for coding designed to develop theory from data systematically. Their coding framework was underpinned by the philosophy of pragmatism and symbolic interactionism. Glaser argued that the procedures used by Strauss and Corbin contradicted the basic principles of grounded theory by forcing data and analysis into predetermined categories (Charmaz, 2009a). These differences in perspectives and Strauss's departure from the seminal grounded theory text, led to subtle adaptations and moves in epistemological positions by future theorists and researchers (Gardner et al., 2012).

In the following years, divergent positions on grounded theory emerged as a consequence of these epistemological differences maintained by Glaser, Strauss and Corbin. There have been new interpretations and adaptions to grounded theory since the post positive approach by Glaser and Strauss (1967), as researchers have their own epistemological position to explore and understand phenomena (Ralph, Birks, & Chapman, 2015). Grounded theory is now viewed as a method for a diverse range of approaches to theory generation (Charmaz, 2009b). However, the form of grounded theory that is followed depends on clarification of the nature of the relationship between the researcher and participants (Mills et al., 2006b). Whilst researchers have overall adhered to the basic fundamentals of grounded theory, these have been used in different ways.

A second generation of grounded theorists emerged with their methodologies underpinned by their philosophical understandings (Charmaz, 2014a). The dimensional analysis approach was developed by Schatzman in the 1970s and refined by Bowers in 2009 (Morse et al., 2009). Schatzman, a student and later colleague of Strauss, proposed dimensional analysis as an alternative method for the generation of grounded theory. Schatzman was interested in grounded theory as a general approach to "naturalistic qualitative research" (Robrecht, 1995, p. 172), but contested some of its procedures. In keeping with grounded theory, the design of

dimensional analysis was that theory was directly generated from the data (Bowers & Schatzman, 2009). Schatzman embraced the symbolic interactionist approach. He saw the aim of the analysis in grounded theory as being to discover meanings in observed human interactions. This contrasted with other variants of grounded theory such as the constructivist approach that looked at discovering the basic social processes that were occurring in a setting (Robrecht, 1995).

In 2003, Adele Clarke sought to develop a new approach to grounded theory analysis. This variant to grounded theory she termed 'situational analysis' (Clarke, 2005). Clarke, a post-modernist grounded theorist was influenced by Strauss's work on social worlds and arenas and the discourse of Michael Foucault (Clarke, 2005, 2009). Situational analysis is an inductive approach that uses the core elements of the grounded theory method. This approach reframes data to consider everything (people and objects) as affecting the situation in some way, and combines three types of situational maps and analysis. These are situational maps, social worlds and arenas, and positional maps (Birks & Mills 2015).

Charmaz began her journey with grounded theory as a student of both Glaser and Strauss. The invitation from Glaser and Strauss to use grounded theory flexibly resulted in Charmaz developing a constructivist approach to grounded theory (Kenny & Fourie, 2014). Glaser and Strauss (1967) spoke of discovering theory that emerged from the data. However, Charmaz alleged that neither data nor theories were discovered. Grounded theories are constructed, as Charmaz (2009a) argued "through past and present involvements and interactions with people, perspectives, and research practices" (p. 10).

Charmaz was the first researcher to overtly name her research approach as constructivist grounded theory by arguing for a form of grounded theory positioned between positivism and post modernism (Mills , Chapman, Bonner, & Francis, 2007). Constructivist grounded theory came from a social scientific perspective that assumed people (researcher included), construct multiple realities that are cognitively and socially constructed. This constructivist approach to grounded theory was interpretive and studied how (and/or why) meanings and actions were constructed by people in a specific context. Like Strauss, Charmaz built on the pragmatist foundations in grounded theory and extended the application of symbolic interactionism to assume a relativist position.

However, all grounded theory uses a methodology situated in the naturalistic paradigm that covers a range of approaches still based on natural inquiry, depending on the variant of grounded theory researchers use (Lincoln & Guba, 1985). Charmaz (2009) has positioned her approach to grounded theory within the constructivist paradigm. Constructivist grounded

theory repositions the researcher as the author of a reconstruction/co-construction of shared experiences and relationships with participants (Charmaz, 2009a; Mills et al., 2006b).

Charmaz's Approach to Grounded Theory

On the invitation from Glaser and Strauss (1967) to use their original grounded theory flexibly, Charmaz took this offer a step further. In keeping with her constructivist approach, this flexibility enabled Charmaz to create an "abstract interpretive understanding of the data" (Charmaz, 2009a, p. 9) without losing the participant voice. Moreover, with her pragmatist background, Charmaz acknowledged the multiple truths, realities and meanings cognitively and socially constructed by people's engagement with the world (Stern & Porr, 2011). The research process of the constructivist approach also includes reconstruction of meaning, is subjective and the researcher takes a reflexive stance. The theory resulting from the analysis of data is acknowledged as being co-constructed by both the researcher and participants (Charmaz, 2014a).

Constructivist grounded theory has as its goal, the generating of a substantive understanding of social and psychological processes that may be occurring within a specific context.

Constructivist researchers study the 'how' and 'why' meanings and actions are constructed by participants in certain settings. This is achieved through a detailed analysis and theorising of the social interactions and structures taking place within that setting (Charmaz, 2006). The constructivist view is that participants involved in the research are influenced by both the situational context they are in, and how they perceive that context (Charmaz, 2009a). Moreover, this pragmatic approach asserts that a participant's reality constructions are closely linked to their everyday experiences in the world and are time and context dependent (Lincoln & Guba, 1985).

Charmaz considers process to be crucial in grounded theory. She describes the term 'process' as "unfolding temporal sequences" (Charmaz, 2014a, p. 17), taken in response to situations or problems that lead to change. For example, as individuals react to situations that occur in their everyday life, they do this through a sequence of behaviours. These behaviours constitute the processes individuals apply to manage, cope or negotiate when interacting with people in their everyday life and work.

However, there was a main point of departure for constructivist grounded theory from the Glaser and Strauss (1967) seminal approach. This was the role of the participant and researcher in the process of generating knowledge, and the interpretation of the type of knowledge generated (Charmaz, 2006; Gardner et al., 2012). Constructivist grounded theory

acknowledges the interrelationship that exists between the researcher and participants (Birks & Mills 2015). Underpinning the constructivist approach by Charmaz is the assumption that it is the interactions between the researcher and participants that produces the data. This approach places importance on the research topic, and views both the data and analysis as being shaped from the researcher's shared experiences, relationships with the participants and other data sources (Charmaz, 2009a). Constructivist grounded theory recognises the co-construction of a theory containing both the researcher's and participants' stories, accounts of situations and views (Mills et al., 2006b).

A further characteristic of constructivist grounded theory acknowledged by Charmaz (2006) is the recognition that there are multiple ways of knowing. The term 'knowing' refers to the recognition that some things need to be experienced and cannot be articulated. Charmaz (2014a) contends it is not always feasible to explain or understand what one knows in language form. Therefore, she urges that tacit knowledge in constructivist grounded theory be preserved, as it is useful in encompassing the non-verbal language/cues from participants. Charmaz (2009a) maintains preserving tacit knowledge enables the researcher to retain the focus on participants' language, meanings and actions. When analysing data, the researcher must delve deeply into interpreting the participants' tacit meaning(s) Charmaz (2009a) asserts. The constructivist approach recognises that in many professions, tacit understandings amongst members are not articulated. However, they are inherently understood by all the members of that profession.

Furthermore, inherent in this constructivist approach is also the assumption that the researcher will become familiar with the participant's world from their perspective. This will enable the researcher to gain some understanding of how participants construct their worlds (Charmaz, 2008). Essentially, Charmaz (2014a) advises the researcher to 'walk in the shoes of their participants'. Through this experience, she asserts the researcher may gain deeper understanding of participants' actions, interactions, beliefs and assumptions on how they construct their meanings and actions.

However, Charmaz (2014a) also acknowledges that actions and interactions by participants may sometimes also be embedded in larger and often hidden social structures, networks, organisations, situations and relationships. Therefore, what is seen and to what extent the researcher can see these actions and interactions may not always be straightforward. Many can remain tacit and silent.

With the constructivist researcher studying the 'how' and 'why' meanings are constructed by participants, this re-positions the researcher as the author of a reconstruction/co-construction

of experience and meaning (Mills et al., 2007). As such, the researcher must acknowledge that inevitably inherent within the analysis will be their own values, as there exists an interrelationship between researcher and participants. The reflexive stance taken by social constructivist grounded theorists assumes that all data and analysis are a reflection of the conditions of their creation. Charmaz (2014a) reminds constructivists to be aware of their own presuppositions and wrestle with how they affect the research. Charmaz cautions the researcher to be mindful in recognising their own perspectives and biases in the observations made and views formed (Mills et al., 2006b).

Evolving Epistemology, Ontology and Grounded Theory

Over the past four decades, the epistemological and ontological position of grounded theory has moved. Grounded theory is now viewed as a methodology for a diverse range of approaches to theory generation (Charmaz, 2009b). Diverging approaches and positions of grounded theory have developed from the first seminal text by Glaser and Strauss in 1967, and been transformed into contemporary grounded theory research designs. Constructivist grounded theory as articulated by Charmaz, is one such contemporary design. However, the form of grounded theory that is followed depends on "a clarification of the nature of the relationship between the researcher and participants and on an explication of the field of what can be known" (Mills et al., 2006b, p. 2).

Epistemology underpinning constructivist grounded theory

This research is underpinned by a constructivist epistemology. From an epistemological perspective, a constructivist grounded theorist views knowledge as being socially produced by the individual and collective actions of people (Bryant & Charmaz, 2007; Morse et al., 2009). The constructivist grounded theory approach informed by Charmaz assumes a relativist epistemological position of subjectivism. This epistemological position recognises that the researcher cannot be objective, as a co-relationship is present between the researcher and participants (Mills et al., 2006b). Ontologically, constructivists take the relativist position, whereby the researcher acknowledges there are multiple truths and realities that can only be understood within the wider context, a certain time, place and culture (Morse et al., 2009).

Constructivism epistemologically highlights the subjective interactions between the researcher and participants resulting in a co-construction of meaning. The constructivist understands the term 'meaning' as the way people act/react to situations on the basis of the meaning that situation has for them. Moreover, the meaning of act/react is usually tied to practice (Charmaz, 2014a). The constructivist asserts one does not create meaning, but constructs meaning. The constructivist views all reality as meaningful reality that is socially constructed,

and examines practices and actions. It does not explain reality, but sees many different realities. The questions a constructivist asks are what do people assume is real, how do they construct this and what actions do they take in view of that reality? (Charmaz, 2009a).

However, there is also the recognition that reality for people is constructed under particular conditions. This reality is constantly reforming due to fluidity between individuals and the social groups they align themselves with (Birks & Mills 2015; Charmaz, 2008). To the constructivist, a grounded theory stance accepts multiple views of what constitutes the meaning of truth and reality, which are often unconscious and influenced by our history, culture and are socially constructed (Charmaz, 2014a).

Pragmatism and constructivist grounded theory both view the concept of truth as fluid, conditional and changeable. This is based on the assumption that as one gains more knowledge through further experiences in the world, one's view of what truth is changes (Charmaz, 2017). Whilst Charmaz positions her approach to grounded theory in the constructivist paradigm, she considers that pragmatism as a theoretical perspective remains the basis for constructivist thought. Charmaz (2014a) strongly advocates for retaining pragmatism in constructivist grounded theory, and views it as encouraging openness, curiosity and an empathetic understanding of research participants' meanings, actions and worlds. These underpin the whole purpose of grounded theory. Furthermore, Charmaz (2014a) contends this pragmatist basis for constructivist grounded theory encourages researchers to protect and highlight participants' language, meaning and actions.

Constructivism and pragmatism

Pragmatism as a theoretical perspective still remains a fundamental for constructivist thought. The links between constructivist grounded theory and pragmatism are significant. Charmaz (2017) claims that "essentially constructivist grounded theory is a direct methodological descendent of the pragmatist tradition" (p. 38).

Pragmatists subscribe to the belief that people act for a reason, either social or personal. Constructivist grounded theorists and pragmatists both view reality as involving a fluidity and rather indeterminate process. It is a process that recognises multiple perspectives emerging from people's actions to resolve issues in their world (Charmaz, 2009a). From these actions, people construct meaning and then co-construct their behaviours. It is through these actions that people come to understand their worlds (Stern & Porr, 2011).

Constructivist grounded theory and pragmatism both support honesty, curiosity and a belief in acquiring knowledge about the world through participating and experiencing the realities in it

(Charmaz, 2017). Fundamentally, pragmatism and the constructivist grounded theory perspectives are social. Therefore, neither perspective separates the individual from the social realities in which they exist (Charmaz, 2017). Pragmatist philosophy and constructivist grounded theory both assume that the researcher and participants work together, link facts and values, and believe there is no absolute truth, only the truths that a particular individual or culture hold (Bryant & Charmaz, 2007; Charmaz, 2009a). Facts are defined as the constructed meanings both the researcher and participants have, and the actions they take towards objects and people because of these constructed meanings. This approach is a complete contrast to the scientific positivist approach (Morse et al., 2009).

Pragmatism as a philosophy and method was introduced by Charles Sanders Peirce in (1905), William James (1907) and John Dewey (1938) along with George Herbert Meads (Bryant & Charmaz, 2007; Crotty, 1998). Pierce (1905) created the term 'pragmatism' and was instrumental in developing many of the principles of this paradigm for social research (Morgan, 2014). The pragmatist philosophy was to challenge people to explore notions about absolute truth. Pragmatists argue that truth is not absolute, but created through a process of experiences rather than a transcendent reality waiting to be discovered (Crotty, 1998). Anselm Strauss can be credited with the pragmatism evidenced in grounded theory (Bryant, 2009). Whilst Glaser placed emphasis on emergent theory, Strauss with his pragmatist philosophical stance, viewed people as being "active agents in their world rather than passive recipients of larger social forces" (Charmaz, 2009a, p. 7). Strauss was interested in how people's actions were constructed through processes. He embraced pragmatism to preserve and place importance on the research participant's language, meaning and actions. However, what both Glaser and Strauss gave to research was the combination of two different philosophical and methodological approaches from Columbia University's positivism and University of Chicago's pragmatism in the form of grounded theory (Morse et al., 2009).

Charmaz (2009) believes preserving the pragmatist foundations in grounded theory allows the researcher to construct an interpretive version of the phenomena being studied. It then does not just become a description of events and statements. Thus, pragmatism and its underpinning theoretical perspectives of openness, curiosity to a phenomenon and an empathetic understanding of participants' meanings and actions in their worlds is inherent in constructivist grounded theory. Moreover, this participant centred approach, whereby time sequence is acknowledged and one that offers a subjective focus on meaning and process, are examples of the pragmatic theoretical perspective inclusion in constructivist grounded theory (Charmaz, 2009a). Following this pragmatist base to a constructivist study, Charmaz (2009) contends it helps preserve the focus on language, meaning and action in grounded theory.

However, there are some minor differences between some key assumptions of pragmatism and those of constructivist grounded theory as seen in Table 1 that need acknowledging. Table 1 emphasises the subtle differences between the two approaches. Nonetheless, there is still a relative co-relationship between the pragmatism and constructivist grounded theory.

Table 1. Main differences between pragmatism and constructivist grounded theory. Adapted from Charmaz (2017).

Pragmatism	Constructivist grounded theory
• Assumes process	• Studies process
• Acknowledges multiple perspectives	• Seeks multiple perspectives
• Emphasises the significance of language	• Pays analytical attention to language
• Sees meaning and actions as emergent and as affecting each other	• Studies emergent meanings and actions and how each affects the other
• Takes temporality into account	• Offers tools to study temporality
• Unites the viewer with the viewed	• Bonds the researcher with the researched
• Advocates social reform	• Provides a method for critical inquiry

Nevertheless, constructivist grounded theory is interpretative and therefore aligns itself well with Meads' (the founder of social psychology) symbolic interactionism perspective (Charmaz, 2009a). However, Birks and Mills (2015) assert that methodological preference discussions centre on how one views what truth is, or the nature of reality. Indeed, within grounded theory, how one uses the essential grounded theory methods depends on one's view of what constitutes reality (Birks & Mills 2015).

Symbolic interactionism

Symbolic interactionism is derived from pragmatism, and assumes that through interactions, people construct self, society and reality (Charmaz, 2014a). This theoretical perspective attempts to discover or understand symbolic meanings and actions formed from verbal or non-verbal interactions between individuals and groups of people. For the researcher, symbolic interactionism is a perspective that enables comprehending situations and understanding of people's meanings, actions and happenings within the field of study. Symbolic interactionism contends that how one interprets a situation affects how one responds (Charmaz, 2014b). Symbolic interactionism views individuals as "active, creative and reflective and that social life consists of processes" (Charmaz, 2014b, p. 345). Processes are ongoing actions, interactions and emotions adopted by individuals or groups when responding to situations or problems (Birks & Mills 2015). Moreover, temporality and the importance of interpretation of actions that arise from interactions are embraced in this theoretical perspective.

The term ‘symbolic interaction’ originated from Herbert Blumer (Crotty, 1998). Blumer was influenced by the teachings of Meads, and formed a theory and methodological approach that he termed ‘symbolic interactionism’. According to Crotty (1998), there are three basic interactionist assumptions that Blumer (1969) stated. The first assumption is that a person acts towards things on the basis of the meaning those things have for them. Next, is that the meaning of such things is derived from interactions with others. Lastly, meanings are modified through an interpretive process which the person uses when dealing with things they encounter. This perspective views people’s actions as constructing self, situation and society, and that people act in response to how they view or define a situation (Charmaz, 2014a). As a result, our actions and those of others affect these situations, and often our interpretation of what is occurring, or could possibly occur, is altered.

Moreover, in symbolic interactionism, language and symbols play an important “role in forming and sharing our meanings and actions” (Charmaz, 2014a, p. 262). Symbols may be physical objects, institutions or people’s ideals and values that take on significance and meaning during interactions. Charmaz (2014a) contends we act on how we define a situation, and labelling and naming helps us to understand the situations. Strauss and Corbin (1998) had previously stated this view and explained that naming involved the way we recognised, pigeonholed, situated, evaluated and worked with objects, individuals or groups. Thus, naming can subconsciously set the relationship position to that which is named.

Charmaz proposes that constructivists reinterpret early symbolic interactionist views of the existence of a ‘real world’ to that of a world “made real in the minds and through the words and actions of its members” (Birks & Mills 2015, p. 51). Although Charmaz (2008) assumes the existence of an immovable real world, she claims people interpret this in many ways. This is due to their construction from their own history and social experiences that have shaped their views, actions and collaborative practice. This reinterpretation infers from a relativistic position that an individual’s reality is changing constantly in response to the social group they are interacting with (Birks & Mills 2015).

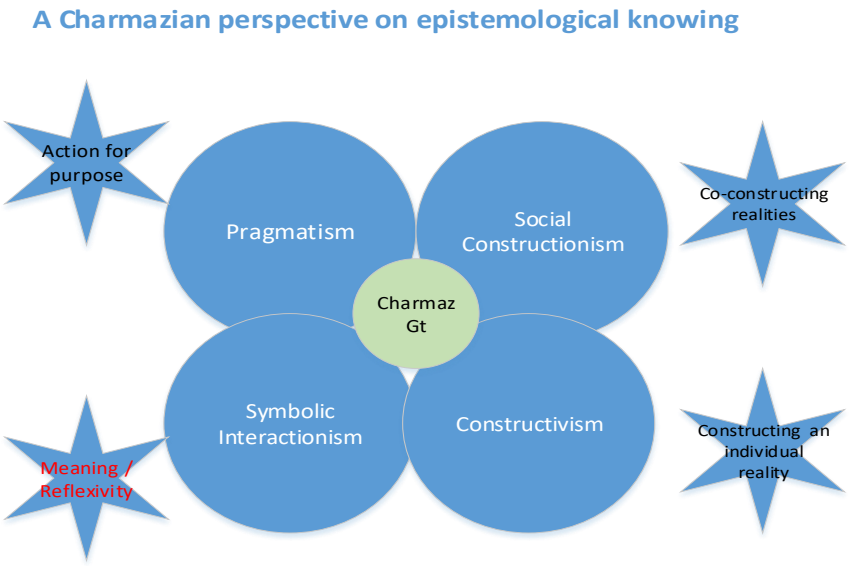
Symbolic interactionism considers that people have the ability to think about their actions before responding to situations or experiences (Charmaz, 2009a). This theoretical perspective subscribes to the philosophical stance that acknowledges people take on roles in social situations. This is central to symbolic interaction thinking, as roles and role taking construct the basis for understanding social behaviour. In symbolic interactionism, a role is a set of ideas an individual constructs in order to cope with the situation (Crotty, 1998).

Charmaz (2014a) views symbolic interactionism as the philosophical base underpinning constructivist grounded theory. However, she would argue that not all grounded theory needs to adopt a symbolic interactionist perspective. Gardner et al. (2012) and Morse et al. (2009) concur with this. Although, Charmaz (2014a) makes it clear that symbolic interactionism is central to constructivist grounded theory, she acknowledges that there are a variety of ways it is used in grounded theory.

Symbolic interactionists do not subscribe to the view that it is possible to separate the researcher from the participant in the generating of data (Birks & Mills 2015). Constructivists hold the view that the researcher interprets their participants' meanings and actions, and the participants interpret the researchers. Like symbolic interactionists, constructivist grounded theorists articulate and scrutinise how their own life experiences and views of reality influence their construction of meaning. This is known as 'reflexivity' (Charmaz, 2009a).

Reflexivity is where the researcher endeavours to construct what the participants see as their "social reality" (Morse, 1994, p. 215) whilst acknowledging their own subjective influences on the research process. Thus, the Charmazian constructivist approach in this research incorporates symbolic interactionism and forms part of the methodological underpinnings of the current project focusing on the relationship between meanings arising out of actions as seen in Figure 1. Figure 1 is a diagrammatic representation of the influences on Charmazian grounded theory.

Figure 1. The Charmazian epistemological perspective



Constructivist/ism or social constructionist/ism

There have been many debates about the use of the terms 'constructivism' and 'social constructionism' and the differences between the two terms. Considerable ambiguities exist in distinguishing between these two terms (Young & Collin, 2004). These terms have similar roots and are sometimes used interchangeably by various authors, including Charmaz, who has defended her position on using both terms interchangeably.

Charmaz (2009b) contends her approach to constructivism is to include reflexivity and also to differentiate from earlier versions of social constructionism. This version of social constructionism explained participants' actions as constructed, but ignored considering the researcher's actions or situation. Constructivist grounded theory as articulated by Charmaz (2014a), acknowledges subjectivity—that the researcher is involved in the construction and interpretation of the data. Furthermore, Charmaz situates the research in keeping with the social context affecting and influencing the situation.

Central figures attributed to the constructivism viewpoint are those of Bruner (1990), Piaget (1996) and Vygotsky (1978). All these authors were known for their learning theories on developmental stages for children and cognitive development (Young & Collin, 2004). Charmaz (2014a) considers her use of the term 'constructivist' aligns well with social constructivists. These social constructivists include Les Vygotsky (1962) and Yvonna Lincoln (2013), an American methodologist. Both Vygotsky and Lincoln emphasised social contexts, interactions, exchanging of points of view and interpretative understandings (Charmaz, 2014a).

Crotty (1998) however, disagrees with Charmaz's use of the terms constructivism and constructionism interchangeably. He argues there is a distinction between the two despite their concepts and theories both being constructed. Crotty (1998) believes the term 'constructivism' is reserved for an individual's constructed version and perspective of reality and how they make sense of the world. Crotty (1998) views 'social constructionism' as placing emphasis on culture and examining how it shapes people collectively and changes how they perceive and feel things. He considers that the social constructionist places the focus on "a collective (and transmission) of meaning" (Crotty, 1998, p. 58).

Young and Collin (2004) acknowledge the use of the terms 'constructivism' and 'social constructionism' being used generically as the term 'constructivism'. Young and Colin suggest that these two terms are used so haphazardly, that difficulties arise as to what is meant. These authors defend this generic usage by explaining constructivism as focusing on "how the

individual cognitively engages in the construction of knowledge from social construction" (Young & Collin, 2004, p. 373).

Within grounded theory, Charmaz (2009a) refers to her work as constructivist rather than constructionist. The reason for the use of this terminology according to Charmaz, when referring to her earlier works, was to "distinguish it from objectivist iterations" derived from positivism (Charmaz, 2008, p. 409). Charmaz emphasises that social constructionists do not specifically include the researcher's actions as constructed and do not consider the researcher's reflexivity. Thus, although the terms are closely linked, Charmaz (2008) indicates that her choice of using the terms constructivist or constructionist depends on the purpose of the discussion. Furthermore, Charmaz (2009a) argues that researchers do not live in a social vacuum. Much of the researcher's construction with participants of their social actions is influenced by the researcher's past experiences, colleagues and people they have met in their lives.

Aside from some viewing that the difference between these two terms is based on whether construction is an individual cognitive process or a social process, there is little else to distinguish the two terms. However, a new sub-variety termed 'social constructivism' has been generated that shares many characteristics of social constructionism (Young & Collin, 2004). Accordingly, constructivism and constructionism may be seen belonging to the "same extended family" (Young & Collin, 2004, p. 378).

Concurring with Charmaz (2009a) and Young and Collin (2004), the term constructivist grounded theory will be used in this study and prefixed with the word 'social', thus situating the epistemology in a social context. The prefix social will be understood when talking of constructivist grounded theory. The rationale for calling this a social constructivist grounded theory is explained in the following. The individual police officer brings their constructed 'self' into the police profession. The constructed self becomes moulded by a greater social and professional organisation—the New Zealand Police Force. The reconstructed professional self, that brings together both the individual and professional self, is filtered through a social construction of expectations and values that are imposed through social, legal and political constructs.

Methodology

In their seminal text, Glaser and Strauss (1967) proposed core elements/principles for defining grounded theory methodology. However, there has always been much debate over what constitutes the core elements of grounded theory in the different variants (Birks & Mills 2015;

Bryant & Charmaz, 2007). Nevertheless, there are core elements common to all versions of grounded theory proposed by Glaser and Strauss (1967). These are simultaneous data collection and analysis, constructing codes and categories from data, constant comparative analysis, incremental theory development when collecting and analysing data, memoing, theoretical sampling and conducting the literature review after analysis of the data (Charmaz, 2014a; Glaser & Strauss, 1967).

However, the distinguishing feature of all grounded theory is the systematic and iterative process of collecting and analysing data and gradually transforming it into concepts (Strauss & Corbin, 1998). In grounded theory, these three processes are iterative. Rather than waiting until all the data is collected, analysis begins as soon as the first bits of data are in, while further collection of data build on the first analysis of it. Possibly this iterative process is the most notable difference between grounded theory and other forms of research. In some other research approaches, the processes of selecting, collecting and analysing data are linear—one cannot start before the other finishes. However, Hood (2006) would argue that theoretical sampling, constant comparison of data to theoretical categories and the focus on the development of theory by theoretically saturating the categories, distinguishes the grounded theory methodology from other research methods. Nevertheless, although classic, Straussian and constructivist grounded theory share many core elements there are differences between these three grounded theory approaches. Incongruities exist between coding procedures, opposing philosophical positions and how literature is used (Kenny & Fourie, 2015).

Charmaz's view of grounded theory methodology is that it be regarded simply as a set of principles and practices "not prescriptions or packages, methodological rules, recipes and requirements" (Charmaz, 2009a; p. 9). She considers the constructivist approach reinforces the flexibility offered in this grounded theory research design by Glaser and Strauss (1967) and resists perfunctory applications of it (Charmaz, 2014a). Whilst Charmaz (2009a) adheres to the main principles of grounded theory as initially developed by Glaser and Strauss (1967), she argues that researchers can use these without endorsing the notion of a neutral observer (*tabula rasa*). This is the ontological and epistemological view in the constructivist paradigm. However, a constructivist approach would include reflexivity, an acknowledged interpretive co-construction of the findings by participants and the researcher, and flexibility of when to conduct a literature review, as discussed in Chapter 2. In the following discussion, core elements of grounded theory according to Charmaz (2014a) will be outlined. Differences to other variants of grounded theory will also be briefly noted.

Constructivist grounded theory core elements

Sampling

Participant centred

A key component of constructivist grounded theory research involves the researcher being committed to a relationship of 'give and take' with their participants and it being participant centred. Charmaz (2009a) contends that interpretive qualitative methods involve immersing oneself in your research participants' worlds. Moreover, the researcher's respect for their participants should permeate throughout the whole data collection and analysis (Charmaz, 2009a). Demonstrating respect involves the researcher making a concerted effort to learn about participants' views and everyday work life in an attempt to understand their lives. Nevertheless, attempting to understand the participant still requires the researcher interpreting the participants' views and worlds, not reproducing them as their own.

Purposeful sampling

Purposeful (initial sampling) sampling gets the study started. Charmaz (2006) calls this the "point of departure" (p. 101). Purposeful sampling directs the collection and generation of data and provides the initial data that the researcher analyses (Chun Tie, Birks, & Francis, 2019). Grounded theory uses purposeful sampling to recruit participants. This is where volunteer participants who meet eligibility criteria are selected, and provide rich in-depth information and data that is able to be conceptualised (Bryant & Charmaz, 2007; Stern & Porr, 2011). Purposeful sampling is a non-probability sampling method, whereby the researcher relies on their own judgement when choosing research participants. However, Bryant and Charmaz (2007) caution that in the decision of what participants to sample, the researcher must consider the context and take into account what the implications of the research might be for participants.

Sometimes there is confusion with the use of the terms purposeful and theoretical sampling and they are used interchangeably (Coyne, 1997). Glaser (1998) refers to purposeful sampling as a deliberate decision by the researcher to sample participants in a specific setting that has been organised in advance for the study. Glaser (1998) describes theoretical sampling as the process of data collection, where the researcher simultaneously codes and analyses the data to be able to decide what data to collect next. Determining where to sample next according to emerging codes and categories is known as 'theoretical sampling' (Coyne, 1997). Birks and Mills (2015) maintain that theoretical sampling is not just about what you do next, but it also is about how you do it. Charmaz (2014a) contends that theoretical sampling is crucial in advancing the researcher's analysis.

Theoretical sampling

According to Charmaz (2009a), theoretical sampling is what all grounded theorists should aim for. Theoretical sampling is emergent and unique to grounded theory research (Birks & Mills 2015). Although theoretical sampling is a type of purposive sampling, it is not the same as purposive sampling. This is because it is the "theoretical categories that guide the sampling as a result of the previous stages of analysis" (Hood, 2006, p. 217).

Glaser and Strauss (1967) originally defined theoretical sampling as a process involving collecting data for generating theory. The process involved jointly collecting data, coding and analysing it, and then deciding what data to collect next to develop an emerging theory (Birks & Mills 2015). Glaser (1998) contends that theoretical sampling is the prime mover of coding, collecting and analysing data in grounded theory. These processes are directed by the emerging theory that then directs further progression of an emergent theory. Theoretical sampling, Glaser (1998) maintains, helps deter a researcher from constantly collecting the same data repeatedly. Furthermore, the use of this unique component in grounded theory may mean that researchers end up sampling in settings possibly not contemplated.

Significantly, theoretical sampling is inherent in all grounded theory approaches, with each contending that the research sample cannot be predetermined. Rather, it needs to be a theoretical sample and "dynamically led by the emerging theory until the point of saturation" (Kenny & Fourie, 2015, p. 1271). According to Charmaz (2014a) the value in using theoretical sampling comes after categories have been developed. Charmaz believes it is at this time that the researcher can confirm, clarify or expand on these categories. Contrary to this assertion, Birks and Mills (2015) are of the opinion that theoretical sampling should be used from the first interview when data is collected. Justification for these authors' stance is that concepts begin to take shape even from the earliest stages of analysis. They argue that this then allows the researcher to widen their sources of data or deepen their investigation into an issue.

Regardless of differences of when to begin theoretical sampling, grounded theorists agree it is not about sampling for negative cases if these have not arisen during the initial data analysis. It is instead a response to analytical memos that have identified gaps in the data, highlighting the need to pursue other lines of inquiry that will support category development (Charmaz, 2006). However, knowing when to begin and cease theoretical sampling can be challenging.

Theoretical saturation

In grounded theory, theoretical sampling procedures continue until analysis of the data reveals no new data emerging. It is at this point theoretical saturation of the data is then said to have

been achieved (Kenny & Fourie, 2015). According to Charmaz (2014a), theoretical saturation denotes the point when there are no additional properties or further insights about the categories in the emerging grounded theory. Properties, as defined by Charmaz (2014a), are the "characteristics of a category or concept as ascertained from the researchers study and analysis of his /her data and codes" (p. 344). Charmaz (2006) emphasises that data saturation does not mean to stop gathering data when repetitive patterns of incidences occur. Rather, the researcher must continue "conceptualisation of comparisons of these incidents which yield different properties of the pattern until no new properties of the pattern occur" Charmaz (2006, p. 113).

Glaser and Strauss (1967) contend that theoretical saturation occurs when category properties are saturated rather than the data itself. Strauss and Corbin's (1998) view is that theoretical saturation occurs when the categories are well developed in terms of properties and dimensions. Critics argue about the meaning of theoretical saturation, and believe a researcher may claim the data is saturated without being able to prove it (Bryant & Charmaz, 2007; Charmaz, 2009a). Moreover, there is the concern that the term 'theoretical saturation' is often used to justify small sample sizes. Yet, because of the use of theoretical sampling, it is not possible to know the precise number of research participants that will be sampled (Foley & Timonen, 2015). The reason for this is that variables that might emerge during the analysis may require further elaboration to develop the theory.

Thus, Charmaz (2006) cautions that assumptions of achieving theoretical saturation may be incorrect, and are sometimes seen as an issue affecting the rigour of grounded theory. Constructivists acknowledge that categories may indeed be modified after publication (Birks & Mills 2015).

Data collection

Gathering data is an important aspect in all grounded theory research. Glaser (1998) asserts that in grounded theory, everything gathered is data. However, in constructivist grounded theory, data collection is more considered than in the Glaserian approach. Charmaz (2009a) contends that some forms of data align themselves better to a particular variant of the grounded theory. Moreover, the type of data and how it is collected by the researcher, depends on the research topic and ability to access that information (Charmaz, 2014a).

Data does vary in quality, relevance for the researcher's area of interest, and its usefulness for interpretation (Charmaz, 2006). However, Charmaz suggests guidelines to assist the constructivist researcher to ensure quality data is collected. The guidelines include capturing a

wide range of contexts, perspectives, timeframes and that the data is rich in detail, is not superficial and adds value for category development. Moreover, a researcher must consider that the research topic may dictate the method of collecting data (Birks & Mills 2015).

Part of collecting rich in-depth data requires a skilled researcher who has chosen a method of data collection that suits the research being conducted. Intensive interviewing is a common effective method of data collection in constructivist grounded theory. This method enables an in-depth exploration of participants' views, experiences and actions (Charmaz, 2009a). Moreover, Charmaz (2006) considers that intensive interviewing allows the researcher more control over the construction of data than most other methods.

However, intensive interviewing can be undertaken as a single method of collecting data, or be accompanied by observations, surveys and written accounts of incidences by participants (Charmaz, 2006). In constructivist grounded theory, the observational data collected focuses on the studied phenomenon instead of simply describing the setting (Charmaz, 2014a). When collecting data, researchers are not passive observers, but investigate what lies beneath the surface (Charmaz, 2006).

Data analysis

Coding is the first step in data analysis. The constructivist grounded theorist's approach acknowledges that codes are constructed by the researcher. The constructivist researcher interprets and names what they see in the data based on previous knowledge and experience (Charmaz, 2014a). It is through coding for processes and actions in grounded theory that the data is sorted, separated and labelled. The labels attached to sections of data summarise what is occurring in the data.

Charmaz (2014a) defines coding as an emergent process of separating data, defining and naming what the segments of data are about. As the researcher develops codes, they analyse what they see in the data and pursue new leads. Charmaz's coding system contains many of the classic grounded theory components. These are memo writing, constant comparative analysis, theoretical sampling and saturation (Kenny & Fourie, 2015). Yet, Charmaz's coding system is considered more "interpretive, intuitive and impressionist than either classic or Straussian grounded theory" (Kenny & Fourie, 2015, p. 1279).

The three approaches to grounded theory depict three different coding structures (Kenny & Fourie, 2015). In classic grounded theory, there are two stages of coding: substantive and theoretical, that lead to the discovery of a grounded theory. Strauss and Corbin have a

systematic and rigid coding structure to create, rather than discover, a theory. Their three stage coding stages are open, axial and selective (Kenny & Fourie, 2015).

Constructivist grounded theory presents a third approach to coding. Contrary to Straussian grounded theory, Charmaz (2008) rejected a rigid prescriptive approach to coding and argued that it suppressed creativity for the researcher. Charmaz believed overly prescriptive regulations influenced coding procedures. Constructivist grounded theory coding has at least two main phases: initial and focused. A third type of coding known as theoretical coding may also be used (Charmaz, 2014a).

Initial and focused coding

In initial coding, data is coded by labelling each line or segment with words that reflect actions (gerunds). Initial codes are seen as provisional, comparative and grounded in data. The aim of initial coding is to remain open to all tentative theoretical ideas and look for assumptions, actions, tacit actions and meanings contained in the participants' stories and in the language they use to tell their stories (Charmaz, 2014a).

Focused coding is the second phase. This is not a linear process and requires the use of theoretical sensitivity and reflexivity (Charmaz, 2006). When conducting focused coding, the most significant and reoccurring initial codes are sorted and organised into defining more selective and conceptual concepts. It is a time of exploration using the constant comparative method of analysis to determine the adequacy, robustness of the initial codes and deciding whether the focused codes can be lifted to the level of a tentative category (Charmaz, 2009a).

Theoretical coding

Theoretical coding is a highly developed form of analysis that assists in identifying "possible relationships between categories you have developed in focused coding" (Charmaz, 2009a, p. 83). Initially, Glaser introduced theoretical codes to assist in conceptualising the relationship between the substantive codes so they could be integrated more logically into a theory (Charmaz, 2009a). However, Charmaz asserts that theoretical coding be only used if the analysis indicates this, and should not be applied routinely as part of coding (Charmaz, 2014a). Whilst Glaser (1998) affirms this approach to the use of theoretical coding, he concedes its use can make the final product more relevant, plausible and better integrated. However, Birks and Mills (2015) argue that without theoretical coding, a grounded theory will have difficulty demonstrating the " explanatory power that distinguishes this approach to research" (p. 119).

Constant comparative analysis

Charmaz (2009a) considers constant comparative analysis to be "the core of the method" (p. 178). Glaser and Strauss (1967) introduced the constant comparative approach to analysing data in grounded theory. This process is a key component in all three approaches to grounded theory. Constant comparative analysis where data is collected and analysed simultaneously is a distinguishing characteristic of grounded theory methodology. Constant comparative analysis uses an inductive process, whereby codes are compared with codes, codes compared with emerging categories, and categories compared with each other (Birks & Mills 2015; Charmaz, 2009a; Kenny & Fourie, 2015). The constant back and forth movement between data and analysis assists in developing categories which are in essence, theoretical concepts that are grounded in the participant data (Bryant & Charmaz, 2007; Glaser & Strauss, 1967; Stern & Porr, 2011).

Reflexivity

In the constructivist grounded theory approach, a focus on reflexivity is seen as critically important and viewed as an obligation when theory is being developed (Birks & Mills 2015). Reflexivity is an active systematic process, used to guide the researcher's further actions and interpretations to gain insight into their work (Birks & Mills 2015). Charmaz (2014a) makes it clear that it is the researcher who is expected to be reflexive about what they observe and how they view it all, not the participants. Researchers and participants alike make assumptions about what is real, have knowledge, social status and an agenda that affects their views and actions when together (Charmaz, 2006). The onus is on the researcher to reflect on their underlying assumptions, and how these may influence their analysis of the data (Mills, Bonner, & Francis, 2006a).

Glaser rejected the notion of reflexivity in grounded theory, and the term 'reflexivity' does not appear in the seminal text. However, Strauss and Corbin (1998) acknowledged that the researcher could influence the research process if they did not employ reflexivity (Birks & Mills 2015). These authors advocated that the researcher journal to record their thinking about their topic of research to give insights into their underlying assumptions.

Charmaz (1990) asserts that the use of reflexivity in constructivist grounded theory does not remove the researcher's subjectivity from the theory generated. Rather, it enables participant data to be prioritised over the researcher's previous experiences, assumptions and previously acquired knowledge. This includes any literature reviewed previously on the phenomenon being studied. Thornberg (2012) asserts that the researcher need not disregard their existing knowledge, but they need to engage with it from a critical perspective. Mills et al. (2006a)

contend that everyone is influenced by their history which shapes their worldview and the meaning they assign to truth. However, all grounded theorists use memoing as a reflective tool (Mills et al., 2006a).

Memoing

Memo writing is inherent in all grounded theory (Thornberg, 2012). Memo writing provides the researcher with an analytical tool for entering into a dialogue with themselves and looking at the data from a variety of perspectives (Charmaz, 1990). Writing memos is thought to be a crucial step in grounded theory, as it provides the connection between data collection and theory development (Charmaz, 2014a). Moreover, memos are not simply for "describing the social world of the researcher's data but, they conceptualise the data in narrative form" (Lempert, 2007, p. 245). Thus, memoing provides the researcher with a document of their thought processes and theorising of the data (Thornberg, 2012). Through memoing, the researcher can expand their categories, identify properties, gaps and define the relationship between the categories. Some authors do however differentiate between procedural/process memos and theoretical memos (Lempert, 2007). Memo writing assists in keeping the researcher engaged, reflective and questioning their analysis. Memoing also assists in helping the researcher to acquire and develop theoretical sensitivity.

Theoretical sensitivity

Theoretical sensitivity is a cognitive process, whereby the researcher views the study from many angles, makes comparisons, follows leads and develops concepts (Charmaz, 2014a). Theoretical sensitivity is involved throughout the whole of the research process (Chun Tie et al., 2019). Morse et al. (2009) define theoretical sensitivity as the "ability to render something abstract or conceptual and move it to a more theoretical level" (p. 125). Theoretical sensitivity is developed through theorising. When theorising, the researcher is required to stop, consider and rethink the phenomena being studied from new directions (Charmaz, 2009a).

Early grounded theorists based building theory on developing theoretical sensitivity. Glaser and Strauss (1967) initially used the term 'theoretical sensitivity' in their seminal text of grounded theory. They believed theoretical sensitivity to be the ability by the researcher to conceptualise from the data and "generate concepts from the data and relate them accordingly to normal models of theory in general" (Bryant & Charmaz, 2007, p. 274). Strauss and Corbin (1998) describe theoretical sensitivity as the researcher having insight into what is meaningful and important in the data for developing a theory. Strauss (1994) believed in theoretical sensitive coding for generating strong concepts from the data to explain the phenomenon being researched.

Consistent with guidelines set by Glaser for theoretical sensitivity, Charmaz (2006) emphasises the importance of using gerunds in coding and memo writing. The use of gerunds encourages theoretical sensitivity through prompting the researcher to think about participants' actions. Birks and Mills (2015) state that "as a grounded theorist becomes immersed in the data their level of theoretical sensitivity to analytical possibilities will increase" (p. 12). Nevertheless, the application and developing of theoretical sensitivity throughout the grounded theory research process enables the analysis to be focused towards theory development culminating in an integrated and abstract grounded theory (Chun Tie et al., 2019).

Developing and generating a theory

Developing a constructivist grounded theory is a process of reconstructing the reality of the participants that happen under specific conditions (Charmaz, 2014a). Birks and Mills (2015) define the term 'theory' as "an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity" (p. 108). The final grounded theory generated is an integrated and comprehensive grounded theory that explains a process or system associated with the phenomenon being studied (Charmaz, 2014a).

Classic grounded theory aimed to show how theory was discovered from data that was systematically obtained and analysed (Glaser & Strauss, 1967). Strauss and Corbin's (1998) view of theory was a "set of well-developed concepts related through statements of relationship which together constitute an integrated framework that can be used to explain or predict phenomena" (p. 15).

A substantive grounded theory is defined by Charmaz (2014a) as a "theoretical interpretation or explanation of a delimited problem in a particular area" (p. 344). This definition by Charmaz emphasises that a constructivist grounded theory generates an abstract interpretivist theoretical understanding of the studied phenomenon. Moreover, the generated theory relies on the researcher's interpretation of the phenomenon being studied (Giles, de Lacey, & Muir-Cochrane, 2016). In constructivist grounded theory, the resulting theory "depends on the researcher's views, it does not and cannot stand outside of it" (Charmaz, 2014a, p. 239).

Constructivist grounded theory researchers aim to learn about the social worlds of participants' lives and actions to gain understanding of both explicit and implicit constructions. The finished constructivist grounded theory generates an interpretive understanding of a substantive area that has broader applicability (Charmaz, 2008). Important features of constructivist grounded theory include the concept that data and analysis are emergent social constructions, and are situated in space, time and culture (Bryant & Charmaz, 2007).

Charmaz (2006) asserts that constructivist grounded theory does not depend on finding a single basic process seen in classic grounded theory, or a core category as described by Corbin and Strauss (2008). Rather, constructivist grounded theory has a relativist epistemology, recognising "diverse local worlds and multiple realities and addresses how people's actions affect their local and larger social worlds" (Charmaz, 2006, p. 132). Moreover, constructivist grounded theory aims for an interpretive understanding of the studied phenomena in a theory that has credibility, originality, resonance and usefulness.

Rigour/evaluation and Charmaz – Credibility, originality, resonance and usefulness

In grounded theory, 'rigour' refers to the theory being well grounded in the data. All research must demonstrate forms of rigour and must be evident throughout the research. In this current research, how rigour was determined is demonstrated in Chapter 4. In qualitative research, the perception of quality equates to rigour. There are essentially three factors that influence the quality of a grounded theory (Birks & Mills 2015). These are the researchers expertise, knowledge and research skills, methodological congruence with the research question and procedural precision when using the methods (Birks & Mills 2015; Chun Tie et al., 2019).

Charmaz (2009a) emphasises the importance of using evaluation criteria to demonstrate the rigour of a study. Charmaz (2014a) advocates that criteria for rigour comprises four evaluation processes*: credibility, originality, resonance* and *usefulness* of the research to people in their everyday life and its contribution to making a difference in the world. Of these four criteria, Charmaz (2014a) contends that a strong combination of credibility and originality increases the research's resonance and usefulness.

Other variants of grounded theory have different criteria for evaluating the rigour of research. The seminal work by Glaser and Strauss (1967) for determining rigour of a grounded theory initially suggested that a theory should demonstrate: *fit, be understandable* and *general* enough to be used in a number of differing situations (as cited in Birks & Mills 2015, p. 144). Later, Glaser (1998) modified the criterion to include: *fit, work, relevance*, *modifiability* and added *parsimony* and *scope* at a later date. When describing these criteria, Glaser believed that the grounded theory must *fit* with the data, be *workable* and *understandable* and also *relevant* to those in the area being researched. Moreover, to ensure the ongoing relevance of the theory, *modifiability* was also included as a criterion for demonstrating rigour. Criteria used by Strauss and Corbin for evaluating the rigour of a study were: *data quality*, the *research process* and *empirical grounding*. Later, Strauss and Corbin added "*making judgement about*

the theory itself and the need for the theory to *stand the test of time*" to their evaluation criteria (Birks & Mills 2015, p. 146).

Charmaz (2009a) believes that if the researcher offers a "fresh deeper understanding of the studied phenomena" (p. 153), they make an original contribution. Using a constructivist approach, the research is also evaluated on whether the researcher has viewed the data from a micro to macro perspective to support "the analytical imagination necessary for understanding and theory generation" (Maher, Hadfield, Hutchings, & de Eyto, 2018, p. 12). Charmaz (2014a) asserts that grounded theory narrative must consider the audience. She argues that it is, after all, the audience who will critique the researcher's methodology as they judge the quality of the end product of the research.

Thus, Charmaz's evaluation criterion of a study goes beyond a simple checklist. Moreover, the four criteria Charmaz uses to evaluate the rigour of a constructivist grounded theory merge with social justice inquiry (Bryant & Charmaz, 2007). Social justice is the substantive area of inquiry in this research and is defined by Charmaz (2011) as "exploring the social structures and processes that shape individuals and collective life" (p. 359).

Positioning this research in grounded theory methodology – Why a social constructivist approach for this study?

Grounded theory has the aim of developing a theory to explain the underlying social processes that shape how people understand their worlds when interacting with others (Holloway & Brown, 2012). It places the emphasis on patterns of behaviour and actions, and looks at the what, the how and why of participants' actions. However, there are different philosophical and methodological stances grounded theorists take that impact how essential grounded theory methods are applied (Birks & Mills 2015).

The constructivist grounded theory approach looks at human realities, and acknowledges that one's own reality, knowledge and truth is based upon their own perspectives of their reality. Moreover, constructivists contend that individuals create meanings through their interactions with each other, and that we all construct our realities in our everyday lives and work. Furthermore, the constructivist seeks to understand how people manage everyday circumstances in social settings that are not well understood and have not been researched before (Hunter et al., 2011).

I discovered there was a gap in the literature regarding how New Zealand Police officers work with persons in mental distress within the hospital ED. After reflection, it soon became apparent that other traditional empirical methodologies would not yield sufficient in-depth

understandings of the intricacies of such a complex relationship. Moreover, much research in this area of social justice was objective and came from orthodox positivist methodologies, that philosophically, do not sit well with me. Constructivist grounded theory offered me an alternative approach to social justice inquiry research. This was because the constructivist approach encouraged systematic "integrating subjective experience with social conditions" (Charmaz, 2014a, p. 326), and a constructivist approach would look at multiple realities for police officers when working with those in mental distress within the hospital ED.

Furthermore, the constructivist approach encourages the researcher to explore tensions, choices and constraints, barriers and opportunities within organisations and social institutions (Charmaz, 2011). Using the constructivist approach would enable my exploration of these issues with police officers, and give meaning to the social and psychological processes that influence how these officers work with persons in mental distress in the hospital ED. Nevertheless, there were three distinct criteria in the constructivist approach to grounded theory that captured my interest for this study.

The first criterion was reciprocity between the participants and the researcher in the co-construction of meaning and power balances were addressed. This approach resonated with me as it provided for a research partnership to evolve between myself and the participating police officers to enable the collection of unfiltered in depth rich data. Within this partnership, I recognised that the frontline police officers were the experts in how they worked with those in mental distress in the community and within the hospital ED. Moreover, this constructivist approach overtly and evidentially includes and acknowledges reflexivity and an interpreted co-construction of the findings by the participants and researcher. Using the constructivist approach was the acknowledgement that my rendering of the officers' stories through writing was my interpretation and construction of events (Bryant & Charmaz, 2007). Lastly, the resulting theory needed to have credibility, resonate, be useful to New Zealand Police and make a difference for frontline officers. This choice of methodology would enable this to happen and answer the research questions.

Summary

In this chapter an historical overview of grounded theory followed by Charmaz's approach to constructivist grounded theory was provided. I discussed my understandings of the evolving epistemology and ontological position of constructivist grounded theory including the place of pragmatism and symbolic interactionism within this constructivist approach. The decision to call this study a social constructivist grounded theory was then presented. In the methodological discussion, the principle components (core elements) of grounded theory

according to Charmaz (2014a) were outlined, and differences to other variants of grounded theory noted. The positioning of this research in grounded theory was then explained regarding my rationale for the choice of a constructivist grounded theory methodology. The following chapter explains how constructivist research methods were used to develop the theory.

Chapter 4: Method

Introduction

The previous chapter presented the philosophy and methodology that directed this research. This chapter now addresses the constructivist grounded theory research method used in this study to analyse and generate the collected data into the grounded theory of *doing your best*. The chapter begins with the doctoral journey and ethical considerations and processes that were required before entering into a research project with New Zealand Police. This includes my position as the researcher. Thereafter, participant sampling, locations for interviewing participants, sampling processes used and how participants were recruited for this study, are explained.

The method of data collection including the interviews and strategies employed is addressed next. Following this is a description of how the collected data was analysed and coded. Then the processes of theoretical sensitivity, theoretical sampling and theoretical saturation resulting in the generating of a substantive theory grounded in data are outlined. Evidence of rigour in this study is then provided and discussed, using the criteria of credibility, originality, resonance and usefulness (Charmaz, 2014a). This is followed by a summary.

Getting Started

The journey for this Doctor of Health Science degree began with my completing three papers that included the proposal of the research. The first paper was Health Systems Analysis. On completing this paper, I was able to contextualise my topic and examine the political, legal and societal influences impacting on how New Zealand Police officers worked with persons in mental distress when accompanying them to the hospital ED. The second paper completed was Practice and Philosophies. This paper enabled me to examine literature on the proposed topic and establish a methodological approach that was compatible with the proposed research question. The third paper completed was Research Practices and Methodology. This was where the originality of the chosen topic, knowledge of literature and a research design were presented as a proposal and critiqued by my peers and a faculty committee. In the proposal, I defended the choice of topic and methodology whilst acknowledging any limitations that may arise. I identified that one limitation may be accessing police as participants. Having previously researched prison nursing in New Zealand, I had some understandings of the difficulties of using participants in correctional and police departments. Once these three papers were completed to a satisfactory standard and the proposal had been accepted by AUT University, I sought to gain approval for the research from the Auckland University of Technology Ethics Committee (AUTEC).

Ethics and ethical considerations

There are several ethical processes that need to be followed before entering into a research project with participants. These ethical considerations were: risks and benefits of this study to the researcher and participants, the role of the researcher, the context and setting of the research, any cultural aspects to this study and maintaining participant confidentiality.

Ethics approval for this research was sought through AUTEC which is accredited by the Health Research Council of New Zealand. In New Zealand, the main purpose of an ethics committee is to protect, maintain dignity and safeguard the research participants according to McCallin (2010). As a researcher, there was also the need to be familiar with information set out in the Code of Health and Disability Consumers' Rights (Health and Disabilities Commissioner, 1996). This Code of Rights gives clear guidance to researchers in order to keep their participants safe.

The following documents were submitted and approved by AUTEC: a participant information sheet explaining the purpose of the research, type of research and time involved (Appendix 4); a consent form (Appendix 5); indicative questions for the interviews (Appendix 6); flyer advertising the study (Appendix 3); confidentiality agreements from transcribers (Appendix 7). Ethics approval was granted on the 2nd February 2017 (Appendix 1).

Cultural considerations

In accordance with the ethical requirements of AUTEC and any research conducted in New Zealand, consideration must be given to the principles of the Treaty of Waitangi. The Treaty of Waitangi was signed in 1840 and is an agreement between the New Zealand Government (Crown) and Māori. This Treaty lays out the obligations of the government and governmental departments to Māori (Wilson & Neville, 2009). The principles within this Treaty that must be included in all health research proposals are partnership, protection and participation when working with Māori communities or participants. In light of this, I consulted with the District New Zealand Police Māori Liaison Officer to inform him of the proposed study, and sought his assistance on the correct procedures and protocols should they be required.

However, in this current study there was no requirement to formally consider the principles of the Treaty of Waitangi. Participants were not selected according to their ethnicity. The only requirement was that they were frontline police officers with at least 2 years' experience of working with persons in mental distress in their everyday core policing duties (Appendix 4). Nevertheless, integrating Treaty of Waitangi principles of partnership, protection and participation aligned well with both the constructivist grounded theory approach and ethical considerations. The result of this partnership, protection and participation was the interpreted

co-constructed theory of *doing your best* that was grounded in the data and ensured ethical responsibility was maintained with the participant information.

Journey for gaining consent from New Zealand Police to have officers as participants

There were specific requirements as a researcher I needed to undertake to gain access to have frontline police officers as participants in this study. Knowing the complexities of the justice health nexus concerning mental health, I recognised the need to fulfil these requirements written in the New Zealand Police Research Agreement (Appendix 2). It was over 14 months before the Police Research Team and the AUT Research Office agreed to sign off on the New Zealand Police Research Agreement.

During this time of waiting there were many conditions that the Police Research Team required before giving their approval for my conducting this research. One issue to overcome was when both the AUT Research Office and the Police Research Team could not agree on Clause 11 of the New Zealand Police Research Agreement. Technically, this could allow police to embargo the research if they felt the confidentiality of individuals had not been maintained, or there were identified organisational risks. This matter was resolved. Finally, on completing a Police Vetting Form with my primary supervisor, I was assigned a police liaison sponsor by the Police Research Team. This now enabled me to interview potential participants for this study at three police stations, or at a venue that was preferable to potential participants.

Recruiting participants

To recruit participants, AUTEC approved flyers, participant information and consent forms were sent to the assigned police liaison sponsor. These were left in three of the approved police station reception desks and placed on noticeboards three weeks prior to the interviews. The police liaison sponsor informed the relevant senior officers at the three police stations that I had permission to interview those interested in participating in the study. Six days were set aside for the interviewing to be conducted. I was sent a schedule of the days, times and locations I would be permitted to interview participants. This schedule and the advertising flyer with my email contact details were also placed on each station's noticeboard. Officers interested in participating in the study had the information beforehand about the research and my contact details if they had any queries. I received no such queries. At this stage of the research, I had little idea how many would volunteer to participate.

Sampling process

In grounded theory purposeful sampling is used initially (Charmaz, 2009a). Purposeful sampling is conducted through establishing sampling criteria and organising how you will

access the data. The goal of purposeful sampling using constructivist grounded theory is to source participants who can provide rich in-depth data to explore the research question. In purposeful sampling, participants are selected according to inclusion and exclusion criteria relevant to the research topic. In this study, purposeful sampling was used to select voluntary participants on the basis of the eligibility criteria. However, criteria for this initial sampling differs from that used doing theoretical sampling. In constructivist grounded theory, theoretical sampling is used to direct the gathering of data to enable the explicit development of theoretical concepts and categories. How this was achieved throughout the research is discussed later.

Location of research

This research was undertaken at three police stations in a policing district within a large metropolitan city in the North Island of New Zealand. Twenty-three voluntary participants were interviewed over six days at three police stations. One of these stations was classified as being a rural police station.

Participant selection

The participants were all required to have had at least 2 years' experience in working as a frontline officer with persons in crisis. Participants' experience on the frontline ranged from 2 years to 20 years. Three of the participants had prior experience overseas as frontline officers, but had worked for over 2 years in New Zealand on the frontline. I directed the questions specifically about how these officers worked with persons in mental distress in a New Zealand hospital ED. The term 'a person in mental distress' was explained to each participant as referring to persons they believed to be mentally unwell. Participants came from a variety of cultures, backgrounds and were of mixed gender and ages. Table 2 outlines the inclusion and exclusion eligibility criteria for police officers who wished to take part in this research.

Table 2. Eligibility criteria for participating in the research

Inclusion criteria for police officers	Exclusion criteria of police officers
• Sworn New Zealand Police officers who provided written consent to be participants in the research. • Current frontline New Zealand Police officers with at least 2 years' experience and able to provide rich in-depth accounts of managing individuals in mental distress in a hospital ED. • Police officers with over 2 years' experience who have worked with both the old and current New Zealand police directives concerning persons in mental distress.	• Non-sworn police officers. • Police officers not involved currently in general duties (i.e., not frontline police officers). • Those with less than 2 years' experience as frontline New Zealand Police officers. • Police officers who have not managed mentally distressed individuals in the ED.

One officer who was eager to participate, did not have 2 years' experience on the frontline. In order to demonstrate respect to this officer, I continued with the interview, but did not transcribe and analyse that data. The interest this officer demonstrated in participating was a salutary reminder for me of how important new officers view their working with those in mental distress.

However, my rationale for recruiting officers with at least 2 years' experience of working with persons in mental distress was that these officers would be able to provide rich in-depth data. Furthermore, all these officers would have worked with both the old and current directives from New Zealand Police. The old directive was that persons in mental distress were usually taken back to the police station to be assessed by mental health professionals. The current directive is that officers take all persons in mental distress, unless violent, to the hospital ED to be assessed by mental health professionals.

At the beginning of this research, the number of participants to be interviewed was unable to be definitely confirmed as grounded theory methodology and methods were used to achieve theoretical saturation from continuous analysis (Stern & Porr, 2011). In the ethics approval for this study, the number of participants proposed was up to 30. Eventually, 23 frontline police officers participated.

Data Collection

Collecting data from participants for this research required some deviation from the conventional grounded theory methodology. This was due to the context of having to fit in with the everyday shift work of frontline police officers and the number of days allocated by New Zealand Police to collect the data. A total of six days was allocated to me for the interviewing to be conducted. I was sent a schedule of the days and times I would be permitted to interview participants. As first responders to crises in the community, frontline police officers are unable to be readily accessed for research. This necessitated in-depth analysis of the data to be conducted after the primary data had been collected and transcribed.

Moreover, as Charmaz (2014b) asserts, any data collection strategies must be respectful and congruent with the particular culture and the individual research participants. I knew the New Zealand Police have a specific core value of respect which influences those working in the organisation. I ensured that respect for the organisation and the individuals within it permeated throughout how I collected the data and interpreted the content.

Interviewing

Eighteen interviews were conducted over five days during the participating officers' morning and afternoon shifts, at two urban police stations. At the rural police station, five interviews took place in one day over the officers' morning and afternoon shifts.

Prior to each interview, every participant was given a brief history of my working background, why I was conducting the research and how I would maintain their confidentiality. This allowed me to connect with the participants, demonstrate respect to them and avoid the interviewing process appearing simply as an 'information grabbing exercise'.

When interviewing the participants I was aware that my choice of words and interactional style during the interview needed to be respectful (Charmaz, 2014a). All participants were asked if they had any questions about the research after confirming they had read and understood the participant information sheet. Any questions participants asked were answered before the interview took place. Furthermore, I made it clear that at any stage of the interview, a participant could indicate that the audio recorder be turned off if there was something they wished not to be recorded. I also advised participants before each interview that should an emergency incident occur, or they did not wish to further participate, they were able to leave. There were no such incidences. Two interviews were slightly shortened as these officers were required to support their colleagues in the community at a set time, but were keen to be participants.

Confidentiality

I had foreseen that confidentiality for participants in this research would be important. This was confirmed when several participants stated before the interview, that the New Zealand Police did not necessarily encourage officers to express their opinions. Other participants stated quite blatantly they were concerned that nothing they said would identify them. As Charmaz (2014a) states "both the powerful and disempowered sometimes distrust their interviewer, institutional affiliation and stated purpose of the research as well as how the researcher may use the findings" (p. 73). This alerted me again how crucial it was to maintain participant confidentiality in order to gain trust.

After first ensuring each officer had read the participant information sheet and before they signed two consent forms, I explained how I would maintain their confidentiality. One signed consent form would be kept by the participant themselves; the other form would be stored safely in my primary supervisor's office for 6 years and then be destroyed.

Confidentiality throughout the interviews was further maintained by allocating officers a random identification number. When I asked each participant a question, I referred to them as officer and their allocated number. As a result of this, no names were recorded during the interview or appear on the transcripts to maintain anonymity. All officers participating in this study were interviewed in December 2017 and referenced in the storyline as (Officer xx# year of interview). For example, when quoting from Officer 14, this was shown as (14#^{2017}). Moreover, the grounded theory process itself de-identified individuals and only presents group patterns of behaviour.

Interviewing strategies

Charmaz (2014a) contends that interviewing is the most common method in qualitative research for collecting data. In order to gather data, I began with an intensive interviewing approach. Intensive interviewing is considered a helpful method and assists in obtaining data about how each participant interprets their experiences about the topic being studied (Charmaz, 2009a). In using in-depth interviewing, I sought to understand the topic through questioning, listening and observing participants who had the expertise in the field. Due to the emergent nature of the grounded theory process, flexibility in these interviews was essential (Birks & Mills 2015).

After the first few interviews, subsequent interviews became less structured and began with the use of a few relevant, broad and open questions. In keeping with the constructivist grounded theory approach, questions were not necessarily asked in a linear fashion (Charmaz, 2014a). Questions were based on areas I felt needed pursuing, or those that had not been addressed, or had been generated in the previous interviews. Foley and Timonen (2015) assert that unstructured interviews are useful when researching a topic that is poorly understood or one that little is known about. In addition, I discovered that using unstructured interviews enabled an openness to generate aspects of the officers' realities when accompanying persons in mental distress to the hospital ED.

Interviewing was thus guided by the questions arising from the previous interview that I felt needed to be clarified or expanded upon. Some phrases I used to begin the interviews were: *tell me about… can you describe how that was for you…* and *is there anything else you feel I should know?* Additional information on new issues relevant to the topic was pursued spontaneously. This facilitated an in-depth exploration of what participating frontline police officers did and how they worked with persons in mental distress within the hospital ED.

The semi-structured, broad and open questions used to begin each interview varied depending on what had emerged from the previous interview and the notes and memos I had made. This enabled me to focus on gaining more in-depth learnings about participants' experiences, opinions and actions when accompanying and working with a person in mental distress within the hospital ED. In keeping with the constructivist approach, I attempted to draw out from the participants how they defined certain terms they used, situations and occurrences. In so doing, I could delve deeper into the participant's meanings, implicit assumptions and unspoken rules/understandings they adhered to when working with persons in mental distress within the hospital ED setting.

Each interview took approximately 30–40 minutes. However, interviews were scheduled at more or less one-hour intervals. This gave me time between interviews to listen to the previous interview's audio recording, make notes, write short memos and compare data collected with previous notes and memos I had made. As the interviews progressed, the questions I asked became more probing in order to pursue information on issues that had appeared particularly important to a participant. New questions were added, emerging issues probed further, similarities and differences noted and these directed the questions for the following participants. Throughout the day, there was a steady stream of willing participants ready to tell their stories.

I deliberately decided not to take notes during the interviews, although I had written that I may take notes during the interview in the participant consent form (Appendix 5). Reflecting on this at the time of interviewing and sensing the environment, I felt my taking notes could disrupt the flow of the participants' stories. Moreover, I did not want to make the whole interview look like just an information grabbing exercise or examination. By not taking notes during the interviews, participants had my undivided attention as they told their stories. Any additional information given to me after the audio recording was turned off was when I asked the participants permission to take notes. These participants were then asked if they would read the notes to see if what I had written was correct. If they affirmed that what I had written was correct, as previously mentioned, the participant was then asked to sign these notes if they permitted me to use this as data. Notes not signed were not used as data.

Data analysis

When applying a constructivist grounded theory, the conventional approach is that data collection and analysis occur simultaneously. By collecting and analysing the data simultaneously, "concepts and theory can be developed in an inductive grounded manner" (Timonen, Foley, & Conlon, 2018, p. 5). Nevertheless, at times, data collection and

simultaneous analysis whilst recommended, is not always practical. This was the situation I found myself in. Sometimes, as acknowledged by Foley and Timonen (2015), flexibility in data collection and analysis when using grounded theory is required. Charmaz (2009a) contends that flexibility for researchers in using grounded theory principles is something that Glaser and Strauss (1967) invited. Charmaz's constructivist grounded theory embraces these methodical, yet adaptable guidelines, for collecting and analysing data to construct theories that are grounded in data (Giles et al., 2016).

One of the challenges I encountered when conducting this grounded theory study, was that I needed to accommodate timeframes when participants were available to take part in the study. Strauss (1987) emphasises that "methods too are developed and change in response to changing work context so, use them but modify them with the requirements of your own research" (Bradley, 2010, p. 6). Sometimes when an opportunity arises it is necessary to gather all the data in a set time. This is regardless of being able to conduct in-depth simultaneous constant comparative analysis and coding at the time of collecting the data.

After waiting over 14 months to gain access to have police officers as participants, the data had to be collected in keeping with the New Zealand Police Agreement (Appendix 2) and their requirements. This was just the way it was. However, even when data collection and simultaneous analysis do not follow the ideal order, if the research process grounds theory building within the data, this "satisfies the method's requirements" (Timonen et al., 2018, p. 5). Thus, with this grounded theory requirement being met, I carried out the coding of grounded theory after all of the data had been collected from the participating officers.

Constant comparative analysis

In grounded theory data analysis, the researcher collects data, analyses it and then based on this analysis, collects more data (Stern & Porr, 2011). This is known as the constant comparative method of analysis and is used in the process of coding and category development (Birks & Mills 2015). Comparing new data with previous data to identify similarities and differences allows the researcher to identify emerging patterns.

Although this conventional simultaneous data collection and analysis method for grounded theory was not practical for me in this context, these constraints were manageable. This was managed through me being aware of the situation and the necessity to direct the data being generated, and use the data to expand on the emerging relevant aspects of the phenomena being studied in each of the interviews.

Corbin and Strauss (2008) assert that in research that has data collection done prior to in-depth analysis, the researcher is still able "to compare data with data and search for patterns and social processes" (Foley & Timonen, 2015, p. 1204). In between interviews, I constantly compared the recorded data with the previous recorded data looking for patterns and the social processes occurring. Throughout the data collection process, there was still theory building occurring grounded in the data. This was in keeping with the grounded theory methodology.

Memoing

The importance of memoing in grounded theory is emphasised by Stern and Porr (2011) who proposed "if data are the building blocks of developing theory, memos are the mortar" (p. 66). Memoing was the method I used to record and explore my thoughts when doing this grounded theory research. Writing memos provided me with the means to conceptualise the social processes the participants used. The memos I wrote varied in length, usefulness and quality. However, they were vitally important to unpack my thoughts when collecting the data and later when analysing and coding the data. Memoing was instrumental to me developing the constructed grounded theory of *doing your best*. These memos enabled me to have a written record of my thoughts, assumptions, feelings and responses when collecting the data, and for later analysis.

My early memos were fragmented, speculative and disconnected from one another. However, they were a recorded interpretation at that time and place of emerging patterns about the realities of how frontline officers worked with persons in mental distress. It was important to have those beginning memos as a record of what I had interpreted and why I had pursued certain leads at that time. These early memos enabled me to reflect on how and why I had initially identified patterns of behaviours and queries that I had pursued from the previous interviews.

Memoing was also used to ensure theoretical sampling was conducted throughout the interview process. Between each participant's interview, I listened to the previous interview's audio recording. Through memoing I could compare data between each interview with other data, identify similarities and differences emerging, or gaps. This form of constant comparative analysis between interviews, albeit carried out in a short time frame, enabled me to pursue new leads in the subsequent interviews. The short memos I wrote as prompts between each interview were invaluable in assisting this process of inquiry. Thoughts or hunches about patterns emerging in the data were noted in a memo. As I reflected on these earlier memos, I

detected reflexivity in my assumptions and hunches. That was a good learning for me, but nevertheless at that time, assisted me in pursuing new leads.

Charmaz (2014a) contends that memo writing can vary from simple notes to capture your thoughts, through to conceptual linking and theory development. Below are some examples of early memos and notes written as prompts between interviewing participants:

> ***Memos 5th–11th December, 2017.***
>
> Hearing resignation in officer's voice that role now includes working with mentally ill persons. This officer has been in police for many years. Wonder if it is difficult for others adjusting to contemporary form of policing that involves working with mentally ill? Is this an issue for him and others? Need to follow this up with officers who have been in police for many years. Do they see this as real police role and work? Explore further what officers really feel about this as getting mixed messages? Comments like "it is what it is". I am getting an underlying sense of this officer just wanting to get the job done. Interesting, says he is curious to find out more about mental illness. Thinks this may help when transporting these individuals. Need to explore if other officers want more knowledge about mental illness and why?
>
> Officer has had personal experience with mentally ill persons and expresses a lot of empathy for their situation. A question to explore is do others without this personal experience have the same empathy? Does personal experience influence how they work with persons in crisis? Need to explore further as could be assumed personal experiences influence how officers work with those in mental health crisis.
>
> Starting to emerge it is not the mentally ill that cause officers' frustration, but slow responses and attitudes from health and mental health professionals. Questions to ask are: why is this and why must they wait in the emergency departments for so long. What process is an issue here and how has it developed? "Not a mental health professional" has been constantly stated in the last four interviews. Just learn what to do on the job was what I have gathered.

Later when coding, analysing and conceptualising the data into a tentative developing theory, memoing was crucial. Writing memos assisted in being able to abstract the concrete data into developing emerging theoretical categories, a core category and subcategories with their properties.

Theoretical memoing also allowed me to conceptualise links between the categories whilst coding and analysing the data. Much later the memos I had written enabled the overall theory of *doing your best* to be generated. The theory development occurred through theoretical sorting, memoing and comparing category with category to produce a plausible, authentic understanding of how frontline officers worked with persons in mental distress within the hospital ED.

Transcribing

Once 23 participants had been interviewed, the audio recordings of 22 interviews were transcribed by two experienced transcribers and me. As noted previously, one participant did not meet eligibility criteria and that interview was not transcribed. I transcribed the first five interviews. Due to time constraints, the remainder were transcribed by two professional typists who had signed a confidentiality agreement (Appendix 7). Transcribing the first five interviews was an interesting learning for me. I noted that in the first two interviews the questions were too structured and I was tending to force the data. I observed that my questions were less structured in the next three interviews. I attributed this to becoming comfortable with short memoing between interviews and depending on these memos to follow new leads relevant to the research question. Furthermore, I could hear through using a less structured interviewing approach that conversations appeared to flow more freely resulting in new leads to pursue. When transcribing interview data, while listening to the recorded interviews, I detected emotion in the voices of some participants. That reinforced again for me the need to tell their stories. For some participants it almost appeared a relief that they could in confidence share their thoughts and articulate challenges they encountered, when working with persons in mental distress within the hospital ED.

Coding

As noted in Chapter 3, the constructivist approach to grounded theory is one that recognises that it is the researcher who constructs the codes. The researcher interprets what they see and know and gives these codes a name (Giles et al., 2016). Constant comparison of incident with incident in the data leads to the initial generation of the codes (Charmaz, 2014a).

Constructivist grounded theory coding has three levels. Coding begins with the initial coding of raw data which is abstracted up to focused coding. Focused coding is then abstracted up to theoretical coding which identifies potential relationships between the categories developed in focused coding (Charmaz, 2009a). Each of these levels of coding will be presented in-depth.

In an ideal situation, initial coding takes place immediately after each interview to comply with the grounded theory principle of simultaneous data collection and analysis. However, as previously mentioned, I was unable to do this within the timeframe set by New Zealand Police to collect data. Nevertheless, in such situations, grounded theory principles are flexible and permit coding to be carried out after all of the data has been collected (Charmaz, 2009a; Timonen et al., 2018). Table 3 presents the constructivist version of coding showing the three levels. There is the initial coding in the beginning, which moves to focused coding, which is then abstracted up to theoretical coding. Each of these levels will be presented in-depth.

Table 3. Constructivist approach to coding

Theoretical coding Relates relationship of categories. Integrates final theory.
Focused coding Builds on initial codes to form categories/subcategories. Important words identified, labelled and conceptualised.
Initial coding Line-by-line coding of large amounts of raw data – looking at words segments, lines, incidents. Constant comparative analysis. Use of gerunds to describe actions occurring.

Initial coding

Initial coding is the beginning step in data analysis. I began initial coding of the transcribed data line-by-line. Initial coding was where the raw data I had collected was broken down with each line (even an incomplete sentence) being named. Charmaz (2006) contends that initial coding identifies the actions or beliefs the participants are engaging in. Furthermore, when naming an initial code, Charmaz (2014a) suggests that in order to capture the action taking place, *gerunds* should be used. Gerunds are nouns formed from verbs by adding 'ing' and assist in identifying actions and processes (Birks & Mills 2015).

Initial coding and memoing began from my first interview transcript. The initial codes of the first transcript were short, simple and I used gerunds to show the action that summarised what I had interpreted as occurring. A sample of some of the first initial codes are*: waiting, permissioning to leave, following process, babysitting, hanging around, being dispatched, transporting, keeping all safe, coming alongside, resourcing, training, doing your best, frustrating and making the right call.* These initial codes were then compared with the next transcript and new codes added until 14 transcripts had been initially coded line-by-line. The remaining 8 transcripts were not coded line-line, which will be discussed in the following section. In this initial coding of the 14 transcripts I looked for words that participants used repetitively, colloquialisms or connections. This initial coding assisted in my focusing how participants constructed their own realities of working with persons in crisis in the hospital ED. It allowed me to become reflexive and not assume I shared the same views and world with the participants (Giles et al., 2016).

Focused coding

Focused coding was the next step. Focused coding was conducted by looking at the most significant and frequently used initial codes in 14 of the transcripts. These initial codes were then elevated to focused codes to further explore processes and patterns that appeared to be

emerging (Charmaz, 2014a). By comparing data with data, focused codes were then grouped into tentative categories with subcategories and their properties (Birks & Mills 2015). At times, Charmaz (2009a) asserts it is important for constructivist grounded theorists to preserve participants' meanings of their views and actions in the coding itself. Charmaz (2014a) refers to colloquial terms participants sometimes use as *in vivo* codes. Examples of *in vivo* codes used by participants in this research to describe working with person in mental distress within the hospital ED were: *amping up, kicking off, duck shoving, milking the system, chasing our tails* and *crying wolf.* Some of these *in vivo* codes were preserved in the quotes by officers as seen in Chapters 5, 6 and 7 of the research findings.

When sorting through the 14 transcripts that had been initially coded, I used several whiteboards to write up the frequent, significant, initial codings that were occurring. This enabled me to reflect and consistently compare and gain insights into emerging processes. Coding was a reflexive process and the beginning of me conceptually analysing how to group these initial codes to form focused codes. On returning to the remaining eight transcripts, I felt I now had some sense of "conceptual control over the data" (Birks & Mills 2015, p. 94) and line-by-line coding was becoming redundant. I then began to look at incidences in each of the remaining eight transcripts and compare these with the focused codes from the previous 14 focused coded transcripts.

Initially I had a large number of focused codes. At this stage I became a little overwhelmed and confused as to what the relevant focused codes were. On the suggestion from my supervisor I began to use 'clustering' to organise the focused codes into tentative conceptual categories, subcategories and their properties (Charmaz, 2009a). Clustering and memoing allowed me to test what I had thought may be a core category, and conceptualise how it connected to other tentative categories, subcategories and their properties. These terms used in the language of grounded theory are defined in Table 4.

Table 4. Definition of core category, category, subcategory and properties

Terms	Definition
Core category	The central category that is used to integrate all the other categories.
Category	A higher-level concept that represents a group of codes.
Subcategory	A concept that pertains to a category that specifically clarifies the category.
Properties	The defining characteristics of a category and subcategory.

Later, as I looked back on my first attempt of clustering (Appendix 8) I could see how I had progressed in my conceptualising the data ending with the development of the theory *doing your best*.

Whilst sorting focused codes into conceptual categories, I was constantly diagramming and memoing to raise these codes to conceptual categories. Sorting was a means of making and improving theoretical links and theoretical integration of categories (Charmaz, 2009a). It also enabled me to refine and clarify relationships and involved further memos being generated to explain these links. Once these conceptual categories had been established, I placed each category on a piece of A1 paper and again went back repeatedly to the data to find support for these categories. Post-it Notes containing participant quotes were placed under the relevant category headings (Appendix 9). I spent much time constantly arranging and rearranging these Post-it Notes. I then began to theoretically code the categories and conceptualise how the substantive codes were connected to each other through a core category, and where the categories, subcategories and their properties fitted into the process.

Theoretical coding

Theoretical coding involved a more conceptual approach to the data collection. It was the process by which all my categories and subcategories became integrated into a final theory. In this research, theoretical coding enabled generating new ideas and abstracting concepts as to how New Zealand frontline police officers worked with persons in mental distress within the hospital ED.

Once I started to see patterns forming, this gave me the courage to label these conceptual categories and merge some categories with other categories. This was a huge undertaking and took many months of thinking and conceptualising of the data to develop a theory. I constantly swapped the core category, made categories into subcategories, subcategories into categories and subcategories into properties. With guidance from my supervisor and an A1 pad to rewrite diagrams and rethink categories, I was finally beginning to link and integrate the categories into developing a theory. Birks and Mills (2015) define a theory as “an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity” (p. 108). I used theoretical sensitivity to enhance my being able to recognise elements in the data that had significant for the developing theory.

Developing a theory

Charmaz (2009a) suggests that the interpretative nature of constructivist grounded theory emphasises understanding, instead of an explanation of a phenomena as proposed by Glaser

and Strauss (1967) in their seminal text. Interpretive theory asks for "the imaginative understanding of the studied phenomena" (Charmaz, 2009a, p. 126). The interpretative definition was embraced in this research and presents an interpretive understanding of the data in a theory. However, a theory is much more than simply a set of findings about the phenomena being studied. The constructivist researcher constructs theory through understanding, explanation, grouping, and presentation of the data (Charmaz, 2014a).

The term 'theorising' was the process used in this developing theory. This process was where I had to stop, reflect, contemplate and at times, reconsider certain aspects from the data I had initially thought were important. The process of theorising assisted me to visualise new possibilities, establish links between categories and ask myself analytical questions about the data. As Charmaz (2009a) so aptly describes, theorising is about reaching down to the fundamentals, lifting these up to abstractions and probing experience. Through theorising, theoretical sensitivity was attained in this research.

Theoretical sensitivity

Theoretical sensitivity as defined by Charmaz (2014a) is "the ability to understand and define phenomena in abstract terms and to demonstrate relationships between studied phenomena" (p. 161). Using theoretical sensitivity enabled me to detect meanings in the patterns as they emerged, and identify the distinguishing properties of categories relating to these patterns.

The cognitive process of using theoretical sensitivity enabled me to gain theoretical insights and make meaning of the data as to what was relevant or not in order to conceptualise it. In making meaning of the data, I also had to be aware of my own reflexivity. This awareness was necessary in order to minimise any biases or assumptions. Reflexivity was employed throughout constant theoretical memoing and through discussions with my primary supervisor. An example of this was when at one point of theorising I became fixed on the term *'accommodating'* as being a core category. However, I was unable to make this connect to all the other categories that had emerged. When questioned by my supervisor about this as a core category, I found this term was full of my own preconceptions. Again, I reflected on the memos I had written about this term as a core category. Through my constantly rethinking, asking myself questions and looking for connections between categories, at a later stage I incorporated the term *accommodating* as a subcategory. Going back into the data, memoing and theorising more had made me realise that this term was certainly not a core category; I was forcing the data to fit.

The other method I used, as suggested by my supervisor, was to storyline the tentative theory with its categories and properties. It became obvious when using this method if data was being forced into a theory, or if gaps appeared in the story. Through theoretical sensitivity and theorising, I eventually had a storyline that was grounded in data and could be integrated into a tentative theory. I was now able to articulate this tentative theory in a storyline to my supervisors.

Storyline

A storyline is defined as "an advanced analytical technique used in grounded theory research for the purpose of both integrating and articulating theory" (Birks & Mills, 2019, p. 243). Charmaz (2006) encourages the use of flexibility in the presentation of the storyline and the need to adapt it for the targeted audience if necessary.

The use of storyline had a dual function in this study. Storylining assisted in my theory formation and also provided a means of communicating the theory to two target groups of frontline officers when conducting further theoretical sampling. This was to confirm if theoretical saturation of the categories had been achieved.

Theoretical sampling

Theoretical sampling is a core element of grounded theory and unique to this methodology. In essence, theoretical sampling is purposeful sampling, but is generated from categories. Theoretical sampling directed me where to go and enabled me to end up with a theory that was compatible with the data. According to Birks and Mills (2015), theoretical sampling should begin after the first data is collected as it will give an awareness of issues that need expanding upon or clarifying. However, Charmaz (2014a) argues for theoretical sampling to be used after first establishing tentative categories. This is the method of theoretical sampling I followed in this study.

With permission granted from my police liaison sponsor, I went back again to the largest urban police station and presented the developing theory to two target groups each consisting of 12 officers. None of these frontline officers had previously participated in the research. This process of theoretical sampling was to determine if the emergent categories that constructed the theory of *doing your best* needed elaboration, or if there were gaps in the data that I needed more information about. I also needed to know if I had interpreted the findings correctly.

The theory of *doing your best* was presented to the two target groups in a storyline with the developing theory and categories written up on a whiteboard. Permission was given to have

the sessions audio recorded. Each presentation took approximately 30 minutes. At the end of each presentation, I asked all the officers in the group if the interpreted co-constructed theory had gaps or had aspects that I had incorrectly interpreted. A feedback sheet about the presentation of the theory was also given to each of the group members (Appendix 10). This was to seek further aspects these officers had identified as needing more investigating or correcting.

Samples of the feedback were "*you should have been a police officer", "thank-you for telling our story correctly"* and "*you have nailed how we work with mentally ill people"*. These were but a few of the affirming comments from these two groups of frontline police officers. All the officers indicated there were no gaps in the developing theory, categories or properties that I had presented to them in a storyline. At this point and time, I believed that I had reached theoretical saturation. This decision was reached since no new data was emerging from these two groups of officers. Once saturation has occurred there is no need to continue further with theoretical sampling (Breckenridge & Jones, 2009; Charmaz, 2014a).

Theoretical saturation

After hearing and viewing the comments from the two target groups of frontline police officers, I knew theoretical saturation of the data at this place and time had been achieved. There were no additional properties, or further insights about the categories being generated from the two target groups of frontline officers. According to Charmaz (2014a) and as noted in Chapter 3, theoretical saturation signifies the point when there are no further properties or further insights about the emerging categories. Theoretical categories were now saturated. I realised that no longer would gathering more data provide me with new theoretical insights, nor reveal new properties for the theoretical categories (Bryant & Charmaz, 2007). It was Glaser and Strauss (1967) who used the term 'theoretical saturation' to indicate when theoretical sampling could stop (Birks & Mills 2015). My achieving theoretical saturation had been confirmed through the use of a storyline to these two target groups of frontline officers.

At this stage of the research, I believed an interpretive co-constructed grounded theory of how New Zealand Police officers worked with persons in mental distress in the hospital ED had been generated from the data. As Charmaz (2014a) points out, it is the audience (New Zealand Police officers), who critique the quality, accuracy, and rigour of the end product of the research. Moreover, in research, the perception of quality equates to rigour.

Rigour – Credibility, originality, resonance and usefulness

Charmaz (2014a) advocates that the criteria for evaluating the rigour of research should include credibility, originality, resonance and usefulness, which was the evaluation criterion I used for determining the rigour of this study.

Credibility means the researcher has achieved in-depth knowledge of the topic and included a wide range and number of empirical observations to explain the construction of the categories (Charmaz, 2014a). Furthermore, in attaining credibility, the researcher must have made systematic logical comparisons between observations and categories. Credibility also ensures that the study answers the research question and provides an accurate reflection of the participant's everyday realities (Maher et al., 2018).

This criteria for credibility was addressed in several ways in this constructivist grounded theory study. I first examined my assumptions and biases, which I knew may have accumulated over many years. These came from working as a hospital and correctional mental health nurse, and later as an academic lecturer in mental health. I addressed these assumptions and biases by having two pre-assumption interviews with my supervisor who was familiar with grounded theory. Another part of the criteria for achieving credibility was to attain familiarity with the topic. I achieved this through several different avenues. I researched national and international literature on the topic. I also received permission to attend DAO meetings with police officers and met up with my police liaison sponsor on several occasions. When analysing the data, I discussed the tentative categories with my supervisors. I was asked to justify these categories on many occasions and to provide my rationale as to how and why I had constructed them from the data. My supervisors would prompt me by asking "Show me where this is grounded in the data; explain its relevance and connection". By following this advice, credibility was achieved.

Credibility was further assisted through memoing, diagramming and storylining. These processes enabled the refining of the constructions of categories as the analysis progressed. I also used my own technique of writing tentative constructions into a theory. I did this by writing letters to an imaginary person explaining how the core category, categories, subcategories and properties were connected by a theoretical concept. This was not an original idea, but one I adapted from a book I had read. The book was titled *The Guernsey Literary and Potato Peel Pie Society* by Mary Ann Shaffer and Annie Barrows (2008). Moreover, the findings chapters in this research with extensive use of participant quotes provide further ample evidence that supported category construction. These were the methods by which I ensured meeting Charmaz's (2014a) criterion for credibility.

Originality, according to Charmaz (2014a), refers to the research contributing to new insights in the studied field and giving a new conceptual interpretation of the data. Furthermore, the evaluation criterion for grounded theory originality stipulates that the research challenges, extends or refines current ideas, concepts and practices.

To date, I know of no research that captures the voice, behaviours and resolution processes of how New Zealand frontline police construct their working with persons in mental distress in the hospital ED. This is significant as seen in Chapter 2; that the police officer's role in working with those in mental distress is increasing. Moreover, the directive for officers to take such a person to the ED to be assessed demands the need to gain a sound understanding of how officers interpret these encounters. This constructivist grounded theory addresses this gap by providing an original in-depth interpretive co-construction of meaning and understanding of the social processes influencing the interactions and actions between New Zealand frontline police and persons in mental distress.

Resonance is the term used to describe if the theory makes sense, has relevance and meaning for the participants who took part in the research. It must also resonate with all other individuals in the organisation that the participants belong to (Birks & Mills 2015; Charmaz, 2014a). Furthermore, resonance requires that the research provides participants with a deeper insight into their everyday life and world.

Resonance, in this research, was aided by theoretical sampling. Theoretical sampling is essential to the development and refinement of a theory that is grounded in data (Charmaz, 2014a). Indeed, it was the theoretical sampling of two target groups of frontline officers that confirmed the resonance of the theory. The criterion for resonance, according to Charmaz (2014a), is that the theory makes sense, and has relevance and meaning for research participants including all other individuals in that organisation or institution. When the theory was presented in a storyline to each of the two target groups of 12 officers who had not previously participated in the study, the feedback from these officers affirmed that I had achieved the criterion of resonance. The study made sense to all officers in the two groups, accurately described their work, and the officers felt it was a correct, meaningful representation of a New Zealand frontline police officer's work with persons in mental distress. Throughout the presentation in storyline, officers were nodding in agreement with the theory and its categories and properties. However, a comment from one officer, as mentioned previously, of "*you could have been a police officer with that story"* confirmed the presented theory resonated with the officers and was an accurate construction of their everyday work in this situation and setting.

Usefulness is the criterion used by Charmaz (2014a) to describe whether the grounded theory offers new knowledge that people can use every day to make improvements in their life. When the grounded theory contributes new knowledge, it is considered useful in making a better world for all. This is especially so if the data analysis stimulates more research in other substantive areas. Of these four criteria, Charmaz (2014a) contends that a strong combination of credibility and originality increases the research's resonance and usefulness.

The usefulness of this thesis is evidenced in the findings (Chapters 5, 6, 7) and discussion (Chapter 8). This study provides information to assist in the development of supportive practices in the field, and also identifies what officers want in future training programmes from New Zealand Police. Moreover, it may assist with policy development and add practical knowledge about how the current directive to take persons in mental distress to the hospital ED is working for frontline police officers. Throughout this research, frontline police officers were given the opportunity to voice the realities they confront in daily working with persons in mental distress. This research is an acknowledgement of their working with these individuals in this setting.

Furthermore, this study opens up the opportunity for new research to be conducted on persons in mental distress, perhaps examining their perceptions of how police work with them in the community and hospital ED. Understanding how frontline police officers work with persons in mental distress may also be useful for staff working in the hospital ED and in mental health services.

Summary

This chapter has presented the research method used in this study based on the methodology of Charmaz, a constructivist grounded theorist. This chapter began by describing how the journey of this doctoral research began. The ethical considerations that were required for AUTEC and New Zealand Police were then explained. The journey of gaining access from New Zealand Police to use frontline police officers as participants was discussed and also my position as the researcher in this grounded theory study. Following on, the process I used to collect the data was explained. This incorporated the form of sampling used, interviews and strategies, and how the data was transcribed. How the collected data was analysed and coded using a constant comparative method, ensuring grounded theory principles were still adhered to in this context, was then detailed. This included a description of using memoing, theoretical coding and theoretical sensitivity to assist in the development of this co-constructed theory. The rigour of this study was then discussed using a constructivist paradigm. As encouraged by Charmaz, the theory of *doing your best* was taken back to the two target groups of officers

who had not previously participated in the study and was presented in storyline. These officers confirmed that I had achieved theoretical saturation and the theory presented in storyline had rigour and resonated with them.

The next three chapters present the findings of this study. The findings for this constructivist grounded theory emerged from the raw data as told to me by 22 officers from three police stations in a large metropolitan area in the North Island of New Zealand. Core, main categories, subcategories and their properties including the theoretical category will be italicised in the storyline. In order to allow authenticity with my targeted audience in the next chapters of findings I have ensured the voice of the participants is heard. This is the reason I make no apology for the many quotes within these next three findings chapters.

Chapter 5: Findings

Doing Your Best

Introduction

The following three chapters present the research findings and explain how New Zealand frontline police officers understand their working with individuals experiencing mental distress initially in the community and later in the hospital ED. It was found that police officers manage this situation through *doing your best* to keep all safe. In order to do this, officers are constantly *navigating* between *meeting obligations* and *negotiating challenges*.

The first findings chapter introduces an overview of the theory *doing your best*. The overview will enable the reader to become familiar with the categories, subcategories and properties that emerged from the research. Following the overview, relevant contextual factors are presented. For example, New Zealand Police officers working in the hospital ED with persons in mental distress argue that their organisational processes begin when first responding to the individual in the community. This is important to the findings.

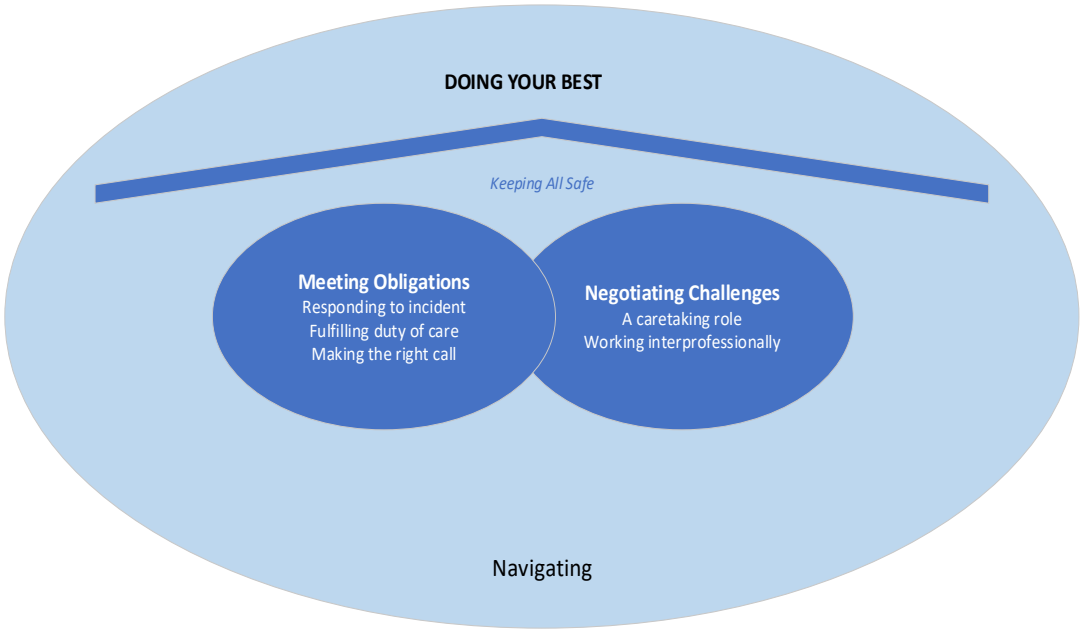
The theory of *doing your best* will be presented in a storyline over three chapters. The storyline in Chapter 5 begins with the core category of *doing your best*. Chapter 6 discusses *meeting obligations,* a supporting category to the core category. Chapter 7 presents a further supporting category, *negotiating challenges*. The latter two chapters (6 and 7) have several subcategories: *responding to an incident, fulfilling a duty of care, making the right call, a caretaking role* and *working interprofessionally*. Each subcategory has properties that describe the processes officers use while working with persons in mental distress. These properties are discussed in Chapters 6 and 7. The integrative theoretical concept of *navigating* made this theory of *doing your best,* cohesive. All three chapters will contain a summary to capture the pertinent points.

Throughout these findings, the individual suspected of being in a mental health crisis will be referred to as a person(s) in mental distress and the reason for this is explained in Chapter 1. Moreover, individuals suspected of being in mental distress may not necessarily have a mental health issue, but it is perceived by officers to be the case. In the following chapters, the core category, categories, subcategories and their properties, including the integrating theoretical concept, will be italicised.

Overview of the theory *doing your best*

New Zealand Police officers manage the person suspected of being in mental distress by simply *doing your best*. Why and what they do was driven by a central motivator—to keep all safe. The officers viewed 'all' as encompassing: the person suspected of being in mental distress, hospital and mental health staff, members of the public and the officers themselves. The overview begins with a diagrammatic view of the theory *doing your best* (Figure 2). This diagrammatic representation of the theory will be explained in the following section.

Figure 2. *Doing your best*: The core category, categories, subcategories and theoretical concept of the theory



The core category *doing your best,* seen in Figure 2, is defined by two supporting categories: *meeting obligations* and *negotiating challenges*. There was constant movement back and forth between the subcategories and properties of these two categories as officers *navigated* how to be *doing your best*. *Navigating* is the theoretical concept that is reflected and woven throughout this theory. Officers were constantly *navigating* what was expected of them as police officers, and what they were comfortable with personally when *doing your best*. This officer demonstrated *navigating* meeting professional obligations while incorporating a personal perspective:

> Even if I have sectioned them like a 109, I still try to get alongside and it's just me as a person as I am not confrontational and that works best for me with people going through mental health (16#[2017]).

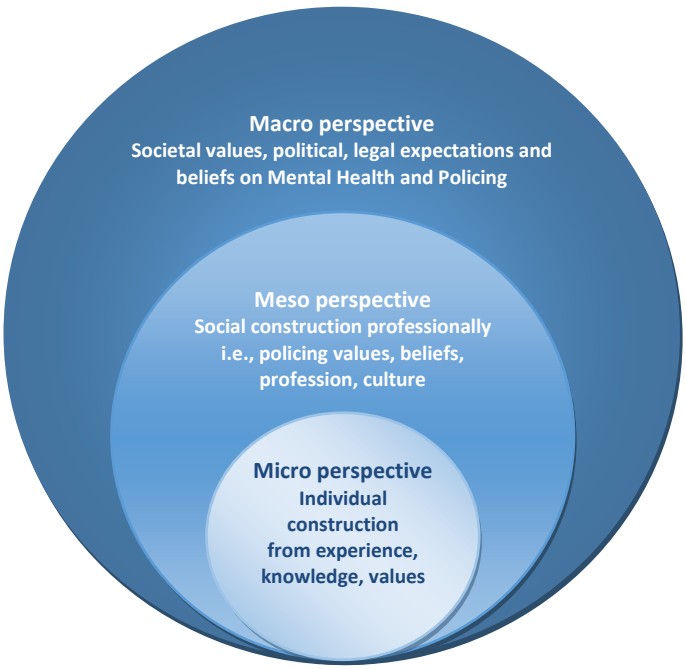
The category of *meeting obligations,* as shown in Figure 2, is defined by three subcategories: *responding to the incident*, *fulfilling a duty of care*, and *making the right call*. Each of these sub-

categories has properties (refer Chapter 6) that give understanding of how officers construct *meeting obligations* whilst constantly *navigating* how to *do your best* to keep all safe.

Doing your best often required officers to *negotiate challenges* confronting them. The category *negotiating challenges*, as presented in Figure 2, is defined by two subcategories: *a caretaking role* and *working interprofessionally.* These two subcategories also have properties (refer Chapter 7) that detail how officers understand being in *a caretaking role* and *working interprofessionally* in the ED with the person in mental distress. Throughout the processes of *caretaking* and *working interprofessionally*, officers were *negotiating challenges* and *navigating* how to *do their best* to keep all safe.

Nevertheless, police officers interpret their world from micro, meso and macro levels, as shown in Figure 3. This view of the world is a result of conditioning from personal history (micro), professional organisational expectations (meso) and societal/political expectations (macro). These levels shape how officers' views and actions are constructed when *doing their best* for the person in mental distress. Figure 3 is a diagrammatic representation of the linking between these three levels.

Figure 3. Theoretical perspective of micro, meso and macro perspectives for police officers



Whilst the participants' stories came from a micro level, there were group patterns at both meso and macro levels that emerged from the individual officer's narratives. For example, at the micro level, the individual officer brought their constructed self into the police

organisation. At a meso level, the constructed self was moulded by a professional organisation—the New Zealand Police. This reconstructed professional self that brought together the individual self and professional self was then influenced at a macro level by policies and societal, legal and political expectations that were imposed. These levels of conditioning as shown in Figure 3, influenced officers' actions and practices determining how they constructed their professional role of working with the person in mental distress.

The theory of *doing your best* is a conceptualisation of how New Zealand frontline police officers work with persons in mental distress. This researcher's interpretation of stories told by officers was that they are working with persons in mental distress in the community and hospital ED by *meeting obligations*, *negotiating challenges* and *navigating* throughout on how to *do your best* to keep all safe.

However, there are some contextual understandings that need to be taken into consideration when reading through the three finding chapters of the theory *doing your best*. The following are the contextual understandings that emerged from the analysis of the theory. These are keeping all safe, persons in mental distress, process beginning in the community, and navigating. Keeping *all safe* and *navigating* appears in the diagrammatic representation of the theory *doing your best* (Figure 2). Although both of these are not categories, their significance to this theory will be explained in the following section.

Contextual understandings of the theory *doing your best*

Keeping all safe

In the theory *doing your best*, keeping all safe was the central motivator for New Zealand Police officers when working with the person in mental distress. Keeping all safe was about officers having a perspective that the person in mental distress could be potentially dangerous to themselves, or others irrespective of anything else they were doing.

Contextually, what emerged through analysis of the officer's interviews is that they are driven to keep all safe at multiple levels. There is the officer's personal motivation, the officer's professional motivation and a societal motivation. These conditionings influence officer's collaborative practices and how they construct their professional role of working to achieve keeping all safe. The officer's view 'all' as encompassing: the person in mental distress, hospital and mental health staff, members of the public and the officers themselves.

The motivation and obligation for officers to keep all safe began initially when responding to a call to assist a person in mental distress in the community, and later in the hospital ED when waiting with the individual. Officers' views of persons in mental distress was they were often

unable to care for themselves and posed a risk to themselves or others. At times like this, officers understood they had a professional obligation and a societal expectation to assist these individuals to get them professional help. How officers achieved keeping all safe was by *meeting obligations*, personally, professionally and societally and *negotiating challenges*, whilst constantly *navigating* between these to ensure they were *doing their best* to keep all safe.

At times, the central motivator to keep all safe was simply implied in the language the officer used as to why they assisted those they suspected were experiencing mental distress. At other times, it was clearly articulated. This senior officer described how all officers prioritised calls to a person in mental distress to achieve their goal of keeping all safe:

> As a police officer, it has been part of our role for so long to help and protect the person experiencing a mental health crisis in the community. Even when we have a whole list of jobs to do, when that sort of job comes in, we call it a 1M – (that's our code for it), which means a mentally affected person. We attend immediately and assist them to get help to keep everyone safe (14#[2017]).

Officers' motivations for keeping all safe when working with mentally distressed persons was an acknowledgement of two common law principles. These principles give officers the power and authority to protect the safety and welfare of the community, and the responsibility for protecting persons with mental disorders who cannot care for themselves. In the quote below, two officers demonstrated their understanding of the application of these two common law principles, when they were working with a mentally distressed individual:

> It's a part of our job to create a safe public environment and do your best. I can't really see anyone else doing it as we have the tools we need if a person is becoming violent, to prevent harm coming to themselves or others (13#[2017]).
>
> We are always going to intervene, because as police officers it's our job to make people safe. We ensure that, the best we can (4#[2017]).

For police officers when working with the person in mental distress, keeping all safe was simply the end goal for the work they do.

Person(s) in mental distress

New Zealand Police officers did not distinguish between an individual who they suspected was mentally unwell and an individual who was suicidal. Officers saw them all as persons in mental distress. Although the distress may be situational and not necessarily be mental health related, it was perceived by officers to be so. Officers' responses to the individual suspected of being mentally ill or suicidal was the same. Both were viewed as being mentally unwell and needing help from health professionals, as seen in the following quote:

> So usually when they are threatening to kill themselves it starts becoming under the mental bracket because it's like, "Why are they feeling this way?" (21#[2017]).

Furthermore, working with the person in mental distress was not just in the hospital ED, but began much earlier, as noted previously.

Process beginning in the community

When interviewing the officers, I began by asking questions of how each worked with the person in mental distress within the hospital ED and what they did. However, all officers took me back further in the process. Without exception, I was made aware that the process of working with persons in mental distress did not begin within the hospital ED. For officers, the process began when officers first encountered the individual in the community when responding to the call out.

Officers viewed this initial encounter as shaping how they would work with the individual in the ED. Clearly for all officers, the first encounter was important and could not be separated from how they then went on to work with the mentally distressed person within the hospital ED. As this officer explained:

> We've got restraints and things like that we can use. If they are a risk to the hospital staff or public then it's kind of our job to create a safe public environment (22#[2017]).

This initial encounter with the individual also determined how officers *negotiated the challenges* of each situation within the hospital ED, whilst *navigating* to *meet obligations* and *doing their best* to keep all safe.

Navigating

The term *navigating* was identified during the analysis as describing the social process that connected the main categories, subcategories and properties when officers were working with the person in mental distress. Officers were constantly *navigating* between *doing your best*, when *meeting obligations* and *negotiating challenges*. *Navigating* was the integrating theoretical concept that was reflected and woven throughout this theory of *doing your best,* as stated previously.

Summary of contextual understandings

The contextual understandings covered in this section provides clarity of the terms used throughout the three findings chapters in the theory of *doing your best*. Keeping all safe clarifies the use of the term 'all'. A person in mental distress refers to an individual officer's suspect that may be mentally unwell or suicidal. Furthermore, when officers were working

with a person in mental distress, their work was not just confined to the hospital ED. The officer's work began when responding to an incident in the community with the person and continued in the hospital ED. Throughout working with the person in mental distress, officers were constantly using the social process of *navigating*. *Navigating* enables officers to plan and direct their actions whilst *negotiating challenges, meeting obligations* (personal, professional and societal) in order to keep all safe by *doing your best.*

The following storyline of these findings begins with the core category of *doing your best*. This category emerged from analysis of the data and explains how New Zealand Police officers constructed their working with persons in mental distress. The extensive use of quotes in the findings chapter of this thesis reflects the constructivist principle of keeping the participants voices prominent (Bryant & Charmaz, 2007).

Storyline

> "Whether the theory remains embedded in the narrative or stands out in bold relief depends on your task and your rendering of it". (Charmaz, 2006, p. 173)

Introduction

Capturing the authenticity of this research was about presenting the findings in their natural form and interpreting these in storyline (Charmaz, 2014a). By the term 'natural form', I refer to storyline as an analytical system that assists a researcher to attain "the highest level of abstraction while staying true to the data" (Birks & Mills, 2019, p. 245). Indeed, the use of storyline is viewed by Birks, Mills, Francis, and Chapman (2009) as enabling a theory to be constructed that is grounded in data and not influenced by external concepts. Thus, using storyline assisted in bringing the categories into a theoretical understanding of how New Zealand Police officers worked with the person in mental distress when responding to an incident and later in the hospital ED.

The storyline in these three finding chapters outlines the theory that emerged from analysing the raw data collected from 22 New Zealand frontline police officers. What the participants said verbatim is maintained in the quotes, ensuring the integrity of what they reported and demonstrating analytical rigour. Throughout the narrative, participants' quotes support the storyline and category construction.

Doing your best

This story of *doing your best* is about how New Zealand frontline police officers work with persons in mental distress. *Doing your best,* the core category, is used as a collective term. The 'your' in this term comes from individual participants; however, it is to be seen as a group

collective term in this study. Additionally, in order to help with the reading of the relationships between the core and supporting categories, sometimes 'their' is also used as a collective term. *Doing their best* is an example of this.

Sometimes working with the person in mental distress necessitated officers to act in specific ways. One officer shared how he carried out his personal and professional obligation of *doing your best* in the community and hospital ED when working with a person suspected of being mentally unwell:

> There is something I do when I deal with someone who is mentally ill. That is to remind them why we are there and say it's not to lock you up. I'm here to do my best to help protect you. That's my job. (16#[2017]).

Similar sentiments were echoed and shared by other officers interviewed. Yet, another officer's understanding of *doing your best* was to simply demonstrate professionalism to the person in mental distress, the public and possibly his colleagues:

> You always have that fundamental want to do the best you can. Sometimes that is lacking, but you do your best. It's just having that professionalism in your approach. You do your best you know to let that be seen. (13#[2017])

However, on occasions while trying to *do their best* for a mentally distressed person, officers struggled. Through no fault of their own, officers were left with the "sense of falling short" (13#[2017]). Sometimes this occurred when working interprofessionally. Occasionally, it may even be a senior colleague, who left the officer with that sense of disappointment and falling short as they tried to do their best for the mentally distressed person. Emerging from the data analysis was that different personal experiences influenced how each officer understood *doing your best*. The following is an example of how the seniority of another officer at an incident prevented a more junior officer with significant personal experience of handling a person in mental distress, from *doing their best*:

> I had full control and could have got him into my car on my own without having two officers handcuffing him. When they did this, he escalated and that bugged me as I had handled the situation and let them know that I was in control when they arrived. I was disappointed, annoyed and really mad with the other senior officers. This was because again I thought of my [relative] who didn't like being touched and would have ended up fighting and injured if handcuffed. (16#[2017])

Although this officer knew from personal experience of a less confrontational way of working with a person in mental distress, they felt unable to convey this to the other officers due to their rank seniority. This officer intuitively knew that working with a mentally distressed person did not always require force. In fact, this officer knew in this instance, using force may escalate the situation. Yet, rank seniority over-ruled in this particular situation and left this

officer with a sense of disappointment. In response to my question of whether or not this officer had spoken to the officers concerned, their reply was:

> No, I chose not to. They were senior officers to me and I didn't feel I could even though I probably should have. I feel a bit guilty that I didn't call them out on their behaviour. (16#[2017])

Having a personal experience and knowing how to do your best for the mentally distressed individual may have resulted in a better outcome for all in this instance, as this officer knew. As seen in the previous quotes, *doing your best* for such an individual was not necessarily confined to an officer's policing experience or seniority, and most officers understood this:

> At the end of the day it doesn't matter too much even if you are new to the job you might have life experience. It doesn't have to be police experience that you put into play. It could be your own personal experience—mum, dad, whatever. (19#[2017])

For all officers, *doing your best* was about *meeting obligations* (professional and societal) whilst *navigating* and *negotiating challenges* to keep all safe. However, when professional and societal obligations had been met, there was still the personal aspect left as to how officers were *doing their best* as, "it does vary" (16#[2017]). Some understood this to be broadly as "purely doing our job just to make sure that the patient is happy and safe and she/he gets the help they need" (13#[2017]). Another officer personalised their sense of *doing your best*:

> I always do my best to come from the empathetic point of view rather than authoritative. And, it's also about me as a person and not being confrontational. Some of them [persons in mental distress] really don't get along with us. In my current role I'm working on changing that as part of what I want to do. That is to make us more personable trying to remind them we are not just a uniform. (16#[2017])

Gratitude for *doing their best* was sometimes expressed to the officers at a later time by an individual who had been in mental distress. When this occurred, an officer was left with a sense of satisfaction of having *made the right call* by *fulfilling a duty of care* to that person when *responding to the incident* (refer Figure 2). Officers knew that *meeting obligations* personally, professionally and societally, was often appreciated later by the person, with comments such as "I can't believe how much you helped us and you haven't judged us" (20#[2017]). These officers knew they had done their best.

Furthermore, it emerged that officers were also acknowledged by their police organisation in assisting persons in mental distress and *doing their best* for such persons. In answer to the question if the officers felt they were supported in their work with persons in mental distress by their organisation, most officers had a similar response to these two officers:

> It is changing as we are getting more kudos for looking after those in need rather than us just arresting people. (16#[2017])

> They [police organisation] let us be and say this is your incident, you manage it fully and do the best you can as it is now our core business. (19#[2017])

Summary

What emerged from the core category of *doing your best* when officers were working with the person in mental distress, was that this phrase had a slightly different meaning for each officer. Personal experiences, professional obligations and societal expectations all influenced an officer's understanding and construct of *doing your best*. Yet, encompassing this was the officer's universal consensus that *doing your best* was about *meeting obligations*, *negotiating challenges* and *navigating* between the two to keep all safe.

Nevertheless, when working with persons in mental distress police officers have a certain set of obligations to meet. These are to protect society and maintain socio-political order. Chapter 6 explains how police officers understand their *meeting obligations* for those in mental distress when *responding to an incident*, *fulfilling their duty of care* and *making the right call*.

Chapter 6: Findings

Meeting Obligations

Introduction

During the analysis it emerged that officers described three conceptual processes when *meeting their obligations* and *doing their best* when working with the person in mental distress. Processes are defined in this constructivist methodology as an ongoing action/interaction/emotion taken in response to situations or problems (Birks & Mills 2015). Moreover, these processes may "remain unseen and unstated but shape participants actions and understandings within the setting" (Charmaz, 2006, p. 20). The first of these conceptual processes concerned *responding to an incident*, the second process was *fulfilling a duty of care* and the third process was *making the right call* involving the person in mental distress. These three processes formed the subcategories of the category *meeting obligations.*

Each of these three subcategories have different properties with the strategies that officers identified they used when working with persons in mental distress. Properties are defined here as characteristics of a subcategory (Birks & Mills 2015). For example, within the subcategory *responding to an incident*, the properties ascertained for this from the analysis and coding of the data were: *being dispatched*, *triaging*, *using discretionary power* and *following procedural protocols.* Table 5 is a representation of the category *meeting obligations* with its subcategories and properties in the theory of *doing your best.*

Table 5. Meeting obligations and the subcategories and properties

Category	Subcategories	Properties
Meeting obligations	Responding to the incident	• *Being dispatched* • *Triaging* • *Using discretionary powers* • *Following procedural protocols*
	Fulfilling a duty of care	• *Protecting society* • *Working within legislated parameters* • *Managing diverse expectations*
	Making the right call	• *Maintaining professional boundaries* • *Learning on the job*

However, once at the incident, officers looked to *fulfilling a duty of care* because as police officers, there is a professional obligation and legal responsibility for them to keep all safe. Officers did this by *protecting society*, *working within legislated parameters* and *managing diverse expectations*. These were the properties of *fulfilling a duty of care*. Throughout this entire process of working to *meet their obligations* with a person in mental distress, officers were also constructing how to *make the right call* in each situation. What emerged from the data was that officers *made the right call* by *maintaining professional boundaries* and using previous knowledge gained from *learning on the job* and for some, also using their personal experiences of how best to work with the person in mental distress. These were the two properties of *making the right call.*

A situational awareness and understanding was required by the police officer when working with a person in mental distress. The reason for this is the requirement that officers meet their societal, professional and individual obligations to manage situations in many different environments. So, whilst these subcategories all worked together, there were different drivers for each subcategory that emerged from the analysis. *Responding to the incident* was primarily a responsibility driven by the obligation police have to protect society. *Fulfilling a duty of care* was driven by officers having a professional obligation to meet when responding to an incident. Yet, in *making the right call* when *responding to an incident* and *fulfilling a duty of care*, it emerged that there was often a strong personal empathetic driver present. However, officers were constantly *navigating* how to *meet their obligations* to *keep all safe*. This is how New Zealand frontline police officers work every day when *responding to an incident* involving a person in mental distress that began in the community and progressed later in the hospital ED.

Responding to an incident

The first subcategory of *meeting obligations* is *responding to an incident*. Most referrals to police when *responding to an incident* involving a person in mental distress were due to the perceived risk that the person may harm themselves or others. The properties of this subcategory are: *being dispatched*, *triaging*, *using discretionary powers* and *following procedural protocols*. Initially, officers will hear on their radio from the Police Communication Centre (Comms) that they are required to respond to an incident involving a person in mental distress. Comms then formally 'dispatches' the officers to the incident, as explained by this officer:

> Generally, I'll be dispatched by Comms to a job involving a person possibly experiencing a mental health issues or distress. (17#[2017])

Being dispatched

The first property when *responding to an incident* was what officers termed *being dispatched*. Officers defined the term 'being dispatched' as the Police Communication Centre (Comms) instructing them to respond to an incident pertaining to a person in mental distress. *Being dispatched* occurred after Comms had received a call. The call could be from an individual in mental distress, a concerned family member, a member of the public, or a mental health crisis team member requesting police assistance. When *being dispatched*, Comms gave the officers the address and their perceived code for the incident. This code may be a 1M, indicating the incident involved a person suspected of being mentally unwell, or 1X, indicating the individual was possibly suicidal. However, the officer's response to either of these codes was one of urgency. The urgency in which officers responded to a 1M or 1X call stemmed from officers always being cautious when dealing with a person in mental distress. As seen in the following two comments, officers viewed such an individual's behaviour as unpredictable:

> I see the mentally ill person as unpredictable even if it is a 1M or 1X. It kind of makes you hypervigilant. I am cautious working with them, careful what I say. I don't want to hit a soft spot and them 'amp up'. The danger with a person suffering from mental health is they can change at any point. It [mental illness] makes ordinary calm people quite angry. (18#[2017])

> Obviously, some of them [person in mental distress] when they have an episode they lose control and maybe hurt members of the public so, we have to be careful. (22#[2017])

There appeared to be a tacit understanding by most officers that they considered the person in mental distress to be possibly dangerous to themselves and others. This was demonstrated in their actions when *being dispatched* to such persons by Comms. Officers automatically escalated a call to a mentally distressed person as requiring an immediate response. The following comment illustrates how and why officers may construct such a call:

> Yes, even when we have a whole list of other jobs to do when that sort of job comes in we go. We call it a 1M or 1X and if we don't attend and something happens then we are going to get criticised for it. (14#[2017])

However, before leaving to respond to an incident, an organisational procedure officers referred to as 'flagging' occurs. Flagging is when officers check on the police database to see if the individual is known to them, has a history of violence, or previous suicide attempts. This officer explained his understanding of the term flagging:

> They have a certain condition and we have captured that in the past that will come up as a flagging for us. Then we would know they have a mental issue or psychiatric issue or have used knives or something like that so, we assess that information. (14#[2017])

Equipped with this knowledge, officers now organise their response to the situation. They begin anticipating potential issues that may require their interacting with the individual in a specific way. Sometimes, this required getting 'back up' (support) from colleagues whilst *navigating,* negotiating and anticipating challenges that could hinder *doing your best* to *meet obligations* ensuring all were kept safe. On arriving at the incident, officers immediately began to *triage* the incident from their policing perspective.

Triaging

The second property of *responding to an incident* is *triaging*. From a policing perspective, officers use of the term 'triaging' was understood by them as the procedure they undertook when *responding to an incident* involving a person in mental distress. On arriving at the scene of the incident, officers talked about *triaging* the situation to determine if the individual was safe from harm, and if others, including themselves, were safe from the individual. According to this police perspective, officers constructed *triaging* as being part of their *meeting professional obligations* and *doing your best* to keep all safe when *responding to an incident* involving a person suspected of being in mental distress:

> We are not trained professionals dealing with them yet, we're still kind of the triage or the initial triage anyway. We are only trained to deal with the physical safety aspects of preventing any further harm to the individual or others. (7#[2017])

Triaging involves officers communicating with the individual, family, or members of the public as to what had occurred and observing if the individual's speech was irrational and/or their behaviours bizarre. These types of behaviours were indicators the individual was probably mentally unwell and they (the officers) needed to respond and get them professional help. *Triaging* involves officers using their initiative, intuitiveness and a variety of verbal and non-verbal communication skills:

> You are talking to people who may have rung us about the person, members of the public and people who live with them to see what's going on. You ask the individual certain questions, are they taking medication whether they are under mental health or if they are seeing someone. You are asking how they are feeling at the time and you are looking to see if they have any marks on their arms where they have tried to self-inflict. (14#[2017])

> Arriving at the scene you are weighing up what you're walking into. On arrival you are triaging, judging each case by itself and how the person is acting. You listen to what you have been told of the observations of the mentally ill person. (21# [2017])

Of course, any decisions officers made involved *navigating* the fine and delicate line between protecting the individual's rights and freedoms and maintaining public safety and security. Officers made these decisions by constantly *navigating* the situation of how to protect the

individual yet, *do your best* to *meet professional and legal obligations* and *negotiate challenges* that may pose a threat to public safety. They did this through *using discretionary powers.*

Using discretionary powers

The third property of *responding to an incident* is the use of *discretionary powers*. These are State given powers and come from a police officer's professional obligation of *parens patriae*, meaning they are to act as a protector for those who cannot protect themselves. Thus, officers are given powers under relevant legislation to apprehend and detain persons they perceive to be in mental distress, and those whose behaviour may potentially pose a risk to themselves or the public.

Discretionary powers provide officers with various options of how to best assist the situation for the person in mental distress. Officers may resolve the matter informally with a verbal warning, or persuade the individual to voluntarily accompany them to the ED. These officers shared how they tried to resolve an incident informally:

> We just have to use our powers of persuasion. Non-confrontational works best and usually resolves the situation with people going through a mental health crisis. (16#[2017])

> Normally we try to get their say on it as we don't want to forcibly take someone to the hospital. (19#[2017])

Officers may also apprehend the individual under Section 109 of the Mental Health Act (1992). Under this section, as discussed in Chapter 1, officers may detain an individual in a public place whose behaviour has led them to believe the individual may be mentally unwell. In such cases, the officers will make the decision whether to transport the individual to a hospital or a police station to be assessed by mental health professionals. Some officers found that the use of Section 109 as a given discretionary power worked well as it ensured all were kept safe:

> It's great that 109. We have that power especially when someone is not in a good state of mind or can't make decisions for themselves and may be a risk to themselves. (19#[2017])

However, if the person in mental distress was violent, officers would not take them to the hospital ED to be assessed by mental health professionals. Instead, the individual would be placed under arrest and taken back to the police cells for an assessment by a DAO when available. The role of the DAO is discussed in Chapter 1. Nevertheless, there was an organisational process that officers followed when working with a person in mental distress who displayed violence. This was described by these two officers:

> If people are violent or threatening violence then we wouldn't take them to the emergency department as they could harm other people. Probably arrest them under Crimes Act 61 and take them to the station and call a DAO. (22#[2017])

> Having a person who is violent is just going to cause havoc to everyone, we would then take them to the cells and then get them assessed there by a DAO. It is a closed base, so it reduces risk to everyone else. (14#[2017])

Officers had a choice of what option(s) to take when *using discretionary powers.* The very term 'discretionary' gives the understanding of officers having some flexibility in their choice. Regardless, whilst there were mandatory professional and societal obligations to meet, how individual officers applied discretionary powers varied. It was interesting to discover several factors that surfaced which influenced how officers used given discretionary powers. These were personal and past experiences, attitudes about mental illness, resourcing, time constraints and previous dealings with the individual in mental distress. All these factors emerged as influencing to some degree what options each officer took when *using discretionary powers*. Following are two quotes from officers of the how they incorporated their life and personal experiences when using their discretionary powers for the person in mental distress:

> Influencing factors for me dealing with a mentally ill person is my life experience as well as personal. So, I understand and empathise with them compared to someone who might not [have had my experiences]. (19#[2017])

> I have had a lot of experience and empathy for people with mental illness. Things that happen in your own life you liken to what's happening in their life. Certain illnesses I would identify more with. These would be past experiences and personal experience. (18#[2017])

However, over time, some officers had become desensitised. Several participating officers commented that when this occurred, it was seen to affect the approach, decision making and use of discretionary powers officers used when working with the person in mental distress. Desensitised officers tended to opt for a quick resolve of the situation. The outcome of this often resulted in restraining and arresting the person, rather than trying to resolve the matter informally or non-confrontationally. The following account is one officer's description of this occurring:

> Some of the people that have been in the job for a long time, I observe their patience has dwindled a bit with mental health people and they arrest them. That's my outside view and I think they have become desensitised. (21#[2017.])

Resourcing and time constraints were other factors influencing what path an officer took *using their discretionary powers* when working with the person in mental distress. The rationale of how time constraints and resourcing (personnel, available cars and money) influenced an

officer's discretionary power options was provided by this officer's construction of a frequently occurring situation:

> I have seen a lot of police waiting at the hospital. That ultimately does have an effect on police dealing with mental patients on the side of the road. It influences your decision to take them to hospital because you know you are up for a long wait which will hold you up and take your car off the road. I would say most police take that into account. It sort of raises the level before you take them to hospital. I mean their behaviour would have to be higher. Your safety concerns [level] would have to be a lot higher than normal. (18#[2017])

From time to time, officers raised their thresholds for intervening with a person in mental distress. One of the reasons for this was to avoid waiting at the hospital for several hours in a situation officers deemed to be unnecessary, particularly if the person appeared to be calm and was cooperating. However, taking this action was used judicially with officers always erring on the side of caution.

In such situations, officers occasionally ran the risk of blurring their professional boundaries by attempting to assess the acuity of the person in mental distress, which they are currently not trained to do. However, whilst acknowledging they were not mental health professionals, at times when under duress with resources stretched, officers found it necessary to do so. Moreover, often as first responders to an incident, realistically it makes no sense to believe *triaging* from a policing perspective with experienced officers does not involve some form of mental health assessment, albeit, at a basic level as seen in this officer's quote:

> We do get enough training to do the basics in our role. For us it's identifying whether this person is suffering from some sort of mental health issue or disorder. After many years you just know by looking at them and talking to them if they need professional assistance. We see if they come up as a flag for us and assess that information as well as what we are seeing at the time. (14#[2017])

Sometimes it was the limited resourcing at the smaller rural police stations that dictated the choices available for officers' *use of discretionary powers* with the person in mental distress. A lack of cars, personnel and sometimes the geographical nature of the rural area made transporting individuals from rural areas for assessment at a hospital ED problematic. This often involved officers covering these rural areas having to be several hours on the road before they could get the person in distress assessed by health professionals. For officers in these situations, their *use of discretionary power* options was influenced by the limited resources available. This often resulted in their opting for the quickest resolution to the incident. There was desperation in these officers' voices as they described trying to *do your best*, yet feeling inadequately resourced to *meet their obligations* to keep all safe:

> It's a time thing. You know there is just one car here today. There is nobody here and that is a problem I have got. It's just a practicality of that. Obviously, our staffing is atrocious and we take the quickest option to resolve the situation-we have to. (13#[2017])

> We all want the same thing; we want these people to get help they need. We can get that help quicker but it relies on better resourcing. We have three units policing the district. We have three incident cars. The whole response team was at the emergency department last night. It was disabling for our core business. (17#[2017])

However, although officers have discretionary powers they can exercise, there were certain procedural protocols officers must follow. These were the professional and societal obligations to meet in order to *do your best* and keep all safe when *responding to an incident* with a person in mental distress.

Following procedural protocols

The fourth property of *responding to an incident* is *following procedural protocols*. One such procedural protocol for officers was informing the person in mental distress and their family of what would be happening and actions they would be taking. Not only does a person have a legal right to be informed, but officers understood this to be a common courtesy, and found it may possibly reduce anxiety for the person and the family. As one officer explained, "you never surprise the mentally ill person with anything, you always tell them everything and what your actions will be as it helps keep them calm" (17#[2017]).

In following the correct procedural protocol, officers make contact with the CATT team who decide where officers are to take the person in mental distress. This may seem a simple procedure. However, often this was far from the truth. A common reoccurring theme in the findings was described by one officer of what happened when attempting to contact the mental health crisis team:

> I picked up a person coded as a mental episode. Required to ring the mental health crisis team to advise them that we have this person to let them know we are bringing them into ED. So many times you ring a number and it's like try this extension or you talk to someone and they patch [put] you through to another person who will then patch you through to yet another person. Ring that number and patched through to another then another. They say they will ring us back but, that's not easy as we are looking after that person and their wellbeing in the back of the car. It is very frustrating. (21#[2017])

If the decision by the CATT team was to take the person in mental distress to the hospital ED, officers followed a procedural protocol. They inform the hospital of their impeding arrival and ask the charge nurse to meet them at an entrance they designated. This poses another frustration officers must navigate and negotiate as each charge nurse has a different rule as to what entrance officers are to use. On arriving at the ED, officers often found that they got "a

bit of push back from certain charge nurses and they question what entrance we use" (2#[2017]). However, some officers navigated this challenge by adhering strictly to what the procedural protocol and directive was as told to them by their senior officers:

> We follow the directive, phone the charge nurse and meet them at the ambo [ambulance] door – got directive we stick to it. That way, no games are played. (4#[2017])

Once in the hospital ED however, officers were obliged to follow hospital protocols rather than those from their senior officers. The first requirement was the filling in of a Police Protocol Form which the charge nurse signed. On this form officers provided as much information as they could about the person in mental distress. This form was for the charge nurse and mental health staff as well as the officer's own report as "we need to put through a report for everyone we transport" (22#[2017]). One officer dryly commented on this new protocol as being good, because "we are policemen so; we are form fillers, that's what we do. Just keeping it simple for us to know". (6#[2017])

However, overall, officers felt there was now more clarity than previously as to what they were required to do at the ED when arriving with the person in mental distress:

> These days we have a much better understanding from a policing perspective what they require when we arrive at the emergency department. (16#[2017])

> We've got a bit of paper we fill in – nice and simple now. It's really good now and more streamlined than before. (17#[2017])

With the paperwork completed, officers usually accompanied the person through to a secure room. It was up to the charge nurse to decide if the officers were to be replaced by security, or whether or not they request officers stayed until the individual had been assessed. Requesting officers to stay on with the person in mental distress so they posed no safety concerns was sometimes a contentious issue for officers. Nevertheless, with officers, there was mostly a benevolent attitude to this request, especially if there was any doubt about the safety of the individual:

> In ED we do go that extra mile. There is always a bit of leeway especially if the individual poses a risk. (20# [2017])

However, all officers were of the same opinion that if a Section 109 had been invoked, "then we need to stay until mental health is happy with them" (20#[2017]). The analysis revealed that there was an enormous amount of empathy officers displayed towards trying not to overburden the hospital ED staff if they were busy and also towards the person in mental distress. This was seen in the following quote:

> We are wary of dumping the person on the hospital staff. Also don't want the mentally ill person to feel they are being dumped. (15#[2017])

Following both professional and hospital protocols for a person suspected of being in mental distress was an important part of officers *meeting obligations* in the ED. This entailed their *navigating* and *negotiating challenges* whilst *doing your best* to keep all safe. This was done through officers *fulfilling a duty of care*.

Fulfilling a duty of care

The second subcategory of *meeting obligations* is *fulfilling a duty of care.* The term 'fulfilling a duty of care' in practice, can be very broad. Most of the officer's instructions about having a duty of care relates to custodial management. The following was an explanation and quote from a police legal advisor of how this term applied to officers working with a person in mental distress:

> Fulfilling a duty of care primarily is a professional obligation linked to the torte of negligence. The police understanding of a duty of care is when police are dealing with, or have in custody or in their care, a mentally disordered person. Police may well assume a duty of care for that person until they leave police care. That is why it is always wise to have a person assessed –then police have discharged their duty of care. (Personal communication, Police legal advisor, November 14, 2018)

Whilst the term *fulfilling a duty of care* does have a broad application, it was a term officers used frequently to describe how and why they worked with the person in mental distress. Officers' professional obligations to *fulfil a duty of care* to a person suspected of being mentally unwell and keep all safe began when *responding to an incident*. This obligation for officers continued within the ED until relieved of their duty, either by hospital security or officers being given permission to leave from the charge nurse. However, although the emphasis was on the officer's professional obligation to *fulfil a duty of care*, there were other aspects that influenced how they accomplished this. There were individual influences and societal expectations that also impacted as to how officers carried out their duty of care whilst working with the person in mental distress. This officer demonstrated how by using a personal approach when *fulfilling a duty of care*, the desired result was achieved:

> I used his first name because the information was in the text from Comms. Good way to get personal with him, establish a rapport and resolve the situation. I didn't invoke a Section 109 because it wasn't needed. (17#[2017])

In conjunction with the individual and professional factors that influenced an officer's *use of discretionary powers*, was also their duty of care to protect the safety and wellbeing of the general public. However, sometimes the public placed unrealistic expectations on police officers with complete disregard for their domain of expertise. This often put officers under

enormous pressure, and it may encourage actions that officers would not normally be inclined to undertake. This officer describes what being placed in this situation felt like:

> It's all just part of what you do; it's one of the never-ending strains of what we do. The public expect us to be all things to all people you know. Our role now, if you were a builder, is like a dodgy crooked nail that just won't go in straight. We are not masters of everything, but we are expected to do everything. We try and stick a plaster on because that's expected of us by the public and move on to the next crisis. I feel a lot gets put on us that we are not trained to deal with. (13#[2017])

Nevertheless, when moving on to the next person in mental distress, all officers continued to *do their best*. Officers achieved this by *meeting obligations*, *negotiating challenges* as they presented and *navigating* how best to societally *fulfil a duty of care*. Whilst *protecting society* was the officer's top priority, they still had to work within their *legislated parameters* and cope with the *diverse expectations* from all, including their own organisation, as they attempted to keep all safe.

Protecting society

The first property of *fulfilling a duty of care* is *protecting society*. Officers frequently used the term 'a duty of care' in the context of their professional obligation to *protect society* at all times. *Protecting society* also included officers safeguarding persons in mental distress from harming themselves or creating harm to others. The following response from one officer was reiterated by several officers as to how and why they constructed this obligation: "it's kind of our job to create a safe public environment" (22#[2017]). Two additional quotes assist in clarifying officers understanding of the use of this term:

> We are not just dumping these people on the hospital. Because we have a duty of care we can't just dump them. (16#[2017])

> I can't just leave him, I am responsible and I have a duty of care. If he jumps off the cliff then I would feel I was responsible for not stopping him. There again if you leave the person with a razor blade, they could attack themselves or members of the public. We have a duty of care – we are compelled to stay until the CATT team turn up. We always attend because we have a duty of care to keep the DAO safe too. (17#[2017])

Throughout, one has an overall sense of the guardianship role officers assume for society in relation to their carrying out this duty of care in the community and the hospital ED.

It is important to acknowledge here that police officers belong to a government organisation that is dedicated to protecting society and maintaining law and order. This organisation, the New Zealand Police, has set protocols and legal obligations officers must follow as to how they *fulfil their duty of care* with the person in mental distress so that individual and the public are kept safe. Furthermore, nowadays it is police who are usually the first to be called to a person

suspected of being mentally unwell. Officers always attended this type of call whether the person was co-operative or violent, threatening family and/or members of the public. It has always been so, and an accepted part of an officer's role:

> Well, they, people with mental illness is/are part of our role. We deal with them almost every day right from start to finish. Right from when we get called to when we hand them over to mental health. So, that's just always been our job. (2#[2017])

> We are there to protect the community and public. Police are the first people called if someone in the public is mentally unwell. We don't want to leave them on their own so, we take them to ED. (14#[2017])

Officers were fully conversant with their duty to protect society. Nevertheless, on occasions, there was the feeling by officers that other services may use an officer's duty of care as a ploy to get them to attend incidences involving a person in mental distress even when there was little need to protect anyone:

> Someone is mentally unwell so people ring mental health. Mental health are saying you need to ring the police knowing that the person and public will not need protecting from the person as, they are not violent. I am finding that mental health won't go out to see anybody and police are attending every mental health incident in the community first. (6#[2017])

Yet, despite this situation, officers still attended and *fulfilled their duty of care* as "it's our job to make people safe and, we ensure that the best we can" (4#[2017]). However, in *doing their best* to *meet obligations* and *fulfil a duty of care* when working with persons in mental distress, there were certain legislated parameters that dictated how officers may act.

Working within legislated parameters

The second property of *fulfilling a duty of care* is *working within legislated parameters*. Officers considered the legislated parameters in Section 41 and to a lesser extent Section 109 of the Mental Health Act (1992), often restricted their *fulfilling a duty of care* to the mentally distressed person in a timely manner. Moreover, some went so far as to say that they felt Section 41 of the Mental Health Act (1992) hindered *their meeting professional obligations* when *doing their best* to keep all safe. As one officer explained, "there are a lot of barriers within legislation of what we can and can't do for the mentally ill people" (19#[2017]).

When using Section 109 of the Mental Health Act (1992), officers may detain an individual in a public place who they suspect of being mentally unwell. They may then transport the individual to get professional help at a hospital or police station. Thus, in a public setting, officers reported that Section 109 worked well despite their being able to detain the person for 6 hours only. However, there were aspects of Section 41 of the Mental Health Act (1992) that officers gave as examples of legislation that limited their powers to assist the person in

mental distress in certain settings. The concern officers had was their inability under Section 41 of the Mental Health Act (1992) to take a person in mental distress involuntarily from a private location if no crime had been committed. Officers were permitted to do this only if a DAO attended the incident and authorised it. The result of this legislation was officers waiting around; unnecessarily they believed, until being authorised to transport the individual to the hospital ED to be assessed. These officers explained how Section 41 of the Mental Health Act (1992) may affect their everyday work with persons in mental distress which included those who may be suicidal:

> When we get called to someone who is feeling suicidal in their own home our powers are very, very limited. I can't forcibly remove them from their own home to get assistance yet, we are still called to go and deal with them. (7#[2017])

> Under Section 109 a person you think is mentally ill in public can be detained for up to 6 hours. But you can't take a person from a private place voluntarily to a public place and then 109 them to detain them which is removing somebody's freedom which is a pretty serious thing. (18#[2017])

> When a mentally ill person is in a house, we try to get voluntary buy-in because we have no powers to take them with us. Only a DAO can tell us you can go in and get the person and bring them with us. (19#[2017])

There was a general understanding and agreement by officers that a mentally ill person could be assisted more efficiently if there was an amendment to Section 41. The amendment officers would like is for the ability to transport an involuntary person in mental distress from their own home to get help and treatment at a hospital ED. The thoughts of this officer about working within such restrictive legislated parameters were replicated throughout the data by fellow officers:

> It's like we are missing some sort of legislation around removing people from their homes to get help. We are not as empowered as we could be sometimes to help the mentally ill. (16#[2017])

Every day officers work under legal, and at times, institutional parameters. The term 'institutional parameters' is defined as the hierarchy of authority, a lack of flexibility and red tape that may impede problem solving for officers when working with persons in mental distress. Under such parameters, trying to navigate how to *fulfil a duty of care*, *meet obligations*, *do your best* to keep all safe whilst accommodating the *diverse expectations* of your role professionally and societally, was something that officers found challenging.

Diverse expectations of officers

The third property of *fulfilling a duty of care* is the *diverse expectations* of officers. There was little doubt at times that officers feel burdened by *the diverse expectations* placed on them.

When analysing the data, it was revealed that an officer's sense of their role was to "be there for everybody" (14#[2017]). The 'everybody' expectation officers interpreted as being the person in mental distress, the public, mental health services, hospital ED staff, and indeed, their own police organisation.

As an emergency service, police are easily accessed and available to the public 24 hours a day, 7 days a week, whereas other services are not. With the public knowledge of police always being available, officers were finding themselves as 'first responders' to the majority of incidents involving persons in mental distress. One officer mentioned several times that "we [Police] are the first port of call" (17#[2017]). One explanation for officers being first at an incident for a person in mental distress was that some mental health services do not operate after set hours. Alternatively, it may be that people automatically think to contact the police in times of crisis. Sometimes when mental health services were unavailable after hours, officers had to think of other alternatives to manage a situation. One such incidence of this occurring was described:

> We pick up a mentally ill person as we believe they need to be under the Mental Health Act. It's at night and the CATT team is unavailable. It's at this point when you go – what can I do now? How do I manage this situation where people who are supposed to assess this person can't make it as they are too busy elsewhere. (19# [2017])

Always being available left officers wondering if they are viewed as a pseudo mental health service or a counselling service for the community. Furthermore, aside from encroaching on officers' other duties and core business, there was a risk of officers being pressured to work outside their scope of practice:

> I feel a lot gets put on us that we are not trained to deal with. We are supposed to pick up and transport – a safety thing for the individual and public. We are now being counsellors – I don't believe we should be doing that. (21#[2017])

However, working with persons in mental distress and being available has just been part of an officer's role for so long and their response to this situation was simply "we are always there to help and protect the community as, we have a duty of care" (12#[2017]).

Being available was about officers *fulfilling a duty of care* to *meet obligations* organisationally and to the community. The importance the New Zealand Police places on officers' involvement with the person in mental distress is such that it has now incorporated mental health as a sixth demand driver in their Prevention First Programme. This changing organisational approach for officers working with persons in mental distress is impacting how they respond. One major change is allowing flexibility in an officer's time management of a situation with a mentally

distressed person to enable a positive resolution for all. How this worked was articulated by one officer as he described changes he saw in the organisation:

> It's changing; we are getting more kudos for looking after those in need rather than just arresting people. Generally, they are not rushing you through. Yes, I definitely think the police organisation is changing. (16#[2017])

Officers were constantly *navigating* between their *meeting obligations* and the *diverse expectations* of their role with the person in mental distress. However, *meeting obligations* was not just about how officers were influenced by personal, professional and societal obligations to keep all safe, but also about their obligation to *make the right call*. In order to *make the right call*, an officer had first to *navigate* how to *fulfil a duty of care* when *responding to an incident* and how to manage the *diverse expectations* as to what was the right call to make.

Making the right call

Making the right call is the third subcategory of *meeting obligations.* This is where the officers determine what the right call is when working with the person in mental distress. The individual dilemma each officer faced was ensuring they made the right call. The two properties of *making the right call* are *maintaining professional boundaries* and *learning on the job.* The combination of these two properties enabled officers to make the right call.

Sometimes *making the right call* was difficult as officers tried to explain to the person in mental distress what was going to happen for them. This challenging situation occurred when it was unclear whether the individual understood why the DAO had authorised police to forcibly remove them from their home and transport them to get help from mental health services. Nevertheless, officers knew that removing that mentally unwell person from their home to get help was the right call professionally. This officer shared how he felt about this occurring:

> You don't know what they are thinking at the time there. You know within yourself that what you are doing is right, but you don't know how the person you are dealing with is actually feeling because they are so mentally unwell, they can't communicate that to you. You know what you are doing is right and you know you are going about it the right way but you don't know why it is difficult. (6#[2017])

Officers understood they were not mental health professionals and each had a strong sense of maintaining their professional boundaries.

Maintaining professional boundaries

The first property of the subcategory *making the right call* is about officers *maintaining professional boundaries*. Below is an example of how this officer made what he considered to be the right call, whilst *maintaining professional boundaries* as he stayed within his scope of practice:

> We talked to him and he calmed down and decided the crisis team at the hospital might be the people to talk to as we are not counsellors. We do not have the expertise or knowledge in that field. He has ongoing care now with the mental health team because of that day. (15#[2017])

In lacking this specialist mental health training, officers sometimes had difficulty in distinguishing between mental health issues and drug or alcohol involvement when an individual was exhibiting complex behavioural issues. Officers were also reluctant to make this judgement. They sensed this went beyond their skill set and was a breach of their professional boundaries and scope of practice. A reoccurring statement by officers in the data was:

> We are not mental health professionals. We haven't been given the same extent of training that they have [mental health professionals] so we can't assess them. (19#[2017])

Transporting the person in mental distress to get help and treatment from mental health professionals was how officers viewed *doing your best* to *meet obligations* and *make the right call*, all whilst *maintaining professional boundaries*:

> We get enough training to do the basics in our role and we stick to that basic boundary. For us it is identifying whether the person appears to be suffering from some sort of mental issue or disorder. Now that is purely someone's [officer's] belief in what they think, and we take these individuals to the hospital because we think that is the right call (14#[2017])

Yet, officers were clear that *making the right call* was by *maintaining professional boundaries*. This involved officers knowing when their role began and ended with the person in mental distress. Officers saw their role in the first instance as *responding to the incident, triaging* the situation to ensure all were kept safe and then seeking a solution as to what was the right call to make. Initially, when *responding to the incident* for a person in mental distress, officers knew their skill set was adequate, appropriate at this time, and required:

> My role in working with the mentally ill person is something we have been doing since I joined the job. We have the tools we need if the person becomes violent to prevent any harm to themselves or others. In the community we have got restraints and things like that if they are a risk to public. It's kind of our job to create a safe environment and transport the person to get help from health professionals. That's all we can and should do. (22#[2017])

However, once the situation with the person in mental distress had been contained in the community with all kept safe, officers were then happy to transport and hand over the individual to expert mental health professionals at the hospital ED. At this stage, officers viewed their role with the person in mental distress and the part they had contributed to assist them, was now completed. By clearly delineating between what their specific role was and where it finished, officers were able to *maintain their professional boundaries*. In *maintaining professional boundaries*, officers understood their duty of care to the person in mental distress would be specific and limited. They understood they were not mental health professionals and unable to assist the person in mental distress any further. Officers knew they needed to stay within their job description and field of expertise by leaving the responsibility for such individuals to health professionals at the hospital:

> I am not an expert in mental illness so I don't conduct myself like I am. I see my role as rather just to support the person as best as I can … go to hospital and allow people trained in it to deal with them. (18#[2017])

> We transport them to the emergency department and just sit and talk to them – you know, not too much detail as that work is for doctors and the DAOs for them to find out what the person's problems are. (22#[2017])

Despite the *diverse expectations* with officers feeling they had to be 'all things to all people', when it came to dealing with other services, officers had a strong sense of keeping within their scope of practice and professional boundaries. Perhaps this was because police officers work for an organisation that is about maintaining law and order, where there are rules and regulations as to what they can and cannot do. Thus, officers conversant with working in a structured system applied the same approach when working with other services. There was a deliberate separation by officers of where their professional responsibility began with the person in mental distress, and when the responsibility needed to be shifted to another service. This type of approach was familiar to officers as they are used to *working within legislated parameters* and staying within their designated professional boundaries.

Officers constructed the handing over of the person in mental distress to health professionals at the hospital as their *maintaining their professional* boundaries and the completion of their role. There was the unspoken understanding at this stage by officers that "the responsibility for this individual is now with your service. You have the expertise and knowledge to further assist and treat this person – we do not have those skills or knowledge". One officer articulated these sentiments:

> We are just there to hand them over to people that know what they are doing regarding the mental health side of things. We are not the experts. We do what we can to control the situation at the time. I believe that we are there to hand over to someone who is going to give them long-term care and help their mental health and

> wellbeing. I think that it is our job just to keep them calm, give them to people that know what they are doing and can help them out with ongoing treatment. (15# [2017])

However, without specialist mental health assessment skills, officers found working with individuals with personality disorders, difficult. Often, the individual with a personality disorder may display extreme behaviours, as described previously (p.7). Frequently, these individuals were also known to the officers. Although officers suspected that the individual would be discharged as they would not meet admission criteria for mental illness, it was not for them to make this call. Nevertheless, it was not unusual for officers to be recalled to such an individual many times after the individual had been discharged. "Chasing our tails" was how several officers defined this challenge. However, officers always persisted time and again with the safe and cautious approach of transporting these individuals to the hospital ED to be assessed:

> Ninety percent of the time we take such individuals with bizarre behaviours that we think are mentally unwell, they are discharged. Frustrated is not the right word, it makes me feel disheartened but that is also not the right word because, I will still carry on. I just keep trying the same thing. If it takes three or four times then, unfortunately that's what it takes. It's quite often people get assessed and then released pretty much immediately and then we have to take them back again. (18#[2017])

> We have one case where we have had 29 calls from this individual in the last 2 to 3 weeks. She will be running down the road naked in the middle of the day screaming yelling abuse trying to outrun all the cars on the road saying she has been raped. We can't ignore it even if we have spoken to her 28 times in the last two weeks we have to follow the right process. Staff at the hospital know her well so, we ring them on the way as we are bringing her down [to the ED]. (14#[2017])

Officers viewed working with personality disordered people who were demonstrating extreme behaviours as frustrating. The frustration for officers came from being unable to accurately determine if the symptoms a person was displaying came from their experiencing a mental health crisis, or if the individual had a personality disorder. Without being mental health professionals, officers had to rely on their instincts. At times, after transporting the individual to the hospital ED to be assessed, the outcome was not what officers wanted. This was because frequently individuals with a personality disorder, who were displaying extreme behaviours, were quickly discharged. These individuals took up much police time, resources and tested officers' patience. Concerns were expressed by this officer about the situation:

> The hardest ones to deal with are ones with behavioural issues. They are definitely a lot harder because you can't tell them to do anything and they take up so much of our time and resources. (6#[2017])

Although working with personality disordered individuals displaying extreme behaviours was a reoccurring, and at times, frustrating scenario for officers, they accepted it and viewed it as

their *fulfilling a duty of care* by *doing your best* to keep all safe. At times, *making the right call* and *maintaining professional boundaries* with these individuals was difficult for officers. This was due to the complexities that surround this diagnosis. However, overall working with persons in mental distress and *maintaining professional boundaries* officers found was getting increasingly difficult. This was due to the growing *diverse expectations* officers must shoulder. The following dilemma was what officers confronted daily:

> It should just be we pick them up and transport them – it's more a transport and safety thing. We are now being social workers come counsellors and that's not something I believe we should be doing. Happy to do it but not trained – it is out of our practice scope and could have a negative impact for the mentally ill person. (19#[2017])

Despite these frustrations, officers continued *doing their best* to *make the right call* by *maintaining professional boundaries*, and *meeting obligations* notwithstanding having to *navigate* and *negotiate challenges* to keep all safe. However, what also emerged from the data was that *making the right call* had another aspect to it – *learning on the job*. When *responding to an incident*, new officers were *learning on the job* how to work with a person in mental distress.

Learning on the job

The second property of *making the right call* is *learning on the job*. There is an ever-growing amount of contact officers have with persons in mental distress and "30% of calls to police are in some way or other affected through mental health" (14#[2017]). However, officers training and *learning on the job* would appear to be disproportionate to the many complex challenges they are presented with on a daily basis. Some acknowledged the limited training at Police College from people with the lived experience of mental illness, as helpful. Part of officers' training involved a number of people who have experienced mental illness coming and explaining how it was from their perspective and how police could best assist them:

> When you go down to Police College in Wellington, they do actually have a number of people who have experienced mental crisis and actually speak to you. They try to explain to you how it is from their point of view, so that helped. (21#[2017])

Nevertheless, as one officer commented:

> Like any form of training, it's hard to put it into context until you actually deal with the people themselves. It's like riding a bike, until you have actually ridden the bike for the first time, you don't know how it is. (12#[2017])

Officers considered their training at Police College as focusing more on aspects of training recruits on their legal rights and powers under the Mental Health Act (1992). Officers deemed the training given at Police College lacked the practical aspects of how to manage and *respond*

to an incident involving a person in mental distress. There appeared to be the assumption by senior officers at Police College that further learning and skills would come from *learning on the job* once the trainees were on the frontline:

> We don't have a large amount of training at college. We are trained on the law, we're trained on the use of force around mental health, we're trained on the books of the law, the policy and everything else we are told comes from experience. (6#[2017])

Although officers felt their training of how to work with persons in mental distress came from *learning on the job*, all were receptive to, and thought more practical skills training would be helpful and give them a better skill-base to work from. Officers acknowledged that there was now some online training that they found useful to some degree. However, they still felt this type of training did not give them the practical skills they required in working with the person in mental distress. The officers overall view of the online training was that whilst useful, it did not replace observing and *learning on the job* from experienced officers. Perhaps this view is not unexpected. After all, frontline policing is a skill grounded in a practical application as to how to *fulfil a duty of care*, *meet obligations* and *make the right call* involving a person in mental distress to keep all safe. Officers accepted that the best learning of how to work with persons in mental distress was a skill they acquired on the job from more experienced officers:

> We are given training through our computer systems as to know what our powers are and how to manage situations. We go through scenarios on our computer systems as to what is the right thing to do. It doesn't go into the extent of detail of this is what you have to do when you are there at the hospital, or the options you've got at the hospital, but having an experienced officer with you makes a bit of difference as to how you manage the situation. (19#[2017])

> There is some online training, but there doesn't seem to be any real training in regards to how to cope with mental health patients. It's about custody management and stuff like that, but there doesn't seem to be any formal training in regards to dealing with mental health patients. I guess the real skills that you have is just your experiences once you start dealing with a lot more people. Just your compassion and stuff like that, but there's nothing other than some online training. There doesn't seem to be any real training in regards to how to cope with mental health patients. (12#[2017])

Some officers doubted whether more training in recognising the symptoms of mental illness would assist how they worked with persons in mental distress. Officers considered the situation of working with these persons as such a big subject that just doing it, and *doing your best*, was how they gained more experience and *learnt on the job*.

For officers who previously had little or no experience with mentally ill people prior to joining the New Zealand Police, *learning on the job* was how they "learnt what to do" (22#[2017]). As reported by this senior officer: "knowing how to work with the mentally ill person is from observation and what I have learnt in my years in the Police" (11#[2017]).

Sometimes previous life experiences assisted with how officers worked with the person in mental distress. Several officers spoke of believing they had a deep understanding of people experiencing mental illness that has not come necessarily from *learning on the job*. They credited their understanding as coming from previous careers they have been in, or personal experiences of having a family member with a mental illness. These officers assumed that these prior experiences provided them with extra empathy and knowledge of how to best handle and communicate effectively with the person in mental distress. Having this extra dimension of previous life experiences with the mentally distressed person somehow seemed to enable officers to feel more confident in working with these individuals, and indeed, find job satisfaction in being able to assist them:

> I use my life experience and that helps. I have had some prior mental health training through a local organisation I have worked with. It's like we are just people and I hope I joined the police force to help people and make their life better, and if that means that we can help someone out of a mental health crisis then that's awesome. (20#[2017])

> For me personally it would be down to my experience and knowing some friends that have gone through mental illness. So, I'm able to understand and empathise with them on a different level compared to someone who might not have seen anything like that. I definitely think that personal experience plays a big part… It doesn't matter… even if you are new to the job … it doesn't have to be police experience, it could be your own personal life experience, having mums, dads, relatives that may have gone through the same thing and you've seen them and grown up around it. (19#[2017])

An officer with many years of experience acknowledged that new officers on the frontline with previous experience of working with persons in mental distress were able to ascertain quickly how to work with these individuals and *make the right call*. The past experiences of these officers meant that often, on the job training simply added to their existing skill-base of how to work with these individuals:

> For a new cop who has just come on the street it would depend on what their background is and what they have done and experienced in the past how quickly they learn what to do with the mentally ill individual. (14#[2017])

Overall though, as the data indicated, officers believed much of their knowledge of how to work with persons in mental distress and *make the right call* came from observing experienced officers and following what they did. This officer validated such a view when he stated "having an experienced officer with you can make a big difference as to how you manage the situation correctly" (19#[2017]).

However, it was not always possible for officers to have a senior, more experienced officer out with them. Officers put this down to a lack of resourcing, the attrition rate of senior staff and the redeployment of frontline staff to other positions within the police organisation:

> In theory you should have someone more senior with you for a period of time until you have been exposed to these situations, but that doesn't always happen. Senior staff leaving or going from the frontline situation to other jobs and not being replaced leaves gaps. (6#[2017])

Officers expressed a desire for a different type of training. They would like more knowledge about the basic symptoms of persons suspected of mental illness and "real life situation scenarios" (19#[2017]) to supplement what is presently available to them. Despite feeling bombarded with training in the many different aspects of their work, officers voiced it would be helpful to have mental health professionals give them more understanding of the different presentations of mental illness. Officers themselves believed that they lacked adequate training in working with persons in mental distress. They wanted to know how to recognise mental illness, how to deal with psychotic behaviours, handle violence with these persons and what to do if the person was suicidal as evidenced by these two officers' comments:

> More training is necessary. Police need a reboot on this kind of stuff – just flip it on its head and get training that is going to get through to us as everyone has different ways of dealing with things. It's just reinforcing, getting more knowledge and maybe a new outlook on training on how we deal with those having mental health episodes. It's also about your own life experiences. (16#[2017])

> I would like to have more understanding of mental health for police in general from professionals. Especially for us in the frontline on how to talk to them in a better way, what signs will show if they are starting to get aggravated or triggered. (17#[2017])

Officers believed that *learning on the job* assisted their knowing how to *make the right call* and *meet obligations* whilst *navigating* how to *do your best* to keep all safe. However, there were still challenges for officers that required *negotiating* and *navigating* on their arriving at the hospital ED with a person in mental distress. These challenges are discussed and expanded upon in Chapter 7.

Summary of meeting obligations

In the theory *doing your best*, individually, professionally and societally, officers must constantly *navigate* how to keep all safe. They did this through *meeting obligations* when *responding to an incident*, *fulfilling a duty of care* and *making the right call* when working with persons in mental distress.

When *responding to an incident* involving a person officers suspected of being mentally distressed, *meeting their obligations* involved officers *triaging* the incident from a policing perspective and deciding what *discretionary powers* should be invoked. If officers decided to transport the person to the hospital ED to be assessed, there were agreed *procedural protocols* between police and the local DHB to follow. Nevertheless, when *responding to the incident*,

officers must also *fulfil their duty of care*. This entailed officers *protecting society* by *working within their legislated parameters*. However, at times officers felt burdened by the *diverse expectations* placed on them from the public, mental health services, hospital ED staff and sometimes, their own police organisation.

However, officers accepted that working with those in mental distress was now part of their core policing duties. They understood the importance of *making the right call* with these individuals, and that this involved their *maintaining professional boundaries.* In order to keep all safe, officers were careful not to blur boundaries. They realised they were not mental health professionals so stayed within their policing expertise and legislated requirements. The responsibility to assess the person in mental distress was left to the hospital health professionals.

Yet, officers wanted more skill-based training in how to work with mentally ill people. They viewed their brief training at Police College and some online training later as inadequate. Moreover, all felt that *learning on the job* from experienced officers, or for some, from personal experiences, was how they acquired their skills of working with persons in mental distress.

However, what also emerged from the officers' stories of *meeting obligations* were the challenges officers had to constantly negotiate. When initially *responding to the incident* in the community for the person in mental distress, officers worked autonomously. However, on arrival at the hospital ED, this autonomy was relinquished. One of the challenges officers were confronted with in this setting was the requirement to wait with the individual in *a caretaking role*. Furthermore, *working interprofessionally* with hospital staff meant officers took instructions from charge nurses. These challenges created tensions for officers that constantly had to be negotiated and navigated as identified in the following chapter.

Chapter 7: Findings

Negotiating Challenges

Introduction

Negotiating challenges is the second category of the theory *doing your best*. This category examines how officers negotiate and navigate challenges presented when working with persons in mental distress within the hospital ED whilst *doing their best* to keep all safe. The category of *negotiating challenges* is specifically about what occurs for officers when working with persons in mental distress within the hospital ED.

A caretaking role and *working interprofessionally* constitute the two subcategories of the category *negotiating challenges. A caretaking role* for officers occurred while they were waiting with the mentally distressed person to be assessed by mental health professionals. *Working interprofessionally* during this time required officers to take orders and direction from health professionals in this ED setting. Each of these subcategories has properties that detail how officers understood, navigated and negotiated how they worked with these challenges. Table 6 illustrates the subcategories and properties of *negotiating challenges.*

Table 6: Negotiating challenges subcategories and properties

Category	Subcategories	Properties
Negotiating challenges	A caretaking role	• *Accommodating the ED environment* • *Getting alongside* • *Waiting frustrations* • *Obtaining permission to leave*
	Working interprofessionally	• *Managing our respective roles* • *Misunderstanding of police powers* • *Lacking clarity of organisational protocols*

There were also challenges to negotiate related to the current directive requiring all police officers to transport persons in mental distress to the hospital ED for an assessment by mental health professionals. However, officers generally understood the directive to be working well. One reason for officers' positive responses to this directive was that they regarded it as a better option than taking such individuals back to police cells to await an assessment by a

DAO. From the data, it emerged that all officers concurred with these two officers' statements below:

> In terms of being directed to take them to the ED I'm happy with that … if something goes wrong we've got all the health resources at hand. A lot of times they don't just have one reason why they are there. They might have some medical condition as well. For me it's quite good to be able to take them to the ED for processing and it does mean we have peace of mind they are going to assessed by a mental health person. (19#[2017])

> Looking from a police perspective it is probably better, because taking someone to a cell that is unwell, it's going to make them further unwell and increase whatever anxieties are going on. I think it's better we're taking them to hospital, making sure we continue that relationship where we can communicate freely with them. To be honest in the last year it has been better, I have found. (16#[2017])

The first subcategory of *negotiating challenges* was officers being directed by hospital staff to *a caretaking role* for the distressed individual. This role began almost immediately when officers arrived in the hospital ED.

A caretaking role

A caretaking role (subcategory) is defined as an officer(s) looking after the person in mental distress in a designated room within the hospital ED. Being placed in *a caretaking role* occurred while officers waited for mental health professionals to assess the individual. Officers understood that the *caretaking role* they were assigned in this setting as their obligation to *fulfil a duty of care*. This duty of care also incorporated *doing your best* to achieve the central motivator for all police officers—to keep all safe.

In analysing the data, four properties emerged detailing how officers worked in *a caretaking role* within this setting. These four properties were: *accommodating the emergency department environment*; *getting alongside*; *waiting frustrations* and *obtaining permission* to leave.

The *caretaking role* by officers for those in mental distress has become an expectation from hospital ED staff. Quite frequently this has resulted in officers waiting several hours in the ED until the individual had been assessed. Officers were constantly *negotiating* and *navigating* with hospital staff as to how long they must remain in this *caretaking role*, and how soon they would be able to *obtain permission* to leave and continue with other policing duties. However, the initial challenge for officers to negotiate in this *caretaking role* with the person in mental distress was *accommodating the emergency department environment.*

Accommodating the emergency department environment

The first property of *a caretaking role* is *accommodating the emergency department environment.* 'Accommodating' was a term used to describe how officers worked in the ED. In this context, 'accommodating' refers to officers having to adapt to working in *a caretaking role* within this environment for the person in mental distress. However, working in this environment presented a challenge for officers. All officers were very familiar with working in different environments and used to giving orders and following instructions in their line of duty. In this environment however, officers must accommodate being told what to do by the charge nurse and mental health professionals. As this officer explained: "We are there [in the ED] to do whatever we're told to do basically" (12#[2017]).

There was also a bit of uncertainty from some officers as to whether the entire ED was classified as a public place. If this were the case, officers were entitled to use their given *discretionary powers* in this setting. One officer pondered about this dilemma and stated "The waiting room would be classified as a public place. Once you are around the back though I am not entirely sure" (14#[2017]). Yet, most officers were in agreement that the entire hospital ED was classified as a public place, thereby entitling officers to *use discretionary powers* if necessary. Nonetheless, officers tried to avoid using force in this environment. They were very aware of the need to keep the person in mental distress calm to avoid upsetting the individual, or put others at risk that were accessing or working in this department. This officer explained the rationale for a cautious approach when working with a person in mental distress in the ED:

> I understand the emergency department is a public place because it's able to be accessed by the public. We are more vigilant in ensuring the person in crisis is calm in the emergency department as we do not want them causing any distress or harm to other patients or staff. (22#[2017])

Although officers have a professional duty of care to *do their best* to keep all safe, in the ED, officers interpreted their role in this setting as being somewhat peripheral in nature. This was because the hospital ED is about assessing and treating the person in mental distress. When *accommodating the hospital emergency department environment* in their *caretaking role* officers are not trained or permitted to assess or treat these individuals. Mental health professionals are trained for this role. Officers are consigned to a 'back seat' caretaking position in this setting with the persons in mental distress and required to take directions from those with the specialist skill sets. Two officers explained how they understood their role here:

> You are in the ED so the mental health patient is under their care now. Even though the DAOs are dealing with them you can't do much, just wait. It's their show. (6#[2017])

> Our work there is purely just to make sure the patient is happy and safe and he/she gets the help they need. We are by no means mental health professionals, but we are just there to make sure that they are safe, and the staff are safe. (13#[217])

On arriving at the ED, officers negotiated with the charge nurse as to which entrance they were permitted to use. Their two options were the ambulance bay or the public admitting area. Some officers preferred to use the ambulance bay as they believed this allowed the person in mental distress a little privacy. One officer explained why he felt it necessary to use this entrance: "It might reduce the anxiety of the person because it is a very personal time and there are often many people in the waiting area" (16#[2017]). However, another officer came from a different perspective. This officer identified that using this entrance may put the officers themselves at risk:

> Taking the mentally ill person through the ambulance bay can put us at risk. One officer still has to line up and say "We have a mentally ill person out the back door." If the person is agitated, two officers are now separated, and that sort of puts us at risk. 21#[2017])

There were two different perspectives here. One came from a personal perspective, and the other from a professional perspective. However, the reality was that officers had little say as to which entrance they used, as this must be negotiated with the charge nurse of the department. Once this had been decided, officers then accompanied the individual to what is known as a 'secure room'. Therein began the next challenge for officers who found working in this environment challenging.

All officers found the allocated secure room and the layout of the ED gave rise to privacy and security concerns. These concerns were for both the person in mental distress and the public using this facility. Officers believed that with the secure room being close to where other patients were, if the person in mental distress became violent, everyone was at risk. Officers were also acutely aware that many members of the public in the ED could be very unwell. Having a person in mental distress near them, whose behaviour was escalating, could be detrimental to these people. Two officers expressed their thoughts on this predicament:

> Biggest issue for us is managing really ill or violent mentally ill … it's a hospital still being used by the public … dealing with a person who is mentally affected, it's not a secure environment. It puts people at risk and it even puts us at risk. The people we are dealing with who are often screaming, kicking and handcuffed are only 5 metres away from people with curtains drawn. It must make these people very uncomfortable … the hospital has got the medical care for the mentally ill but, not secure units. Mentally ill need both … need a separate facility built off the hospital with secure rooms just for really difficult people. (7#[2017])

> Some people are mentally gone … ED is not a safe environment to be able to restrain them if we need to … not the mentally ill person's intention to harm people, but a

> worry for public safety. You have frail people in the ED and you are walking these people through, yelling … affecting the public. I think it is a scary place for mentally ill also … we have nowhere in ED to hold them properly where they could be monitored well. We don't have a lot of powers around how we can actually restrain them, or what you have available in ED. (21#[2017])

Officers believed a separate entrance and secure room away from the general public needed to be negotiated with those who have the ability to make this change. If force was needed to control the individual, it would then not be done in public view. Officers believed this approach would assist in avoiding the person's behaviour escalating and upsetting those in the ED. Moreover, from the data, it was evident that officers were sensitive about placing the person in mental distress in a situation that may cause the individual to feel humiliated in front of others. This was seen in the following comments:

> It would be nice to put them somewhere separate. You know you are walking these people in and you go to the triage desk and you go "It's John Smith he is having some issues" and the lady behind the counter has had a long day. You are trying to be subtle and allow the person some privacy. She says loudly in front of others "Just tell me what is happening, is he threatening to kill himself". (13#[2107])

> When I may have to handcuff them, I try to do it where it's not in the view of the public for their safety and mine. I don't want to upset them in front of the public. We are definitely accountable for the way we treat them and we need to look after their safety as well. (20#[2017])

However, *accommodating the emergency department environment* while in *a caretaking role* also involved officers *getting alongside* the person in mental distress. *Getting alongside* had several benefits for the individual and the officers.

Getting alongside

The second property of *a caretaking role* is *getting alongside*. This is the term officers used to describe working and communicating with persons in mental distress in the hospital ED. There were overlapping personal, professional and societal motivators for officers *getting alongside* the individual. For some officers, it was about 'humanising the blue uniform' when working with such persons. Sometimes, the officer's motivation for *getting alongside* was due to a personal experience with a family member who had experienced mental health issues. However, whilst humanising the blue uniform with the person in mental distress, officers were also able to build trust and gather information for the police database. Any information gathered provided officers with some background knowledge should they encounter the individual again. Furthermore, officers found *getting alongside* and humanising the blue uniform with a mentally distressed person assisted to calm and minimise the risk of the individual harming themselves, or others in this environment. Two officers with some personal

experience of people with mental illness demonstrated how they get alongside the person in mental distress:

> Getting alongside the person begins in the community and at the hospital. I always come from the empathy, not the authoritarian side, and talk and find out about them. From a personal experience I want to break down the barriers so they don't just see me as a uniform when there is a crisis. We can often just be seen as someone who is going to lock them up – some do that! I remind them I am here to protect you – that's my job. Generally, people respond better and calmer because we are treating them like humans. (16#[2017])

> Just sit and chat – they feel more comfortable, I know from personal experience and they [mentally distressed persons] are calmer with you once you start to show you are a person too, not just a uniform. (22#[2107])

For other officers with little or no personal experience of dealing with people in mental distress, the motivator for *getting alongside* the person was simply to establish some sort of rapport and trust with the individual. The rationale for this approach was to improve the individual's reaction to the blue uniform should they meet again in the future. Below are quotes from two officers explaining why they viewed *getting alongside* the mentally distressed individual in the hospital ED as being important:

> Normally we just try and build a rapport with them. You try and converse and find out what incidents have triggered what happened today or what's happening in their life. We know we can't help them then but if they come to the police attention again, we're more informed as to what is affecting those. (19#[2017])

> So, I'll talk to them and the next time if we pick them up, I'll ask them about the things they told me previously. I find it builds up a big trust and then they are more willing to come with you next time. (18#[2017])

Conversely, some officers felt *getting alongside* with the person in mental distress simply meant sitting outside the room of the individual in the hospital ED. For these officers, *getting alongside* did not necessarily involve being in the same room as the individual or trying to build a rapport with them. Indeed, they viewed this as possibly aggravating the person:

> Generally we sit outside the door to give them space. Police presence normally aggravates someone like that especially if they are sitting there for a long period of time. So we give them space and privacy, but still doing our job and try and contain them in that room to protect everyone. (6#[2017])

> If they [mentally distressed person] are not in the right frame of mind, or if they don't want a bar of us, we just sit outside the room and pretty much just wait until we are allowed to go. (2#[2017])

However, when *getting alongside* and working with the person in mental distress, "listening and actually showing you are listening" (22#[2017]) was one way officers displayed empathy

towards the individual and they used this approach to build a rapport. Perhaps the use of this communication tool was because "empathy is a core value for New Zealand Police" (15#[2017]):

> We are trained to be empathetic, listen and to understand the mental health patient's response to a situation. I think a lot of the way I talk with them is a personal thing and it's just the type of person I am. (4#[2017])

Many individuals escorted to the ED in mental distress appeared to appreciate the empathy and compassion officers displayed towards them. In general, an officer's altruistic approach towards working with persons in mental distress emerged throughout much of the analysis as seen in the following two quotes:

> A lot of people who we have taken to hospital tell me that they feel we listen to them more than [named service]. They say they get a better experience from us and a more sympathetic ear. Most of us joined the job to help people. The mental health system in New Zealand is not working and these people can't get help. So, I feel it's nice to offer an ear and listen and take them seriously as I think they need a little bit of hope. (17#[2017])

> In speaking to people sometimes they say, nobody has ever listened or they treat us like rubbish. And it's not just [name of service], but it might be their family or someone else. We get comments like "I can't believe how much you helped us, and you haven't judged us." (20#[2017])

However, *getting alongside* the person in mental distress whilst in *a caretaking role,* was often done while officers waited. One of the greatest challenges officers negotiated in the hospital ED when working with a person in mental distress was the frustration of having to wait or "hanging around" as it was referred to by officers, until the individual was assessed.

Waiting frustrations

The third property of *a caretaking role* is the associated *waiting frustrations*. The very nature of the ED is that it is always very busy. Thus, officers often waited several hours in the ED until health professionals had assessed the mentally distressed person. Not until the assessment had taken place were officers released to return to their other duties in the community. Waiting involved at least two officers staying for several hours often in *a caretaking role.* Officers understood that the primary reason for waiting was to ensure the person did not harm themselves or others in this setting.

Officers indicated there was a MoU with the District Health Board (DHB) and local police district stating that hospital security should take over from officers within an hour of their arriving. This rarely happened. Emerging from the data was that frontline officers and even their senior officers were unaware of what exactly the MoU says. This was because they had not sighted it, nor did they know what it looked like or whether it was available online:

> We don't really know if there is a memorandum of understanding, or you know what the latest is as to whether the police must do this, or mental health must do that. Like I say, on the frontline we don't really know what is in place for us. (12#[2017])

> I guess the MoU states how long we should be waiting. I wouldn't know what it looks like. So, if I don't know I am assuming a lot of other [senior officers] don't know. There is a lot of stuff on our computer system, but I would be quite confident that a lot of senior officers don't know how to access that MoU either. (14#[2017])

Waiting in the ED environment with the person in mental distress essentially contained the situation for officers. If the individual had accompanied the officers voluntarily, there was often no requirement by the charge nurse for officers to wait until the individual was assessed. However, when officers detained an individual using Section 109 of the Mental Health Act (1992), officers had to remain until they had been assessed. Officers acknowledged and accepted their professional obligation to wait if they had detained the individual under Section 109. Nevertheless, some officers suspected they were being used in place of the hospital security guards, or indeed used as 'baby sitters' until the person in mental distress was assessed:

> It's a cross over between us and mental health. It seems to me because I'm on this side, the police side, that it feels like the responsibility falls on us and they [mental health services] know it. And they know we are not just going to leave somebody there and dump and run. We have a duty of care. I think they play on that and they rely on us to babysit. (17#[2017])

When analysing the data, it emerged that officers frequently referred to *waiting* with the mentally distressed individual in *a caretaking role* as 'babysitting'. However, babysitting should be interpreted in the context in which officers used this term. The interpretation was that officers used this as a non-specific term. The context in which officers used this term was not meant to be derogatory to the person in mental distress, nor was it meant to relate to them as 'an infant'. It was simply officers' terminology to describe the *frustration of waiting* several hours in a *caretaking role* for mental health professionals to arrive and assess the individual. The underlying innuendo was that officers felt that their goodwill was over extended on occasions, as mental health professionals relied on the fact officers would not leave until they arrived.

Officers found it frustrating having to often negotiate and challenge hospital staff as to how long they must wait with the person in mental distress. While waiting, officers were required to keep their police radios on. Officers would hear their colleagues requesting assistance to a particular job, but were unable to assist. Officers acknowledged waiting in this *caretaking role* could be frustrating. One reason for this was that it essentially prevented them being able to

attend to other policing duties in the community, or help colleagues who were requesting assistance. These officers expressed their frustration with this situation:

> The radio doesn't stop for us to respond to priority jobs in the ED. It is frustrating when mental health needs our assistance. It prevents us from servicing the rest of the community and especially priority calls for police assistance when we are stuck, essentially babysitting someone on behalf of mental health. (11#[2017])

> It is quite frustrating sometimes having to sit in a hospital for four hours. But I understand why we have to do it … and, I guess numbers-wise, we lose two people [officers] you know doing work helping people on the street because we have to sit with this person in the hospital doing nothing. (2#[2017])

In the ED, waiting proved to be a constant challenge and frustration for officers. In some situations, the person in mental distress posed no security risk and was co-operative with staff. Yet, officers were left waiting several hours for the individual to be assessed. It had somehow become accepted that "officers will always stay until the assessment is done" (20#[2017]). Officers believed there was a preference by staff for getting police to wait instead of using security guards. Officers surmised this was because hospital staff assumed it was only police that have authority to use force if necessary:

> There are nurses at the hospital that won't let you leave because they want police there, not security. I can understand that from their point of view as we can use restraints. But then, we become babysitters for up to 8 hours which is not good use of our time. (6#[2017])

> Ambulance staff never wait around. There is no expectation on them. Police are seen by nurses as being allowed to use force and hold people there, so there is more expectation on us to provide a security service. (18#[2017])

In many situations from a policing perspective, it was the officer's assessment that the individual posed no risk in this environment. In these situations, officers viewed waiting with the person in mental distress until an assessment was completed as wasting police time and resources. This officer summarises the frustrations that many officers voiced of having to wait at the ED for long periods of time:

> It's frustrating spending a lot of time unnecessarily in the emergency department with somebody. Sometimes I spend an entire shift in the ED when I have taken a mentally ill person in. I have spent many shifts where the whole response team are at the ED at the same time. We are waiting for the CATT team to turn up … It is a real waste of police time, not in terms of helping the mentally ill person, its inefficient for us. I'm an emergency responder I should be out there. (15#[2017])

It was interesting to note that despite officers' *frustrations of waiting* in a *caretaking role* for the mentally distressed individual, they understood they must stay until an assessment had been conducted. During the time of waiting, officers also ensured all those in the ED were kept safe. Officers' construction of 'all being safe' came not only from a policing perspective, but

incorporated the perspective of health professionals who have the expertise in this environment.

For some officers, waiting with the person in mental distress had both personal and professional aspects to it. From previous personal experiences, these officers viewed people with mental illness as unpredictable, and as such, a risk to staff in the ED. They felt a personal, professional and moral duty to wait until they felt assured that all hospital staff were safe. Although wanting "to get out on the road as fast as possible", as one officer explained "we need to stay to keep the hospital safe" (4#[2017]). Unless officers were completely satisfied that the person in mental distress posed no risk to self or others, they waited in this *caretaking role* as seen in the following comments:

> I understand the nurses and their fears for safety and so on. If my partner were a nurse I'd be worried about her safety if police dropped a person who is mentally disordered and left. The danger with a person with a mental health issue is that they can change at any point. It's just there's a risk, quite a real risk taking a mentally ill person to ED. (18#[2017])

> We wait for instructions from them [charge nurse]. However, we don't want to leave a situation where we are not happy because, they [the mentally distressed] may pose a risk. So, absolutely we will stay for that. (16#[2017])

However, another challenge for the officers was negotiating with mental health professionals how promptly the assessment could be conducted so they could resume other policing duties. At times, waiting for a DAO to assess the individual may take several hours. Further adding to officers' frustrations was not being kept informed as to when the assessment would be completed. Officers perceived this lack of communication as irritating. One officer's view of this occurring was: "I think they play on it and rely on us to baby sit until they are ready to let us know when they will come" (17#[2017]).

Furthermore, officers also observed that waiting several hours in the ED affected the behaviour and mood of the person in mental distress and decreased their trust in the officers. Aside from the individual being in an isolated special room, officers noticed an elevation in the individual's anxiety and aggressive behaviours when the assessment was delayed. Moreover, not being able to advise the individual when the assessment would take place was frustrating for both. The impact of waiting, feeling ignored and not informed as to what was happening was voiced by one officer:

> They are wondering what is happening, we are also wondering. They are asking us what's happening, we can't answer them as we don't know. The time factor does play quite a bit of how their mood changes. If someone is waiting 2 to 3 hours, they are wondering "Why am I inside this room, why is no one coming to see me?" If someone would say "We are going to be a bit delayed" that would be better than not hearing

> from them. It causes agitation and they get a little aggressive towards us because they then don't believe they are there for mental health. They believe they've been locked up for something else and they are trying to piece everything in their mind and we are unable to give them a direct answer. (19#[2017])

Police officers are not used to sitting around waiting. Officers expressed a sense of guilt and frustration whilst waiting in the *caretaking role* for the person in mental distress. Being unable to assist their colleagues out in the community felt like 'letting the team down' as this officer explained:

> I don't feel it is a waste what I'm doing in terms of helping that person but it is inefficient for us hanging around. I'm an emergency responder, I should be out there. The more I'm at the hospital the less time I am being visible. While I can't respond to other jobs other calls to service to help colleagues it's very frustrating. You want to help them but you can't. You spend hours there just waiting for the CATT to turn up because they are busy or something. (17#[2017])

Aside from being unable to help their colleagues, at times it was also mentally draining for officers if the person in mental distress was agitated and an officer was unclear of what was going on for the individual. Officers felt unable to assist except by ensuring the individual and others did not come to any harm. However, as voiced by this officer, it could be mentally taxing:

> You are dealing with something you are not trained in and they [the mentally distressed] are very full on and ranting. It can then start to be a little hard to deal with 4 hours of that without a break. Especially if you are a newer officer, you'll tend to get left with the person more while the other officer's out dealing with the paperwork or what they can do with other jobs over the phone. Sometimes you need a mental break from it. (21#[2017])

However, most officers were resigned to waiting with the person in mental distress. Although struggling to see waiting as a productive part of their role, officers accepted it, particularly if they had detained the individual under Section 109:

> Waiting with mentally ill people is a bit hard to think of as part of our role. Feel like we are babysitting them a bit. Fair enough if we have detained them under the Mental Health Act and we are responsible for them until we release them to mental health. I don't really mind because at the end of the day I'm trying to help them. So, I've been able to construct it as being part of my role. It is just something that most of us have had to adjust and adapt to. (19#[2017])

It was not uncommon while officers were waiting with a person in mental distress to have Comms call inquiring how long the officers were going to be at the ED. Generally, officers understood that the call was usually made because they were the only police unit available to attend an emergency. The issue for officers here was that they were waiting with the mentally distressed person and were unable to leave without the individual having been assessed. This

was especially frustrating for all officers as seen in the following case, where the person had come voluntarily with officers to the ED, was not violent or a risk to themselves or others. Usually officers still had to wait until a DAO had completed an assessment on the individual. Only then were officers able to *obtain permission* to leave. The exasperation felt about this scenario is evident in the following comment from an officer:

> She was happy to sit there, yet we were not released. I had an urgent job, actually police communications calling me asking "How long are you going to be?". I guess waiting at the hospital having not been released by emergency or mental health staff was very frustrating for me. A person out there was in real danger and I couldn't get there. I am on the phone to the victim telling them I am at an emergency whereas in my mind I wasn't at an emergency, I just hadn't been told I could go yet. (20#[2017])

Obtaining permission to leave the *caretaking role* for the mentally distressed person was a challenge officers constantly had to negotiate and navigate. This was not a decision officers could make. The decision lay with others.

Obtaining permission

The fourth property of *a caretaking role* is *obtaining permission* to leave. In the ED it is mainly the charge nurse, the DAO and security who all need to be in agreement when the officers can leave. At times, it was difficult to get all three to agree. However, overall, officers understood it was usually the charge nurse of the ED who made the final call as to whether the officers were to remain in *a caretaking role* or be given permission to leave and attend to their other policing responsibilities. The word "dictates" and "we don't get a say" in the following quote, revealed how this officer felt about having to defer to the charge nurse's authority in this setting:

> The charge nurse dictates how long we stay. I guess it's for her nurses' safety and their safety and the safety of the people in the ED at the time. It's up to the charge nurse whether or not she feels they [person in mental distress] are going to play up. If they are agitated or aggressive or non-compliant then we have to stay. But, the charge nurse decides that, we don't get a say. So, if we stay for hours, we have to stay for hours. (2#[2017])

On occasions there was a feeling by the officers that the individual they had brought in was not a priority for ED staff or mental health services. Officers surmised this attitude from hospital and mental health staff may be due to their presence and knowing officers would control any potential aggression from the individual. There was the expectation from staff that the officers would remain caretaking the individual until they had been assessed and a decision made as to what was to happen. In this situation, officers realised that they were totally dependent on the charge nurse. How long they must wait was not something that they had control over. The

influence of the charge nurse in determining whether the officers obtain permission to leave is conveyed in the following quote:

> It can be a long wait; the person we have brought in doesn't get prioritised because we are there. Hospital staff feel they don't need to hurry. Charge nurses all have different ways of dealing with us. Some say go straight away, most prefer us to stay for a considerable time. Charge nurses have a big say in whether we have to stay or go. At the end of the day it is their ED. Also, mental health staff … they are very slow … don't get things moving if we are there. (8#[2017])

However, officers accepted the *frustration of waiting* until they had *obtained permission* to leave. They understood this to be just another challenge that constantly had to be negotiated and navigated with charge nurses in the hospital ED. Officers were philosophical about the situation, acknowledging "it will not change in a hurry" (16#[2017]). They understood it to be just part of the job of *meeting their professional obligations*, *negotiating the challenges* whilst constantly *navigating to do your best* to keep all safe. Officers appeared to be resigned to this situation as seen in the following comment:

> If you think negative about it, it's going to be a negative time. So, it is what it is. I know that when I deal with mental health patients, I may have to spend the night in hospital and there's nothing we can do to change it. So, the more negative you are about the situation, the more of an issue it's going to be. (3#[2017])

When in the ED environment, the officer's role is limited as they are not health professionals and the ED is after all a health setting. That is why officers transport persons in mental distress here to get the individual professional help and treatment from health professionals. Once officers handed over the person in mental distress to the health professionals, they understood their only role was to keep all safe within the ED. No longer did officers have authority over any other aspect than their safety role with this individual and others in this setting until relieved of this duty. Although working in this setting was an extension of their *responding to the incident* with the mentally distressed person, officers were no longer 'driving it'. However, *working interprofessionally* with their alliance partners in the ED presented officers with personal, professional and societal challenges. These challenges also required negotiating and navigating.

Working interprofessionally

The second subcategory of *negotiating challenges* is *working interprofessionally*. This is defined as officers working in collaboration with hospital and mental health professionals in the hospital ED with a person in mental distress. *Working interprofessionally* was not without its challenges for officers. From all accounts, the combination of police and health professionals should work well. There are similarities between both health professionals and

police officers that could assist them to work collaboratively. For example, both are there to protect lives, both are on duty 24 hours a day, 7 days a week and each is considered a professional.

Nevertheless, although there are many similarities, there are also differences between them. Officers are focused on the safety issues for the individual they have brought in, the public, staff in this setting and themselves. Nurses, on the other hand, are expected to look after the mentally distressed person's wellbeing and provide treatment. Sometimes officers found *working interprofessionally* in the ED could be challenging. The interprofessional relationship could become fraught from time to time. However, within this relationship there was an understanding between the two professions as to what officers were able to contribute in this setting in order to keep all safe.

When *working interprofessionally* and managing a mentally distressed person, officers had to communicate and collaborate with ED staff (namely the charge nurse), the community and inpatient mental health services. As often first responders to the mentally distressed individual, it was usually the police officers who first instigated the process of interprofessional collaborative working.

Negotiating and navigating the challenges of working interprofessionally consisted of the following properties: *managing our respective roles*, *misunderstanding of police powers* and *lacking clarity of organisational protocols*.

Managing our respective roles

The first property of *working interprofessionally* is *managing respective roles* within the ED. Police officers, ED staff and mental health services are interdependent on each other when working with the person in mental distress. However, each of these professions has their *respective roles to manage* within this hospital setting. When *working interprofessionally*, it was important that each profession reflected their specific area of expertise. Usually there is "a mutual respect for each other's jobs" (15#[2017]). At times when there was an emergency, these roles overlapped. Nevertheless, for officers, it was always about upholding the law and protecting all, as seen in the following quotes:

> Our work in the ED is just to make sure the mentally ill person is happy and safe and he/she gets the help they can get. We are by no means health professionals, but we are just there to make sure that they are safe and that staff are safe – that's our role in it all. We just hang around for police security and just there to make sure they [persons in mental distress] are just safe primarily, safe from themselves, also to make sure that the staff and public aren't in any real harm before we leave. (13#[2017])

> We are just there to hand over to people that know what they are doing regarding the mental health side of things. We are not experts; we do what we can to control the situation at the time. I believe that as police officers we are there to hand over to someone who is going to give them long-term care and help with their mental health and wellbeing. I think it is our job just to keep them safe and calm. (15#[2017])

Mental health and ED staff members' roles, as officers saw it, was to assess and treat the mentally distressed individual. For officers, it was important that each professional organisation *managed their respective roles*, yet worked closely and effectively together. Overall, officer's understanding was that each profession had *obligations to meet* to ensure the best outcome for the person in mental distress, and each had their *challenges to negotiate* and navigate in this quest.

Individually, officers constructed their role when *working interprofessionally* with the person in mental distress in different ways. Some viewed it as a positive experience; whereas others viewed their role in this setting negatively. It emerged from the analysis of the data that officers realised the importance of taking time to build a trusting relationship with ED and mental health staff. Officers found that building positive relationships between themselves and health professionals led to an easier and better working relationship. This enabled each professional to *manage their respective roles* in a timely and collaborative manner. One officer showed insight into the benefits of working collaboratively with alliance partners whilst *managing your respective role* in this setting:

> If you have built up good relationship with them [hospital and mental health staff], they are going to be willing to help you more so each can do their role. They'll go that extra mile or maybe speed up processes with security. There is a pretty direct correlation if you are nice to someone they are going to help you out. Our previous dealings with hospital and mental health staff affect how they are to us. Like I explained, with officers having a bad relationship that's always going to negatively affect their dealings because you know it's the same process and if you are dealing with the same person at the hospital, you are going to be getting the same response. (11#[2017])

However, at times, *working interprofessionally* for officers had the feeling of being in a combat zone. One example of this occurring was when officers were rebuffed by ED and mental health staff who expressed reluctance in allowing officers to bring the mentally distressed person to them for treatment and help. Officers recounted incidences where on occasions, the hospital staff or charge nurse challenged them as to why they brought the individual to the hospital when no physical injuries were apparent. Thus, from time to time, officers found themselves having to advocate for the distressed individual to get assistance for them at the hospital as they got "a bit of push back from certain nurses" (4#[2017]). Officers did, however, acknowledge that this type of challenge was not universal. They described it as probably being confined to a

few hospital staff members who had a different understanding than what officers had been told about their *respective role* under the current agreement between Police and the local DHB. Now and again, as one officer commented: "It feels like you are going against each other as opposed to working together" (11#[2017]). There appeared to be confusion between officers and health professionals about each other's respective roles and duties when *working interprofessionally* with the person in mental distress. Below, an officer articulated the confusion that sometimes existed when adhering to the agreed upon protocols and role when *working interprofessionally* with a mentally distressed person:

> Our understanding of the agreement is that the hospital is the place where they go even if they don't have a cut arm or a broken wrist. They still need to go to the hospital because that's the agreement we have. So just because he doesn't have any visible injury it doesn't mean he doesn't go to hospital. Quite often the nurses or charge nurse will say, "There's nothing medically wrong with them, why is he here?" (4#[2017])

Police officers are used to following rules and clear-cut directives from their superiors. The directive they have is that once they pick up a person suspected of being in mental distress, the next step in *fulfilling a duty of care* is to transport the individual to be assessed at the hospital. Now, every officer realised there was a distinct possibility they may have a long wait in the ED with the individual until they had been assessed. However, they accommodated this situation and the challenges that may present as all being part of the current agreement between Police and the local DHB. However, not every health professional was on board with this arrangement and officers experienced some "push back" (14#[2017]). Another officer further articulated their views of what was occurring:

> We have ED staff fighting us because they don't want them [person in mental distress]. We have mental health fighting us because they don't want them. Our understanding of the agreement is that hospital is the place where they go even if they don't have a cut or broken arm. Hospital staff don't have the understanding that we are not bringing people to them because we don't want them in the cells. We are bringing them to them because that's the rules and directive. (4#[2017])

At times, officers found the hospital staff and charge nurses very understanding and they assisted to minimise the officers waiting time with the mentally distressed person. These health professionals acknowledged that the officers needed to get out on the road again, and they did their best to achieve this outcome for officers. This attitude from health professionals signalled to officers that there was a mutual respect and understanding of each other's roles, as one officer demonstrated:

> Some charge nurses are really helpful, they want us gone. They are not saying we do not want police here; they are really respectful of what we need to do. But I think about what they need to do as well. We don't want to leave them with someone who is going to cause trouble, but every time recently they are very quick to get us replaced and get us on our way. There is a mutual respect for each other's jobs. (15#[2017])

However, some health professionals who were "just keen to get officers out of the ED" (15#[2017]) did not always have the authority to release the officers from their *caretaking role* for the person in mental distress. Therefore, in such instances, officers had to remain and wait until mental health professionals came to the ED and assessed the individual.

Regardless of the challenges presented from the directive, officers still constructed their role of transporting a mentally distressed person to the hospital ED as a positive action. They realised that the ED was an environment that did not criminalise those in mental distress, unlike a police cell. Officers considered the ED environment to be a safe place for the individual to wait until seen by mental health professionals. Although, as seen in the comment from this officer, while it was viewed as an alternative to a police cell, it was simply a better option:

> It's not really the emergency department's role to treat them because they are not mental health experts. It is somewhere for them to be other than the cells until mental health show up to speak to them. (15#[2017])

Nevertheless, often the extended waiting time in the ED for officers was due to lack of co-operation between the various mental health teams. Officers suspected these teams were very territorial in regards to what district the mentally distressed person was from, and as a consequence, whose role it was to do the assessment. Officers found this infighting frustrating. They were bewildered as to why mental health services did not work more collaboratively with each other. Although officers had carried out the requirements of their *respective role* with the person in mental distress, the infighting between health services affected the time officers waited. Only when this situation was resolved and the assessment had been conducted, did officers *obtain permission* to leave. Officers found this situation frustrating and challenging. As police officers, they understood the necessity for teamwork and were perplexed when others did not seem to understand:

> A lot of the time we are waiting on the [name of service] mental health team or the [name of service] mental health team who are trying to decide whose role it is to assess the patient from that area as it's not their jurisdiction. It shouldn't matter whose district it is; someone from a mental health team close by should be able to attend. I'm guessing they all follow the same protocols and procedures … it shouldn't matter who does the assessment as long as it's done. It's more the mental health staff where the issues are as opposed to the hospital staff. You would think as long as they are being assessed by someone qualified to assess then the other team could follow up with them later. If there's a call for service in any area wherever, then, that's what we as police act on. It's about the person calling for help. (12#[2017])

Officers found *working interprofessionally* with hospital ED staff and mental health services to be a "work in progress" (14#[2017]). One of the reasons officers believe this is that hospital and

mental health staff misunderstand the limited powers officers have when working with the person in mental distress.

Misunderstanding of police powers

The second property of *working interprofessionally* is a *misunderstanding of the powers police* have. Officers believed that hospital and mental health staff appeared to misunderstand the limited powers police officers have in regards to working with mentally distressed persons. This was a result of health professionals not being fully conversant with the legal and professional boundaries police must work within. Officers rationalised this misunderstanding as each organisation being focused on their own work, and having a limited understanding of the legal parameters of the others' profession. Examples of the legal parameters officers must work within are discussed in Chapters 1 and 6.

Nevertheless, on occasions when alerting the emergency and mental health staff of their impending arrival with a mentally distressed person, officers were asked if they could instead arrest the individual for 'something' (officers were unclear what the something was) and take them back to police cells to be assessed later. Officers were concerned that arresting the mentally distressed individual was considered as the first option by some hospital or mental health staff. All officers acknowledged the unsuitability of police cells for those with a mental illness if they were not violent, and no offence had been committed. Officers refused to be coerced into using the police cells simply to accommodate the schedule of hospital and mental health staff. Officers' thoughts on this were clearly expressed:

> Now, that shouldn't be arrest as the first option because it's just not practical all the time. We shouldn't be placing people who are appearing to be mentally affected in a police cell. I don't believe that is the right place for them purely just because no one is available to assess that person. (14#[2017])

> A lot of times there are certain nurses actually saying "Take them to the cells; we're too busy to deal with them". But police policy is we don't bring them to the cells unless they have committed an offence. Only if we are going to charge them then they can be seen in the cells, but, the cells are not the place for mental health patients to be assessed. (3#[2017])

From past experiences, officers knew that this request to arrest the mentally distressed person was made if the ED was busy and if there were no mental health professionals immediately available to conduct an assessment. The frustrations officers had here was both for the individual and themselves. They constructed this request as health professionals apparently misunderstanding the directive requiring that officers transport all persons in mental distress to the ED for assessment by mental health professionals. Furthermore, unless an offence had been committed, officers were legally unable to arrest the individual and take them back to

the police cells. Aside from these misunderstandings by some health professionals, officers felt it to be demeaning for those with mental illness to be treated as criminals. They also reasoned that taking the individual back to the police cells could potentially exacerbate the individual's condition, heightening the risk for all concerned. One officer voiced these concerns:

> One of the main issues is mental health putting it back on the police to say can you arrest them, can they be arrested for something, so they can be taken to our cells … The problem with us is we need to know first whether they can be arrested. If they are suffering from a mental disorder, we don't want to arrest them. We feel that for mental health, that that is an easy option for them, they [mentally distressed person] are placed in the cell, they can't go anywhere and then they [mental health services] can take their time to get out there and do the assessment. (14#[2017])

Legally and professionally, officers understood that arresting a person in mental distress who had not committed an offence, or was not displaying violence, was unacceptable. Moreover, officers knew that unless a crime had been committed by the individual, the Custody Sergeant would not readily accept them in the police cells. Custody sergeants also have strict criteria to adhere to. Unless an individual has committed an offence and been arrested or is violent, detaining the individual in cells is viewed as an unlawful detainment. A further deterrent for officers to bring a person in mental distress back to the cells unnecessarily was mentally distressed persons requiring special monitoring and a 'watch' outside their cell. As this officer commented, the Custody Sergeant would view this situation as unlawful, resource intensive, inappropriate and possibly creating a risk for all:

> Taking them back to the cells ties up resources for us. If the person is deemed to be high risk then we need to have frequent monitoring which is someone sitting on a chair directly outside their cell watching them 24/7 and that is resource intensive. The Custody Sergeant in the cells would be very reluctant to accept them if they do not fit criteria to be arrested … If yes, they do fit the criteria to be arrested and are violent then we would not take them to ED. We will take them to the cells. However, if they are not violent then yes, we will take them to the hospital. (14#[2017])

Overall, officers adopted a realistic and non-blaming attitude to the challenges needed to be negotiated arising from the misunderstandings that occurred from time to time between police, hospital and mental health staff. Officers acknowledged that although they get frustrated with these misunderstandings occurring, they presumed that ED nurses and mental health staff probably felt the same about police lacking understanding of their position or powers:

> At the end of the day it's not about assigning blame or anything, it's just the system is not working and it's incredibly inefficient. We all want the same thing, we want these people to get the help they need. (17#[2017])

> I think there's a little bit of misunderstanding between the agencies about what the other can do … it's quite easy for me to say that for sure mental health misunderstand

> the amount of powers that we have and what we can do. Same thing for nurses, they think that we have a lot more grounds to do things. But I would argue that would probably be the same way for us. Police staff generally think that mental health and the nurses can do more than they can do. There is a misunderstanding where each agency fits in the machine. (18#[2017])

Perhaps there was another reason for hospital and mental health staff misunderstanding police powers and vice versa. This could be due to a lack of clarity of the protocols/processes each must follow when *working interprofessionally*.

Lacking clarity of organisational protocols and processes

The third property of *working interprofessionally* is a *lack of clarity in how organisational protocols and processes* work between each profession. The term 'organisational protocols' is used to define what the agreed upon rules are. Organisational processes are the series of steps taken to ensure the work is carried out efficiently and effectively while following agreed upon protocols. Police, hospital, and mental health services need to work together in a variety of roles due to legislative requirements for each organisation and the nature of their work. The question of "Who takes the lead?" (16#[2017]) was posed by officers when *working interprofessionally*. From the analysis of the data, it surfaced that officers believed the national, local and jointly agreed policies between police, DHBs and the Ministry of Health needed to be clarified and better communicated to all frontline staff. Officers suspected this would improve interprofessional functioning. With each officer operating in a similar manner and clear on their organisation's protocols and processes, inconsistencies and confusion could be avoided when *working interprofessionally*. Furthermore, officers believed that clarification of policies and interagency agreements for officers and health professionals would also improve outcomes for persons in mental distress when police brought them into the hospital ED:

> We have an MoU I think, but it is viewed differently by people. So, if there was something more set in concrete and everyone knows it, there would be more partnership between mental health, police and the hospital. Sometimes it feels like you are going against each other as opposed to working together. Theoretically, at the end of the day we want what's best for the person and members of the public and we want them [mentally distressed person] to get the help they need and ongoing support. So, I guess just more understanding and clarity about the liaisons between agencies and what's been agreed upon. (11#[2017])

Within the data, the phrase "needing to all be on the same page" was used constantly by officers as they expressed their challenges when *working interprofessionally* with ED and mental health staff. Officers were not reassured that their hospital and mental health service partners were on the same page as police. They sensed there was a lack of clarity between

themselves, ED and mental health staff as to what the specific terms of the MoU were in respect to the police role when working with mentally distressed persons:

> If everyone gets on the same page and tries to take responsibility, then you can get a better understanding of how everyone is meant to work. It comes down to some sort of basic communication that we are all on the same page. (14 #[2017])

> There is a memorandum of understanding that outlines what's supposed to happen, but not everyone is on the same page with that. (11#[2017])

The *lack in clarity of organisational protocols and processes* by hospital staff gave rise to officers being challenged as to why they were bringing the mentally distressed person to the ED and not directly to the mental health unit or police cells. As one officer stated: "ED need to be on board with the new directive, not just police and mental health" (14#[2017]). "Each has their own ideas on how things should roll" (12#[2017]) was a comment from another officer. Officers viewed this *lack of clarity of organisational protocols and processes* as occasionally resulting in acrimony and friction between officers and hospital staff. Two officers gave examples of what occurred when organisational protocols and processes were not clear to all:

> I got told the other day, they said "You don't bring them here you take them to the mental health unit". Whether your senior sergeant or whoever it is tell you to bring them here, that's not the deal. And my reply was "It is the deal and our decision is to bring them here is because it's the agreement". (6#[2017])

> I've read an email about streamlining the processes and an agreement between police management and hospital DHB management. I followed what's been agreed upon in the email. I get to the hospital and find the nurses are unaware of it. They had no understanding or knowledge of an email or an agreement. And, it's been the other way around. So, it seems like there's a bit of a miscommunication. The management might be communicating fine between the two organisations, but it's not going down both sides. (18#[2017])

There was confusion on both sides as to what the organisational protocols and processes were and where each profession's responsibility began and ended. Officers acknowledged they lacked clarity of national and local protocols and agreements between police, DHBs and the Ministry of Health. There were several possible causes officers identified for this lack of clarity. These were: a lack of communication and education about the national MoU and local service agreements; officers being unaware of the existence of these agreements; both senior and frontline officers not knowing how or where to access the information, and the assumption that the information was available only to top management. Two officers expressed how they viewed this situation:

> At the end of the day we can't change anything. Frontline officers can't anyway. It's higher than us, it always been that way, but it would be good to change it. (2#[2017])

> The MoU is just word of mouth. What you have to do comes from the sergeant or senior sergeant. It's 'bosses to know and us to find out about'. Most of the information for frontline officers is from the hierarchy to the sergeant who is dealing in that area. If there is an MoU, maybe it needs to be resent out to all staff and be more accessible. (15#[2017])

Lacking clarity of organisational protocols/processes was a challenge that officers negotiated and navigated when working interprofessionally with a person in mental distress. Emerging from the data was that officers worked with this lack of clarity by relying heavily on their more experienced colleagues or senior staff to *make the right call*, *meet obligations* and *negotiate challenges* whilst *navigating* how *to do your best* to keep all safe:

> Some know the processes better than others. Well I guess it's just crossing your fingers and hoping that you know 'she will be right' at the end of the day or hoping that someone probably knows the process. I wouldn't know what the MoU looks like so, and if I don't know then I am assuming a lot of our sergeants don't know. (14#[2017])

Sometimes a *lack of clarity in the organisation's protocols and processes* led to officers being unsure of what their exact role was when *working interprofessionally* with the person in mental distress. This uncertainty of who was responsible and who did what caused controversy at times between the different organisations. Officers acknowledged there were difficulties *working interprofessionally*. However, they considered it was up to each organisation to collaborate more with each other and seek clarification of the specific organisational processes required of them. Were this not to occur, officers foresaw the existing ambiguities and misunderstandings between police and their alliance partners when working with persons in mental distress in the ED would continue to be a challenge.

Nevertheless, the following quote summarises how officers felt overall about working interprofessionally with their alliance partners in the hospital ED: "They are mostly good people to work with. They understand what we go through and, we understand what they go through when working with the mentally ill" (19#[2017]).

Summary

When *doing their best* to keep all safe within the hospital ED, officers were confronted with challenges they must negotiate and navigate. These challenges arose when in a *caretaking* role for the person in mental distress and when *working interprofessionally* with ED and mental health staff in this setting.

Arriving at the ED, officers experienced a sudden role shift when assigned to their peripheral *caretaking role* for the mentally distressed person. Officers no longer were in charge of the situation. Instead, they must take instructions from charge nurses, nurses and mental health

professionals. However, a further issue officers found was accommodating the physical layout of the ED. Officers viewed the layout of this department as posing a potential safety concern. Their concern was for the mentally distressed individual, the public, hospital and mental health staff and the attending officers. In order to minimise this potential safety risk, officers tried to keep the distressed individual calm by getting alongside them, using empathy and humanising the blue uniform.

Although officers and health professionals all had a common goal of helping the person in mental distress, *working interprofessionally* was challenging. Officers found long waiting times, not being kept informed of what was happening and being unable to leave until obtaining permission from the charge nurse frustrating.

With each profession, *managing their respective roles* in this setting, at times confusion existed between professionals as to what the role of the other was. Each had their own agenda. A further frustration for officers resulted from health professionals misunderstanding the legal powers police have with those in mental distress. Moreover, officers, health and mental health staff lacked clarity of agreed upon organisational protocols and processes. These identified tensions will be discussed in the following chapter.

Chapter 8: Discussion

Introduction

The initial aim of this research was to generate theoretical concepts and understanding by addressing the identified knowledge gap of New Zealand frontline police officers work in the hospital ED with individuals they suspected of being in mental distress. However, when analysing the data, officers spoke about this work beginning in the community when responding to a mentally distressed person. This was an important finding as it emerged that the officer's initial interaction with the individual was seen to be an influencing factor and impacted how officers worked with them later in the hospital ED. In keeping with the constructivist grounded theory methodology, the research question broadened to include officers' work in the community and later in the hospital ED with persons in mental distress.

The intention of this research and the subsequent development of the theory *doing your best*, was not to investigate how police officers personally felt about people in mental distress. Rather, the focus was to create an understanding of how officers constructed their everyday working with these persons beginning in the community and continuing in the hospital ED. The substantive theory of *doing your best* highlighted the inter-related personal (micro), professional (meso) and governmental/societal (macro) levels that emerged from the data as influencing factors of how officers worked with persons in mental distress.

The generation of the theory *doing your best* addresses gaps in knowledge and answers the research question. Furthermore, this theory also provides an original contribution of new knowledge and potential policy/practice recommendations for New Zealand Police. The purpose of this research was to provide practical knowledge to inform the development of supportive practices in the field. Having this knowledge will assist in future training programmes and policy development for frontline police officers when working with persons in mental distress.

The following sections discuss challenges New Zealand Police officers articulated and their significance in the context of existing knowledge. Although these challenges are not exclusive to New Zealand frontline police officers, some aspects are uniquely New Zealand, and influence the degree of both the concern and outcome.

The key challenges from the findings of this current study that will be discussed are: officers *doing their best*, *meeting obligations* (micro, meso and macro) by *making the right call* and *negotiating and navigating challenges* in the hospital ED. The discussion concludes with potential suggestions of how officers may be able to improve on *doing their best* followed by a

summary. The limitations of the study are acknowledged before ending with recommendations and a concluding statement.

The interagency/alliance partners referred to in this study are: New Zealand Police, District Health Boards (DHBs) and mental health services. It is important to note that this discussion is bounded around inter-collaboration with service agencies, not non-service agencies.

Doing your best

Doing your best was the term officers used constantly during the interviews to describe how they worked with those they perceived to be mentally distressed. Doing your best is an interesting term that can be described as determining what your best can be on any given day, and accepting that your best may sometimes not always be perfect. Doing your best can also mean that sometimes decisions made in a particular situation will likely alter as more experience and training is gained in a particular field. Indeed, a side benefit of doing your best can be that it provides a path for people to learn something new that they were unsure of before. However, when doing your best, there has usually been a conscious decision for people to do their best and they have acted upon it. This can result in a sense of accomplishment and job satisfaction. Nevertheless, doing your best is an attitude that can be personal and/or professional in the workplace[9]. Despite challenges that may be encountered, *doing your best* is how police officers endeavour to bring value to the work they do.

In spite of having obligations to meet and challenges to negotiate and navigate at many levels, data drawn from this study found that officers were constantly *doing their best* when working with mentally distressed persons. These current findings reveal that officers believe that their involvement with these individuals in certain situations is both necessary and positive. Officers also felt encouraged by their organisations initiatives to assist officers in *doing their best* by implementing more collaborative working with interagency partners.

It emerged from the study that when officers were working with persons in mental distress, the term *doing your best* had a different meaning for each officer. Individual experiences, professional obligations and societal expectations all played a part in influencing an officer's understanding and construct of *doing your best* for the mentally distressed person.

In analysing the interview data, some officers incorporated a personal understanding and perspective of how they worked with the distressed person. Given the high occurrence of mental illness in the general community, many officers had personal experience with mentally

[9] For further information, refer: https://psychcentral.com/blog/do-your-best/

distressed people. This could be a friend or family member. Officers with this personal experience were seen to incorporate a high level of empathy and worked at attempting to do their best to 'humanise' the blue uniform. Morabito (2007) refers to this as "the temporal factor" (p. 1584) in officers decision making. This is when an officer's knowledge extends beyond the specific incident due to their having someone in their personal life with a mental illness. In many instances, these officers were found to be more likely to provide a high level of assistance to the individual rather than detain, or ignore, the person. This is referred to by Watson et al. (2010) as "officers familiarity with mental illness" (p. 305) and was discussed in Chapter 2. However, these officers also incorporated the professional and societal obligations required of them when working with those in mental distress.

There were officers in this current study that had become desensitised over time, and others that had little personal experience working with mentally distressed persons. These officers either did not want to, or found it difficult to, relate with distressed individuals. Such officers tended to remain in the professional mode of *doing their best* to simply contain the person safely until they had been assessed by mental health professionals. The same officers tended to only take a professional and societal view of the situation. Maintaining public safety in the community and ED setting, and monitoring the risk posed by mentally distressed individuals in these environments, was their primary concern. These were the different aspects and interpreted meanings of what it meant for officers to be *doing your best*. Yet, encompassing this was the universal consensus from the officers interviewed that *making the right call* was a key requirement for officers in *meeting their obligations*.

Meeting obligations and making the right call

An obligation is when a person is bound and required to take certain actions which arise from a duty of care, customs or the law[10]. In the context of policing, *meeting obligations* is sometimes referred to as *fulfilling a duty of care*.

There has always been the obligation for New Zealand Police to protect society and maintain socio-political order. Included now within these obligations are the certain legal, professional and societal obligations New Zealand Police officers must meet when working with individuals in mental distress. With the community approach to policing, this has meant that officers' roles and obligations to those in mental distress have shifted to adapt to societal changing needs (Li et al., 2018). These shifts are aligned with the fundamentals of contemporary policing

[10] For further information, refer https://legal-dictionary.thefreedictionary.com/obligation

which has moved to embrace a more social welfare and 'guardian' aspect to officers' core policing duties.

There is a requirement nowadays for police officers to meet societal, professional and in some instances, personal obligations to manage the diverse expectations placed on them when working with mentally distressed people. With the focus today on the rights of mentally distressed persons, it is also important police meet their obligation to observe the rights of these people whether working with them in either the community or hospital ED (Cotton & Coleman, 2010).

One of the six core values for New Zealand Police is to respect and treat everyone with dignity and uphold their individual rights and freedom. A second core value is for officers to display empathy by attempting to understand and consider the experience and perspective of those they serve[11]. When officers in this study spoke about how they worked with persons in mental distress, their conversation throughout was punctuated with the acknowledgement of their obligation to uphold these core values. It was evident the importance these officers placed on implementing these values of respect and empathy when working with people in mental distress in the community and ED.

However, emerging from the findings of this study was that *making the right call* for the person in mental distress in the community and at times in the ED, was challenging for officers.

Challenges making the right call in the community and emergency department

When *responding to an incident* involving a person suspected of being in mental distress in the community, officers use their given discretionary powers to determine what the right call is for the individual. However, it emerged from the findings in this current study that when officers were *doing their best* in responding to mental health related incidents, *making the right call* was sometimes not easy. One of the reasons was that officers triaged the situation only from a safety perspective. Nevertheless, officers are not mental health professionals and they have professional boundaries to maintain. Assessing persons for specific types of mental distress is outside of their field of expertise.

However, in the data from this study, *making the right call* was not about officers being able to accurately determine the mental health status of a person. It was about responding to the call for a mentally distressed person and transporting the individual to the ED to be helped by

[11] For further information, refer https://www.police.govt.nz

mental health professionals. When this was achieved, officers felt they had done their best for the person, met their obligations and *made the right call*.

It also emerged from the data that officers were at times unable to confidently *make the right call.* Due to their lacking mental health assessment skills, officers were often unable to determine whether the person they were called to was mentally distressed, or had other issues. Lacking these assessment skills meant officers frequently relied solely on behaviours being exhibited by a person (Shapiro et al., 2015). The problem this posed for officers was whether or not the person's behaviour would meet the criteria for a psychiatric admission if they transported the individual to the hospital ED. Research indicates that police officers in many countries encounter this same dilemma, particularly with personality disordered persons[12] (Marsden et al., 2020; Martin & Thomas, 2015). Ironically, the main reason police officers initially become involved with these individuals is their behaviour in public can be bizarre, dramatic and draws public attention (Klein, 2010).

Nevertheless, when analysing the interview data, it emerged that officers tended to err on the side of caution. Officers transported most individuals they suspected were mentally distressed to be assessed at a hospital ED. This was the right call to make as it is in keeping with the New Zealand Police directive. However, a less obvious reason for this cautious approach to emerge was generally that the officers did not want to attract public or press critique for their inaction in case something more serious eventuated. As identified in the data of this study, this was especially so with an individual who was known by officers to have a personality disorder, but was exhibiting bizarre behaviour and drawing public attention and concern.

Many individuals who have a personality disorder fail to meet the threshold for involuntary admission into psychiatric inpatient units and are discharged (Klein, 2010). In this study, it emerged that such individuals were frequently discharged. The challenge presented to officers then was what to do with such people, especially as the behaviours they had exhibited were still evident. The conundrum officers faced was that despite *doing their best* and *making the right call*, they still found themselves in the same situation of being unsure of what more they could do for the person. This situation appeared to be universal and was seen to be a time consuming exercise for police officers and took them away from other core duties (Al-Khafaji et al., 2014; Clifford, 2010; Holman et al., 2018). Based on previous situations, officers knew they could and would, encounter many of these individuals again and the cycle would be repeated. It emerged from this study that such a situation left officers feeling frustrated,

[12] Refer to personality disorder definition on p.7.

disheartened and cynical about the process of constantly responding to those officers termed 'revolving door clients'.

However, globally, health and mental health professionals have usually pre-empted that most persons with personality disorders will not meet criteria for an ED admission (Martin & Thomas, 2015). This leaves police with no other option than to reluctantly use police cells for the individual. Effectively this is criminalising those who are mentally unwell (Lamb et al., 2002; Martin & Thomas, 2015; Morabito, 2007). Unfortunately, those with the diagnosis of a personality disorder have a complex relationship with police, that in many ways is reflected in their complex relationship also with health and mental health services (Johnson & Elbogen, 2013).

In New Zealand, one of the reasons for this discussed situation occurring is that the Mental Health Act (1992) does not specify that persons with personality disorders are subject to, or come under, the Act (Law Commission, 1994). Therefore, it is difficult to place these individuals under the Mental Health Compulsory Assessment and Treatment Act (1992) as they frequently fail to meet the threshold for an involuntary admission to an inpatient unit (Ministry of Health, 2012).

However, when officers were waiting with the mentally distressed person in the ED, few opportunities presented that required officers to take control of a situation and *make the right call* from a policing perspective. The findings of this research indicate that in the ED, the officer's role is simply to provide peripheral support to ED staff. This support continues until the individual has been assessed by mental health professionals and either admitted, or discharged, from the department. Nonetheless, when the safety of all in the department is threatened by disruptive behaviour from the individual, officers are then required to *make the right call* and take primary responsibility for the person from a policing perspective.

Still, in *doing their best* to *make the right call*, there was a reoccurring theme that emerged in the data collected for this study. This theme was that officers felt ill prepared in how best to work with the person in mental distress at times and achieve a positive outcome for all. An important finding in this study, was that officers viewed their mental health training as often being inadequate to meet the demands of the many situations they encounter with individuals in mental distress. The officers' constructions of the inadequacy of their training is not new and matches with overseas study findings (Lamberti, 2004; Marsden et al., 2020; Wells & Schafer, 2006).

Officers' training in mental health

For many years there has been a universal assumption that giving police more training and knowledge about mental illness, will improve officers' interactions when working with those in mental distress. This may sound a logical assumption and message, however, Thomas (2013) contends that little is known about what does actually work for officers to improve their interacting and working with this group of people.

In the community, police officers usually have enough training and the basic skill set required when working with those in mental distress to contain a situation and keep all safe (Lamb et al., 2002). Nevertheless, from analysing the data of this study, it became apparent that in the community, there still remained an element of uncertainty by most officers. This uncertainty was not about being able to keep people safe. Officers knew they had the skills to manage that aspect. The uncertainty came from officers wondering if they could have handled specific situations differently had they a wider understanding and skill-set of how to work with people in mental distress.

It also emerged that when waiting with these individuals in the ED, officers identified that a different and broader skill set was required, and one many felt they lacked. Officers recognised that in this particular setting there was the need to have more training in specific communication skills and de-escalation techniques that were sometimes required to keep the person in mental distress, calm. A finding from this research was that having more training in these specific areas would give an officer confidence that they can *make the right call* for these individuals in the ED when necessary.

A recent study in the UK that focused on police officers' decision making with those in mental distress was conducted by Marsden et al. (2020). The findings from this study revealed that officers also wanted more training in how to communicate with those in mental distress, training in de-escalation techniques, and generally, a better understanding of mental health. These areas officers felt would assist in enabling them in "doing what's right" for those in mental distress (Marsden et al., 2020, p. 4). Noteworthy, from this UK study findings, the areas officers wanted more training in were also identified as being the same areas that 'service users' wanted police to receive more training for.

Training by service users (those who have experienced mental distress)

A service user is a generic term for a person who at times uses mental health services and has the 'lived experience' of mental distress (University of Otago, 2019). In data generated from this study, it emerged that service users provided police recruits with practical insights and

first-hand information of what was, or was not helpful, when they engaged with police when unwell (University of Otago, 2019). One of the key messages delivered from service users to these trainees is that police officers are not expected to be mental health professionals. However, officers still need to recognise if a person is experiencing mental distress and provide transport to the ED for these individuals to be assessed by mental health professionals.

In the data collected from this study, it emerged that officers viewed hearing the 'lived experience' from service users during their training as helpful. The underlying purpose of the lived experience workshops was to reduce officers' preconceived attitudes, prejudices and stereotyping of persons in mental distress. Whilst attending a workshop for new recruits run by service users at New Zealand Police College, I observed that many misconceptions, fears, myths and prejudicial attitudes recruits had previously held, appeared to be corrected and dispelled.

Concurring with this experience, a Mental Health Awareness in Action programme in the UK identified an important factor in changing attitudes, reducing stigma and stereotyping by police of individuals in mental distress. This was achieved through officers listening to the personal stories of service users at facilitated workshops (Pinfold, Thornicroft, Huxely, & Farmer, 2005).

Indeed, personal contact with individuals who have experienced mental distress has been found to be the most important factor in changing officers' attitudes (Moore, 2010). Yet, it remains unclear if service-user facilitated training workshops permanently reduces an officer's discriminatory attitude towards those in mental distress once the recruits become frontline officers. Godfredson et al. (2011) argue that whilst police recruits may demonstrate enthusiasm to undertake training and participate in workshops about mental illness, translating this knowledge into practice once on the frontline may not occur.

Although there is lot of literature that discusses attitudes and attitudinal shifts that occur as a result of attending service-user workshops (Watson et al., 2008), this was not evident from officers in the data of this current study. Officers spoke only about the workshops providing practical knowledge of how to *do their best* and *make the right call* when working with mentally distressed persons. It is unclear why an attitudinal shift by officers as a result of attending the service-user workshops was not mentioned, or evident in the data.

Nevertheless, the perception of officers in this study was that the best training on how to work with those in mental distress was from *learning on the job.* Officers constructed that this was how they would acquire new skills on how to *do their best* and *make the right call* for these

individuals in the community and the hospital ED. *Learning on the job* resembles an apprenticeship type learning model. Apprenticeship training refers to a course of training that consists of basic theoretical instructions and practical on the job training in the workplace. Most police training is based on this model (de Tribolet-Hardy, Kesic, & Thomas, 2015; Godfredson et al., 2011).

Officers learning how to work with those in mental distress

The theory of *doing your best* identified that officers credited knowing how to *make the right call* with persons in mental distress as predominantly coming through *learning on the job* and personal experience. Officers did not consider that the best training came through official training programmes. In this study, it emerged that officers found this view to be supported by senior officers at Police College and those more experienced officers already on the frontline of policing. When analysing the data from the study findings, it emerged that the appeal by officers for this type of training is that it can be applied directly to their core policing duties.

These findings concur with other national and international study findings that found officers perceived that most of their learning of how to work with persons in mental distress came from on the job experience (Dew & Badger, 1999; Godfredson et al., 2011; Marsden et al., 2020). Officers in these studies maintained that no amount of formal training could prepare them for situations they attended involving individuals in mental distress. A recent study by Marsden et al. (2020), reported that officers still felt much of their formal training at Police College of how to work with those in mental distress was irrelevant, outdated and too general. These officers wanted their training of how to work with those in mental distress to be updated regularly, incorporate a multi-agency approach and the content of the training, improved. This they asserted, would assist their learning and knowing how to 'do what was right' with the mentally distressed.

However, there is a difficulty with this apprenticeship-type of *learning on the job* approach to training. Whilst it may be a great practical way to learn for police, there is always the risk that new officers could adopt poor practice and attitudes from more senior officers (de Tribolet-Hardy et al., 2015). Senior officers may have adapted their own individual approaches to dealing with individuals in mental distress. As seen in the findings of this study, some senior officer's practices may not necessarily have been in line with 'best practice'.

In the context of policing, best practice refers to officers adopting organisational processes in working with those in mental distress that are proven by experts in the field to be superior to any alternatives. These organisational processes will result in better outcomes for those in

mental distress than those achieved by other methods. One example that could be viewed as best practice is the directive from New Zealand Police. As previously discussed, the directive is that officers transport all those in mental distress they come in contact with to the hospital ED to be assessed. Prior to this, the practice for officers was to transport such persons to police cells. However, police cells are not considered an appropriate environment for those in mental distress and could effectively be criminalising these individuals (Clifford, 2010; Wise, 2014). Nevertheless, latest best practice indicates that EDs may also not be an appropriate environment for the mentally distressed person (McKenna et al., 2015b; Wise, 2014; Wood & Watson, 2017).

Training requirements for the contemporary approach to policing

With the focus now on community policing, there is the requirement for officers to learn many new skills as they increasingly interact with those in mental distress (Cotton & Coleman, 2017; Li et al., 2018). Many police organisations have acknowledged that the mental health training their officers have received in the past is in many cases inadequate to meet the requirements of policing today. The overall aim of police organisations has been to upskill officers on the contemporary social welfare approach now required when working with those in mental distress (de Tribolet-Hardy et al., 2015). The failure of those training police to acknowledge new approaches to policing can create a 'theory to practice gap'. This term is defined as "the separation of the practical dimension of policing from that of the theoretical knowledge" (Rolfe, 1998, p. 672). The implications and danger of this gap occurring is that potentially, it may place both officers and persons in mental distress at risk in the community, and to a lesser extent, within the hospital ED (Wells & Schafer, 2006).

However, from the findings of this research, it emerged that any amount of mental health training officers undertook did little to assist with the challenges they had to navigate and negotiate within the hospital ED when working with those in mental distress.

Negotiating and navigating challenges in the hospital emergency department

"I think if we all worked together, things would improve". (19#[2017])

When analysing the interview data, the frustrations and challenges officers had to negotiate and navigate in the ED had little to do with their working with persons in mental distress. To the contrary, officers viewed working with these individuals as being a requirement of *doing their best* to *meet their obligations* for the mentally distressed. However, the two main areas in this setting officers perceived as their main challenges were the *caretaking role* they were expected to undertake and *working interprofessionally* and collaboratively with their interagency partners.

A caretaking role in the emergency department

Data generated from this study identified that officers took on *a caretaking role* for the mentally distressed individual on arriving at the hospital ED. This occurred after officers handed over their primary responsibility for the individual to ED staff. Nevertheless, it emerged that whilst in *a caretaking role*, an officer's role could shift to their again being primarily responsible for the individual. This role shift was more likely to occur if the safety of all in the ED was being threatened by disruptive behaviour from the individual. In such incidences, officers *did their best* to contain the situation and *negotiate challenges* that presented. In analysing the interview data, it emerged that regular role shifts for officers when working with persons in mental distress within this setting may occur several times a day and frequently with the same person.

When an individual is displaying unwanted behaviours in a hospital ED, the challenge officers must negotiate is at what point to intervene, take back control and assume the lead role again with the individual (White & Weisburd, 2017). In this study the role shift for officers as to who should take the lead role in this setting and at what point, was complicated. It was entirely influenced by what was occurring with the individual and officer's interpretation of the behaviour. However, most officers are aware that when taking the lead role with a mentally distressed person in the hospital ED environment, any show of force from police could be counterproductive (Buerger et al., 1999).

It also emerged from the findings that the physical layout of the ED made it a challenge at times for officers to contain an individual in mental distress, should this be required. A study by M. Fry and Brunero (2004) suggests that the physical layout of an ED may in some instances lead to the care of these individuals being compromised. Generally, in most hospital EDs when those in mental distress are at risk of self-harm, harming others or self-discharging, these settings are not secure enough environments. This is frequently the reason police are being used as security guards in this environment (Knott et al., 2007).

However, what was evident in this study was an officer's *caretaking role* involved spending an inordinate amount of time waiting with individuals in mental distress. Until an assessment on the individual has been conducted by mental health professionals, it is a condition of the current directive and MoU that officers wait (District Health Board Mental Health Services & New Zealand Police, 2015). The implications of this directive now means that officers are the transporters of those in mental distress to the ED, the caretaker for the individual in this setting and a security guard for the department.

The findings from this study has several parallels to other international studies. Anecdotal evidence from Australia suggests that the caretaking role by police in the hospital ED for mentally distressed individuals also involves waiting for mental health professionals to arrive and assess the person. This waiting was identified by officers as source of frustration. However, it was also a statutory requirement (Clifford, 2010; Huppert & Griffiths, 2015; McKenna et al., 2015b).

However, what surfaced in this current study and from international literature was that officers considered their *caretaking role* in the ED to often be a waste of police time and resources. Furthermore, officers perceived waiting with the individual placed a burden on their fellow officers out in the community who were attending to other core policing responsibilities (Godfredson et al., 2011; McKenna et al., 2015b; Schulenberg, 2016; Wood et al., 2011).

Nevertheless, it was evident throughout the data that overall, officers supported the directive from New Zealand Police that they transport those deemed to be mentally distressed to the ED. However, once in the hospital ED, officers encountered challenges they had to negotiate and navigate when *doing their best* to *meet their obligations* for the individual in mental distress. The challenges officers spoke of in this study emanated from the interactions, or lack of, with their interagency partners in the hospital ED.

Underlying challenges for officers working interprofessionally and collaboratively with interagency partners

One would imagine that agencies working together for a common goal or purpose of assisting those in mental distress in the ED would work together harmoniously as each profession contributes its own expertise (Bradbury et al., 2017). Professionals working collaboratively somewhat indicates that there is an assumed equally shared/collaborative working relationship between agencies or organisations (Wood & Watson, 2017).

The term 'interagency collaboration' is used to define the relationship between different agencies or organisations (Biggs, 1997) and involves different levels of joint information sharing and resources (Parker et al., 2018). Regardless of these levels, there are three fundamental principles when working collaboratively with one's interagency partners. These are: information sharing, joint decision making taking into account organisational protocols and processes, and co-ordinated interventions, whereby each professional can maintain their respective professional boundaries whilst working collaboratively (Parker et al., 2018).

When analysing the interview data, it emerged that when officers were *doing their best* in a *caretaking role* for the mentally distressed individual in the ED, that these fundamental

principles of interagency collaboration functioned at a low level. The implications of this were: minimal information sharing with officers from emergency and mental health staff about plans for the distressed person, poor adherence from one of their interagency partners (hospital ED staff) in regards to the MoU and service level agreements (SLAs), and ED and mental health staff continuing to misunderstand the limited powers police have when working with persons in mental distress. The findings of this study mirrored those found in the study by Marsden et al. (2020). Participant officers in that study revealed similar challenges resulting from the low level of interagency collaboration from their interagency partners (Marsden et al., 2020). The overall result of these findings suggests that with the overwhelming number of mental health calls police respond to, interagency working in its current form is often ineffective. This may adversely impact the outcome for the individual in mental distress (Hollander et al., 2012; McLean & Marshall 2010).

From this study it was found that police officers and health professionals worked alongside each other in the ED. Each professional remained within their own sphere of expertise. Whilst this avoided any role blurring, it also did not facilitate the opportunity by police and their interagency partners to work collaboratively. How officers in this study worked in the ED with their interagency partners paralleled data from a study by Schulenberg (2016). This author contends that in EDs, police officers and their interagency partners work alongside each other, but operate in their own silos. Schulenberg (2016) found that there appeared to be little understanding of each other's roles, perspectives and respective challenges. There is, however, a paucity of literature about how police officers view working collaboratively with hospital ED staff and mental health services (McLean & Marshall 2010). This may be an area for future research.

Until the lack of interagency collaboration has been sorted, confusion will exist between police and their interagency partners and the status quo will prevail. Challenges for officers to negotiate and navigate when *doing their best* to *meet obligations* for those in mental distress in the ED, will continue. Valuable police time will be misused by mental health services as officers wait for these professionals to assess the person in mental distress. Memoranda of understanding and SLAs will be interpreted according to individual interagency requirements. Moreover, ED staff will continue to misunderstand the limitation of police powers when they are working with those in mental distress. Furthermore, attempts to pressure officers to arrest the mentally distressed when no crime has been committed, will also continue (Clifford, 2010; Marsden et al., 2020).

In this study, evidence of officers being pressured to arrest those in mental distress when no crime had been committed emerged from the data. Similar pressure placed on police by ED and mental health services to arrest those in mental distress despite no offence being committed, were also reported in the UK study by Marsden et al. (2020). However, potentially, more information sharing, adherence and a commitment to organisational protocols and processes and quicker response times when waiting with the mentally distressed in the ED setting would assist in resolving the discussed interagency challenges for police.

A less acknowledged challenge affecting how police work with the mentally distressed is the mental health care system itself. This system is based on the notion of integrated systems and services with different organisations working collaboratively to respond and assist those in mental distress. Hoffman et al. (2016) argue that generally, these systems fail to provide a co-ordinated response. The use of the ED for those in mental distress, Hoffman et al. (2016) claim, epitomises this lack of co-ordination. These authors contend that the main underlying factor in failing to provide a co-ordinated service for persons in mental distress in the ED, is the different roles performed by frontline police officers and ED staff (Hoffman et al., 2016). Although in many countries this lack of collaboration between police, ED staff and mental health services is a widely acknowledged concern, there have been few ideas on how to improve this situation.

Nevertheless, the move towards a community orientated policing model has necessitated officers now adopting broader social welfare roles and responsibilities (Stenning & Shearing, 2005). When working with those in mental distress, the police officer's role now is to facilitate access for these individuals to receive care in the ED (A. Fry et al., 2002). The role of the mental health professional is to assess the mentally distressed person and provide them with the care and treatment needed. However, the reality today is police, ED staff and mental health services interact and care for many of the same clientele, and need to be interdependent on one another (A. Fry et al., 2002).

Whilst resolution to these identified challenges occurs at an organisational level, applying quick-fix solutions to organisational change seldom addresses underlying problems and challenges (Kreitner, Kinicki, & Buelens, 2002). Furthermore, the environment of a hospital ED can make negotiating challenges between police and hospital staff impossible and often ill-advised (Coleman & Cotton, 2016). In the findings of this study, the identified challenges that seemingly posed as individual disagreements between police and their interagency partners, possibly reflect deeper systemic issues. Potentially, these challenges could be more effectively

negotiated outside the context of the situation with the individual in mental distress and addressed at organisational levels.

Doing your best, better

"If these things were to change, it could make things better". (21#[2017])

A novel finding in this research was that the use of the term *doing your best* by officers contained an audible, silent 'but'. This silent 'but' was interpreted by me as officers wanting to understand how they could *do their best* for the mentally distressed person, better. This was when officers were responding to, and working with, these individuals in the community and the hospital ED.

When analysing the interview data, it emerged that officers spoke about two specific areas when *doing their best* for the person in mental distress that could be improved and made better. However, the areas where change was required would need to penetrate through institutional barriers within the ED and mental health services to effect the identified changes. From this study, it emerged that officers believed that hospital EDs and mental health services may not be 'on the same page' as police were with the directive and agreed upon protocols and processes each organisation (or service), was to follow.

The first change officers required was ED staff members' adherence to the protocol and processes agreed between their respective organisations as noted in the MoU and SLAs. If ED staff were to consistently adhere to these protocols and directives, officers believed this would enable the facilitation of a timely and non-confrontational admission for the person in mental distress. Keeping to what the current directive and agreements state would potentially stop officers having to negotiate and be challenged about every admission for a person in mental distress they transport to the ED.

As evidenced in the data from this study, officers were often challenged by charge nurses as to why they were transporting the mentally distressed individual to the ED to be assessed and not taking them back to the police station. This was despite the individual displaying no violent behaviour, nor having committed a crime. On the one hand, officers understood this as ED charge nurses being unclear of the directive, protocols and processes agreed upon by police and their interagency partners. On the other hand, officers felt some charge nurse were not prepared to adhere to the agreed upon directive and protocols. When officers were challenged, the resulting discussion between officers and charge nurses was often contentious, and tended to elevate the psychological distress for the individual accompanying the officers. Interestingly, the study findings revealed that a non-confrontational handover of care for a

distressed individual to health professionals that was better able to assist the person, left officers with a sense they had *done their best*, and *made the right call.*

It is important that police and their interagency partners foster a professional collaborative relationship with each other. One way to enhance this collaboration is through each of the interagency partners, including police officers, being all on the same page and adhering to the agreements between their organisations. Moreover, having a collaborative working relationship between police and their interagency partners has been seen to assist the pathway for those in mental distress to receive timely and appropriate care (Boscarato et al., 2014). These interagency partnerships are valuable and need to have robust protocols, processes and directions adhered to by all those involved. With the increasing involvement with police and persons in mental distress, interagency collaboration has become a common platform from which both police and mental health services operate from (Cotton & Coleman, 2010; Independent Police Conduct Authority, April 2015; Thomas & Watson, 2017).

There was another area officers spoke about where if change were to occur, it would improve their being able to *do their best* for the mentally distressed. Officers identified this area as being their need for direct and prompt access to mental health services both in the community and ED. A constant theme to emerge from the data was officers' difficulty in accessing the Crisis Assessment and Treatment Team (CATT) for mentally distressed persons. This issue was particularly highlighted by officers in the ED. In this setting, officers often wait several hours for mental health professionals from the CATT or occasionally, the Psychiatry Liaison Team, to arrive and assess the individual. Not only is this anxiety provoking for the mentally distressed person, but also prevents officers from attending to other policing duties.

Officer's constructs of the consequences of not having prompt and direct access to mental health services is police being the default mental health service in the community and caretaker in the ED. 'A work in progress and needing to change' was how officers in this study described the challenge of trying to access mental health services when officers needed advice or support.

It became evident in the findings that officers assumed that having direct and prompt access to mental health services would lessen the challenges they had to negotiate when wanting to *do their best* for the individual in distress. Police are not mental health professionals, and aside from working within restrictive legislative parameters with these people, they are not experts in this area. Certainly a key message from a programme run by service users for recruits at New Zealand Police College was they should also not expect to be experts (University of Otago, 2019).

However, the difficulties experienced by officers that surfaced in this study of being unable to gain immediate access to mental health services is not new, nor simply confined to New Zealand Police officers. A number of overseas studies reported gaining access to mental health service for person in mental distress as the main problem for police (Fisher & Grudzinskas, 2010; Godfredson et al., 2010; Martin & Thomas, 2015; Wells & Schafer, 2006).

In many countries there has been a drive from police organisations for officers to receive more training in how to *do their best* and *make the right call* for the person in mental distress. However, more training may not necessarily be the answer. Realistically, as seen in this study, most officers recognise if an individual is in need of mental health assistance. This is not the issue (Fisher & Grudzinskas, 2010; Godfredson et al., 2010; Morrissey, Fagan, & Cocozza, 2009; Wells & Schafer, 2006). Rather, the issue is that officers are not mental health professionals; therefore officers must have ready access to those who are.

Potential pathways to build on doing your best, better

Fortunately, there appears to be a political eagerness between New Zealand Police and their interagency partners to address these identified challenges and trial new methods of training and different approaches to interagency collaboration (New Zealand Police, 2017a). These initiatives were discussed in Chapter 2. However, the present police response system may be unsustainable as the volume of mental health related calls New Zealand Police receive continues to rise.

Furthermore, contrary to the current New Zealand Police directive (discussed previously), many overseas police response models to those in mental distress are aimed at diverting these individuals from EDs to facilities now considered more appropriate. Overseas studies have found that detaining those in mental distress, and police transporting these individuals to the ED, is expensive (Wood & Watson, 2017). Moreover, the ED is considered by some as an unsuitable environment for those in mental distress (Hoffman et al., 2016; McKenna et al., 2015b; Wise, 2014).

There still remains the viability for police to do better and build on *doing their best* for mentally distressed individuals. In analysing the interview data, potentially, this could be accomplished by a combination of officers having additional mental health training and prompt access to mental health professionals. This combination could resemble a different more effective police response model which may be the change officers are seeking. From the findings, it is noteworthy that several officers in this study were interested in furthering their knowledge of how to work with those in mental distress.

In this study, officers reported a degree of satisfaction with the recent initiatives taken by New Zealand Police to assist their *doing their best* for persons in mental distress. The inclusion of mental health as one of the six official core "drivers of demand" and the directive to transport those in mental distress to the ED were viewed by officers in a positive light. However, the next initiative could involve a different police response model to that used presently for persons in mental distress. For New Zealand Police officers, this could potentially make *doing their best* for these people, better.

Summary

Doing your best was seen to be a personal and professional mindset and an influencing factor of how officers work with persons in mental distress in the community and ED. In *doing their best*, officers' focus was to keep all safe to ensure a positive outcome for the mentally distressed person, staff in the ED, the public and officers involved. There were varying approaches officers took when working with persons in mental distress. Some incorporated a personal aspect to their professional and societal obligations. However, this did not detract from officers *doing their best,* but was seen to enhance it.

As officers are not mental health professionals, *meeting their obligations*, *making the right call* and *doing your best* was difficult with persons diagnosed with a personality disorder. Officers had trouble distinguishing between behaviours that may present as mental illness, but would not meet the criteria for a psychiatric admission. Officers wanted more mental health training in how best to work with persons in mental distress. Nevertheless, there was a general consensus by officers that understanding how to work with persons in mental distress in the community and ED predominantly came from *learning on the job.*

In the ED there were challenges for officers to negotiate and navigate. The physical layout of the ED presented officers with security concerns that had to be navigated. Waiting an inordinate amount of time for mental health services to arrive and assess the individual in mental distress, effectively rendered officers unavailable for other policing duties. Furthermore, the fundamental principles of interagency collaboration operated at a low level in the ED. There was minimal formation sharing, poor adherence to the MoU and SLAs and misunderstanding the limited powers police have when working with those in mental distress. A less acknowledged challenge affecting how police worked with the mentally distressed was the failure by the mental health care system itself to provide a co-ordinated response.

There were two areas officers highlighted, that if addressed, would enhance *doing their best* for those in mental distress. These were the need for police and their interagency partners to

'all be on the same page' and adhere to organisational directives, protocols and processes, and officers having direct and prompt access to mental health services.

However, as mental health services are struggling to cope with the growing number of calls received, police have become first responders to persons in mental distress. Officers identified the current response model to these individuals is not working effectively enough for the person in mental distress and police. Officers want to see change in how they currently work with those in mental distress and their interagency partners in the community and hospital ED. Therefore, the following are recommendations emerging from this study and are targeted at different sectors in New Zealand. These sectors are the New Zealand Government, local Police Districts and New Zealand Police, universities, mental health services and service users.

Recommendations

Recommendation 1 (New Zealand Government)

From this study there is sufficient evidence to indicate that the present police response model to persons in mental distress in the future may be unsustainable. Therefore, I would recommend that:

- A different police response model is trialled. This could mirror a police-based response model such as the CIT, a co-responder model such as PACER, or a combination of these models to something that fits uniquely for the New Zealand context.

Recommendation 2 (Local police districts)

Negotiating challenges between police and hospital staff when working with mentally distressed persons in the busy acute environment of a hospital ED can be difficult, unwise and unproductive. Therefore, I would recommend that:

- Every local police districts have one known contact person in all hospital EDs with whom they are in regular contact with. Ideally, the person will act as a liaison between police officers, mental health services and the ED. Having an identifiable contact will assist in rectifying reoccurring issues and decrease the amount of time spent sorting out issues related to individual cases, or a particular staff member.

Recommendation 3 (Police, universities, mental health services and service users)

Research partnerships are crucial for enhancing policing policies and strategies. It has been found collaborative research between police, universities and mental health services assists in finding ways for researchers and police staff to work together and tackle specific issues and challenges. Innes (2010) contends that collaborative research can shift paradigms, and shift

the lens through which police officers see the world they are involved in. Therefore, I recommend that:

- More collaborative research between police, mental health services and universities is conducted in order to bridge the theory to practice gap. This would assist building on the theory that promotes best practice for police officers of how they work with those in mental distress. There is also the need for reciprocal educational initiatives between police and mental health professionals so that the knowledge and skills of each discipline informs their partnership.

- Future studies could include service users of mental health to solicit their perceptions of how police could improve working with them in the community and hospital EDs.

Limitations of the study

There are limitations of this research that need to be considered. One limitation is that the choice of a constructivist grounded theory methodology may not necessarily mean the co-constructed interpreted findings are necessarily generalisable. This is due to grounded theory methods not using representative sampling, and findings being abstracted away from the individual to reflect group patterns of behaviour (Charmaz, 2009a).

Another limitation to the generalisability of this study was that it is unclear whether the officers who volunteered to participate in this research may have had a particular interest in mental health and working with persons in mental distress.

A further limitation was that as a researcher it was difficult to exclude all sub-conscious biases that may exist. My role as a mental health clinician and researcher brings both strength and limitations to the study. Prior assumptions from having worked in the field as a mental health nurse needed to be acknowledged and set aside. Undertaking a 'self-interview' was beneficial, as was listing personal assumptions as a reference point to return to if unsure about the forcing of my interpretations on the data.

Finally, this study did not consider cultural aspects that may have influenced how frontline police officers worked with persons in mental distress. Given the over-representation of those who identify as Māori with mental illness and their disproportionate involvement with police, this is an area that requires further research. Furthermore, the ethnicities of the participating officers in this study were not identified to ensure confidentiality. However, with diversity being the main drive in recruiting new officers, this could be explored in future studies to

understand if it influences how officers work with the mentally distressed in the community and hospital ED.

However, despite these limitations, employing a constructivist ground theory methodology for this research has enabled a theory to develop that is grounded in the data. This occurred even when the generation of data did not adhere to the ideal sequence.

Conclusion

My contribution has been to generate a substantive theoretical interpretive understanding of how the directive between New Zealand Police and DHB mental health services is impacting how officers work with those in mental distress.

Having analysed the interview data from 22 frontline police officers, I have been able to determine how they work and what they require when working with people in mental distress in the community and then the hospital ED. What has emerged is that officers have a much wider role in both setting when working with those in mental distress that has not previously been recognised.

My original contribution has been to capture the voice, behaviours and resolution processes of how frontline New Zealand Police officers construct their working with persons in mental distress. To date, I know of no other research that has achieved this. Additionally, I have made an original contribution of new knowledge and potential policy/practice recommendations for the New Zealand Police which will assist in future training programmes. This research also adds New Zealand specific information into the global body of research in the area.

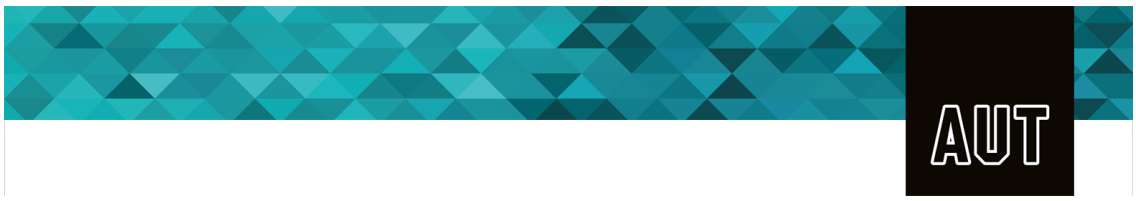
The emergent grounded theory co-constructed by me and the 22 participating officers can be summed up in a simple phrase. New Zealand frontline police officers are consistently *doing their best* when working with those in mental distress.

A memo I had written seemed an appropriate conclusion for this study. The memo stated:

> Despite innovative thinking and good intent to 'patch up' a mental health system which appears to be in crisis, the issues for police officers when working with those who are mentally distressed are still unresolved. Roles have shifted for police officers over the last decade. Interagency agreements are not communicated or adhered to by officers' interagency partners. The police organisation cannot simply merge the old system of policing into the contemporary approach required today. Although, new recruits, who with the best of intent try to embrace the social welfare approach aspects to their policing, it continues to still be basically constructed around 'a warrior' rather than 'guardianship' model. A fresh approach is needed and is constantly being sought to ensure a positive outcome for the officers and those in mental distress. (10.11.18)

Appendices

Appendix 1:Ethics Approval



AUTEC Secretariat
Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

2 February 2017

David Healee
Faculty of Health and Environmental Sciences

Dear David

Re Ethics Application: **16/413 New Zealand Police management of people in mental health crisis within a hospital emergency department**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 2 February 2020.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 2 February 2020;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 2 February 2020 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Jenny van der Harst

Appendix 2: NZ Police Research Agreement – AUT

New Zealand Police Research Agreement

THIS AGREEMENT is made on…… [20th]……[November]……2017

BETWEEN Her Majesty the Queen in Right of Her Government in New Zealand acting by and through the Commissioner of Police ("Police")

AND the Principal Researcher: AUT research student: Jenny van der Harst (9024824), Research Supervisor, Dr David Healee, and the Auckland University of Technology (AUT).Research Office
……

AND/OR Principal Researcher's Organisation
Auckland University of Technology (AUT)

Please note: If the principal researcher is employed by or affiliated to a NZ University the University will be the party to this agreement. This agreement should be entered into through the University's Research Office.

BACKGROUND

The NZ Police (hereinafter Police) want to make high-quality data available for research:

1. in as much detail as is necessary and possible
2. as widely as practicable
3. as soon as possible
4. as conveniently as is reasonable having regard to the impact on the activities of Police

while ensuring all legislative and ethical obligations governing access to, and safekeeping of, individualised and personal information are followed.

a. The Principal Researcher has submitted to Police an application to undertake research, including a Research Proposal as set out as Schedule One ("The Application").

b. The Researcher has submitted The Application after having read and understood the Police Policy for External Researchers Access to Resources, Data or Privileged Information

c. Police has accepted and approved The Application.

d. This Agreement documents the terms and conditions upon which Police allows the Researcher to conduct research accessing the resources of Police. The scope of the research is detailed in the approved Research Proposal appended as Schedule One.

e. If the Researcher wishes, at any stage, for additional individuals to undertake research (or to substitute individuals) they must first obtain Police consent in writing

and understand that those additional individuals may first need to clear appropriate and reasonable security and additional checks before undertaking research.

f. The Researcher agrees to conduct research in accordance with The Application.

g. The Researcher has approval from an accredited institutional ethics committee, or the proposal has been reviewed by a recognised human ethics body.

h. Other than information being gathered for the research, the Researcher agrees to keep confidential all information about Police and its operations about which the Researcher becomes aware and where this information is not in the public domain. This condition survives expiry or termination of The Project and this Agreement.

i. Researchers are welcome to provide comments on their experiences with conducting research with Police to research@police.govt.nz that will be included within the review of the Police Policy for External Researchers Access to Resources, Data or Privileged Information that will occur every 24 months.

THEREFORE IT IS AGREED AS FOLLOWS:

1 INTERPRETATION

1.1 "Police" means the New Zealand Police.

1.2 "Principal Researcher" means an individual who takes responsibility for the project or collaboration of researchers, the lead researcher, or the supervisor of any student research.

1.3 "Researcher" means any person working on The Project.

1.4 "The Researcher" means the collaboration that is the Principal Researcher and all researchers directed to work on the project by the Principal Researcher.

1.5 "Police Liaison Officer" means [Inspector Shanan Gray, Shanan.Gray@police.govt.nz Mobile: 0211914279

1.6 "Police Subject matter Expert" means [Not applicable]

1.7 "The Project" means EV-12-number: [EV-12-433].

1.8 "Police information" includes any data held by Police or produced through the use of any Police activity, or produced using any resource(s) that belongs to Police.

1.9 "Privileged Police Information" includes:

(a) information stored within any Police database, file or documentation, not otherwise publically available; and

(b) the views and information supplied by current and former Police employees interviewed or surveyed for The Project;

1.10 "Personal Information" has the same meaning as in the Privacy Act 1993.

1.11 "Ethical Standards" means The Royal Society of New Zealand Code of Professional Standards and Ethics.

1.12 "Release" means submit, present, publish, disseminate or otherwise disclose The Project Findings.

1.13 "Project Findings" includes Privileged Police Information; any derived data, analyses and results from analyses, the recordings of interviews and any draft or completed Project Reports.

1.14 Subject to clause 12, the "Term of this Agreement" is from the date of this agreement until:

(a) day month year, or

(b) The Project Findings are released, or

(c) The Project is terminated, (whichever occurs first).

1.15 Singular and Plural: The singular includes the plural and vice versa.

2 GENERAL TERMS AND CONDITIONS

2.1 The Researcher proposes to undertake a research project, "The Project".

2.2 The Project requires the Researcher to access relevant Police Information.

2.3 Police agree to make available to the Researcher such resources, Police Information and help as is feasible and reasonably necessary for The Project.

2.4 It is the Principal Researcher's responsibility to have had the project assessed by an approved Ethics Committee if such is necessary.

2.5 The Researcher agrees to maintain the security and confidentiality of all Privileged Police Information obtained for The Project.

2.6 Only those individuals identified in The Application and named in this Agreement as Researchers may undertake The Project. Prior to commencing the research, The Researcher will meet all of Police's security or any other requirements (which may relate to Health and Safety, for example) relating to access to any institution and to participants.

3 JURISDICTION

3.1 This Agreement is governed by and construed according to the law of New Zealand.

3.2 Where the Principal Researcher and any other Researcher is resident out of New Zealand, or carries out any work related to The Project out of New Zealand, or in any case where any foreign court might otherwise have been considered to have any jurisdiction in regard to this Agreement, the Principal Researcher agrees to submit to the exclusive jurisdiction of the New Zealand Courts.

4 STATUS AND OBLIGATIONS OF THE PRINCIPAL RESEARCHER

4.1 The Principal Researcher must ensure that all Researchers conduct The Project in accordance with this Agreement.

4.2 The Principal Researcher has declared any relevant interests, all associations or any employment which might meaningfully impact on this agreement. Where the Principal Researcher is employed by a University the University will be party to this agreement.

5 POSSESS PRIVILEGED POLICE INFORMATION LAWFULLY

5.1 The Principal Researcher and any other Researcher may only access Privileged Police Information if Police approve their access to it pursuant to the Police Policy for External Researchers' Access to Resources, Data or Privileged Information and this Research Agreement.

5.2 The Principal Researcher and any other Researchers must not access, attempt to access, or use Police property or Privileged Police Information unless it is for the purpose of The Project.

5.3 The Principal Researcher and any other Researcher must comply with section 50 of the Policing Act 2008. Under this section, it is an offence to have Police property without lawful authority, or reasonable excuse.

6 MAINTAIN INFORMATION SECURITY AND CONFIDENTIALITY

6.1 The Principal Researcher and any other Researcher shall protect Privileged Police Information against unauthorised access, use, modification, disclosure, misuse or loss by storing Privileged Police Information on computers or devices with at least:

a. individual user challenge and authentication (user name and password)

b. individual user access logging firewalls;

c. intrusion detection system and server authentication;

d. operating system and application security measures (e.g. up to date antivirus screening, anti-"spyware" measures);

e. protecting Privileged Police Information stored electronically with passwords;

f. Protection of information or datasets electronically communicated over a public network (such as the internet).

And in the case of physical storage, printouts or media holding the data must be stored in lock cabinets.

6.2 The Principal Researcher and any other Researcher shall not:

a. disclose any Privileged Police Information to any third party.

b. use for any purpose (including educational or further research purposes) any Privileged Police information obtained during the Term of this Agreement other than for the purpose of The Research Project.

c. attempt to data-match or identify individuals in data which has been confidentialised.

d. make any copies of Privileged Police Information except where reasonably required to permit the research.

6.3 In relation to outputs from data analysis, the Researcher shall:

a. apply any confidentiality rules stipulated in the metadata, by Police and/or the data owner, before outputs are released.

b. actively consider whether outputs could be an inappropriate disclosure risk even with the confidentiality rules applied and take further steps to protect the output if necessary.

c. not provide outputs to anyone who is not an authorised researcher with the Project unless the outputs have been sufficiently confidentialised.

6.4 As soon as possible, and no later than 3 weeks after the end of the Term of this Agreement, the Principal Researcher shall provide the Police Liaison Officer with a schedule outlining all Privileged Police Information that Researchers hold. Police will provide directions as to whether and how to return the information or destroy it securely and the Principal Researcher and any other Researcher will comply with these directions, either returning the information or destroying it securely accordingly.

6.5 When destroying Privileged Police Information the Principal Researcher and any other Researcher:

a. must not place hard copy material in ordinary office wastepaper or rubbish bins;

b. must shred hard copies (to below 5mm), or dispose of them as secure waste (e.g. through a contractor such as the DDS “blue bin” system);

c. must delete all electronic copies from systems, computers, and devices; and

d. must confirm in writing that all Privileged Police Information has been returned or disposed of securely, as directed by Police.

6.6 The Principal Researcher shall agree to release data collected under the provisions of this Agreement to Police upon request, unless there is an ethical consideration that prevents the Principal Researcher from doing so.

6.7 If the Principal Researcher discloses, accidentally or otherwise, any Privileged Police Information in the possession of the Principal Researcher where not permitted by this Agreement, or becomes aware or suspects that any person has obtained unauthorised access to or has used or attempted to use any Privileged

Police Information for purposes not permitted by this Agreement, the Principal Researcher will:

a. immediately notify the Director of Research and Evaluation at Police;

b. use best endeavours to retrieve the Privileged Police Information and identify the person and secure the Privileged Police Information against any further unauthorised access or misuse.

7 CONDUCT RESEARCH

7.1 Where Police has approved The Project, the Principal Researcher shall ensure that all Researchers:

a. carry out The Project in accordance with The Research Project Proposal, which is attached as a Schedule to this Agreement;

b. follow any statistical obligations and quality rules stipulated in the metadata, by Police and/or the data owner.

c. work in consultation with the assigned Police Subject Matter Expert.

8 ADHERE TO A REPORTING SCHEDULE

8.1 The Principal Researcher will e-mail an update on the progress of The Research Project to research@police.govt.nz at intervals specified in the proposal or every 3 months.

8.2 At any time, Police may request the Principal Researcher to provide an update of progress, covering what has been achieved, what results have been produced, planned publication, and a list of the current research team. Refer to clause 9.4 for requirements in relation to Police review of research outputs prior to dissemination.

8.3 The Principal Researcher will provide Police with advance notification that they are about to seek Police peer review, via an e-mail to research@police.govt.nz at least 10 days before seeking peer review.

8.4 The Principal Researcher and any other Researcher will use the full Project reference (see clause 1.7) in all correspondence with Police.

9 RESULTS OF THE RESEARCH

9.1 The principal researcher must agree to a reasonable timeframe for completing the research and publishing results.

9.2 All results must include an appropriate reference to the source of the data collection and appropriate acknowledgement to the efforts of Police staff.

9.3 All results must include a disclaimer indicating that the researchers take full responsibility for the outputs. For example, “the results presented in this paper are the work of the authors.”

9.4 The Principal Researcher must send copies of results, publications and presentations to Police, with sufficient opportunity for material to be reviewed, prior to dissemination, so that Police is informed before any public interest is generated. Progress updates covering results and outputs can be requested by Police at any time (refer to clause 8.2).

9.5 Police may publish links to published work on its external website.

10 COPYRIGHT

10.1 Intellectual property and copyright of any Privileged Police Information provided by Police to the Researchers shall belong to Police.

10.2 The Principal Researcher will provide to Police electronic copies of all final journal articles, thesis, presentations or any other reports prepared for The Project. All such documents may be used and copied by Police for any internal purpose, including, without limitation, publication on internal websites with appropriate acknowledgements as to source.

11 TERMINATION

11.1 The Police Director of Research and Evaluation may review The Project operating under this Agreement and present the review to a member of the Police Executive with the recommendation to terminate this Agreement.

11.2 If an Executive member of Police agrees with the recommendation then Police will advise the Principal Researcher of the review and seek their response.

11.3 If no resolution is achieved within 10 working days, the Director of Research and Evaluation may exercise the recommendation and terminate this Agreement by giving written notice to the Principal Researcher.

11.4 The foreseeable circumstances in which this clause might be exercised are:

a. The Researcher fails to comply with reasonable timeframes.

b. The Researcher fails to exercise a professional standard of practice.

c. The project creates an unanticipated and/or unreasonable demand upon Police resource beyond that represented in or contemplated by the Research Project proposal.

d. The researcher engages in conduct which, in the opinion of Police, is or may be likely to injure the reputation or interests of Police or brings or potentially brings Police into disrepute.

e. The researcher commits a material breach of this Agreement.

f. Breach of confidentiality and security. Breaches that are deliberate or a result of a lack of due care may also affect future access requests.

11.5 The Researcher can terminate this Agreement for any reason and without cause, by giving the Police one month's written notice.

11.6 If this Agreement is terminated, Police is not obliged to provide any support to The Project or any further information to the Principal Researcher or any other Researcher in relation to this project.

12 NON-TERMINATION

12.1 The Principal Researcher agrees that the obligations in this Agreement to maintain the confidentiality of Privileged Police Information shall be continuous and, in particular, shall continue in force beyond:

(a) the termination of this Agreement;

(b) the completion of The Project;

(c) release of the Project Findings; and

(d) the end of the Principal Researcher's involvement in The Project.

13 AMENDMENTS

13.1 No amendment of this Agreement shall be effective unless it is in writing and signed by both parties.

14 DISPUTE RESOLUTION

14.1 Subject to Clause 11, the parties agree to try to resolve any dispute arising from this Agreement by mediation (using the LEADR New Zealand Inc. standard), before starting any arbitration or legal proceedings.

15 COMPLETE AGREEMENT

15.1 This Agreement constitutes the full and complete agreement between Police and the Principal Researcher for the Project and supersedes all previous agreements, representations and contracts in relation to the Project.

16 GENERAL

16.1 The conditions of this Agreement which are capable of having effect after this Agreement expires shall remain in full force and effect after this Agreement expires.

17 ADDITIONAL TERMS

17.1 The following additional terms apply to this Agreement:

SIGNED by	..... (signature)	..... (name in block letters)
on behalf of **THE COMMISSIONER OF NEW ZEALAND POLICE**		
	Police National Headquarters 180 Molesworth Street Wellington 6140	Director, Research and Evaluation Police
SIGNED by the Principal Researcher	J.M. Van der Harst ..... (signature)	JENNY VAN DER HARST ..... (name in block letters)
	7b Arkles Strand Arkles Bay Whanaparaoa ..... (address)	Doctoral Student AUT ..... (Position)
SIGNED by Researcher [repeat as necessary]	.... (signature)	DAVID HEALEE ..... (name in block letters)
	90 Akoranga Drive Northcote Auckland 0622 ..... (address)	Senior Lecturer School of Clinical Sciences AUT ..... (Position)
SIGNED by a representative of the Principal Researcher's Organisation, [*where necessary*] *This may be a Manager or CE and depends on the policy of the organisation that allows the principal to enter into this agreement.*	.....pp.... (signature) Dr Rosanne Ellis	Prof John Raine..... (name in block letters) Director Research Strategy + Management
	55 Wellesley Street, Auckland 1010..... (address)	PVC – Research & Innovation..... (Position in Organisation)

Schedule One ("The Application").

Appendix 3: Advertising Flyers

WANTED

New Zealand Police Officers who have experience in working with people in mental health crisis in a hospital emergency department.

My name is Jenny van der Harst. As part of a study, I am interested in interviewing Police Officers who have experienced interacting with people in mental health crisis involving a visit to a hospital emergency department.

If you wish to participate:

If you are interested in participating in this study you can obtain an Information Sheet and Consent Form from the reception desk at the Police Station where you work. Alternatively, you can contact me by email to discuss your participation and at what appropriate venue you would like the interview to take place.

For those wishing to be interviewed at your place of work. I will be at your Station for approximately 2-3 days to conduct the interviews. There will be a notification advising the days I will be coming.

A recorded interview, or possibly two, is all that is required of you. The interview will take approximately 40-60 minutes. Confidentiality for participants is assured and a requirement of this research.

Looking forward to your expression of interest to participate in this research.

For further information, email: jenny@vanderHarst.co.nz

Appendix 4: Participant Information Sheet

Date Information Sheet Produced:

October 2017

Project Title

"New Zealand Police management of mentally distressed persons within the hospital emergency department".

An Invitation to participate:

My name is Jenny van der Harst. I am interested in researching how New Zealand police officers work with people in mental health crisis within the hospital emergency department. I am seeking to understand what you do when accompanying such individuals experiencing a mental health crisis and how you manage the situation. By talking to you, I hope to gain a sense of what is involved and how it can be made better.

What is the purpose of this research?

The purpose of this study is to explain and understand how you, as frontline police officers manage the situation when accompanying and an individual in mental health crisis. In addition, the findings will provide information on your important role in this setting and will help to inform the development of supportive practices in the field, in future training programs for NZ Police, and policy development.

Also, as a result of the research, I will gain a doctoral degree with Auckland University of Technology (AUT). Findings from the research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You will have responded to the recruitment flyers/posters looking for volunteers to participate in the study. Your experience with the topic will be valuable in helping to determine how working with people in mental crisis can be improved from the front-line police perspective.

How do I agree to participate in this research?

If you are interested in voluntarily participating in this study, you can contact the primary researcher via email or when I am at your workplace. You will be given/sent an Information sheet and a contact number to discuss how you can participate. Once you agree to be a participant, you will be asked to sign a consent form.

Your participation in this research is voluntary. You will be able to withdraw from the study at any time. If you choose to withdraw you will be offered the choice to have any identifiable data removed or allow it to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

The research involves a recorded interview at a venue and time which suits you. I will ask you to talk to me about how you as police officers work with people in mental health crisis in the hospital emergency department. The interview will be transcribed and analysed. The interview transcript will be sent to you, where you may add, delete or amend the information. All interviews will follow the same process and will be analysed for processes that explain how you work with people in mental health crisis.

What are the discomforts and risks?

There are no intended discomforts or foreseen risks involved in the study. Your participation will not be disclosed to your employer or be available to another person or organisation.

How will these discomforts and risks be alleviated?

However, if, during the interview, you are discussing situations that make you feel uncomfortable, the interview can be postponed. If required, free counselling is available.

AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling.

What are the benefits?

By participating in this research, a document will be produced that provides a better understanding of how police officers work with the mentally ill, not just in the community, but also in the hospital emergency department.

How will my privacy be protected?

In order to ensure confidentiality, you will be given a pseudonym that will be used throughout the research. The information you provide will only be used in my research, and it will not be possible for you to be identified in any reports that are prepared from the study. The interview tapes, transcripts and consent forms will be in a secure storage facility at AUT for at least 6 years. Only the primary researcher, project supervisors and a typist, will have access to the information you provide.

What are the costs of participating in this research?

The only cost is the time taken for an interview which would be approximately 40-60 minutes. You may be asked for a second interview (approximately 30 minutes) but this will be negotiated with you. The total potential time involved could be a maximum of 120 minutes.

What opportunity do I have to consider this invitation?

Up to a maximum of four weeks

Will I receive feedback on the results of this research?

A summary of the research will be made available if you request it.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr David Healee* *dhealee@aut.ac.nz* *Phone: +64 9 9219999 ext. 7642*

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Jenny van der Harst

jenny@vanderharst.co.nz

Project Supervisor Contact Details:

Dr David Healee dhealee@aut.ac.nz Phone: +64 9 9219999 ext. 7642

Appendix 5: Consent Form

Consent Form

Project title: ***New Zealand Police management of people in mental health crisis within a hospital emergency department.***

Project Supervisor: ***Dr David Healee***

Researcher: ***Jenny van der Harst***

- ○ I have read and understood the information provided about this research project in the Information Sheet.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

  I understand that the NZ Police may request a copy of the transcribed interview; however, a unique identifier is used.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 28 November 2016

AUTEC Reference number 16/413

Note: The Participant should retain a copy of this form

Appendix 6: Indicative Interview Questions

Indicative Interview Questions

Project title: **New Zealand Police management of people in mental health crisis within a hospital emergency department.**

Project Supervisor: **Dr David Healee, Professor Brian McKenna**

Researcher: **Jenny van der Harst**

Interview Questions:

These are only indicative interview questions. Prompting questions may be used to clarify participant responses. The participant can respond in their own time.

Opening the Interview question:

- Tell me what you know about interacting with people with in mental health crisis

During the interview: (Clarifying or exploratory questions)

- You mentioned…., please tell me more about this
- Could you explain what you mean about…?
- Do you have examples of…?
- What was your understanding of…?

Concluding the interview:

Is there anything else that you would like to tell me?

Appendix 7: Confidentiality Agreement

Confidentiality Agreement

Project title: "New Zealand Police management of people in mental health crisis within the hospital emergency department".

Project Supervisor: ***Dr David Healee***

Researcher: ***Jenny van der Harst***

- ○ I understand that all the material I will be asked to type is confidential.
- ○ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature: .....

Typist's name: .....

Typist's Contact Details (if appropriate):

.....

.....

.....

.....

Date: 10.01.2018

Project Supervisor's Contact Details (if appropriate):

Dr David Healee

Lecturer/Head of Post graduate programmes

School of Clinical Sciences

Auckland University of Technology

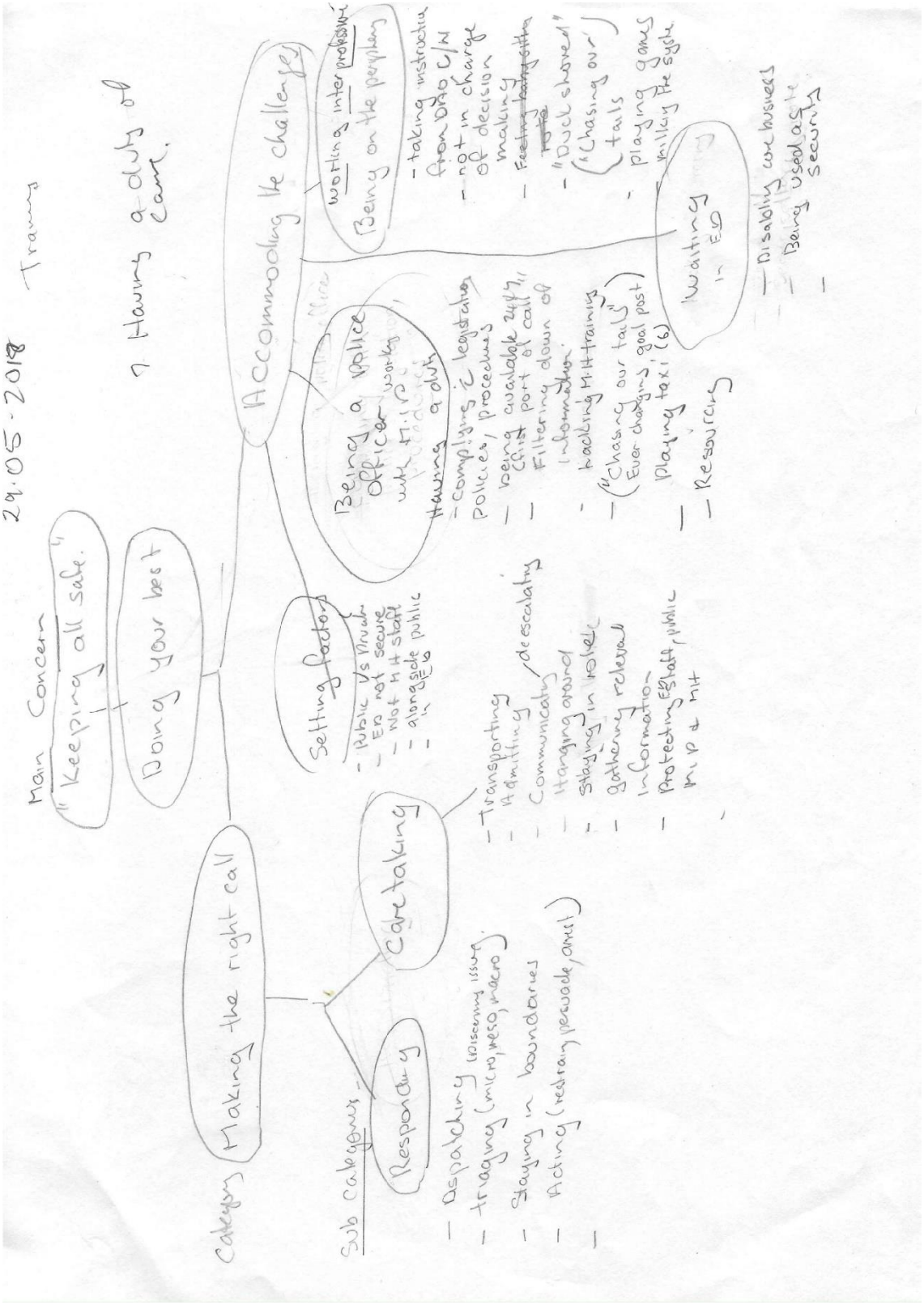
09 921 9999 x 7642

.....

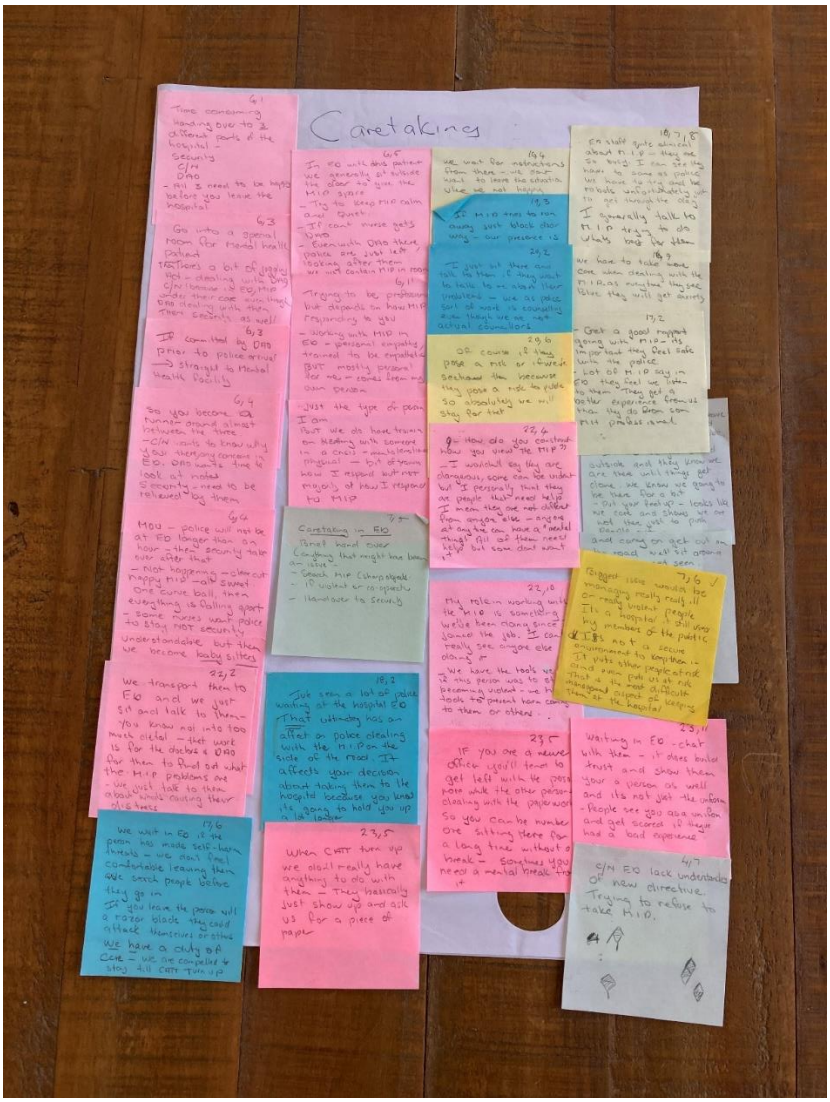
Approved by the Auckland University of Technology Ethics Committee 2 February 2017 AUTEC Reference number 16/413

Note: The Typist should retain a copy of this form.

Appendix 8: Clustering of Tentative Focused Codes



Appendix 9: Post-it Note Coding Method



Appendix 10: Group Presentation of the Theory *Doing Your Best*

Project title: **New Zealand Police management of people in mental health crisis within a hospital emergency department**

Project Supervisor: **Dr David Healee, Professor Brian McKenna**

Researcher: **Jenny van der Harst**

After interviewing twenty-three of your colleagues from three different Stations I have analysed their responses. From the data collected, the theory of *doing your best* is my interpretation of how you as frontline police officers in New Zealand work with those in mental distress within the hospital emergency department.

In order for me to ensure I have interpreted the processes correctly and not left out anything, could you please give me feedback on the following questions?

1. **Is the theory that I have presented titled '*Doing Your Best*' of how you work with persons in mental distress in the hospital emergency department resonated with you as being correct?**

Comment:

2. **Have you identified any gaps in this theory that are pertinent to how you do work with those in mental distress in the hospital emergency department?**

Comment:

3. **If so, what have I misinterpreted, or have missed out?**

Comment:

4. **Is this an accurate account of how you work with these individuals within the hospital emergency department? If not, why not?**

Comment:

5. **Any further comments you wish to add?**

Comment:

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