# People in mental distress, police and out-of-hours health services: a qualitative exploratory case study of experiences and the intersect of safeguarding services.

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# People in Mental Distress, Police and Out-of-Hours Health Services: A Qualitative Exploratory Case Study of Experiences and the Intersect of Safeguarding Services

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# Abstract

**Aim:** To explore the experiences of people in mental distress who come to the attention of police and healthcare professionals outwith routine hours.

**Background**: Some people in the community call on police officers to help manage their self-harm behaviour, with the intention of preventing serious harm. As conduits to healthcare and in keeping with police safeguarding policies, officers will seek healthcare practitioner assessment and support.

This can be problematic when an individual's needs are not associated with a severe mental disorder, time-critical medical emergency, or the person is intoxicated. Consequently, police officers may feel unable or insufficiently confident to discharge safeguarding responsibilities when they, or the individual perceive needs are unmet. This can find some people, police officers and healthcare practitioners exposed to lengthy wait times and repetitive distress presentations.

This thesis addresses a gap in existing literature through the exploration of the relationships and experiences of people in mental distress, and Police and Health Care Professionals involved in their safeguarding during out of hours. It also provides an in-depth account of the factors and features of Police and Health Care Professional processes that facilitate or impede safeguarding journeys.

**Methods:** An in-depth, qualitative case study with three phases, was conducted. This study was underpinned by broadly social constructionist perspectives with each phase building on the in-depth understanding and interpretation of data.

1. Semi-structured interviews (n = 12) with police and health managers providing a landscape of the police / health care intersect when supporting people in mental distress.
2. Three clinical cases in which police and healthcare practitioners responded to people in mental distress were explored critically, using semi-structured interviews (n = 15).
3. Three focus group interviews with operational police officers and healthcare practitioners (n = 18) explored front line perspectives of supporting people in mental distress and helped contextualise and enhance phases 1 and 2 findings.

Template Analysis supported the thematic analysis of findings, which elaborated on and interpreted through the inter-related theoretical lens of Defeat and Entrapment Theory (Gilbert and Allan, 1998), Cry of Pain Model (Williams and Pollock, 2001) and the Stark et al. (2011), Conceptual Model of Suicide.

**Findings**: Health and Police systems and human responses can influence individuals' experiences and undermine safeguarding journeys. A predominantly medicalised model of unscheduled care, gaps in inter-agency safeguarding policies and legislation, inconsistencies in levels of sobriety to conduct mental health assessment and availability of appropriate safeguarding environments can find people displaced between criminal justice and health services. Police and healthcare practitioners' organisational cultural and professional perspectives of peoples' needs find those practitioners working in conflicting ways and the individual inadvertently overlooked. These factors were particularly problematic when people were distressed, intoxicated or aggressive.

This study identifies a relationship between feelings of entrapment, intoxication, aggression and inter-agency safeguarding. Police officers encounter situations where an individual is distressed, intoxicated and aggressive and who cannot be assessed by health services. Collectively, these factors can create situations exposing people to additional stressors such as inappropriate safeguarding environments, e.g., police custody as a safeguarding space, police escorted transportations and coercive processes such as handcuffs and strip-searching. This leads to a lack of dignity and re-traumatisation, thus reinforcing cyclical distress journeys.

**Conclusion:** There exists a gap in environments, policies and processes to keep people in mental distress safe which impacts upon safeguarding journeys. Police and health system shortcomings may result in a person in mental distress being managed in the criminal justice system if no other options are available. This is due predominantly to a medicalised model of emergency care which is further complicated if the person in mental distress is intoxicated.
For the person in mental distress, their reality is a safeguarding journey which may be convoluted, cyclical and one which reinforces, rather than supports, their distress needs. Although unintended, police and healthcare professionals' responses reinforce a cyclical safeguarding journey which does not meet the needs of the person in mental distress and can place pressure on police and out-of-hours health services. These findings have important implications for trauma-informed Police and HCP practice. The issue of how police and health care professionals respond to people who are distressed, intoxicated and aggressive, should be explored in further research.

KEY WORDS: Mental distress, self-harm, police, people's experiences, out-of-hours emergency health, systems, interagency safeguarding, qualitative case study.

MeSH TERM: Psychological Distress

# Glossary of Terms

**Justification for key terms I have used in this thesis can be found in Appendix 1**

| | |
|---|---|
| *999* | The telephone number to initiate an emergency response (Ambulance, Police or Fire and Rescue) |
| *ASPA* | Adult Support and Protection (Scotland) Act (2007) |
| *BAC* | Blood Alcohol Content |
| *CPN* | Community Psychiatric Nurse |
| *CSR* | Case Study Research |
| *E. D.* | Emergency Department |
| *FY2 Doctor* | A Foundation Doctor (FY1 or FY2 also known as a house officer) is a grade of a medical practitioner on a two-year, general postgraduate medical training programme |
| *G. P.* | General Practitioner |
| *HCP* | A health care professional. In this thesis, in the main, the HCP participants I refer to are emergency medicine and Mental Health Nurses, Psychiatrists, G.P.s, Emergency Medicine Physicians and Doctors |
| *Human responses* | In terms of human responses, I mean heath care professional and Police Officer ways of working as a result of professional and organisational practices and cultures |
| *iVPD* | Interim Vulnerable Person Database. Police Scotland |
| *Kardexes* | Medications prescribing and administration chart used in hospitals |
| *NHS* | National Health Service |
| *NHS24* | Scotland's national tele-health and tele-care organisation providing telephone advice and triage for out-of-hours periods |
| *MHCTA* | Mental Health (Care and Treatment) Act (Scotland) 2003 |
| *P. D.* | Personality Disorder |
| *PiMD* | Person(s) in Mental Distress |
| *Police concern report* | A report written by the attending Police Officers, screened by a Police Concern Hub and shared with partner agencies such as primary health care or social work services highlighting police engagement with a person they believe to be vulnerable or at risk |

| | |
|---|---|
| *POS* | Place of Safety |
| *PFRSA* | Police and Fire Reform (Scotland)Act |
| *Psychiatric Emergency Plans* | Locally agreed multi-agency guidance for staff who may be involved in various functions under the MHCT Act<br>The guidance applies to all health care and local authority personnel, police officers, ambulance personnel, and fire and rescue officers |
| *Safeguarding journey* | Out-of-hours safeguarding journeys involving PiMD who come to police attention within the community, who are referred by police to health services, and later discharged home or to police custody |
| *Self-Harm* | For this thesis, I define self-harm as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. Thus, this 'umbrella' term views acts of self-harm and suicide as being on a continuum. It includes suicide attempts as well as acts where little or no suicidal intent is involved (e.g. where people harm themselves to reduce internal tension, distract themselves from intolerable situations, as a form of interpersonal communication of distress or other painful feelings, or to punish themselves.) |
| *Systems and structures* | In terms of systems and structures, I mean the network and organisation of police and health services. |
| *SOP.* | Standard Operating Procedure |
| *W.H.O.* | World Health Organisation |

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# Chapter 1: Introduction

## 1.1 Overview

In this thesis, I both explore and seek an understanding of the relationships, experiences and processes influencing how people in mental distress (PiMD) are kept safe outwith routine operational hours.

This study focuses on PiMD who self-harm or wish to self-harm, who come to the attention of police officers, are assessed by a healthcare professional (HCP) and returned home. This group represents a significant proportion of the population who may not benefit from, or do not meet the threshold for admission to medical or psychiatric inpatient care, and for whom another out-of-hours community-based support, such as family, is insufficient.

Explored through the lens' of PiMD, Police Officers and HCPs involved in mental distress incidents, this thesis identifies systems and human shortcomings within police and health service inter-agency working. By addressing this gap, the thesis articulates the relationship between peoples' experiences of mental distress and police and health care systems and structural factors (network and organisation of police and health services). Factors and human inputs that enable or disable mental health distress during out-of-hours safeguarding journeys are illustrated within a novel conceptual model (pg.187).

In this first chapter, I analyse critically, the context and factors associated with the nature of mental distress and the police / health care intersect. I set out the aims and the scope of this study, positioning myself in this thesis - drawn from my clinical experience working across health and police services in adult and mental health nursing. I define the 'case' in this study and the key term 'safeguarding journey' used throughout this thesis. My experience working across both sectors provides the impetus for this research. I will illustrate my first steps towards constructing the research questions and the focus of the literature review in Chapter 2 in which I discuss the support of PiMD at the intersect of police and health services.

In concluding this chapter, I provide an overview of each subsequent chapter to guide the reader through this thesis

## 1.2 Introduction

The Scottish Government Mental Health Strategy (2017c), Police Scotland Policing 2026 Strategy (Police Scotland, 2017), and the Christie Commission (Christie, 2011), identify

actions for each organisation to work more effectively in partnership to support people with mental health needs. These actions highlight that police are often first responders to people during out-of-hours periods where their main issues are mental distress where no offence has been committed. Therefore, police officers hold an important role in keeping people in mental distress (PiMD) safe and as conduits to emergency health care. Partnership working between police and unscheduled care mental health and emergency medicine services, therefore, is crucial.

Despite Scotland being championed for its progressive mental health legislation (Stavert and McKay, 2017), how PiMD, are supported within the UK health and criminal justice systems is contentious. The Scottish Government (2016) reported that only 1 in 3 people who would benefit from mental health treatment receives it. After a decline in suicide rates in previous years, attributed to the introduction of the Scottish Suicide Prevention Strategy (2013), 2018 saw a 15% increase in deaths by 'intentional self-harm'. In the period between 2009-2015, over one quarter (30%) of people who died by suicide attended the E.D. in the three months before their death (ISD Scotland, 2017). This suggests there are gaps between emergency care and community mental health care to intervene effectively to prevent suicide death.

Moreover, the experiences of people accessing emergency mental health care can be poor. People with a mental health problem are more likely than others to wait longer than 4 hours in the E.D. and often feel their needs are not being taken seriously (MIND, 2011). When police officers are involved in a mental health response, people can experience agencies working in isolation and being hastily referred from one agency to the next (MIND, 2011). Additionally, PiMD can experience increased perceived stigmatisation with police involvement, causing further distress and anxiety (Corrigan, 2014, Corrigan et al. 2014). Therefore, there appears a disconnect between what PiMD need and provision of timely, dignified and compassionate care to meet those needs.

Critics argue UK austerity policies over the last 10 years find the mental health system under significant pressure (Cummins, 2018). The closure of adult mental health hospital beds finds demand for crisis services outstripping supply (Mattheys, 2015). Shortcomings in out-of-hours mental health care sees an over reliance on police officers managing community-based mental health interventions (Spence and Millott, 2016, McLean and Marshall, 2010), and the ‘Emergency Department’ shift to being a service for 'Anything and Everything' (Kerasidou and Kingori, 2019).

There also is criticism of the criminal justice system, arguing that police organisations need to institute urgent reforms to rectify a culture of complacency towards mental health care. This can find the use of police discretion to be unprotective, resulting in the unacceptable treatment of people with mental health problems (McDaniel, 2019).

Despite there being no definitive data on the nature and scale of PiMD coming into police and emergency health services contact in Scotland, it is becoming increasingly recognised there is a significant demand on police and out-of-hours health services to keep PiMD safe. Police Scotland responded to around 57,000 mental health incidents in 2015 (Graham, 2017). The Mental Welfare Commission reported in 2016, that 1,133 people were transported by police officers to a Place of Safety, such as an E.D. or psychiatric hospital under their powers of detention of Section 297 of the Mental Health (Care and Treatment) (Scotland) Act (2003)(MHCTA) (Mental Welfare Commission, 2018).

It is striking that 97% of people were not detained in a hospital when brought to a Place of Safety by police. Similar patterns are seen in England and Wales, with a six-fold increase in police mental health concern referrals over recent years (Keown, 2013). Nevertheless, there is a decline in the number of people admitted to hospital when brought to health services by police (House of Commons Home Affairs Committee, 2015). This suggests there is a group of people who come to police attention for whom they are seriously concerned yet fall in a gap between inpatient psychiatric care and community-based services.

These figures do not provide a complete picture. The Mental Welfare Commission data presented in the previous paragraph accounts only for PiMD for whom police officers have used their powers of detention. There appears to be disparity in the number of people police respond to with mental health needs (57,000), compared to those recorded detained in a Place of Safety (1133).

Potentially there are people with mental health needs, being supported by police officers outwith the MHCTA. The Mental Welfare Commission data does not account for those not detained under police legislative powers when transported to health services for mental health assessment, for example, those willingly escorted by police to psychiatric or emergency health services. Nor does it account for those assessed in their own homes by out-of-hours G.P.s, or PiMD who are intoxicated or violent and managed in police custody. This would suggest a need for better understanding of the nuance and crisis nature of PiMD safeguarding beyond MHCTA detentions.

In 2017, the Scottish Government developed the Strategic Health and Justice Collaboration Improvement Board (Scottish Government, 2017a), to support innovative cross-disciplinary working, and better support people coming to the attention of health and criminal justice services. The care of people with mental health needs is one of the three key priorities identified by this group. Highlighted within their programme of work, is a need for a robust evidence base to better understand responses to PiMD, to develop innovative approaches to inter-agency working between police and health services in Scotland (Scottish Government, 2018).This thesis seeks to contribute to this knowledge gap.

## 1.3 Aims and Scope of this Thesis

Previous research on the support of PiMD by Police and HCP tends to focus on the most severe psychiatric diagnoses such a schizophrenia, inpatient care or police custody (Rehman and Farooq, 2007, Hoffman et al. 2016, Soares and Pinto Da Costa, 2019, Allen et al. 2014, Hayward and Moran, 2007, Leese and Russell, 2017, Ogloff et al. 2011). Research attention on PiMD whose self-harm behaviours do not reach thresholds for psychiatric detention or where there has been no offence committed, is limited. Nonetheless, this group appear to be at risk of future serious self-harm (Dougall et al. 2014) with cyclical mental health safeguarding journeys placing significant demand on police and emergency health resources (Paton et al.2016, Bradbury et al.2014).

Existing qualitative studies associated with PiMD, Police or HCP relationships, have focussed on experiences in discrete areas of safeguarding journeys. For example, police responses in the community, or HCPs in the E.D. The evidence base lacks qualitative investigations which provide a rich, in-depth understanding of the relationship between the individual's distress and police and health care structural (organisation of police and out-of-hours health care services), and human responses (police and HCP knowledge, beliefs and culture) shaping how PiMD are kept safe.

Thus, my study had two aims:

**(1) to understand the relationships and experiences of PiMD, and Police and HCPs involved in their safeguarding.**
**(2) to identify factors and features of Police and HCP processes that facilitate or impede safeguarding journeys.**

By conducting an in-depth qualitative case study, I contribute to understanding police and health service inter-agency policy and partnership working. This thesis articulates how PiMD, police and HCPs experience out-of-hours mental distress support. It explores facilitators and limitations in the way police and HCPs support PiMD which enable or disable mental distress during out-of-hours safeguarding journeys. I make recommendations for improving both the structural factors and human responses to support the safeguarding and dignity of PiMD, and to inform frustrations experienced by clinicians and police officers working at the law enforcement and health care interface.

I also contribute to the literature by illuminating the relationship between an individual's experiences of mental distress and the structures and human responses influencing police and HCP safeguarding. Findings are elaborated using Defeat and Entrapment Theory (Gilbert and Allan, 1998), Cry of Pain Model (Williams and Pollock, 2001), and the Stark et al. (2011), conceptual model of suicide.

Collectively, elements of these underpinning theoretical / conceptual frames provided more in-depth insight into the interplay and complexities of PiMD needs, the context in which safeguarding takes place, professional beliefs and behaviours and processes within police and health service inter-agency working. Using this approach, I developed a conceptual model illustrating relationships between PiMD internal and external stressors and police and health services structural and human responses influencing safeguarding journeys (Chapter 8, Figure 15 pg.187). This holistic model seeks to provide a nuanced way of understanding how PiMD can escape or become entrapped in distress cycles and thus support policymakers, police officers and HCPs address shortcomings in service planning.

## 1.4 Positioning Myself in the Thesis

The motivation for this study is rooted in my clinical practice experience. I have worked as an adult and / or mental health nurse since 1980 in a range of mental and physical health and educational environments. I have also worked in police services within police custody and public protection. Experience working across two sectors has shaped the impetus for this research. This experience introduced me to viewing organisational and professional responses to mental distress through different social worlds. It highlighted the common ground and differences in health and police approaches to PiMD.

My first experience of supporting PiMD was as a general (now referred to as an adult) student nurse in the E.D. in 1981, in Scotland. I remember having little concern for people who self-

harmed. To me, there was a sense in emergency medicine that people who injure themselves were almost an inconvenience in a busy E.D. This was an area where staff prioritised critical illness and trauma which were accidental rather than intentional (Crowley, 2000). I cannot ever remember considering why people were mentally distressed. For me, this element of care sat with mental health services. I perceived mental health care to be a 'dark art' and was strictly not part of my job, nor did I want it to be.

Two years later, as a newly qualified staff nurse working in gynaecology, I began making connections between physical and psychological trauma, and the criminal justice system. I remember caring for a 17-year-old woman, admitted to the ward following a violent sexual assault, who required extensive surgery because of a third-degree perineal tear as a result of sexual violence. She was psychologically traumatised and asked me to remain with her while she provided a statement to the police officers. On completion, both police officers and I privately shared our concerns for her psychological vulnerability. Yet, there did not appear to be a process in which we could highlight our concern connecting criminal justice and physical and mental health care systems in a way supportive of her needs. She completed suicide two days after discharge from the ward.

That experience was the beginning of many important questions for me regarding the intersection of police and health services, trauma, physical and mental health care. Questions which remain with me.

In 1988, I was working as a Nursing Sister in substance misuse services in Australia. This setting was a stark reminder of a disconnect between criminal justice, physical mental health, and substance use services. Many people had acute health problems such as injecting injuries, frequent overdose, as well as chronic health conditions such as HIV / AIDS/ Hepatitis C and heart disease (Darke and Ross, 2001). Many people I cared for came to the attention of police due to homelessness (Krupski et al. 2015), working in the commercial sex industry (Alleyne, 2006), drug sales, and violence (Torok et al. 2014).

Experiences of mental distress, self-harm, sexual trauma, and exploitation from childhood through to adulthood, were commonplace, significantly impacting on people's recovery (Reid and Piquero, 2014). An important point here is that I learnt from the people in my care, that the complexities of their social worlds made it difficult to engage with services. People become stuck in a cycle of mental health distress, substance use treatment, relapse, criminal justice systems and, often, premature death. There was often a mismatch between peoples' needs

and the organisation of services. As I will show in this thesis, a similar mismatch of services exists for PiMD.

In 1996, I had the opportunity to team with an innovative midwife. Over the next ten years, we took responsibility for supporting the perinatal care of women using substances disengaged from traditional maternity services. We developed a sizeable perinatal service in collaboration with a third sector organisation. Many pregnant women we supported worked in the commercial sex industry, lived in insecure accommodation, were exposed to domestic violence, and were involved in the criminal justice system (Alexander, 2013). Often this made it difficult for them to attend perinatal care. As a result, we developed outreach services into women's environments to better support their care.

Critical to this thesis, these experiences underpinned my belief that if we are to be effective in improving outcomes for people with complex, and often chronic health and social care needs, we need to understand barriers to traditional models of care. It is therefore vital to consider how services are delivered, organised and intersect around people and organisations' needs.

In the 1990's and early 2000's, the developing substance use in pregnancy evidence base, tended to focus on issues of methadone dosage and neonatal withdrawal (Kelly et al. 2000) and did not readily translate into understanding of service delivery and access to care for women who used substances.

Thus, I had my first tentative steps into research. Working with the University of Wollongong, I was involved in evaluating the perinatal service we had developed (Hodoba, 2005). Using research as leverage to embed and expand this model of care, I became mindful of the power of evidence in mobilising and shaping services.

My role regularly interfaced with police officers. In the latter years of working in New South Wales, I practised as a police custody nurse bringing me more directly into the care of PiMD at the centre of this thesis. Working within the custodial environment introduced me to a different way of viewing the social world beyond health and social care services. I developed a greater understanding of the processes and occupational culture driving police approaches to mental health care explored in this thesis.

By 2008, I was back in Scotland working within the former Grampian Police (becoming one single police organisation called Police Scotland following police reform in 2014). As Adult Protection Co-ordinator within the Public Protection Unit, I supported the integration of a newly

developed area of Scottish safeguarding legislation – The Adult Support and Protection (Scotland) Act (2007). This multi-agency legislation sought to bring health, social care and police services together to support people at risk of harm. It was not until working in the police service I became aware of the pivotal role police officers had on outcomes of people with emergency mental health needs, and the gaps in legislation and services for some PiMD.

Working as Adult Protection Co-ordinator, I recognised a cyclical pattern in police reports concerning PiMD. Frequently the same people, displaying self-harm behaviours, came to police attention out-of-hours, yet they did not require inpatient care and were returned home by police officers. Often, underpinning these cyclical presentations was disagreement between health and social care practitioners, and police officers regarding perceptions of self-harm risk. There appeared a disconnect between the needs of people, inter-agency practice, and safeguarding legislation.

Furthermore, I have had the opportunity to be involved in criminal justice and health and social care policy developments and partnership working. Working alongside politicians and government officials introduced me to the political context in which these sectors intersect. Engagement with policy brought an additional lens for me to consider the social worlds influencing the care and safeguarding of PiMD, and the political influence in which police and health services interact.

Based on my experiences in nursing and police services, the rationale for this thesis began through observations in practice, being that the response to some PiMD during out-of-hours periods in the community is flawed in some way. Drawing on my clinical background and a review of current literature explored in the next chapter, I will show the key to understanding these flaws lies in the development of new knowledge of PiMD needs, police and health service inter-agency processes and systems, occupational cultures and the relationship between out-of-hours health care and the police. It also lies in understanding the needs, experiences, and relationship between services and PiMD.

This section has provided a personal backdrop to the thesis. In locating myself herein, I recognised through my socialisation in police services that my nursing identity changed in a way where I have adopted an 'intra-professional identity' (Joynes, 2014). I feel I have ‘membership’ in both professions and understand the core values of each. Although this position brings opportunities to challenge discourse around police and health service practice, I recognise my experiences influence the research, my relationship with participants, their responses to me and how I interpret my findings. This has informed the philosophical stance

by which I approach this study, the study design, the data collection process, analysis and the interpretation of findings discussed throughout this thesis.

In the next section, I will introduce perspectives of mental distress with a focus on the nature of self-harm and how these are managed at the intersect of police and health services. This background knowledge provides an overview of inter-agency policies, practice, and the experiences of PiMD. This will be further explored in Chapter 2.

## 1.5 The Nature of Self-harm

The prevalence of self-harm, any act of self-poisoning or self-injury carried out by a person, irrespective of their motivation (N.I.C.E, 2013), and the high rate of repetition and eventual suicide, make self-harm a significant healthcare problem. The World Health Organisation (W.H.O.) (2012), estimate some 803,900 people died from self-harm related injuries in 2012, with approximately half of all people who die by suicide, previously having self-harmed. People who self-harm have a 50 to 100-fold higher likelihood of dying by suicide in the 12 months after an episode than people who do not self-harm. This represents 1.4% of total deaths worldwide (W.H.O., 2012).

By far, the most common mental distress presentation dealt within out-of-hours health services is that of self-harm and suicidal behaviours (N.I.C.E, 2011).The peak time for hospital presentation of self-harm is during out-of-hours periods (Bergen and Hawton, 2007). Despite people accessing care, 1 out of every 25 self-harm patients will die by suicide in the ten years after their index presentation to the E.D.  Within the UK, 15% – 20% of those who die by suicide visit a hospital for self-harm treatment in the year preceding death. Therefore, a history of self-harm is reported consistently as the most important risk factor for eventual suicide (Cavanagh et al.2003).

The crisis nature of mental distress can be a catalyst for engagement with emergency services with an overwhelming need for safety, and a desperate need to gain peace or escape (Holm and Severinsson, 2011). The National Institute for Health and Care Excellence (N.I.C.E., 2014), The Royal College of Emergency Medicine (2019), and the Royal College of Psychiatrists (2019), all highlight the importance of people who self-harm receiving care with a minimum of delay, the importance of quick referral and equality of access.

Although people can access emergency services, they still can remain at risk of harm when discharged. One in five who attend an E.D. following self-harm will again harm themselves in

the year following (Bergen et al.2010). A small minority of people will do so repeatedly (Howson et al.2008). This could be explained by poor recording in health records, discharge and follow up processes.

Contrary to NICE guidelines stressing the importance of clear documentation, (N.I.C.E, 2013), serious self-harm risk factors are often poorly documented with results from mental state examination not recorded for many people discharged from the E.D. (Haq et al. 2010, Horrocks et al. 2002). Opportunities to prevent potential future self-harm can be hampered by no, or minimal, communication to primary care following discharge from the E.D. (Cooper et al. 2015, Cooper et al. 2008).There also appear inequalities within the diversity of self-harms. Runeson (2001), highlights people who injure themselves through cutting do not receive the same level of care or access to specialist follow-up, as those who self-poison. Given they are less likely to be admitted to hospital those who injure themselves are a particularly vulnerable group. This suggests there are gaps in health care processes and missed opportunities to intervene and disrupt repetitive self-harm and potential suicide.

Although some who self-harm experience compassionate and dignified care (Clarke et al. 2014, Clarke et al. 2007), on the whole, the literature reflects this is more often not the case (Kendall et al. 2011). Inter-agency emergency services for mental health can sometimes compare unfavourably with emergency services for physical health care (Vecchio et al. 2018). Some poor experiences are associated with structural aspects of care. For example, a key factor highlighted in a report by MIND (2011), was the need for a 'timely and effective response', 24-hour help to avoid escalation of the crisis and people being listened to (MIND, 2011). Similar findings were identified in other studies (Eales et al. 2006, Regan and Ryan, 2009, Spence et al. 2008, Strike et al. 2006) with vulnerable people discharging themselves from the E.D. because of excessive waiting times (Horrocks et al. 2002).

There is evidence people can feel discharged before they are fully stabilised. At times PiMD feel ‘batted away’ or ‘deflected’ from receiving support when needed (Digel Vandyk et al. 2018). Other adverse experiences are associated with staff attitudes to supporting people who self-harm. Owens et al. (2016), report incidents of some staff refusing to use anaesthetic when stitching self-harm wounds or people being denied usual care, including pain relief, on account of having caused their injuries. People can feel publicly humiliated when questioned about their injuries in spaces which lack privacy (Horrocks et al. 2005). Also, there is evidence of diagnostic overshadowing when people are labelled and triaged as ‘psychiatric’ regardless of their presenting physical complaint (Clarke et al. 2007).

Negative attitudes among HCPs towards PiMD can also reinforce stigma, further isolating people (Rosenrot and Lewis, 2018). People who self-harm have stated that stigmatising attitudes among health professionals can evoke negative emotional responses and cause them to view contact with healthcare as undesirable (Lindgren et al. 2018). Negative attitudes by some HCPs and police can be identified in the terminology used to describe their needs and can conflict the seriousness of distress. For example, describing people who self-harm as 'attention-seeking' (Fox and Hawton, 2004).

Yet, given that many who do self-harm, do so in secret and do not seek help, suggests that it is not for secondary gain (Fox and Hawton, 2004). Labelling people as ‘manipulative’ can dismiss the distress and pain the person is experiencing (Heilbron et al. 2010). Potentially, at times, people may not be taken seriously by HCPs. This can impact on clinical decision-making, access to support and the way care is delivered (Weight and Kendal, 2013, Forrester-Jones and Thomas, 2018).

Most studies reflecting police attitudes to mental health needs are concerned with serious mental health problems (Wood et al. 2016, Fisher and Grudzinskas, 2010, White et al. 2006).Watson et al. (2014) highlight police officers can view people with mental health needs as being less responsible for their situation, more worthy of help, yet more dangerous than those where no mental illness is identified.

As a result, PiMD behaviours can be perceived by police officers, as risky and unpredictable. This can result in officers feeling frustrated when they feel unable to discharge safeguarding responsibilities to health services where they, or the PiMD, perceive their needs are unmet (Forrester-Jones and Thomas, 2018).

By contrast, people do have positive experiences of supportive staff, particularly in psychiatric liaison services (MIND, 2011). Descriptions of positive experiences are that of humane treatment, when there is non-discriminatory care, and delivered with kindness (Owens et al. 2016, Owens et al. 2002, Winness et al. 2010). Similarly, understanding peoples’ needs and being supportive are viewed as crucial to gaining trust, engagement, and de-escalating crises involving police and HCPs (Evangelista et al. 2016). This suggests compassion, dignity, care and understanding are essential to the positive experiences of PiMD.

The poor experiences of some people that self-harm when supported in the current out-of-hours system, highlights there are inequalities in care and risk associated with suicide or repetitive self-harm. This underscores there are a group of people for whom the current system

can fail. In this next section, I discuss the safeguarding of PiMD during out-of-hours periods. I argue that the organisation of services, within a medicalised model of care, may contribute to gaps in services for some PiMD who do not have a serious mental disorder diagnosis.

## 1.6 Self-harm at the interface of Police and Health Services

In this section, I introduce the impact of de-institutionalisation of psychiatric services on police and emergency mental health care. I then critically examine the Scottish policy context in which PiMD are safeguarded. Finally, I discuss inter-agency support of PiMD.

### 1.6.1 De-institutionalisation and the Shift in Emergency Mental Health Care

De-institutionalisation of large psychiatric hospitals and changes in the provision of mental health care in the 1980's has seen the development of key policies in the care of people with mental health needs (Pilgrim, 2017). The shift from institutional psychiatric care, and efforts to contain costs in mental health services, are highlighted by Kritsotaki et al. (2016), as a catalyst for the development of emergency psychiatry. Although the prevalence of mental health disorders has remained the same, the number of people seeking help through emergency services has increased by 50% (Barratt et al. 2016). People are more likely to seek help through 'low threshold' services outwith psychiatric hospitals, such as E.D.s and general medical settings (Al-Khafaji et al. 2014). Thus, out-of-hours support for PiMD has shifted into services which traditionally have not served this group and can be ill-equipped to provide effective care (Betz et al. 2013, McCann et al. 2007).

De-institutionalisation is frequently cited as a key reason for a significant demand on police officers' roles in the management of people with mental health needs (Lamb and Weinberger, 2005, Wood et al. 2016), with a significant increase in police incidents linked to mental health issues over the last decade (Clifford, 2010, Cotton and Coleman, 2010, Shapiro et al. 2015, Puntis et al. 2018).

Although the intent of de-institutionalisation had its merits, it shifted access to mental health services and treatment predominantly to "first responders", who have become the primary means by which PiMD are de-escalated, detained, and transported for mental health assessment (Dempsey et al. 2020). The transfer of mental health care into emergency health services or police custody has seen increasing interest in how services work together to support people in crisis with mental health disorders (Brennan et al. 2016, Hollander et al. 2012). What is less clear is the nature of how police and emergency services work together to

support those with self-harm behaviours who do not reach clinical or legislative thresholds, where inpatient care is inappropriate and / or where no offence has been committed.

### 1.6.2 Inter-agency Safeguarding Policies supporting Mental Distress in Scotland

The policy landscape in which this thesis is situated has important implications for how inter-agency safeguarding is managed by police and HCPs, how services work in partnership and how PiMD experience crisis and recovery.

Since devolution in 1999, legislation to support and protect the well-being of individuals and communities has had a clear departure from policy and practice direction from the rest of the UK (Stavert, 2018, Fyfe, 2014). It is argued that the Scottish Government has led the way in the UK on improving mental health policy, practice and protection of vulnerable people. In doing so the Scottish Government signalled a philosophical shift to a rights-based approach and the intention of mental health and safeguarding legislation to provide services within the least restrictive environment which were morally and socially acceptable (Mackay and Notman, 2017, Stavert and McGregor, 2018). Similarly, Police Reform in Scotland (2012), articulated a new narrative about policing putting a focus on community well-being, suggesting an important shift from a narrow enforcement-led approach to policing. This acknowledgement recognises the population, which police officers are in contact with, is frequently a vulnerable one in health and well-being terms and underscores the breadth of the police officer role beyond law enforcement.

Three key pieces of legislation[1] underpin how services work together to support PiMD. The **Mental Health (Care and Treatment) (Scotland) Act (2003)** (Mental Health (Care and Treatment) (Scotland) Act 2003) (hereafter known as MHCTA), the **Adult Support and Protection (Scotland) Act (2007)** (Adult Support and Protection (Scotland) Act 2007) (hereafter known as ASPA) and the **Police and Fire Reform (Scotland) Act (2012)**(Police and Fire Reform (Scotland) Act 2012) (here after known as PFRA).

Embedded in each piece of legislation are expectations of inter-agency collaboration, roles and responsibilities for HCPs, social workers, and police officers. The emphasis on multi-agency working within these key policies recognises the risks to the individual, and organisations, of siloed working in the care of vulnerable people. The introduction of these key pieces of legislation have had a profound impact on Scottish safeguarding activity between

[1] Although the Adults with Incapacity (Scotland) Act (2000) holds a significant place within the framework for Scottish safeguarding legislation, it is not influential in the context of this thesis. Therefore, it will not be considered further.

police, health, and social care services, through improved cross-agency information sharing, organisation of services and placing the individuals wishes central to safeguarding (Campbell, 2016).

In the out-of-hours safeguarding of PiMD central to this thesis, the roles and responsibilities of each service, drawn from these key areas of legislation, are outlined in locally agreed police / health and social care partnership agreements and psychiatric emergency plans. For police officers involved in keeping PiMD safe, safeguarding involves the removal and transportation of people to a designated 'Place of Safety' for safeguarding and / or mental health assessment. This is usually in an E.D. or psychiatric hospital, or out-of-hours G.P. service. Only under exceptional circumstances should police custody be used as a 'Place of Safety'. This recommendation follows the Report of the Bradley Inquiry (Bradley, 2009), which highlights the police custody environment can exacerbate mental ill-health, heighten vulnerability, and increase the risk of self-harm and suicide.

The key responsibilities for HCPs is in the assessment and, at times, involuntary detention of people in hospital. In addition, police officers and HCPs have a duty to report concern of those they believe to be at risk of harm to the local authority for investigation and support. These key pieces of legislation have important implications for this thesis as they underpin HCP and police safeguarding processes and practices in the care of PiMD, and opportunities to collaborate and disrupt cycles of harm.

### 1.6.3 The Gaps and Weakness in Safeguarding Legislation to support PiMD

There exists gaps and weakness in legislation associated with supporting PiMD who self-harm. Firstly, since the implementation of the ASPA, there has been a consistent sense of the complexity of definition and categorisation of self-harm. Critics suggest this is because of a lack of clarity in terminology or meaning of 'self-harm' within the legislation (Fennell, 2016). The lack of clarity in meaning of terms could explain disparity in referral rates of concerns by police and HCPs to local authority adult protection teams', with significant difference in police and HCP rates of referral of people who self-harm. Campbell identified that 21.4 % of ASPA referrals were categorised under self-harm, suggesting self-harm is a significant issue. The majority of concern referrals were by police officers with police adult concern reports making up over 70% of all referrals. In contrast, 4% were referrals from the NHS (Scottish Government, 2011). Within NHS referrals, the E.D. had the lowest level of referral of concerns of people at risk of harm, compared to other clinical areas. This is important, given the high number of PiMD presenting to the E.D. discussed earlier in this chapter.

Despite the high numbers of police concerns reported, self-harm is rarely seen as requiring safeguarding action by local authorities within the ASPA, possibly because there is no external perpetrator to blame or charge (Fennell, 2016). This raises the possibility that there is a difference in professional perspectives, identification and understanding of risk associated with self-harm across Police, HCPs and Social Workers.

Importantly for this thesis, 40% of police referrals under the ASPA were recorded as 'no further action' by the local authority as they failed to reach the threshold for multi-agency investigation (Campbell, 2013). This means people who have come to police attention, whom they believe to be at risk of serious harm, were not considered by the local authority to require intervention under the ASPA. Like those referred by police under MHCTA highlighted in pg.3 who did not reach thresholds for inpatient care, there also appears to be a gap in inter-agency processes to intervene for those who do not reach safeguarding criteria under ASPA. Challenges in cross-agency agreements are not unique to Scotland. Paton et al.(2016), in a rapid synthesis of models of care for people experiencing mental health crisis in England suggest where problems exist in emergency mental health care they often happen where health, social care and police services intersect. The difficulties lie in professional interactions and how the transfer of PiMD occurs from one service to another (Paton et al. 2016).

The effectiveness of safeguarding policies can be influenced by the diversity and severity of self-harming behaviours. These can cloud and challenge decisions of whether legislation can support PiMD. When an adult contemplates serious self-harm, compulsory intervention may be appropriate to ensure safety for a limited time. However, the position with other aspects of self-harm is less clear with a substantial variety in intent to cause serious harm.

Additional factors such as intoxication can increase risk of poor decision-making and impulsivity, or facilitate serious self-harm (Ames, 2017). Understanding the degree of risk self-harm behaviours pose, and when safeguarding intervention should take place, balanced against individuals' rights, can be complicated. As Persaud (2016), highlights, there is a need to define, assess and restrict safeguarding legislation to protect individuals' human rights and avoid inappropriate compulsion and invasion into their lives. Self-harm can variously arise from difficult life situations, medical conditions or both (MacIntyre et al. 2018). This gives rise to complexities around self-determination, civil liberties, and decisions when services should intervene or not, and could further explain the variety in understanding the need for professional safeguarding.

A further potential shortcoming in safeguarding legislation is that thresholds for multi-agency intervention can be reliant upon diagnosis of mental disorder. Yet, the absence of 'disorder' can exclude people from support and protection when their distress is associated with socio-economic problems such as unemployment, or homelessness (Fitzpatrick and River, 2018, Grover et al. 2018). Critics suggest an over-reliance on biological models in mental health practice can be detrimental to people where social factors contribute to their mental distress (Tew, 2011, Mills, 2015). Furthermore, diagnosis can vary according to time and space, and by practitioners (Bentall, 2004). Multiple factors such as intoxication or trauma can also confuse the diagnostic picture (Yost, 2002, Zisman and O'Brien, 2015). This brings into question the continued authority and validity of psychiatric diagnosis on safeguarding legislation.

The medicalisation of mental unrest and emotional pain has a powerful effect on the management of PiMD within police and health systems. As Pridmore (2011), points out, police officers, to some extent also, medicalise mental distress by seeking to transfer everyone they apprehend who indicates self-harm into the hospital system. Operationalisation of inter-agency collaboration through reliance on psychiatry may restrict opportunities to intervene, support and protect people whose self-harm is associated with social factors such as loneliness or abuse, rather than a psychiatric diagnosis. This gap can find police officers, unable or confident to discharge safeguarding responsibilities when they, or the PiMD, perceive their needs are unmet, and they remain at risk of harm (Forrester-Jones and Thomas, 2018). As McAllister (2003), contends, various meanings of self-harm, indicates clinicians need to have multiple and flexible responses to people, knowing there are often many reasons for this behaviour. Unless several meanings of self-harm are acknowledged, then the likelihood is that conventional and ill-fitting responses will remain. It is possible the mismatch of police policies against health service provision for some PiMD, could account for the high number of people being referred to care by police, yet returned home with their distress needs unmet.

## 1.7 Summary

In this introductory chapter, I have highlighted that, despite Scottish Government ambitions to improve safeguarding for people at risk of self-harm, there remain gaps in out-of-hours police and health systems to provide effective support.

The high number of police concern reports shared with health and social care, suggests there is a group of people who occupy a space where their distress is sufficiently concerning for

police to seek partnership support and intervention, yet their needs cannot be supported within the out-of-hours model of emergency health care or legislative framework. I highlighted, despite the increasing focus on Scottish safeguarding legislation, there are failings in the legislative frameworks which can find some PiMD excluded from support and protection policies and opportunities for inter-agency collaborative interventions. I suggest, in part, this is because of a focus on the diagnosis of mental health disorder and lack of clarity of the term self-harm.

Although safeguarding policies can shape how police and health services work together to support PiMD, the context in which self-harming takes place can also have a significant impact on inter-agency care and treatment. Peak times for self-harm behaviours tend to occur during out-of-hours periods when access to primary health care or alternative support is limited, finding police officers and the E.D. at the forefront of safeguarding (Blenkiron et al. 2000, Bergen and Hawton, 2007). Vecchio et al. (2018), suggest people with mental health needs often do not access services until they reach a crisis. When an individual is in crisis and a danger to themselves or others, entry to E.D. frequently occurs through third party intervention such as the police. Essential to this thesis, this suggests the timing and crisis nature of self-harming behaviours are important in how out-of-hours services are organised and are suitable for peoples' needs.

This thesis proposes there are gaps and tensions between how police officers respond within policy guidance, to keep people safe and the availability of out-of-hours health services to respond effectively to PiMD needs. PiMD can be stuck in a cycle of out-of-hours emergency distress responses and displaced between criminal justice and health services. By addressing this gap, this thesis seeks to articulate how PiMD experience shortcomings in services. Illuminated are factors which enable or disable mental health distress during out-of-hours safeguarding journeys.

## 1.8 Defining the Safeguarding Journey and the Case

Before moving to Chapter 2, it is necessary to clarify what the term 'safeguarding journey' means and to define the 'case' within this case study.

This thesis is concerned with the engagement between PiMD, Police and HCPs and their experiences within a specific context. The case in this research is therefore defined as an event -– that being – 'Out-of-Hours safeguarding journeys involving PiMD who come to Police attention within the community, who are referred by Police to Health Services, and later

discharged.' The case is therefore a product of the network of Police and Health Services, how these are organised to support PiMD, and how these journeys are experienced by PiMD, Police and HCPs.

In the context of this thesis, the term ‘Safeguarding’ is multi-faceted. Firstly, it highlights the need to be kept safe by services accessed by the PiMDs who participated in this study when they themselves feel no longer able to do so. Secondly, the term also underscores the overarching aim of police officers and HCP participants in keeping people safe within the scope of their professional practice. Thirdly, the term safeguarding reflects the influence of public protection legislation driving how services work together.

A variety of definitions exist to conceptualise transitions through and between services, such as clinical pathway, care pathway, integrated care pathway, critical pathway, or care map, (De Bleser et al,2006). Whilst these may have relevance in health, they do not translate easily into Police processes where terms such as operational or procedure tend to be used. Thus, I chose to use a term judged appropriate to both services, signalling that there is no clear attribution to either policing or health care.

By using the term ‘journeys’, I sought to reflect the non-linear and complex experiences of PiMDs whilst being kept safe. The notion of a journey can mean traveling between services through different routes, often over an extended period and frequently repeatedly. This thesis highlights an interplay between gaps in systems, and human responses of professionals working to address those gaps. The trajectory of how people move between services fluctuated and changed depending on a range of factors; for example, if the PiMD was intoxicated or aggressive. Thus, the term ‘journeys’ articulates the indirect and often cyclical nature of peoples’ experiences.

Joint local inter-agency agreements and mental health legislation, Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCTA), guide inter-agency working. In practice, there will be one of three outcomes from this assessment. The person will be admitted to hospital involuntarily, voluntarily or discharged. This thesis focussed on the latter; the person is discharged. This thesis will illustrate that systems gaps and human inputs can shape the trajectory of out-of-hours safeguarding journeys. The complexity of the journey is dependent upon the PiMD’s needs or the context in which they come to police attention. Points of contact and journey trajectory of the three participants who experienced mental distress are summarised in a ‘Map of the local psychiatric emergency plan pathways and safeguarding journeys within the study area’ in Figure 1.

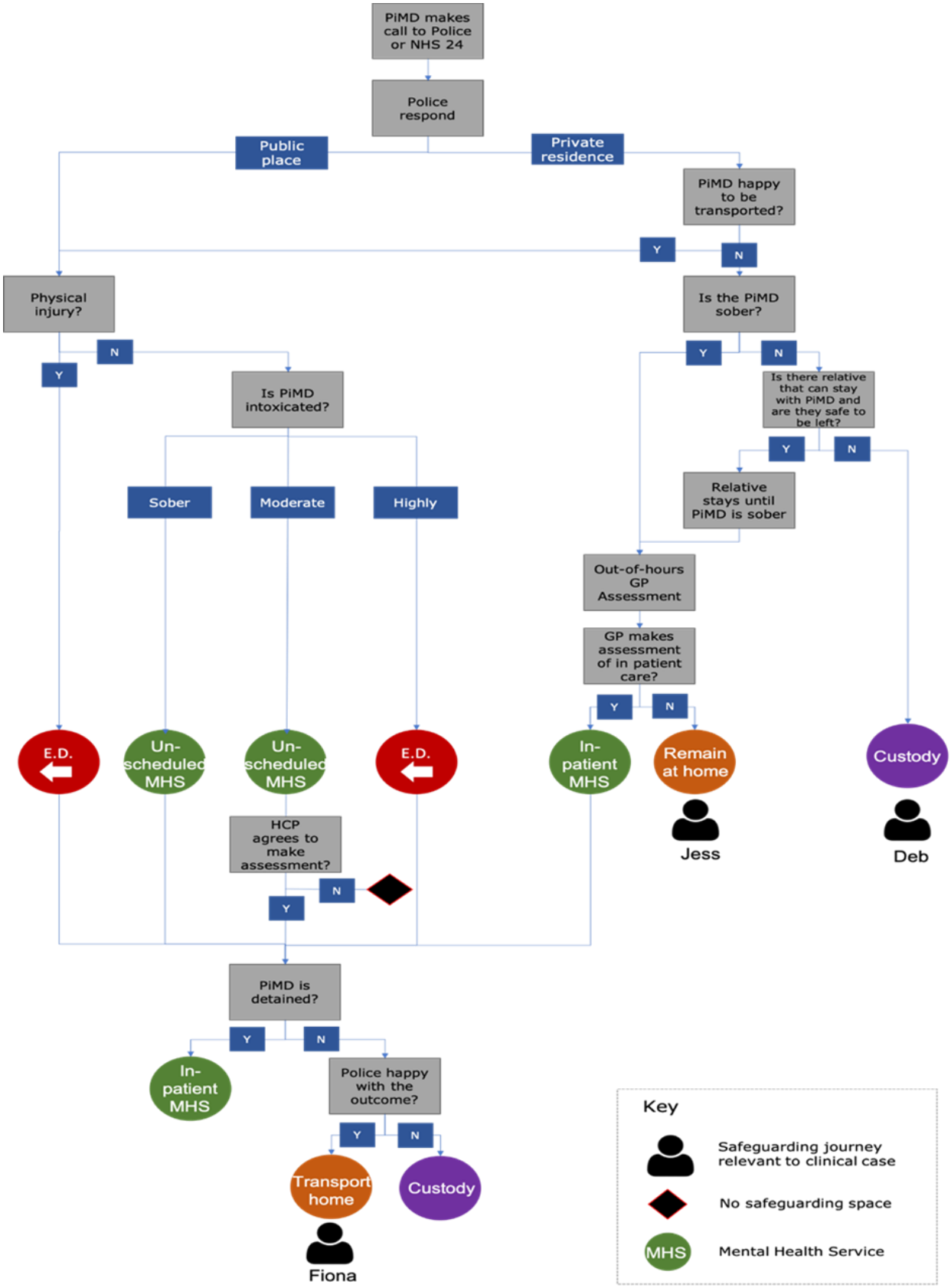


*Figure 1: Map of Local psychiatric emergency plan pathways and safeguarding journeys within the study area*

## 1.9 Thesis Structure

Organised in 9 Chapters, this thesis follows a linear- analytic reporting structure format (Yin, 2003a). This first chapter provides a detailed account of the context in which this thesis is situated. I have identified that the impetus for the research has evolved through my clinical experiences in nursing and work in Police Scotland. I then provided a synopsis of safeguarding, mental health, health and social care, and policing policy, and the legislative landscape in Scotland underpinning approaches to mental distress. This chapter concludes by defining the meaning of 'safeguarding journey' and the 'case' within the context of this study.

An overview of the literature identifies the problem central to this thesis through discussion of gaps in care for a specific population who experience mental distress through self-harm, and approaches by health and police services to keep them safe.

Chapter 2 provides an integrative review of the literature. I present the approach used and the findings presented as three key themes. These include safeguarding and care experiences of PiMD, working with complex needs and risks, and professional perspectives and experiences of safeguarding and care. Chapter 2 concludes by identifying the academic rationale for the study, drawn from the review findings, and underscores why addressing the gaps in knowledge are important. This is followed by identification of the aims and objectives of the research and introduces the research questions.

In Chapter 3, I present the theoretical approach underpinning the research design discussed in Chapter 4. I discuss my philosophical stance, situated in a broadly social constructionist epistemological frame, and the influence brought to bear on the research design. I also present the theoretical lens used to elaborate the findings. I discuss where the theoretical strands are interwoven and how they have informed my thinking to help bring a plausible interpretation of participants' experiences.

Chapter 4 presents a description of the qualitative research design linking the theoretical approach, research purpose and questions to the processes for data collection and data analysis. I justify why an exploratory holistic case study, with three embedded subunits was a suitable approach to answering the research questions. An essential part of this study was the

ethical considerations of researching with potentially vulnerable people. Therefore, this chapter also discusses the ethical deliberations, access to participants and the recruitment process in detail. I present details of data collection and management, followed by a description of and justification of the use of Template Analysis to conduct a thematic analysis of these data within the interpretive approach. A reflection on my role as a researcher concludes this chapter, drawing on my perspective of working as an 'insider' and ‘outsider' across two different sectors.

Chapter 5 is the first of 3 findings chapters. This chapter presents findings from the thematic analysis of the first of three embedded subunits in this holistic case study (phase1). This initial phase of data collection describes findings from senior police and health service manager

(n = 12), semi-structured interviews. The purpose of the manager interviews presented in this chapter is twofold. Firstly, to provide a broad landscape of the out-of-hours healthcare and police service interface in supporting PiMD, within the case study area. Secondly, to present a governance perspective of inter-agency relationships and organisational processes in the care of PiMD.

Chapter 6 presents findings from subunit 2 (phase two), which was informed partially by preliminary and ongoing analysis of phase one data. Here, I report on findings from the thematic analysis of three clinical cases involving three women who each experienced a mental distress episode, and the police officers and HCP involved in their safeguarding. These findings bring together people with lived or living experience of mental distress, and professional perspectives.

In Chapter 7, I present findings from the thematic analysis of subunit 3; three focus groups conducted in the final data collection phase (phase three) of the study. Participants were HCPs, police officers, and police staff working in operational policing or clinical environments. The focus groups explored the experiences and cross-organisational relationships of those working in the day-to-day practice of safeguarding people experiencing mental distress. I draw on themes derived from previous findings in Chapters 4 (managerial interviews) and 5 (clinical case interviews) as a framework to bring context to and extend the findings. This chapter concludes with a presentation of the six key arguments drawn a cross case synthesis of the findings. The six key findings support the discussion in Chapter 8.

Chapter 8, the discussion chapter, presents and interprets the key findings in light of the existing literature. I elaborate my findings by drawing on elements of Starks Conceptual Model of Suicide(Stark et al. 2011), the Cry of Pain Model (Williams and Pollock, 2001) and Defeat and Entrapment Theory (Gilbert and Allan, 1998), presented in Chapter 3 . I discuss critically the relationship between PiMD internal and external stressors, and the structural factors and human responses brought to bear by the organisation of out-of-hours police and health services and professional cultures and practices. A conceptual model (pg.187) of my findings, which seeks to articulate the relationship between PiMD and system and human responses in which out-of-hours safeguarding takes place, is presented. I suggest a range of factors can undermine the dignified and effective care of some PiMD and contribute to tensions at the police and health service interface.

In the concluding chapter, Chapter 9, I critique the strengths and limitations of the research and consider the extent to which the study met its aims. I discuss recommendations for future research, policy, education, and practice. The contribution this thesis makes to the literature is considered. This chapter and the thesis will close with a reflection of my role in the research.

# Chapter 2: An Integrative Literature Review

## 2.1 Introduction

In this chapter, an integrative review of the literature, I examine the empirical literature about the experiences of PiMD during police and HCP safeguarding. Following a discussion of the background and the rationale for this integrative review, I present details of the methods used to conduct the review. The rationale for this study follows the exploration of gaps in the evidence. The chapter concludes with the identification of the research questions.

## 2.2 Background

As introduced in Chapter 1, there is increasing demand on police and emergency health services to respond to PiMD (Livingston, 2016, Sondhi and Williams, 2018).

To date, much research focus on the police / PiMD / health intersect, has involved effort to decriminalise people with severe mental health disorders through diversion to psychiatric inpatient services, mental health care in police custody settings or models of police and community collaboration (Cummins, 2012, Dorn et al. 2013, Bennett et al. 2011, Hensen et al. 2016, Ogloff et al. 2007). These, however, do not support an understanding of safeguarding journeys of people where self-harm is not associated with a severe mental disorder or an offence.

There have been no previous systematic reviews conducted examining safeguarding journeys involving PiMD, Police, and those discharged home, and very little research conducted in a Scottish context. Two previous reviews of literature have examined elements of safeguarding journeys. Firstly, an international integrative review by Chidgey et al. (2019), investigating police responses to individuals displaying suicidal or self-harming behaviours. Secondly, a literature review by Borschmann et al. (2010), which examined the pathways of people on detention under section 136 of the English mental health legislation, Mental Health Act (1983), (hereafter referred to as S136).

The integrative review by Chidgey et al. (2019), appraised the literature surrounding police response to individuals in suicidal crisis and included 11 quantitative and one mixed-method study which utilised retrospective quantitative data and English language studies. Chidgey found police are involved with a large proportion of individuals in suicidal crisis, with intoxication being a key factor in managing the crisis. Those intoxicated may also be aggressive towards others, including police. Prior contact with police, either as victim or

perpetrator, is common for individuals in suicidal or self-harm crisis. Chidgey et al. reported intoxication can increase non-compliance and violent behaviour, increase the severity of symptoms bringing an additional complicating dimension.

Drunkenness is likely to shape and inform the options chosen by police in responding to an incident, suggesting that in some countries, police officers have discretion over safeguarding when PiMD are intoxicated or aggressive. A limitation of this review is that eleven of the studies were quantitative, when the review question focused on how police respond to individuals displaying suicidal or self-harming behaviours. The attitudes of police officers, PiMD, and healthcare professionals (HCPs) were not explored in detail. Chidgey et al. (2019), concluded that the perspective of people who have experienced police support during suicidal or self-harm crisis is missing from the literature. Lessons can be learnt through consideration of the views of those with lived experience, thus enable improved responses to PiMD by police and HCPs.

A systematic review conducted by Borschmann et al. (2010), examined the pathways of people detained under section S136 of the English Mental Health Act (1983). This review identified 42 papers. Included were literature reviews, population and demographic studies, surveys of police officers and mental health professionals and, a single qualitative study. Borschmann et al. found most of the research was conducted in London, making it difficult to draw comparisons with less densely populated areas of the UK. Key findings included that many people detained had previously been held under S136 at some time in the past, suggesting that police officers repetitively play a vital role in the safeguarding of some people in crisis. Most studies reported a strong positive correlation between the police officers' beliefs about a person's mental state and corresponding psychiatric assessments, with the high rates of people detained and admitted when brought to hospital by police. This could mean police officers can accurately recognise the signs and symptoms of serious mental illness, or, as the reviewers argue, police officers could have a higher tolerance of unusual behaviours in the community, only bringing to hospital people who are seriously unwell.

Although sample sizes varied considerably in the demographic studies reviewed by Borschmann et al. these findings are noteworthy given that in Scotland, very low rates of people referred by police are detained under similar legislation with 97% returned home following psychiatric assessment (Mental Welfare Commission, 2018).

Similar to the Chidgey et al. (2019), review, a limitation of Borschmann's review was it returned mainly quantitative studies despite the broad scope of the review being the S136

literature. Furthermore, the broad inclusion criteria might affect quality / trustworthiness of findings. The main recommendation for future research from the findings of the Chidgey et al. (2019), and Borschmann et al. (2010), reviews is for the development of qualitative studies exploring the perspectives of PiMD, health professionals, and police officers experiences to help inform improvements in inter-agency practice.

My preliminary searches identified limited understanding of peoples' experiences of engagement with services when first calling on police services for support, particularly during out-of-hours periods. This included what police officers and HCPs understood about safeguarding PiMDs without formal diagnosis of a severe and enduring mental illness such as schizophrenia or bipolar disorder. This area of mental health care has received limited attention despite recommendations by the Christie Commission (Christie, 2011), that public services work more closely in partnership to protect those vulnerable within society. Findings from my preliminary review identified a lack of research on police and HCP responses to PiMD within Scotland or understanding of the complex journeys presented in Chapter 1 (Figure 1).

Previous literature reviews lack consideration of influences and impact of organisational processes, professional relationships and cultures on the safeguarding experiences and safeguarding journey trajectory for those in MHD (Borschmann et al 2017, Chidgey et al 2019).

It was important to establish what exists in health and police literature to inform Scottish Government ambitions for effective service collaboration in the care of vulnerable populations, and those with mental health needs (Scottish Government, 2017c, Police Scotland, 2017). There is an extensive catalogue of recommendations for improved cross-sector communication and joint working highlighted in serious case reviews (Mental Welfare Commision, 2020). These highlight a need for improved access to quality mental health care in Scotland. This review seeks to illuminate barriers or facilitators to multi-agency practice in safeguarding PiMD.

The overall aim of the review was to determine current knowledge about the safeguarding journeys of PiMD supported by police and HCPs. Therefore, is focused on human experiences and police and HCP systems. The review question was:

"***What are the safeguarding experiences of people in mental distress, and what are the care experiences and processes of police and health practitioners in supporting PiMD needs?"***

## 2.3 Integrative Review Process

The purpose of a review is to find out what is known about an issue based on evidence. Therefore, it is important to be inclusive of experimental and non-experimental studies, and empirical literature from a range of methodologies across health and social science landscapes. An integrative review addresses this focus. It brings a comprehensive, methodological approach to a complex, multi-faceted problem arising typically in nursing and social sciences (Souza et al. 2010). Incorporating both qualitative and quantitative studies, notwithstanding their different approaches and analysis, should provide a richer and more comprehensive understanding of the topic (Whittemore and Knafl, 2005). Used extensively to review theories, evidence and explanation of concepts, an integrative review is relevant to underpin this cross-disciplinary investigation, where there are multiple experiences and relationships in a range of settings (Toronto et al. 2020). The four central steps identified by Whittemore and Knafl (2005), informed this review by providing a comprehensive, reproducible and rigorous method of review; searching the literature, extracting and analysing the data, synthesising and presenting the findings.

### 2.3.1 Data Searching and Extracting

Ten databases were searched from across health and social sciences. The search for relevant literature was conducted between December 2015 and May 2016, and searches were re-run in May 2018. The databases searched (see Table 1) were the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Web of Science, Medical Literature Analysis and retrieval System Online (MEDLINE), The Cochrane Collaboration, Applied Social Sciences Index and Abstracts, Database of reviews of effects (DARE), PsycInfo, EMBASE, Psychology and Behavioural Sciences Collection (PSBC), National Criminal Justice Reference Service, and Google Scholar. Hand searching included studies appearing in books, published, unpublished works, conference proceedings, related citations, and reference lists of relevant papers. Search alerts were also set up for each of the databases in order to ensure all of the available literature were included in the review.

| Searched Databases and Other Sources<br>From 1st January 2002 to December 2018 |
| --- |
| • MEDLINE<br>• THE COCHRANE COLLABORATION<br>• EMBASE<br>• ASSIA<br>• CINAHL<br>• Psychology and behavioral Sciences Collection (PSBC).<br>• PsycINFO<br>• GOOGLE SCHOLAR<br>• ISI Web of Science<br>• THE NATIONAL CRIMINAL JUSTICE REFERENCE SERVICE<br>• Unpublished work (grey literature)<br>• Hand searching articles from reference lists of included studies |

*Table 1: Searched databases and other sources*

The search terms (see Appendix 2) were refined and adapted following the initial search. For example, the terms “law enforcement” and “psychological distress” were included when I recognised that these terms frequently appear in North American literature. Inclusion dates were 2002 to 2018. The dates were chosen for two reasons. Firstly, to include contemporary key legislative and policy change in the care of PiMD, such as the safeguarding legislation identified in Chapter 1. Secondly, the dates were set from a pragmatic perspective to manage a potentially high volume of data.

The review question seeks to address gaps in knowledge in experiences and processes, meaning it is important to draw on a range of qualitative and quantitative sources. Included in this integrative review are evaluations of inter-agency experiences between police, emergency health services and PiMD, original qualitative and quantitative papers written in the English language. Excluded were papers reporting on children (under the age of 16), hospital inpatients, other forensic settings such as prisons, police custody settings (other than issues relating to processes of safeguarding procedures), and papers with an identified focus on people with severe and enduring mental illness.

### 2.3.2 Management and Selecting of Key Literature

Key search terms were applied (Appendix 2). Citations, abstracts, and full text articles were collated and managed throughout the search process supported by Endnote software. The initial search yielded 12,451 papers. These were reduced to 4,001 with electronic limiters. Titles were screened on title alone and after duplicates removed, 462 remained. Further screening of title and abstract, and the addition of eight papers through hand searching of reference lists and citations, resulted in 44 papers. The full text papers were read through with three papers removed, as they did not fit the criteria. I then scrutinized and quality appraised the remaining papers (n = 41). This process is presented in a PRISMA flow diagram in Figure 2.

The applied language restriction included English language literature only, which may have limited the findings. An age restriction was applied to include adults from 16 years upwards to reflect the definition of an adult in Scottish safeguarding legislation (Adult Support and Protection (Scotland) Act 2007) (ASP). This categorisation is lower than most other countries, where the definition of an adult is 18 years, such as England, and 21 years in some states in the United States of America (U.S.A.). Working from the lower age group allowed for the inclusion of literature in the Scottish context.

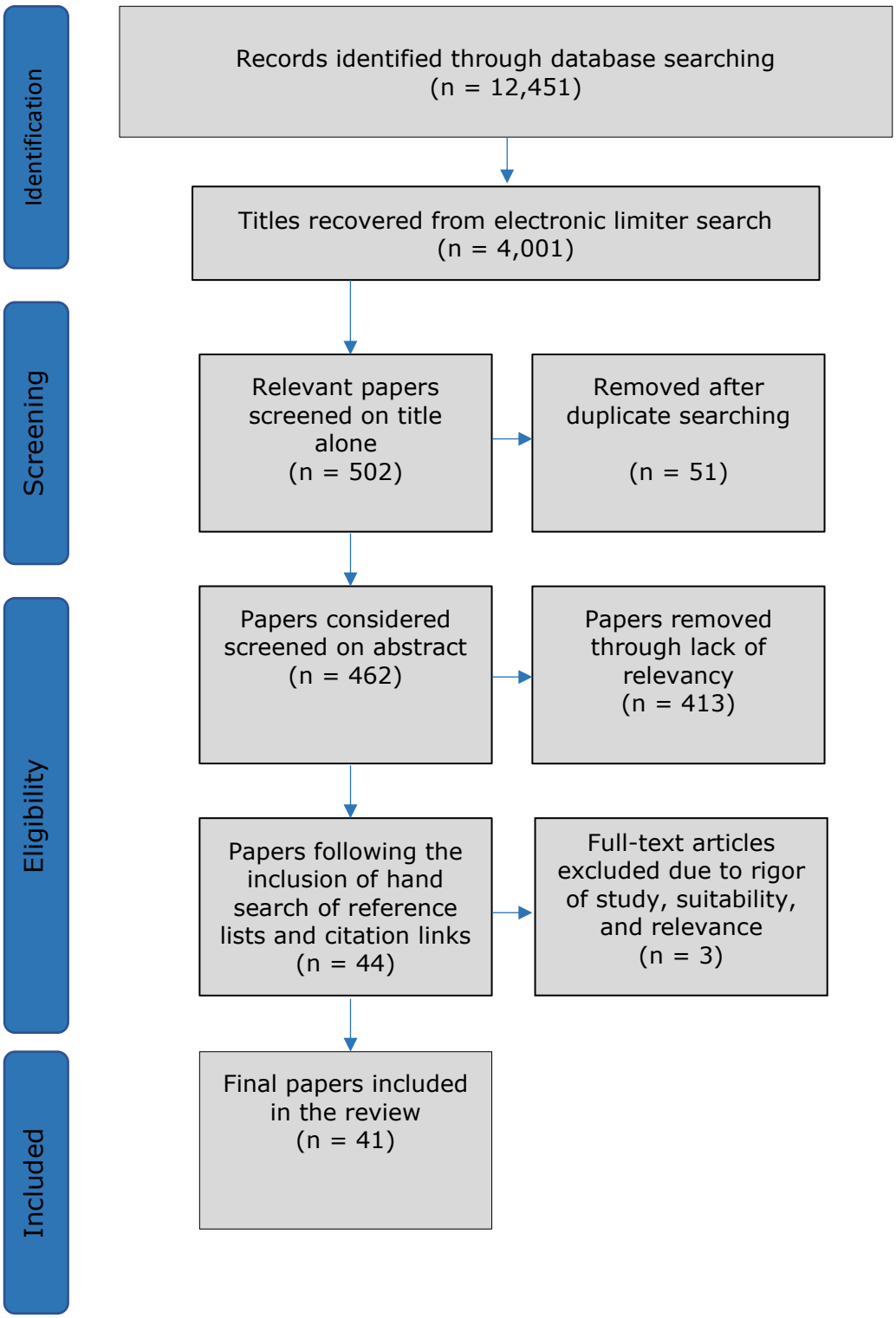


*Figure 2: PRIMSA Flow Diagram*

### 2.3.3 Quality Appraisal

The significance of the critical appraisal of data retrieved is well established (Denscombe, 2014, Silverman, 2013, Parahoo, 2014). Polit and Beck (2014), suggest the highest quality evidence available is vital to inform evidence-based practice. Quality checklists and tools provide a systematic and operational way to identify rigorous research with valid deductions and to assess risk of bias / lack of trustworthiness in the findings. In contrast, Sandelowski and Barroso (2002), argue for flexibility in check listing, suggesting some researchers may use inappropriate terminology in their papers, yet still have produced worthwhile findings which can add to knowledge in the field.

In contrast to the two systematic reviews discussed earlier in this chapter, I identified a high number of qualitative papers (n = 23), likely due to the focus on human experiences within the review question. Debate and little consensus exist about quality assessment in qualitative research. There appears little empirical evidence to base decisions for excluding studies, on quality alone (Thomas and Harden, 2008, Harden and Thomas, 2005). Published studies can be of varying quality. Including poor quality studies in the review may misrepresent the synthesis, whereas excluding studies of poor quality may bias the synthesis (Evans, 2007). I decided all studies which met the inclusion criteria and were relevant to the review question be considered, despite low-quality ratings to allow for more diversity amongst the sample.

The Critical Appraisal Skills Programme (CASP) (Critical Appraisal Skills Programme, 2018) supported a systematic quality appraisal of qualitative studies. An example of a paper appraised by CASP is provided in Appendix 4. Quantitative and mixed-method studies were assessed using a tool informed by Crombie (1996) in which the quality of each paper was scored according to specific criteria. One point was allocated for fulfilment of each quality appraisal item. The maximum score, (indicating high quality), was 16, with the lowest possible score being zero. The methodological quality of each study was subsequently rated as low (0–5 points), moderate (6–11 points), or high (12–16 points). Of the 18 quantitative and mixed-methods papers, nine scored low, eight scored medium and one scored high. The CASP tool of 10 questions also rated papers as high / medium / low. Of the 23 qualitative papers four were rated ‘high quality’(meeting at least 8 of the 10 criteria),sixteen ‘medium quality’ (meeting 5–7 of the criteria), and three ‘low quality’ (meeting 4 or less criteria).

NVivo 11 data management software was used to collate data from primary sources to simplify, abstract, focus, and organise data into a manageable framework. This software also served as an audit tool reflecting transparency of processes and thematic decision-making.

Each paper was read several times with key findings extracted and recorded using a spreadsheet (Miles and Huberman, 1994). This approach supported the organisation of the literature to facilitate data synthesis. Initially, the synthesised findings kept very close to the original findings of the included studies. The findings of each study were combined into a whole via a listing of themes, which reflected PiMD, presentations, policy, police and health professionals' experiences. The initial synthesis did not directly address the review question concerning what is known of peoples' experiences, care, and safeguarding processes between the services. This synthesis had not 'gone beyond' the findings of primary studies and generated additional concepts, understandings or hypotheses. Thorne et al. (2004), describe this as the defining characteristic of synthesis.

The next step involved identifying and coding findings from each study to construct descriptive themes. Initially, 13 descriptive themes were identified: risk tolerance; service demands; complexity; the multiplicity of the process; protecting communities; protecting the individual; inter-agency working; siloed working; relationships; professional attitude; professional cultures; risk and trust; and professional disparities. The final stage involved returning to the review question with the descriptive themes to allow the emergence of abstract or analytical themes. This synthesis was developed through extensive discussions with supervisors and a cyclical process of review and reconsideration against the review question until the three key themes were sufficiently abstracted and captured. This process of synthesis has been criticised by some, who contend that individual studies are de-contextualised (Britten et al. 2002). Whereas Thomas and Harden (2008), argue, the researcher can generate new propositions within a particular context and thus, conceptual innovation.

## 2.4 Results

Of the 41 papers included, a large number (18) papers were from Australia. Four were from Canada, five from the U.S.A., four from England, two from Scotland, three from Ireland, one from the Netherlands, one from New Zealand, one from Belgium plus two International studies.

Of these, 23 were qualitative papers, 15 were quantitative papers and three mixed-methods studies. The majority of the qualitative studies utilised semi-structured interviews. One paper used focus groups. Ten qualitative studies were concerned with HCP experiences or attitudes of supporting people who self-harm or of experiences of people referred by police. Four papers were concerned with PiMD experiences of E.D. visits and two of experiences being supported by police officers. Of the quantitative papers, 11 used a cross-sectional survey design and one Delphi study. 12 studies included retrospective review or audit of police or E.D. records. The

majority of retrospective records reviews were concerned with characteristics of PiMD attending the E.D. or coming to police attention. Co-morbid distress and intoxication was a factor in five papers. Potentially due to the nature of PiMD safeguarding, no randomised controlled trials were identified. The data extraction / summary tables for each theme is presented in Appendix 3.

Three overarching themes emerged:

***Safeguarding and care experiences of people in mental distress*** (9 papers).

***Intoxication, self-harm, and aggression*** (11 papers).

***Professional perspectives and responses to PiMD*** (24 papers).

Three papers (Doyle et al. 2007, Watson et al. 2008b, Chapman and Martin, 2014) crossed two themes given the broad scope of their study and have been counted twice.

In this next section, I will briefly describe each theme and critically examine the findings.

### 2.4.1 Safeguarding and Care Experiences of People in Mental Distress

How PiMD experience care through the police or emergency services was reported in 9 studies. Experiences were discussed in two main ways: ***Using the E.D. for mental health care*** - 6 studies and ***Experiences of the police / and or emergency health services*** -3 studies. These became the titles of the two subthemes in this overarching theme. The crisis nature of mental distress can find people seeking support through unscheduled care services such as the E.D. The literature highlights that the experiences, quality, and accessibility of care for PiMD is highly variable. It is noteworthy that much of the literature examining peoples' experiences of the police health intersect are focused on novel models of police collaboration such as Crisis Intervention Teams and Street Triage, which seek to improve the care of PiMD and demand on services (Boscarato et al. 2014, Huppert and Griffiths, 2015, Evangelista et al. 2016). Evidence from these papers suggests collaborative models involving police and health HCPs appear to have some success as far as improving PiMD experience. Yet, these models vary greatly, are not embedded in routine police / health practice, and have limited long-term evaluation. Thus, such models are outwith the scope of this review.

#### *2.4.1.1 Using the E.D. for Mental Health Care.*

Experience of using the E.D. for mental health care is reported in 6 papers (Bruffaerts et al. 2006, Digel Vandyk et al. 2018, Brunero et al. 2007, Spence et al. 2008, Kuehl et al. 2012, Joubert et al. 2012). None of these were UK based studies. The E.D. was found to be an important entry point to mental health care. Some groups were frequent users of the emergency services with individual characteristics such as psychiatric diagnosis, and process issues such as poor linkage back to primary care, as having an influence on recurrent E.D. use.

In terms of help-seeking for mental health support, the E.D. appears to be used by people with a wide range of mental health needs. In Belgium, Bruffaerts et al. (2008), mixed-methods study examined clinical data demographics, clinical characteristics and utilisation of E.D. services
(n = 3719). Bruffaerts found the E.D. had become a critical point of contact for people with common mental health problems such as mood and anxiety disorder which were previously relatively uncommon in the emergency medicine environment. Instead of primary health care, six in ten people used a psychiatric emergency room (PER) within in a general E.D. for the very first time as part of their mental health help-seeking journey. The PER was the first mental health treatment contact ever for one in three people. These data suggest that there may be limitations of accessible mental health care in the community, finding the E.D. as the only support option.

There is also a small subset of people who make a high number of repeat E.D. visits for mental health complaints. A qualitative study, in the U.S.A by Digel Vandyk et al. (2018), noted important differences in utilisation patterns according to psychiatric diagnosis by people with 12 or more visits to the E.D. to a tertiary care hospital over one year. Using semi-structured interviews and survey, Digel Vandyk found participants visited the E.D. on average 20 times per year. Participants reported they felt compelled to come to the hospital to prevent serious harm. For them, every visit was necessary, yet they felt their needs were dismissed by E.D. staff. Importantly, this study teased out experiences of participants with primary personality disorders who reported they hated visiting the E.D. but felt they had nowhere else to go when at risk of serious self-harm.

Dismissal of their needs was interpreted by participants as disrespect and prejudice. A lack of adequate discharge planning upon release from the E.D. appears to further perpetuate E.D. use, especially when safe transportation home is not available. In contrast, Digel Vandyk found people with a diagnosis of a psychotic disorder viewed the E.D. as a safe place to go when

their symptoms became unmanageable. People with psychotic disorders were more likely to be treated as needing support. This suggests diagnosis and staff perception of individuals needs can influence experiences and outcomes for PiMD attending the E.D. There appears to be gaps in care and connections to support PiMD on discharge with a diagnosis of personality disorder.

Furthermore, recurrent users are much more likely to be transported to the E.D. by police services. Brunero et al. (2007), in a sample of people brought by police for care (n = 868) in a general hospital in Australia, found a trend towards more police referrals amongst PiMD who attended between 2 and 3 times in 12 months. Potentially recurrent police referrals may be explained by some PiMD coming to police attention in other areas of policing. For example, there is strong evidence of illicit substance use co-morbidity, domestic violence and homelessness linked to self-harm, police attendance and emergency care (van Dijk et al. 2019, Kothari and Rhodes, 2006, Hodges et al.2006, Saddichha et al. 2014). The complexity of these problems can find some people unable to change their circumstances perpetuating frequent involvement with police and discharge back to the community.

Focusing on the individual and diagnosis may not provide a full picture of recurring mental distress presentations to the E.D. Three papers (Spence et al. 2008, Kuehl et al. 2012, Joubert et al. 2012), point to systemic problems such as a lack of appropriate community-based services forcing people to repeatedly use emergency services as a last resort to keep themselves safe from self-harm. There is also a recognition that emergency services are not fully equipped to deal with the complexity of PiMD needs, meaning people can be discharged with none, or only some, of their needs met, and with no follow up care.

A qualitative paper by Spence et al. (2008), explored the perspectives of Canadian men who self-harmed and used substances (n = 25) who presented frequently to the E.D. Participants reported that the lack of community-based services accelerated the use of emergency services. However, often they felt their needs were beyond the purview of the E.D. This suggests the system in which people seek peace and safety to escape or obtain relief from situations of extreme distress can fail them (Holm and Severinsson, 2011). Potentially this can contribute to cycles of distress and repetitive emergency care.

Kuehl et al. (2012), also propose the reasons behind those re-presentations are rooted in systems failures. A retrospective records review from New Zealand identified in, over 12 months, a small group of people rapidly re-presented to the E.D. within 24 hours following intentional self-harm. Of the 73 re-presentations by 48 people, more than half (55%) occurred

within 24 hours of the index presentation. Re-presentations within one day included 9 (12%) and on the same day, 31 (43%). The authors suggest reasons for people to return included having had a limited mental health assessment and inadequate follow-up on discharge. Thus, there appears issues with systems within the E.D. which can contribute to repeat presentations of some PiMD.

By way of contrast, the E.D. is reported as providing a secure and supportive environment for some PiMD. In some health services, the E.D. appears to play an essential role in establishing connections to community mental health support for people following the first onset of emotional problems. Joubert et al. (2012), identified linkage back to the community, with E.D. clinicians acknowledged as key to community services. The Joubert et al. (2012), retrospective quantitative study in Australia found most patients (78%) received their care in the E.D. with 12% requiring brief admission to an inpatient ward for management of medical conditions such as post-overdose monitoring. Similar to other studies, 62% of PiMD presentations occurred outside regular business hours.

Whilst some PiMD feel they are not a priority and 'batted back' home (Barratt et al. 2016), Joubert et al. (2012), point to a need to "keep" people to allow comprehensive assessment and care planning before their return to the community. Given the high number of people previously identified who present without diagnosis or any previous link to mental health care, the E.D. in this study appears to more effectively connect people to appropriate mental health care and reduce the high demand and transitory journey through emergency services.

#### *2.4.1.2 PiMD Experience of Police and HCP Support*

How people experienced police and HCP support was discussed in three international papers (Watson et al. 2008b, Wise-Harris et al. 2017, Clarke et al. 2007). Few studies have examined PiMD experiences of the police intersect outwith the collaborative models discussed in 2.4.1.

The role of police officers as law enforcers and their approach to keeping people safe can impact on individuals' experiences of safeguarding. Watson et al.(2008a), in a qualitative study using semi-structured interviews, conducted in the U.S.A, explored the retrospective experiences of twenty PiMD in 67 encounters with police. While participants encountered police in a variety of ways, two main themes emerged. Firstly, PiMD can feel vulnerable and fearful of police, and secondly, the way police treated them mattered. Adverse experiences were verbal and physical abuse from police officers and feelings about the absence of a voice. The authors point to police behaviours such as being rushed and the use of force to manage incidents. Positive experiences, on the other hand, were being treated well and with kindness, dignity and being heard.

PiMD can experienced a similar lack of kindness in health services. Wise-Harris et al. (2017), mixed-methods Canadian study reports findings from self-reported, quantitative surveys (n = 166) and in-depth, qualitative interviews (n = 20) with frequent E.D. users with mental health and / or substance use challenges in a large urban hospital. This study is limited in that participants did not all have a mental health issue - some had only substance use problems (6 %). However, Wise- Harris et al. highlight participants had predominantly negative experiences within the E.D. with the busy clinical environment ill-equipped to support their complex needs. The authors point out, a lack of 'fit' of PiMD in generalist E.D.s can contribute to experiences of a pervasive stigma, discrimination, and perfunctory and unsympathetic care. The authors call for appropriate training and support for HCP to address complex physical and mental health needs.

This interpretation differs from that of another Canadian qualitative study of eight focus groups held with mental health patients and their families to determine their care experiences in the E.D. (Clarke et al. 2007). Although participant experiences were, for the most part poor, with lengthy waiting, negative attitudes of treatment by staff and diagnostic overshadowing, participants universally stated they wished to be seen in a generalist E.D. and did not want a separate specialist psychiatric service. This was due to concerns of stigma associated with a psychiatric facility and an inability to deal with physical care. These studies underscore stigma for PiMD is experienced across a range of contexts.

So far, this review has focused on the utilisation of services and experiences of PiMD. The next part of the review moves on to examine critically, the risks associated with self-harm behaviours and how police and out-of-hours health services work to manage this risk.

### 2.4.2 Intoxication, Self-harm, and Aggression Risk

A key theme in this review is associated with the experiences of police and HCPs in the management of PiMD, who were intoxicated or aggressive and was reported in 11 papers; (Borges et al. 2006, Larkin et al. 2014, Griffin et al. 2017, NHS Quality Improvement Scotland, 2008, Downes et al. 2009, Zisman and O'Brien, 2015, Maharaj et al. 2013, Maharaj et al. 2011, Morphet et al.2014, Doyle et al. 2007, Lord and Bjerregaard, 2014). Evidence suggests that co-occurring intoxication and aggression are commonplace in police and emergency health responses to PiMD. These can impact care delivery, and police and E.D. resources.

Epidemiological studies consistently identify high rates of co-occurring alcohol use with people presenting to services who self-harm, particularly in out-of-hours periods (Xuan et al. 2016, Johansen et al. 2010, Bagge et al.2017). A World Health Organization quantitative study of 10 E.D.s (n = 4320) by Borges et al. (2006), found that risk of self-injury increased tenfold after six units of alcohol. These findings broadly support the work of other studies in finding alcohol as an independent indicator for suicide and self-harm. Borges et al, call for a tailored clinical approach when PiMD are intoxicated to minimise the risk of further non-fatal or fatal self-harm (Larkin et al. 2017, Griffin et al. 2017). Similarly, in Scotland, a NHS Quality Improvement Scotland (2008), audit into harmful drinking, consisting of 15 mainland E.D.s, found more than half of those presenting with self-harm injuries had consumed alcohol prior to attending emergency services. Around 27% of men and 19% of women cited alcohol was a trigger for self-harming, supporting evidence of alcohol consumption and intoxication as a key co-occurring factor in the management of PiMD presenting through emergency services.

The impact of intoxication on cognition and behaviours, such as violence and aggression, can be the catalyst to bring people to the attention of police and health services. Understanding of community-based aggressive behaviours associated with self-harm and intoxication is limited in the policing literature despite how often this occurs. Acute behavioural disturbance is a common occurrence in the E.D. and has received slightly more attention. Downes et al. (2009), in an Australian retrospective review of acute behavioural emergencies (n = 143) requiring management by a specialist hospital violence management response team, points to the primary problems of aggression as associated with people presenting with self-harm (38%), alcohol and illicit drug intoxication (33%) and psychiatric, organic illness and drug withdrawal (29%). What is unknown from this study is if there were any identified reasons behind the aggression, for example long wait times. However, Downes et al. (2009), suggest co-occurring intoxication and violence brings an additional layer of challenging behaviour for emergency services when managing the care of some PiMD.

Police referrals of PiMD who are intoxicated to psychiatric services is commonplace. This is made explicit in a retrospective cohort study by Zisman and O'Brien (2015), who explored the relationship between alcohol and other substance use, and the process and outcomes of detentions under Section 136, in a London mental health trust. A total of 245 individuals were assessed over a 6-month period. Threatening to self-harm (n = 100, 44.8%) was the most common reason for an assessment. Zisman and O'Brien reported that PiMD brought to psychiatric services by police had high rates of intoxication with alcohol or other substance (69.5%, n = 66). Intoxication was reported as a critical reason for longer assessment times. Given the previously reported high risk of serious self-harm associated with drunkenness, it is

concerning that those who are intoxicated are significantly more likely to be discharged home than admitted to hospital, indicating perhaps they did not need emergency psychiatric services. However, of those discharged, the majority (61.5%, n = 83) were intoxicated at the time. A limitation of this retrospective study is that data were drawn from electronic notes, which limits the detail available and raises questions around accurate recording and reporting bias. It does not explain how people who were intoxicated were managed whilst awaiting assessment, or how they returned home, for example, by police escort.

In contrast to the findings of Zisman and O'Brien (2015), a comparative Australian study (Maharaj et al. 2011), through a retrospective audit of 200 patient health files, found those referred by police were more likely to be intoxicated, yet more likely to be admitted to the psychiatric unit. Characteristics of people referred by police (n = 101) were compared with those referred by other sources (n = 98). The authors found people referred by police had significantly higher rates of mental distress and aggression, because of psychoactive substances, compared to those not seen by the police. Potentially, PiMD who are intoxicated or have aggressive or unusual behaviours because of substances, are more likely to come to the attention of police because of these behaviours. Potentially, also, the difference in outcomes for PiMD referred by police is reflective of different agreements between police and health services as to whose responsibility it is to manage and safeguard people who are intoxicated.

Compared to the previous study, PiMD referred by police were more likely to be discharged after a few days than people referred by other sources, suggesting that their mental health needs may have been because of co-occurring substance use, rather than a mental health problem alone (Zisman and O'Brien, 2015). It may also signal there is recognition that to keep people safe when intoxicated, they may benefit from inpatient care.

As well as the difficulties with intoxicated behaviour, intoxication can compromise the clinical assessment of mental well-being and risk. Co-occurring intoxication from alcohol or other drugs and self-harm can delay decision-making and challenge the supervision of people in clinical environments (Yost, 2002). In part, this is due to lengthy wait times awaiting PiMD sobriety and availability of a psychiatrist to conduct a mental health assessment. A Delphi study by Morphet et al. (2014), suggests the combination of long waiting times for assessment, drugs and alcohol are highlighted as key contributors to violence in the E.D. Thus, there appears to be a relationship between psychiatric assessment procedures, intoxicated behaviours and lengthy wait times which can impact on PiMD experience in the E.D.

Another reason PiMD who are intoxicated may be escorted by police in the E.D. is that there can be a risk PiMD leave before they are assessed (Griffin et al. 2017). This behaviour may be partly in response to delayed assessment whilst awaiting sobriety. Given the increased risk of serious harm or completed suicide associated with mental distress and intoxication (Olfson et al. 2013, Spence et al. 2008, Brierley et al. 2010), these findings are important to suicide prevention initiatives.

In an analysis of data on self-harm presentations to hospital E.D.s in Ireland and Northern Ireland, Griffin et al. (2017), found 43% of people presenting with self-harm were intoxicated. This group were more likely to leave the E.D. without being seen by a clinician. Additionally, nurses felt ill equipped to care for the complex needs of this population; such cases being more likely to occur outside of usual working hours and at the weekends when there were fewer resources available to manage such behaviours. Griffin et al. (2017), also found PiMD who are intoxicated are more likely to be escorted by ambulance or other emergency service personnel. Griffin et al. (2017), fail to define whom other emergency personnel are, however, given the out-of-hours nature of the presentations, it can be assumed these are police officers.

Similar findings were reported in an Irish qualitative study of nurses (n = 42) experiences of caring for PiMD (Doyle et al. 2007). Through semi-structured questionnaires, nurses reported that a key challenge working with this group was preventing the patient absconding and acting on further self-harm. They reported becoming hyper-vigilant, thus decreasing time available for other patients and draining resources in an already busy clinical area. Nurses in this study sometimes felt uneasy and stressed when caring for these individuals especially those who were violent, aggressive or ‘unstable’. Participants reported they did not feel equipped to manage PiMD and this was not their role. Doyle et al. (2007), concludes there is a need for multi-agency involvement and systems change to better support PiMD to receive the care needed.

Two papers identify aggressive behaviours of PiMD referred to health services by police (Lord and Bjerregaard, 2014, Maharaj et al. 2013). In the United States, Lord and Bjerregaard (2014), examination of 3,635 cases in police and health files in the E.D., revealed police referrals to psychiatric emergency services are very different from those referred from other sources. The situations in which police are involved was significantly more likely to be volatile. Those referred by police were twice as likely as those referred by HCPs to be aggressive, intoxicated, psychotic and / or mood-disorder diagnosed. Lord and Bierregaard, suggest police involvement in managing aggressive behaviours is partly because as law enforcers they are perceived as being equipped to protect the public from harm in dangerous situations; hence,

they are more likely than other referral sources, to be initially involved in aggressive incidents involving PiMD.

Similarly, in Australia, the Maharaj et al. (2013), in-depth qualitative study points to high levels of aggression in PiMD referred by police officers to psychiatric services. Through semi-structured interviews, this study explored the experiences of mental health nurses (n = 9) caring for people referred by police. Maharaj found people so referred were stereotyped by nurses as ‘the worst’ patients. They were easily distinguishable by their aggressive behaviours. Notably, nurses dichotomised people referred by the police as those ‘deserving' of care and those ‘undeserving’. People with ‘genuine mental illnesses’ were believed to be deserving of care. The salient features of the ‘undeserving’ people were that they were drug and alcohol affected, demonstrating suicidal and threatening behaviour, and tended to become generalised to all police referrals.

The authors argued, being stereotyped as 'the worst' patient serves to de-legitimise patients and impedes the rebalancing of power and control in nurse-patient relations. This study is based on one health service in Australia, meaning the findings are less easily transferred to the Scottish context, therefore, should be interpreted with caution.

### 2.4.3 Professional Perspectives and Responses to PiMD

The majority of studies in this review (n = 24) reported professional perspectives and experiences of safeguarding. No studies focused on both HCP and police perspectives; therefore, the theme was divided firstly into HCP and then police perspectives and experiences and are presented in this way. This theme will conclude with a discussion of literature associated with professional relationships, organisational processes and professional cultures.

#### *2.4.3.1 HCP Attitudes and Experiences of Caring for PiMD*

The literature suggests a relationship exists between HCP attitudes, beliefs and behaviours about self-harm on their interactions with PiMD. In this section, HCP attitudes and experiences of supporting PiMD are reported in 10 papers (McAllister et al. 2002, Summers and Happell, 2003, Conlon and O’Tuathail, 2012, Chapman and Martin, 2014, Doyle et al. 2007, Commons Treloar and Lewis, 2008, Betz et al., 2013, McCann et al.2006, Friedman et al. 2006, Thompson et al. 2008).

Studies measured and explored factors influencing HCP attitudes such as professional experience and related concepts in terms such as perceptions of the 'genuineness' of the individual's needs.

PiMD, who do not receive positive, empathetic and caring attitudes, are less likely to remain in the E.D. for treatment (McAllister et al. 2002). Nurses' attitudes to people who self-harm appear shaped by judgements made on the act of self-harm itself (Conlon and O'Tuathail, 2012). Through a quantitative questionnaire, Conlon and O'Tuathail (2012), sought to measure Irish nurses' (n = 87) attitudes towards deliberate self-harm using the Self-Harm Antipathy Scale. The authors contend self-harm is frequently judged by nurses as morally wrong and therefore, implies critical judgments are made upon help-seekers. This is possibly due to whether nurses distinguish behaviours being an individual choice or response to mental illness. In other words, if nurses felt these behaviours could be alleviated by a clinical intervention, then they may act more positively towards the individual.

Similarly, judgements are also made by emergency medicine clinicians on the 'genuineness' of the individual seeking support in relation to the frequency of attendance to services and the type of harm (Chapman and Martin, 2014). Chapman and Martin (2014), in an Australian qualitative study reported that staff experienced PiMD to be manipulative. Some clinicians clearly differentiated between those whom they considered having made a genuine suicide attempt compared to those whom they believe were labelled 'attention-seeking'. Although some report feeling empathetic towards people who deliberately self-poisoned and felt they treated all patients the same, many participants expressed frustration with this population. These findings mirror the experience of PiMD identified earlier in 2.4.3, where they felt they were often not taken seriously. Therefore, it could be unhelpful and potentially dangerous if E.D. clinicians hold a belief that a PiMD is 'attention-seeking'.

Several authors (Doyle et al.2007, Commons-Treloar & Lewis 2008), cite frequent presentations of the same person, with no change, increased pessimism, loss of empathy and consequently, the development of negative attitudes in E.D. clinicians. Exposure of repeat presentations have been reported as reinforcing some beliefs and doubt about the likelihood of PIMD going on to complete suicide. There is evidence also of clinicians scepticism of the preventability of suicide, which shifts the focus from the individuals' behaviours to the confidence and clinical skills of clinicians to intervene with those who re-present to the E.D. in distress (Betz et al. 2013). In a multi-site survey of 8 E.D.s in the U.S.A, Betz et al. (2013), found few physicians and nurses (n = 631) believed the suicidal patient treatment was a top priority. Yet, participants reported frustrations over gaps in their skills and practices in risk

assessment and provision of referral resources to prevent repeat presentations by PiMD. These findings are concerning given the literature presented earlier in this chapter identifies people may not have their needs met and can remain at risk of repeat self-harm or suicide after attending the E.D.

In contrast, positive attitudes of community mental health nurses and E.D. nurses appear to be influenced by the extent of nurses experience and education associated with self-harm (McCann et al. 2006, Friedman et al. 2006, Thompson et al. 2008). These studies report older and more experienced nurses demonstrate more positive attitudes compared to younger colleagues. This may be linked to confidence developed over years of experience of assessment and management of PiMD. These findings indicate that whilst these nurses did express frustrations over repeat presentations, they held sympathetic attitudes towards PiMD. Further, they did not discriminate against these patients in their triage and care decisions.

It is also proposed increasing therapeutic and interpersonal communication in, and directly after, presenting to the E.D. could be beneficial for someone in a psychiatric crisis (Summers and Happell, 2003).This suggests staff knowledge, experience and skills can have an influence of PiMD experiences of care and potentially increase engagement with services.

#### *2.4.3.2 Police Officer Attitudes and Experiences of Supporting PiMD*

14 papers focused on police officers' attitudes and experiences in supporting PiMD. These tended to differ from those in the HCP studies in the previous section, in that for the most, the emphasis of these papers was on frustration over practical tasks and access to health services, rather than attitudes towards PiMD per se. International literature consistently reflects high rates of police interaction with PiMD (Lee, 2006, Lee et al. 2008, Al-Khafaji et al. 2014). Police Officers' approaches to dealing with PiMD contrasts between dignified and respectful engagement (Watson et al. 2008a) and perceptions of threatening and over-reactive contact (Boscarato et al. 2014).

5 papers reported police officers difficulties transferring care of PiMD to health services (Godfredson et al. 2011, McLean and Marshall, 2010, Fry et al. 2002, Al-Khafaji et al. 2014, Martin and Thomas, 2015).

Godfredson et al. (2011), conducted a qualitative survey of 3,534 Australian police officers to explore the 'approach styles' of police when responding to PiMD. Several officers expressed frustration at having to 'babysit mentally ill people' in hospital waiting rooms, while others found

the mental health system to have a 'revolving door policy'. This suggests people can be released from health services only to return to the attention of police officers.

Police officers report help from HCPs is unavailable in a timely, or even in an urgent manner (Fry et al. 2002). Similar challenges of lengthy wait times and difficulties in discharging care to health services are echoed in a Scottish study (McLean and Marshall, 2010). Based in a large urban area of Scotland, this qualitative study of semi-structured interviews with police officers (n = 9) reported they felt there can be an inappropriate burden placed upon the police service to support PiMD. This impression was reinforced by a belief health services failed some vulnerable people. Police found themselves supervising people on ‘suicide watch’ within custody suites, rather than in health services, drawing them away from ‘real police work’.

Police officer engagement with health services appears more challenging when transferring care of some PiMD and after 5pm (Martin and Thomas, 2015). Martin and Thomas (2015), in an Australian qualitative study, sought to examine police encounters with people with mental health needs through semi-structured interviews (n = 25). A key finding from this study was that officers specifically identified difficulties in engaging HCP support for people with a diagnosis of personality disorder (PD). Similar to Chapman and Martin (2014), reported in the previous section, participants in Martin and Thomas’s study reported HCPs labelled this population as 'attention-seeking', thus leaving police officers with ethical dilemmas and frustrations in keeping people safe when there was no health care support. Police officers expressed concern over the unmet needs of some people, placing responsibility on police services to provide care. Martin and Thomas draw attention to a gap in care for a specific group, making connections between HCPs beliefs in their abilities to intervene and police officers’ abilities to transfer care.

Police can use their powers under mental health legislation to facilitate access to mental health care. A retrospective medical review by Al-Khafaji et al. (2014), sought to understand the characteristics of patients brought by police under mental health legislation in Australia. This legislation attempts to balance public safety and timely access to mental health care for people who police believe are mentally unwell. Using police legislative powers can do so at some cost to personal freedom, and physical and psychological risk associated with detention and involuntary transport. Al-Khafaji et al. reports 61% of people did not require restraint, sedation, or hospital admission. 67% of PiMD were discharged home (Al-Khafaji et al. 2014), suggesting they did not require this level of detention. In 1.6% of cases, there was no evidence in the documents of threat / risk to self or others. These cases would appear to fall outside the provisions of mental health legislation (Al-Khafaji et al. 2014).

There is evidence also of other emergency services ‘leaning in’ on police officers to use their powers of detention to facilitate access to mental health care for some PiMD.

In England, Rees (2016), a Grounded Theory study, investigated paramedic responses to the care of PiMD. Paramedics reported situations where there were tensions between legality and judgement of good practice when caring for people who refused transportation to a hospital. Calls for support by police was reported as standard practice for paramedics as a means of using police powers to detain a person and transport them against their will. This practice reflects ways in which services work around gaps in systems yet suggests this may come at the expense of the dignity of PiMD and may breach ethical and legal principles.

International literature reflecting a failure on the part of HCPs to hospitalise PiMD, caused considerable angst among police (Fry et al. 2002, Schulenberg, 2016, Godfredson et al. 2011). Schulenberg (2016), in a Canadian mixed-methods study including observation of police decision-making when dealing with PiMD, found officers wished to be part of a solution to keep people safe and advocate for diversion from the criminal justice system where possible. However, in too many circumstances, police officers were faced with arrest decisions for public order behaviour when unable to discharge care to HCPs, thus laying criminal charges for minor offences due to limits on their decision-making autonomy (Schulenberg, 2016).

Cotton (2004) concurs, finding Canadian police officers face complex situations, and their decision-making operates in a 'grey zone’. Despite their professional judgment that criminalisation of PiMD is contrary to PiMD well-being, police officers can feel forced to place a criminal charge to manage PiMD behaviour. Cotton (2004), suggests police officers are in an untenable position. There is a social expectation to ‘‘do something,’’ while at the same time having no clear reason to arrest and knowing full well a visit to the E.D. is unlikely to lead to admission or treatment, unless the individual is acutely homicidal or actively suicidal.

Challenges in balancing law enforcement and social welfare roles, when called on to safeguard some PiMD, were also reported in three studies. For the most, there is evidence police officers feel compassion and understanding of PiMD with feelings of having made a positive impact on some people (McLean and Marshall, 2010). Godfredson et al. (2011), found Australian police officers expressed empathy for PiMD and a desire to protect them. Godfredson highlighted an enthusiasm by large numbers of police officers to take part in mental health training to improve care. Yet, applying mental health skills in police practice was found to be challenging. This was because a culture of doing 'real police work' such as crime-

fighting, can be strong, and health services were being under resourced to support police referrals (Godfredson et al. 2011). Thus, despite a willingness to improve police responses to PiMD, in practice both inter-agency systems and police culture can impact upon PiMD support.

Positive police officer experiences in the management of PiMD on the other hand, is associated with connecting PiMD to health services or managing less urgent distress without transfer to mental healthcare or criminalisation. Van Den Brink (2012), in a Dutch study of police records, suggests police are experienced conduits to mental health services. Half of PiMD coming to their attention were not previously engaged in psychiatric services, yet police officers were responsible for connecting a substantial portion of individuals (21%) with mental health services. Half of all encounters were dealt with by police alone. This study did not illuminate how PiMD were managed, or of the outcomes of intervention, yet Van den Brink implies officers in the Netherlands have a greater level of agency and discretion associated with their approach to PiMD. They appear confident in their ability to deal with mental health issues beyond arrest or referral to health services. Van Den Brink's study suggests this does occur in some jurisdictions. Officers discretion in mental health care was not identified in other papers reviewed.

## 2.5 Answering the Literature Review Question and Discussion.

At the beginning of this chapter, I pose the question:

**What are the safeguarding experiences of people in mental distress, and what are the care experiences and processes of police and health practitioners in supporting PiMD needs?**

Taken together, the findings of this integrative review suggest the experiences of PiMD during safeguarding are varied and multi-faceted in nature. Although there is evidence of positive experiences where people are treated with kindness and compassion, a substantial number of the reviewed articles report negative experiences. These appear linked to tensions between the crisis nature of self-harm and intoxication, bringing people to the attention of police and emergency HCPs professional responses to their needs, and the intersect of emergency police and health systems in which support is provided.

When comparing PiMD experiences; being heard, believed, and treated with dignity are important factors in how PiMD experience safeguarding. These factors can be influenced negatively by police and HCP responses to PiMD diagnosis and beliefs about self-harm, the

co-existence of physical and mental health problems and frequency of attendance to the E.D. The review highlighted that experiences are particularly challenging for people with a diagnosis of personality disorder, PiMD who are intoxicated or aggressive. Police / health systems where safeguarding is poorly organised can contribute to poor experiences of care.

A thread running throughout the papers was that police officers occupy an essential position in safeguarding PiMD. This is underscored in the focus of the studies in the integrative review with 14 of the 44 studies focused on the police experience. Police officers can be challenged in balancing their law enforcement and welfare roles. In part, this can be because of difficulties in being able to discharge the care of some PiMD to health services, and balancing police officer law enforcement and welfare responsibilities. Adding to this, police processes such as legislative powers and restraint used to manage challenging behaviours and access to mental health support, can be experienced as frightening and coercive, potentially increasing agitation and aggression.

Police officers and HCPs experience a high level of frustration in supporting PiMD. HCP frustrations appear aligned to PiMD behaviours rather than that of health and police systems in managing PiMD. In contrast, police officers frustration appears more focused on gaps in resources. Although police officers may wish not to criminalise PiMD, the inter-agency criminal justice / health system can impede transfer between services, thus leaving few management options open to police officers. There is a relationship between professional attitudes to PiMD, clinical knowledge, competing roles and available police and HCP resources. These do not seem to work and can obstruct or act against each other, highlighting failings in inter-agency practices and systems to support some PiMD adequately.

There is limited understanding of the role of police officers' interactions on the individual's aggression and anxiety, for example, if the individual is handcuffed during transportation. Potentially, the use of coercive practice may increase agitation and humiliation and impact negatively on aggression. Evidence suggests police officers are using their powers under mental health legislation as a pathway to discharge their duties of care for people with a range of mental health needs. This underscores a gap in processes in safeguarding people who do not reach thresholds for inpatient care, yet may still be at risk of harm. It also suggests people are being exposed to potentially undignified and frightening police procedures to transport and detain them whilst awaiting mental health assessment. This could suggest some PiMD are disadvantaged in their care because of being referred by police officers.

In terms of HCP responses to PiMD, there was little evidence of holistic, person-centred approaches to PiMD in emergency care. When physical and mental health needs co-exist, these tend to be responded to separately. This disconnection can contribute to lengthy wait times, which can see people leave emergency services without adequate assessment, potentially leaving them vulnerable to further harm or re-presentation to emergency services. Considering these experiences alongside negative stereotyping of those referred by police, and delayed discharge whilst awaiting sobriety for assessment, the cyclical nature of distress and inappropriate / early discharge emerges. As such, people can be discharged back to their communities without their needs fully met, or ongoing support.

In summary, police and health care systems appear disconnected and ill-equipped to safeguard this specific population group. For this group, their self-harm distress brings them to the attention of the Police and the E.D. Yet, there does not appear to be a smooth and clear pathway through services responsive to their needs.

### Summary of the Main Review Findings:

- Experiences of PiMD during out-of-hours safeguarding vary. Access to services, diagnosis, sobriety, levels of aggression, and professional attitudes are influential.
- Poor experiences are associated with specific diagnosis and presentations such as personality disorder, frequent presentation and those intoxicated or aggressive.
- Positive experiences are associated with feelings of being heard, being treated with compassion and dignity and taken seriously.
- Police officers can find it difficult to discharge safeguarding responsibilities for some people they believe to be at risk of harm especially outwith routine hours. Police officers can use coercive measures such as their legislative powers to facilitate the transfer of people to health services. Yet, many people are returned home without assessment suggesting they do not need psychiatric care or inpatient safeguarding.
- The clinical environment and staff mix are often ill-equipped to support the complex needs of PiMD, particularly those who are intoxicated or aggressive. Physical and mental health needs are not routinely assessed holistically. Staff can hold stigmatising beliefs about this group; some people do not receive a psychological assessment or adequate discharge back to community support.
- There is a relationship between presenting to the E.D. with suicidal behaviours and repeated self-harm or completing suicide after leaving services.

### Gaps in the Literature

- The safeguarding journey is complex and there exists limited evidence as to the relationship between the various stages of, or the impact on, PiMD behaviours on police decision-making and processes throughout the safeguarding journey.
- PiMD not admitted to inpatient care may be at risk of harm following discharge from health services or re-present to emergency care. Much less is known about PiMD, Police and HCP perspectives of risk and risk management throughout the final stage of this journey.
- The use of a 'Place of Safety' in a hospital environment is fairly well established. However, it is unclear under which circumstances police custody is used to keep people safe and why this occurs. Little is known about the use of a private dwelling (person's home) as a Place of Safety when people are distressed as set out in the MHCT Act.
- Studies examining out-of-hours attitudes and approaches to PiMD tend to be focused in the E.D. Little is known about safeguarding journeys which do not involve E.D. or the perspectives of out-of-hours G.P. or mental HCPs who may be involved in mental health assessment in individuals' homes or in unscheduled care psychiatric services.
- Most studies in this review were not theoretically based and in those which were, the theoretical underpinnings were limited. There are opportunities to apply a theoretical lens to findings, to develop new understandings of the relationships between PiMD experiences of seeking safety and police officers and HCP processes and behaviours whilst supporting safeguarding.

## 2.6 Limitations of the Review

The searches in this review returned more qualitative papers (n = 24) compared to quantitative studies (n = 17) and may reflect the focus on human experiences. Papers included empirical studies from ten countries. However, these results should be interpreted with caution, given these were English language studies alone, and may not reflect the experiences from other populations and cultures. Data from 12 papers were drawn retrospectively from police or health records and could be subject to recording bias, thus limiting the quality of these studies. In addition, due to the nature of the studies included in the review, a meta-analysis or systematic review was not feasible. Integrative reviews may be considered as lacking the rigour and objectivity of other approaches to reviews. While I developed the search string for the literature search in consultation with a health science librarian, I screened title and abstracts and quality of the literature alone, which may have resulted in bias and inaccuracies. A team approach may have provided a more robust selection of papers (Crombie, 1996).

Nonetheless, the methods used in this review were comprehensive using the approaches specified by Whittemore and Knafl (2005).

Within included studies, there may be significantly different contextual issues such as safeguarding policies, mental health legislation and cultural differences making comparisons difficult and not easily transferrable to the Scottish context. For example, many studies were conducted in the U.S.A. and Australia where there is limited comparison to access government-sponsored universal healthcare systems such as the NHS, and much higher rates of mental health-related exchanges with police involving firearms. These could potentially influence PiMD professional experiences.

## 2.7 Study Rationale

Key to the rationale and focus of this study are the following points:

**Gaps in safeguarding processes:** This review underscores gaps in out-of-hours emergency health and police processes to support effectively the needs of some PiMD. Specifically, these gaps impact on PiMD where inpatient care is not required. The recurring and crisis nature of mental distress coupled with a lack of out-of-hours community-based care appears to find PiMD reliant on police and emergency health services to support their needs (Watson et al.2008b, Wise-Harris et al.2017, Clarke et al.2007). Yet, both police and the emergency health care systems appear ill-equipped to support the needs of this population. This can find people returned to their communities and disconnected from primary health services.

There remains a poor understanding of how these factors relate and shape key stakeholder experiences during mental distress. This gap in the literature is a particularly important one to address as some people can remain at risk of serious harm and are unable to escape a cycle of mental distress. Systems gaps contribute to stress on police and emergency health care resources resulting in frustrations between those working at the law enforcement and public health interface. Articulating the inter-connectedness between these gaps can help illuminate factors which can support or act as stressors to mental distress during out-of-hours safeguarding journeys.

**Intoxication and aggression during safeguarding**: Findings from this review highlight PiMD can experience overwhelming feelings of lack of control and anger during distress episodes. Intoxication and violence are also frequent during safeguarding journeys involving police and HCPs (Lord and Bjerregaard, 2014, Maharaj et al.2013, Zisman and O'Brien). These factors

can increase the risk of serious self-harm, challenge assessment and the management of people in emergency clinical environments. So far, the research focus of managing such behaviours has been with in the E.D., yet there is evidence PiMD who are intoxicated and aggressive are more likely to be brought to health services by police. There has been limited exploration of stakeholder experiences where PiMD are intoxicated or aggressive at other points of the safeguarding journey, for example, when police first respond in the community or subsequent management whilst awaiting HCP assessment. Addressing this knowledge gap can help articulate how police and HCP intoxication and aggression management of PiMD, enables or disables mental distress and the trajectory of care.

**Compassion and dignity:** The literature suggests some PiMD are transported to health services using coercive measures such as police powers of detention in order to access psychiatric support (Al-Khafaji et al 2014). Adding to this, most people are returned home - suggesting these coercive measures are potentially used inappropriately. PiMD experiences include not being taken seriously, feeling unheard, and exposure to long waiting times for healthcare (Chapman and Martin, 2014). These processes are at odds with clinical practices to de-escalate distress, and the needs of people to be treated with dignity and compassion, in line with legislative requirements. Therefore, gaining an understanding of current police and health service processes and the impact on PiMD is important in the provision of safe, dignified and compassionate care sitting at the heart of safeguarding practice.

**Working in the gaps: Collaboration and co-operation:** As presented in Chapter 1, the issue of co-operation and partnership between health and police services has received considerable attention in police and mental health strategic plans and safeguarding policies. Yet, evidence presented in this review suggests there can be tensions at the police / health interface (Schulenberg, 2016, Godfredson et al.2011). Police officers report feeling unsupported by HCPs (Fry et al. 2002). and can be at odds with each other regarding perspectives of PiMD needs. For, example, police appear to view self-harm behaviour as dangerous and in need of control in protecting the wider community (Al-Khafaji et al 2014), Contrariwise, it may be possible HCPs are less concerned about self-harming behaviours, seeing such behaviours as symptoms which may or may not require attention and inpatient care. Exploration of these concepts is vital if safeguarding policies and police / health service collaborations are to be effective. There is a need to address how gaps in out-of-hours services and police and HCP occupational cultures and perspectives of PiMD relate.

**Police and safeguarding outside the E.D.** Previous studies have examined the experiences and factors involving PiMD in the E.D (Godfredson et al.2011) and of those transported by

police to hospital (Maharaj et al.2011, Van Den Brink 2012). No research has examined police and HCP responses to keeping PiMD safe in their own home or when police custody is used as a last resort. Understanding the nuance in safeguarding journeys is widely missing from the literature. At the time of this review no studies have considered the nature of keeping people safe within a private dwelling. Articulating the nuance and trajectory of the safeguarding journey is essential in building a comprehensive picture of barriers and facilitators towards keeping PiMD safe and allocation of police and health service resources.

**Keeping PIMD safe in Scotland:** Whilst there has been some research focus in England about police and emergency health care responses to PiMD (Rees 2016, Zisman and O'Brien 2015), this does not always translate easily into the Scottish context due to different approaches to policing identified in Chapter 1, devolved healthcare and safeguarding legislation. To my knowledge as at 2020, no study has been published which considers out-of-hours police / emergency health care for PiMD in Scotland. It is therefore important to explore the three stakeholder experiences through their lens' to address this gap and support a depth of understanding of how services work together and how PiMD experience care within a Scottish context.

## 2.8 Research Questions

The purpose of this study was to gain an understanding of the relationships, experiences, and processes between PiMD, Police, and HCPs, within the context of out-of-hours safeguarding journeys of people expressing self-harm behaviours.

Overall, the study aims were:

1) understand the relationships and experiences of PiMD and Police and HCP involved in their safeguarding.

2) identify factors and features of Police and HCP processes that facilitate or impede safeguarding journeys.

The research questions:

1. **What are the experiences of people in mental distress whilst seeking help through police and healthcare practitioners?**
2. **How do organisational processes, partnerships, and professional cultures influence care journeys of those in mental distress?**

3. **To what extend do expectations and relationships between police, people in mental distress and health practitioners' impact on support and safeguarding?**

In the next chapter, I will detail the theoretical framework underpinning this study. Following on from Chapter 3, Chapter 4 details the qualitative methods which are useful when the research is exploratory, as used in this study. I present my approach to recruitment processes, data collection, management, analysis and ethical considerations. The chapter will conclude with detail on how I addressed challenges associated with conducting the study.

# Chapter 3: Theoretical Approaches to the Field

## 3.1 Introduction

This chapter presents the theoretical underpinnings of the thesis. I discuss critically, the rational for, and implications of, taking a broadly social constructionist approach to the research. I establish first the philosophical stance underpinning the research and the need for a qualitative methodology in this research design. I also discuss the relevance of drawing on elements of Defeat and Entrapment Theory (Gilbert and Allan, 1998), the Cry of Pain Model (Williams and Pollock, 2001) and the Stark et al.(2011) Conceptual Model of Suicide, in helping me make sense of, and elaborate my findings. I conclude this chapter with a critical overview of the relationship between the different theories and concepts, which have informed the development of my conceptual model (Chapter 8).

## 3.2 Qualitative Methodology

This study lies in a qualitative domain, which is well suited to research exploratory in nature seeking to understand the multiple meanings people attribute to their experiences and relationships within their social worlds (Parahoo, 2014). Creswell (2013) proposes all researchers bring a set of beliefs and philosophical assumptions to research which underpins their theoretical approach.

Theoretical approach conveys the use of a theory or theories in a study which simultaneously conveys the values of the researcher providing an articulated signpost or lens for how the study will process new knowledge (Collins and Stockton, 2018). Four main assumptions and structures support the researcher's focus and lens to their study; epistemology; ontology; axiology; methodology. Epistemology is concerned with ‘how we know what we know’ (Crotty, 1998). Guba and Lincoln (1998, p.108), describe it another way, stating it is 'the nature of the relationship between the knower, or would-be knower, and what can be known’. Ontology is concerned with what constitutes reality and how we can understand existence. Axiology focusses on the values in research. Methodology is the justification for using particular research methods (Holloway, 2010). These four assumptions have informed my research design, transparency and understanding of my study decision-making processes. Viewed as crucial to enhancing research rigour and quality, I will now detail these more by considering what these concepts mean in relation to my research.

### 3.2.1 Epistemology

In considering the decisions taken to situate this current research in the qualitative paradigm, it is important to consider my study in relation to the interpretivist philosophical position underpinning qualitative methodology (Guba and Lincoln, 1994, p.119). Two distinct epistemological paradigms described within social science are positivism and interpretivism (Ritchie et al. 2013). The positivist researcher reasons all phenomena can be reduced to empirical indicators which represent the truth that research can be validated using objective quantitative methodology which is replicable, such as experiments (Guba and Lincoln, 1998, p.106).

A fundamental tenet of positivism is the commitment of the researcher's neutrality in the study (Barbour, 2014). Alternatively, the current study is situated in interpretivism. The interpretive position stresses the importance of subjective interpretation as well as observation in understanding social worlds (Holloway, 2010). The interpretivist researcher emphasises the contingent nature of knowledge and reality, arguing there is no ultimate objective reality (Barbour, 2014). Thus, epistemologically, how I have approached my research design and interpreted my findings, has important implications for how new knowledge has been developed and understood in my research. As I will show in Chapter 4, whilst I developed research methods to gather research data and identify ways of knowing which were meaningful to the PiMD, police officers and HCPs, I also acknowledge my role in interpreting their individual accounts of their social worlds.

### 3.2.2 Ontology

In positioning myself in this thesis in Chapter 1, I highlighted I believe my experiences and clinical practice which brought me to this research, have influenced my understanding of the world. An ontological position refers to researcher relationship with the reality of their study. For example, whether the researcher considers reality as being independent of their knowledge, or whether they participate in the construction of that reality (Guba and Lincoln, 1994, p.110).

Ontologically, I take a standpoint that the meanings which different individuals such as PiMD, police officers and HCPs ascribed to their social experiences, and how I understand these, are interconnected. It is the nature of these multiple realities, the relationship between them, and my interpretations of the research, that brings the richness to my qualitative study. Thus, reality is not independent of my knowledge. From an interpretivist perspective, knowledge and meaningful reality is constructed in and out of interaction between humans and their world and

developed and transmitted in a social context (Crotty, 1998, p.42). Therefore, individual constructs and multiple realities are elicited and understood through the interaction between me as researcher and the study participants.

### 3.2.3 Methodology

I highlighted in Chapter 2 that little is known about the relationship between PiMD experiences of safeguarding journeys, processes and professional practices brought to bear by police officers and HCPs in keeping PiMD safe. Qualitative methodology aims to understand phenomenon from an individual's perspective and examines interactions among individuals and groups, as well as from the past, political and cultural contexts which people occupy (Creswell, 2018). Consequently, qualitative methodology was deemed to be an appropriate approach to understanding peoples' perception of relationships and experiences in this study. Furthermore, qualitative inquiry is congruent with the philosophy of mental health nursing. The changeable and fluid nature of qualitative research reflects the ambiguous nature of mental health where concepts of health and illness can be uncertain and changeable. Foster et al. (2006), suggest the role of the researcher in qualitative inquiry, may be viewed as synchronous to that of the mental health nurse. Both are attempting to use themselves; their thoughts, feelings, understanding, and experience, to work in partnership with others so that further understanding and meaning of the lived experience be understood and the lives of the 'others' in particular, enhanced. Therefore, I judged qualitative methodologies well suited to the aims of the study. I could draw on the philosophical underpinning of mental health nursing to support my research, then had to decide which qualitative approach would be most appropriate.

Social constructivism is one theoretical approach often drawn upon in qualitative research. It has driven my work, is based on the belief that social reality exists as individuals experience it and assign meaning to it. This understanding is created through social interaction with other individuals via a continual process of interpersonal communication and negotiation. Hence, multiple realities of a phenomenon can be understood (Appleton and King, 2002).

Understanding multiple experiences and realities of mental distress safeguarding, and the influencing factors, lie at the heart of this study. A social constructionism approach places value in both participant and investigator interpretations within the research (Ormston et al. 2014). This is a particularly useful position for this thesis as it provided me with a basis to explore and interpret the individual's perspective, the relationship between Police and HCP processes and individuals' experiences during safeguarding. It is the nuance and multiple perspectives of key stakeholders complex interactions and the relationship between their real

worlds within an important policy context, which underpins the development of new knowledge within the thesis.

A potential difficulty in applying a social constructivist approach to research is there can be a blurring of definitions of social constructivism (Kim, 2001). Barbour (2014) suggests the use of a *broadly* social constructionist approach allows flexibility within the research. This approach can effectively provide an understanding of the interaction between participants in the study context. There is potential for contrasting, dynamic, and socially constructed realities, which can capture diverse accounts of PiMD, Police Officers and HCPs. Therefore, I adopted a broadly social constructionist approach as the central theoretical assumption for this research. As I will detail in Chapter 4, a broadly social constructivist approach was used to guide the research design and iterative process of analysis.

Qualitative methodology has its limitations and can be criticised for its legitimacy, trustworthiness transferability and dependability (Gerrish et al. 2015, Parahoo, 2014). Holloway (2010 pp.297-312), asserts there are several approaches which can strengthen the rigour and trustworthiness of findings. The methods I adopted and integrated into the study will be outlined in Chapter 4 detailing the research design and methods.

### 3.2.4 Axiology

Throughout this thesis, I aimed to be transparent and honest about my experiences and impetus for the research to provide a clear audit trail regarding decisions made, actions taken and relationships with the supervisory team and participants throughout. These are interwoven into the thesis in terms of reflexivity (Chapters 1, 4 and 9) and my approach to research design. For example, I chose to write in the first person signalling my values are not removed from the research process. In Chapter 1, my position is laid out within the thesis. In Chapter 4, I acknowledge that connections and relational dynamics such as perceptions of power, can exist between the researcher and researched, and is reflected in my approach to ethics within this study.

I acknowledge that my values are not separate in data collection and interpretation. Guba and Lincoln (1998, p.108) propose only 'human instruments' can retrieve multiple perspectives from data and are fundamental in their interpretation. Thus, being the only 'human instrument' involved in the data collection, clarity of my personal and professional values influence how I collect and make meaning of the data.

Axiology is also concerned with researcher values in the study design. My clinical experiences and engagement with the literature, as reflected upon in Chapter 1, have shaped my personal and professional values. The researcher's subjective values, intuition, and biases are important — they play a role in the dialogue of social construction and inform the interpretation of data.

Holloway (2017 p.9) contends researchers should make their values known within the study by actively reporting their values and bias' as well as the value-laden nature of information gathered from the field. Being transparent about the research process and the experience of the researcher is viewed as a crucial way of enhancing quality and rigour in qualitative research.

I contend the mismatch of services and PiMD needs, and the medicalisation of emergency mental health care is a salient part of the experiences of PiMD, and Police Officers and HCPs supporting their care. Relevant to this thesis is my observation that elements of the inter-agency approach to PiMD may be obscure or relatively silent because of their lack of 'fit' within criminal justice and health services. The point here I believe, is that the care of people who self-harm may require new forms of knowledge to support the organisation of services to prevent serious self-harm, provide dignified care, disrupt distress cycles and displacement between services.

I also indicated in Chapter 1 that policy assumptions appear to view people who do not reach thresholds for safeguarding interventions as a burden on police, emergency health and social care resources. I believe this raises signals about the value of people whose problems may rest outside the positivist dominance of psychiatry, emergency medicine and criminal justice.

Bradbury-Jones et al (2014), highlight the importance of researchers articulating how theory has been used in research design. Sandelowski (1993), asserts theory can be "brush-stroked" into a study or sit centrally to the study to test or elaborate findings. Where it enters or leaves the study can also differ depending on the research approach (Green, 2014, Evans et al 2011).

The cross-disciplinarity of my research found me working in a novel space, and in an area where little was known about the experiences of PiMD, Police Officers and HCPs supporting their care. Thus, there was a need to ensure an inductive approach to this qualitative study. Therefore, a broadly social constructivist approach informed my data collection and data analysis. As I will describe in Chapter 4, I used an inductive approach to my data analysis, working iteratively across three data collection phases, to construct the thematic framework

from the data. Through this process I began to recognise relationships between human input and inter-agency systems and processes. These insights informed the theoretical lens applied post hoc to elaborate and make sense of my findings. Morse and Mitchim (2016) and Evans et al (2011), highlight that this approach is common in qualitative research involving complex phenomena where data analysis is messy and non-linear. In exploratory research, such as my study, there can be no requirement for new theoretical insight to emerge directly from the data. Equally, the researcher can move from initial theoretical assumption to pursue more interesting, lucrative or relevant theoretical avenues inspired by their descriptive analyses and such an approach was relevant here (Neale 2020).

To elaborate my findings, I drew on the inter-related theoretical and conceptual perspectives of Defeat and Entrapment Theory (Gilbert and Allan, 1998), Cry of Pain Model (Williams and Pollock, 2001), and the Stark et al.(2011) Conceptual Model of Suicide to elaborate my findings and develop new knowledge within the thesis.

In this next section, I introduce this theory and conceptual models. I will justify which elements of the theory or model are useful in informing this thesis.

## 3.3 Theoretical Considerations in the Elaboration of Findings

In Chapter 2, I argue there is a need to understand the relationships and experiences of PiMD with Police and HCP safeguarding processes. Therefore, it is important to consider relevant theory or models which can help inform an understanding of an individual's mental distress which may find them call on emergency services for support. It is also important to understand the influence of such support on the individual's distress and recovery. I have drawn on three inter-related theory or models to help elaborate my findings; Defeat and Entrapment Theory (Gilbert and Allan, 1998), the Cry of Pain (CoP) Model (Williams and Pollock, 2001) and Stark et al.(2011), Conceptual Model of Suicide.

The choice of theoretical lens' to elaborate my findings emerged as the data collection, analysis and interpretation developed through the reflexive process of trying to understand and refine my findings. Example: I recognised the relationship between the urgency for the individual to find peace from their escalating distress, intoxication and the swift 'in person' control a police officer demonstrates. These factors also related to the tension the PiMD experienced as the result of the shame, embarrassment and potential safeguarding in police custody because of the police response. Using elements of these theoretical lens' helped 'get underneath' the data to understand the dynamic relationship between the PiMD and the Police

Officers and HCPs involved in their safeguarding. Also, I chose these three works because, to my knowledge, no single theory or model explains the relationship between the individual's experiences of mental distress and the nature of Police and HCP support on their distress - something this thesis addresses.

I have drawn on elements within each of the above works, which I believe collectively help inform my findings. Whilst there is no scope to explore each theory or model in-depth, I will now detail an overview of each work and explain which components are useful in illuminating and informing this thesis.

### 3.3.1 Gilbert and Allan (1998) Defeat and Entrapment Theory

My data highlighted a reliance on police officers by PiMD to intervene when they could no longer self-manage an overwhelming need for self-harm. I believe using suicide and self-harm theory helps to better understand the relationship between self-harm behaviours and police support. Two central theoretical constructs assumed to be involved in mental distress behaviours are defeat and entrapment (Gilbert and Allan, 1998). The concept of entrapment originates from animal-based arrested flight models of defensive behaviour (Dixon, 1998).
Experiences of defeat have been described as the perception of a failed struggle and feelings of powerlessness. When coupled with feelings of a loss of social rank and humiliation, an individual is vulnerable to feelings of defeat. Entrapment occurs when people are motivated to escape a stressful, unpleasant state or situation. However, the flight is blocked because of *internal* (e.g., insufficient coping agency, meaning capacity for individuals to tolerate or self-manage their distress) or *external* circumstances (e.g. no help by others). Gilbert and Allan (1998), argue feelings of internal and external entrapment are closely associated with depression and can explain heightened flight arousal (need to get away). Feelings of entrapment, anger, and a need to escape are also common in people who self-harm (Clarke et al. 2016). The relevance of these constructs is also evidenced in the development of depressive and anxiety disorders, as well as suicidality. Where people experience defeat, no escape and no rescue, their risk of suicide increases (Taylor et al. 2011, Siddaway et al. 2015, Griffiths et al. 2014, O'Connor and Kirtley, 2018, O'Connor and Nock, 2014).

Defeat and Entrapment theory has mainly been applied in psychology research and a small number of studies on mental health nursing (Dunster-Page et al. 2018) or emergency care settings (Tzur Bitan et al. 2019). Elements of defeat and entrapment theory applicable to this nursing thesis, link to the relationship between *internal* and *external* factors. Understanding how these are connected helped inform on the PiMD initially seeking help through the police and illuminates the impact of the external support brought to bear by both police and

emergency health services. Viewing internal stressors of PiMD as proximal to the external factors and stressors affecting support (police and health services), can bring a deeper understanding of the relationship between these factors and PiMD experiences of safeguarding.

### 3.3.2 Williams (1997) Cry of Pain Model

This study is concerned with safeguarding journeys of PiMD who do not have a diagnosis of serious mental illness. I have highlighted in Chapters 1 and 2 that the majority of PiMD brought by police to health services are not detained in hospital but returned home. Understanding the factors involved during episodes of mental distress, where there may be no wish to die, can therefore help support an understanding of the experiences of PiMD who call on police for support. The Cry of Pain (CoP) (Williams and Pollock, 2001), model is a psychological model which extends existing theories of escape (Baumeister, 1990), and defeat and entrapment (Gilbert & Allan, 1998), proposing that self-harm behaviours be considered as a 'cry of pain' rather than the traditional 'cry for help' (Figure 3).

Williams and Pollock broadened the focus beyond escape theory to take account of how their theories fit with social, biological and genetic facts (Williams and Pollock, 2001, Williams and Pollock, 2000, Williams, 1997). Critically, this model allows for consideration of the processes underlying self-harm behaviour without suicidal intent. As illustrated in Chapter 2, an understanding of this population is missing in safeguarding policies and out-of-hours safeguarding practice.

Williams and Pollock (2001), argue that although some self-harming behaviour may not be motivated by a wish to die, a common theme in these behaviours is a wish to escape from an unbearable situation and to find peace. They assert these behaviours are the end-product of a perception of being trapped in a stressful situation from which there is no escape and no rescue. For instance, stress may take the form of environmental factors (e.g. police custody) or adverse life experiences (e.g. trauma). Within this route to escape, there can be three moderating and mediating factors which can either facilitate or block the pathway to suicide or serious self-harm. Williams and Pollock describe these factors as (a) the presence of defeat, (b) feelings of entrapment or no escape, and (c) no rescue or support. The presence of rescue factors (e.g. social support) should moderate the effect of escape to reduce suicide risk. When support is accessible and provided with empathy, it can reduce suicidal behaviours. By contrast, when the individual believes support to be unavailable, or not helpful of their needs, the likelihood of suicide increases. Williams and Pollock refer to these as 'rescue factors'.

Thus, understanding an individual's effective rescue factors could potentially halt serious self-harm (Williams and Pollock, 2001, Williams and Pollock, 2000).

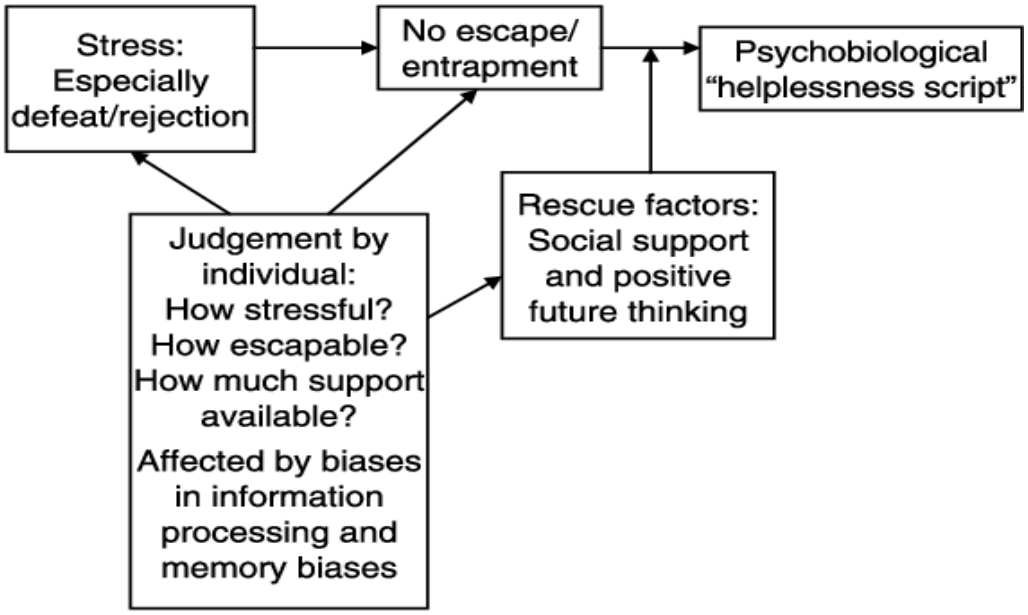


*Figure 3: Cry of Pain Model (adapted from Williams and Pollock, 2001)*

There is support for the application of the CoP model in empirical research. The utility of the model has been used to understand factors influencing people who engaged in first and repetitive self-harm (Rasmussen et al. 2010). Slade and Edelman (2014) used the CoP model to help predict dynamic risk factors for suicide ideation in a high-risk prison population. Furthermore, a combination of arrested flight and the absence of rescue are identified as powerful factors in the suicidal process (O'Connor, 2010).

In consideration of the utility of elements of the CoP model in helping me elaborate my findings, it was important to consider limitations of the application of the model in the literature. Johnson et al. (2008), argue some studies are unclear in their theoretical basis because of ambiguity around terminology within the model. For example, the third term 'no rescue' is sometimes referred to as 'hopelessness' (Panagioti et al. 2012), while other studies refer to it as 'no rescue' (Slade et al. 2016). 'No rescue' can be considered the belief that one will not receive any external help. Hopelessness, on the other hand, can be defined as pessimism for the future. Studies which use 'no rescue' as the third component of the model have it measured as a level of social support (or loneliness) and have found it to be an important factor in explaining suicide and self-harming behaviours. In contrast, studies employing 'hopelessness' measure it using the Beck Hopelessness Scale, which measures cognitive, affective and motivational factors (Panagioti et al. 2012). Therefore, it appears the researcher's

interpretation and application of the terms can impact on the approach and findings within the research, making comparisons difficult.

In respect of the current thesis, there appears a limited translation of concepts from the CoP model research into mental health treatment strategies or approaches to a psychiatric emergency. Despite such limitations, elements of the CoP model can provide a useful frame to elaborate on the findings in this thesis. In particular, there is value in using the element of 'no rescue' when considering the relationship between PiMD internal factors and the external processes of support by Police and HCP in keeping people safe. Using this lens can help identify shortcomings in the safeguarding journey by illuminating their processes, which are experienced as 'rescue' or support, which processes reduce or contribute to stress, or block or facilitate escape.

### 3.3.3 Stark (2011) Conceptual Model of Suicide

In seeking to understand the individual's experiences, research questions are concerned with the Police and HCP processes influencing safeguarding journeys. Although there is limited application of the two previously discussed models into mental health nursing practice, Stark et al. (2011), drew on critical factors in the work of Gilbert and Allan (1998), and the Cry of Pain model (Williams and Pollock, 2001), to inform a Conceptual Model of Suicide (Figure 4). This model sought to help HCPs consider possible suicide and self-harm interventions in rural areas of Scotland.

Stark et al. (2011), state that the CoP model and Defeat and Entrapment Theory can support the identification of key stressors and factors which reduce or contribute to suicide within unique settings and contexts. Stark drew on and adapted the main factors identified by Williams and Pollock - stress, escape potential, and helplessness. These then were related to specific stressors and factors associated with people living in rural areas. For example, stressors such as isolation and political and social exclusion can contribute to stress. Factors affecting support can influence escape potential such as the availability of mental health services, social support, cultural norms on seeking help and stigma. This model also acknowledges cross setting factors, drawn from broader suicide literature, such as gender, poverty, mental illness, substance use, biological factors including genetic risk and coping skills thought to influence defeat, entrapment, and risk of suicide.

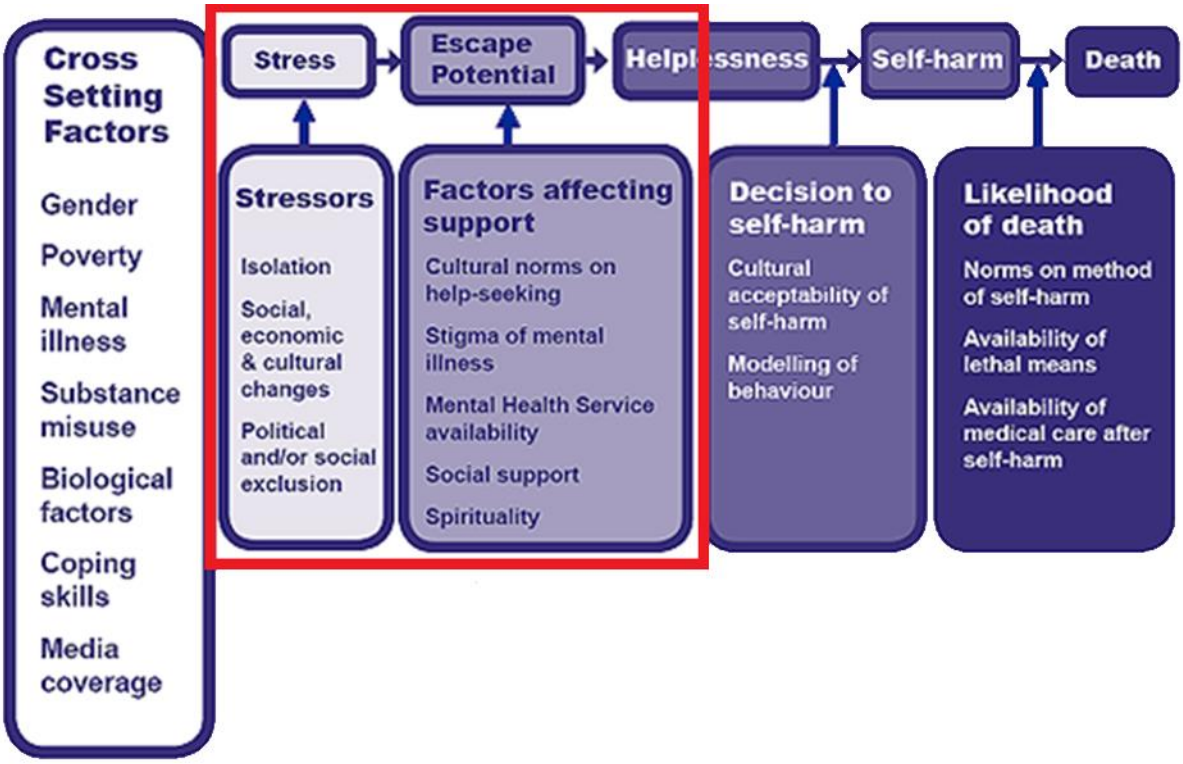


*Figure 4: Stark et al. (2011) Conceptual Model of Suicide*

The strength of Starks' approach lies in the relationship between social, psychological, and biological factors. Stark diverges from psychological domains to bring a cross-disciplinary conceptualisation of suicide and self-harm. Instead of discounting these essential factors, Stark proposes a reimagining of the relationship between biological, social, and psychological factors. Crucially, sitting central to this model are the stressors and factors influencing risk identified in the Cry of Pain Model and Defeat and Entrapment Theories. Stark et al. (2011), bring a biopsychosocial and applicable conceptualisation of factors influencing the risk of serious self-harm. Starks conceptual model prompts a deeper understanding of the influence of accessible, professional support, and the relationship these have with stressors on PiMD central to my thesis.

A limitation of Starks conceptualisation is it is linear in format. Potentially this does not reflect or fit with the complex and divergent intersection of Police and HCP practice and policies, and different sources of knowledge central to my research. There are elements of Starks model, such as 'Decisions to self-harm' and 'Likely-hood of death', which are outside the scope of this thesis.

However, two elements of Starks' model – 'Stressors' and 'Factors affecting support' are particularly relevant in informing an understanding of PiMD experiences of safeguarding and

resonate with questions at the centre of the current study. Specifically, Stark draws attention to the relationship between external factors such as Mental Health Service availability and stressors such as social and political exclusion (highlighted in red in Figure 4), both of which are identified in previous chapters as impacting on out-of-hours support and allocation of resources.

## 3.4 Conceptualising the Theoretical Approach

A broadly social constructionist approach was adopted as the central theoretical assumption for this research study. I have drawn on elements across Defeat and Entrapment Theory (Gilbert and Allan, 1998) (*relationship between the internal and external factors*), The Cry of Pain Model (Williams and Pollock, 2001) (*Rescue and Stress factors*) and Stark et al. (2011) Conceptual Model of Suicide *(Stressors and Factors affecting suppor*t). Collectively, these helped me make sense and elaborate on my findings and informed the development of my conceptual model (Chapter 8). The elements from each theory or model used to support my analysis are illustrated in Figure 5.

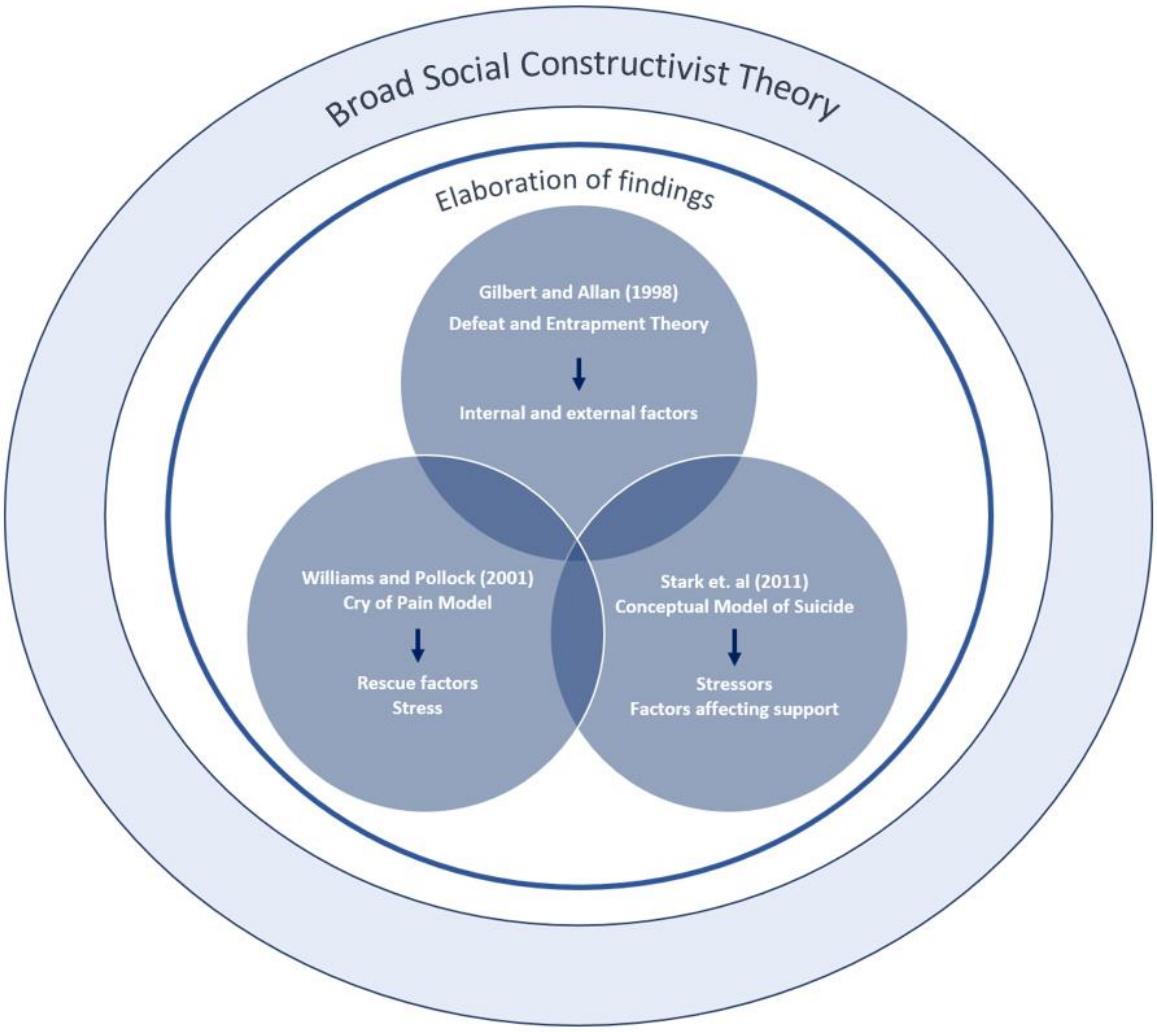


*Figure 5: Conceptualisation of theoretical approach*

## 3.5 Theoretical Implications for the Thesis

I will now discuss where theoretical strands are interwoven, critique their points of convergence and weakness and how they have informed the elaboration of my findings and the development of new knowledge presented in Chapter 8.

I have outlined how my own clinical experiences have influenced my values and the impetus for this thesis. This is congruent with the broad social constructionist approach underpinning the research design, reflexivity and the relational aspects of Defeat and Entrapment Theory, Cry of Pain Model, and Starks' conceptual model used to elaborate my findings and conceptualisation in Chapter 8. These are recognised in my approach to data collection and analysis, and the themes within the research findings are in keeping with social constructionism. In weaving these theoretical and conceptual threads, I seek to signify the

inter-connectedness of the journeys reflected in the participants' experiences and the sense of journey for myself as a researcher within this thesis.

Drawing on psychological conceptualisations and broad social constructivist theory raises the possibility of tensions between relatively one-dimensional safeguarding, police and emergency health care policies and practice which this thesis seeks to inform. Qualitative research can be considered as unscientific and undervalued in the contribution of knowledge relevant to policy and practice (Green and Thorogood, 2014). Arguably, a positivist approach may be less at odds with an out-of-hours system dominated by a highly medicalised ideology. This could be viewed as a key weakness in my approach. Nevertheless, a less flexible and reflexive methodology may lack sensitivity and fail to capture accurately the realities of those people at the centre of this thesis. I believe it is the narrative within this thesis, alongside my own experiences which bring to life the complexities and inter-relationships between different sources of knowledge and seek to enhance an understanding of the nuanced experiences of the three stakeholders.

## 3.6 Chapter Summary

In summary, I explained the philosophical assumptions underpinning theory informing my thesis. Epistemologically, I set out my own beliefs about the origin of knowledge as being socially constructed, and that new knowledge is a dynamic process. In this thesis, it is a product of reflection and inter-connectedness of experience accessed through the meanings different individuals such as PiMD, HCPs and Police Officers ascribe to their social experiences, and how I interpret them.

Importantly, I recognise there are limitations within these theoretical approaches. Reflecting on and discussing weaknesses of my theoretical approach with the supervisory team has been crucial throughout this thesis. It has helped me to consciously consistently check, redevelop my assumptions, and sharpen my analytical skills as a developing researcher. These will be discussed in Chapter 4 and Chapter 9.

This thesis aims at being a body of applied research to influence safeguarding, police and health policy and practice. The purpose is to create a plausible interpretation of participants' experiences, and from there to create a worthwhile argument from the interpretation. As such, the theoretical approach outlined in this chapter seeks to bring new knowledge of the safeguarding journeys of PiMD and the professionals involved in their care. Through a process of interpreting the meaning of participants' experiences, informed by theory and conceptual

models, and bringing personal accumulated knowledge to bear, a new interpretation and explanation can be created and constructed.

In my next chapter, I will show, as a researcher, I recognise the value of using this philosophy to inform the qualitative research design. I present and justify Case Study Research (CSR) as a methodological approach to answer research questions. I will detail the case construction, and methods used. The research process, including ethical approval, identification and recruitment of participants, and the interview and focus group processes are described. The analytical process used to code, interpret and generate meaning from the data also, will be presented.

# Chapter 4: Research Design and Methods

## 4.1 Introduction

In Chapter 3, I presented the theoretical approach underpinning this thesis. Now I will explain why CSR is suited for this qualitative study and provide a rationale for my research design; an exploratory holistic case study with three embedded subunits. I present a conceptual map of the research design, which draws critical points together from this and the three earlier chapters. I then justify the choice of methods, which include semi-structured interviews and focus groups in keeping with a broadly social constructionist approach to provide a clear audit trail of the steps I have taken and explain my approach to participant recruitment.

Following a description of my approach to data gathering and reflection on field experiences, I justify and detail the Template Analysis used to analyse thematically the data. I conclude by presenting the ethical considerations of the study and approval acquired through appropriate research governance committees; the safeguarding approaches adopted in researching with vulnerable people; and reflecting on various ethical dilemmas faced and addressed as a researcher.

## 4.2 Case Study Research

Research questions sought to explore a range of perspectives and experiences, as well as intra and inter-organisational processes, cultures and relationships shaping safeguarding journeys. The nature of this challenge brings focus to CSR, enabling flexibility in the exploration of "real world", dynamic and complex contexts (Taylor, 2013). Crucially, this approach provides an in-depth focus on the ability to view experiences and perspectives through the multiple lens' of those involved (Yin, 2014).

Central to this study is identifying and exploring diverse meanings within and between stakeholders' experiences. Given, participants of the study include people who have experienced mental distress, it was important to consider the most appropriate approach respectful of and considerate of potentially vulnerable populations. De Chesnay and Anderson (2012), advise that qualitative approaches, such as CSR, lend themselves to generating emic data, meaning the focus is on those involved in the safeguarding journeys. The research participants' words and perspectives are the starting point and it is an insider or bottom-up approach which respects the autonomy of those who participate in the study.

The inter-disciplinary and relational focus of this study is also particularly suited to CSR. A CSR approach can bring understanding to the political dimensions of a phenomenon through the illumination of accountability and inter-agency working which is inherently political (Simons, 2008). These are concerned with power distribution and allocation of resources as well as equalities and opportunities in society. Such concepts were vital to my research aim and questions in seeking to understand the subtleties and intricacies of relationships between stakeholders. CSR allows more in-depth investigation of relationships and multi-faceted social processes denied by other methods. Denscombe (2014, p.93) states:

> To understand one thing, it is necessary to understand many others and, crucially, how various parts are linked. The case study approach works well here because it offers more chance than the survey approach of going into sufficient detail to unravel the complexities of a given situation.

It is the 'unravelling' processes of CSR, which Denscombe (2014), suggests, which are suited to this thesis. By applying several research methods, it is possible to view safeguarding journeys through multiple lens' to understand a range of perspectives and relationships. Stake (2000), suggests case studies can offer purposive, situational, or inter-related descriptions of a complex event, which is central to this study. Using multiple types of data from a variety of sources and a range of research methods, CSR brings a depth rather than breadth of understanding to a particular context. Such approach supports recognition of the complexity of viewpoints held by the participants in my research. Thus, CSR offers an exploration of diverse experiences, perceptions and assumptions of safeguarding, core to the research questions in this study.

I have highlighted little is known about the relationships between PiMD, and police officers and HCPs involved in their safeguarding. CSR is particularly useful in areas where theoretical and conceptual frameworks are limited and is relevant to this exploratory study to help position future research. Merriam (2009), advocates CSR therefore plays a vital role in progressing a field's body of knowledge in which this study is focused.

### 4.2.1 Strengths and Limitations of Case Study Methodology

It is important to appreciate the strengths and limitations of CSR and recognise these in the research design in order to ensure trustworthy and robust findings and reduce any shortcomings (Parahoo, 2014).

In Chapter 3, I highlighted that qualitative methodology may be perceived as lacking rigour. Arguments exist that some CSR designs provide a limited basis for traditional 'scientific

generation', which means that the evidence from case studies is mostly restricted to generalisation regarding other similar events (Hodkinson and Hodkinson, 2001). Much of this stems from conventional procedures for assuring quality and validity from positivist approaches to research (Simons, 2008). Hodkinson and Hodkinson (2001), assert there can be too much data within case studies making it difficult to represent analysis simply, time consuming and expensive if conducted in large scale. Nevertheless, it is argued the real strength of CSR lies in multiple sources of evidence to bring convergent lines of enquiry (Yin, 2014 p.120). This process brings a more convincing and accurate conclusion based on the convergence of several sources of information, thus enhancing the trustworthiness of the research.

CSR methodology has long been contested terrain in social sciences research characterised by the varying approaches adopted by researchers, thus, finding reliability, validity and generalisability challenging (Cohen et al. 2011).

Furthermore, critics fault CSR for its lack of representativeness and rigour in the collection, construction and analysis of empirical materials (Buchanan and Bryman, 2009). In contrast, Thomas (2016 p.62), argues reliability and validity are not important concepts in CSR. What is believed to be important is quality which can be addressed through clarity of writing and concepts, careful selection, reflexivity and openness of the researcher (Thomas, 2013 p.66).

CSR can bring holistic understanding of the complexity of the phenomenon and the relationship between a range of factors. Through in-depth understanding from different perspectives, CSR offers support to the research questions and prospects of 'thick descriptions' of the phenomenon. Holloway (1997), refers to this as a detailed account of field experiences in which the researcher makes explicit patterns of cultural and social relationships and places them in context. By describing a phenomenon in enough detail, an evaluation can be made of the extent to which the conclusions may be drawn and are transferable to other periods, practice areas, surroundings, circumstances, and people. Accordingly, this approach is a way of achieving a type of external validity (Lincoln and Guba, 1985).

Having considered potential limitations, I sought to develop strategies in consultation with my supervisory team, to enhance the trustworthiness of this study. I will discuss my approach in this next section explaining my research design. I will also discuss the limitations of this approach in Chapter 9, having completed the study.

## 4.3 Research Design

As previously stated, this study is concerned with exploring experiences and relationships between PIMD and Police and HCP safeguarding processes. I judged an exploratory holistic case study with embedded subunits, as a design suited to the aims and research questions (Thomas, 2016 p.104). The conceptual map of the research design can be found in (Figure 7 pg.77). Case design decisions are the 'foundational blocks' to the depth and value of this study. Thomas (2016 p.13) describes these as the "wrapper", which provides the framework for the case design. The first steps taken in designing the case study was to define the 'case', developing a theoretical proposition and identifying boundaries in line with the research aims and questions. These will now be discussed.

### 4.3.1 Theoretical Proposition

Propositions are helpful in CSR but are not always present, particularly in exploratory case studies (Hodkinson and Hodkinson, 2001). Yin (2003 p.37), suggests when a case study proposal includes specific propositions it raises the prospect that the researcher will be able to place limits on the scope of the study and increase the feasibility of completing the project. The more a study contains specific propositions, the more it will stay within feasible limits. This was important to help me maintain focus on the research questions, the original impetus for the study and the findings from the literature. Propositions may come from the literature, personal / professional experience, theories and generalisations based on empirical data. The theoretical proposition for this CSR was drawn from the literature presented in Chapters 1 and 2 and my own clinical experiences:

***The case study will show there is a relationship between the experiences of people in mental health distress and gaps within out-of-hours safeguarding policies and processes in police and emergency health care systems. These shortcomings can contribute to cyclical distress journeys and impact negatively on police and emergency health resources.***

### 4.3.2 Defining and Binding the Case

Setting boundaries and describing the case was particularly valuable in this study given the complexity of mental distress and Police and HCP safeguarding practice. I decided the case boundaries from the outset in order to help me firstly define the case and to decide on the most appropriate data collection methods. This was an iterative process of returning to the study aims and literature whilst considering ethical and pragmatic data collection methods.

Different terms are used to describe a 'case' (Yin, 2003b, Stake, 1978, Merriam, 2009). Some authors suggest it is not necessary to define the boundary of the case at the beginning of the research as these may shift once the researcher enters the field (Simons, 2008 p.29). Miles and Huberman (1994, p.25), argue that the term 'case' is identical to the unit of analysis and is, in effect, the primary unit of analysis. Within the case, there may be subunits which may be individual(s) or a group of people, an event, a process, an organisation or part thereof (Rowley, 2002).

As discussed in Chapter 1, the case in this research was defined as a phenomenon - that being – **'*Out-of-hours safeguarding journeys involving PiMD who come to police attention within the community, who are referred by police to health services, and later discharged.'*** Thus, the case is concerned with the process of engagement and relationships between people and services rather than the case being those individuals who are part of the process.

In defining the case, I returned to the research questions and findings from the literature review to inform the defining boundaries. Case bounding is concerned with making clear distinctions of who / what is within the case and subunits of analysis and defining the beginning and end of each unit. Thomas (2011 p.11), describes these as the edges placed around the case, focusing the direction and extent to which the research will go. Suggestions on how to bind a case include: (a) by time and place (Creswell, 2018); (b) time and activity (Stake, 2000); and (c) by definition and context (Miles & Huberman, 1994). These boundaries can assist in limiting and focusing on data collection (Gerring, 2007).

My case boundaries include context, time, activity and place, and were defined as: an adult in Scotland (over 16 years); people who come frequently to the attention of police in mental distress but may not have a serious mental health disorder who have not committed an offence; police were conduits to mental health services and refer the PiMD for mental health assessment; and may keep them in a place of safety until they are returned home (Figure 6). The scope of this case, including the case boundaries, is illustrated in Table 2 and links to the map of the 'Map of local emergency psychiatric plan pathways and safeguarding journeys in the study area' as set out in Figure 1 (pg.19).

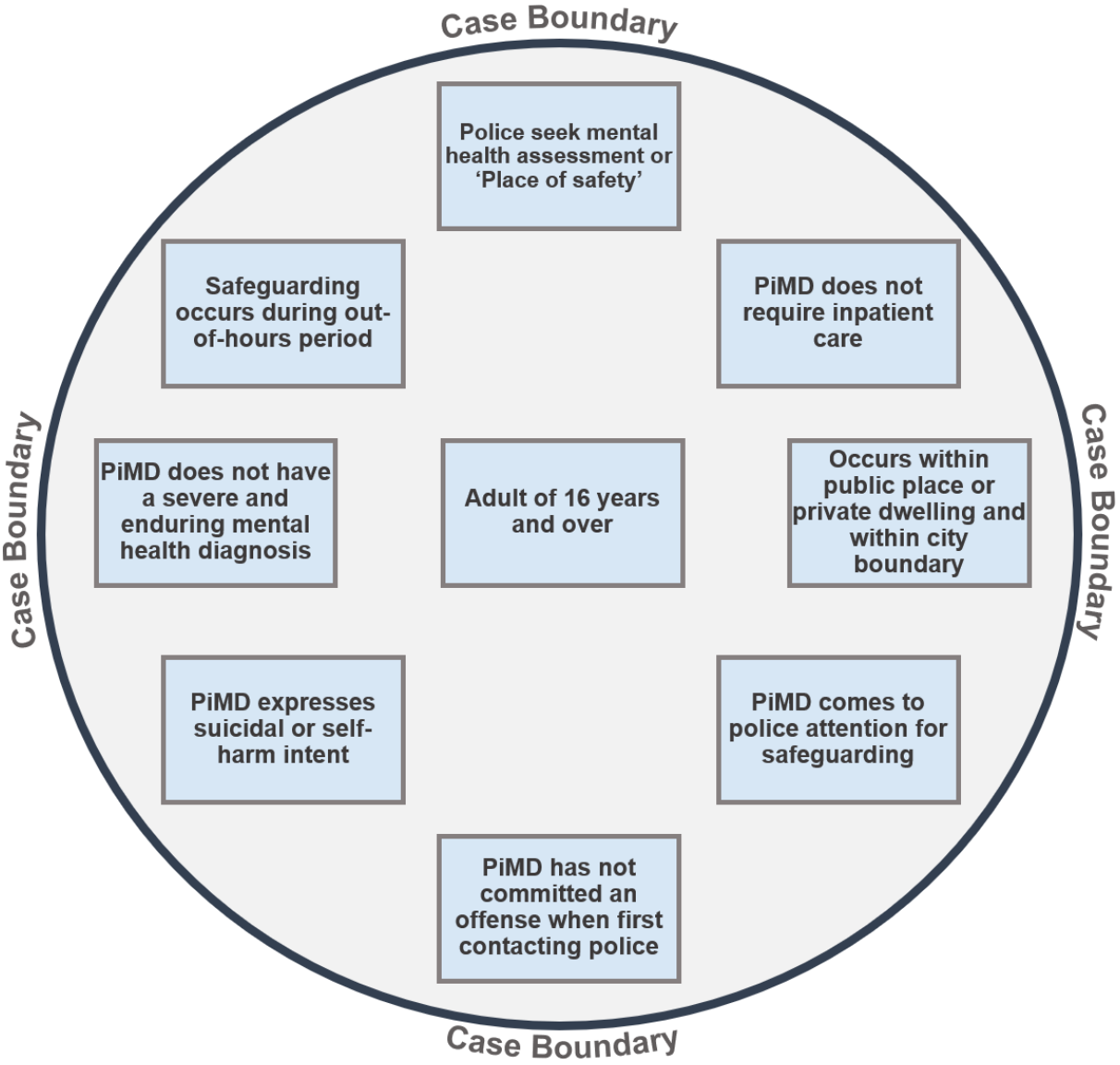


*Figure 6: Case Bounding*

| | | |
|---|---|---|
| Theoretical Proposition | The case study will show there is a relationship between the experiences of people in mental health distress and gaps within out-of-hours safeguarding policies and processes in police and emergency health care systems. These shortcomings can contribute to cyclical distress journeys and impact negatively on police and emergency health resources. | |
| The Case - Phenomenon | Out-of-hours safeguarding journeys involving PiMD who come to police attention within the community who are referred by police to health services and discharged later. | |
| Purpose | To bring in-depth understanding and new knowledge to inform policy and practice interventions, for safe and dignified care of PiMD. | |
| Approach and Design | Exploratory holistic case with embedded subunits (Yin, 2003). Thematic analysis using Template Analysis (King,2014). | |
| Context | • Geographically situated in a large Scottish city (anonymised) with a population of about 230,000, served by Police Scotland, and a large NHS general hospital and psychiatric hospital.<br>• Out-of-hours health care (5pm – 8 am and weekends) was supported by NHS24, a large general medicine E.D., an out-of-hours G.P. service, and unscheduled care psychiatric service. | • PiMD has come first to police attention in a public place or private dwelling because they were in mental distress and expressed suicidal or self-harm intent, not because they have committed an offence.<br>• They, or someone else, has contacted police services or NHS24 for safeguarding.<br>• Police and HCPs are involved in the care journey with mental health or Place of Safety assessment made. |
| Participants' Characteristics | • PiMD expressing suicidal or self-harm intent but not diagnosed with severe and enduring mental health diagnosis, who require mental health assessment or safeguarding. | • People from within the city boundary who are adults (16 years and over) who have come to police attention in a public or private place in mental distress. |
| Spatial and Temporal Boundaries | Commencement - from the first point of contact with the Police or HCP during the out-of-hours period. Police engage health assessment through telephone, home visit, or transport the individual to out-of-hours psychiatric services or E.D. The PiMD is assessed or managed if intoxicated and returned to police management. Closure -when the PiMD returns home. | |

*Table 2: Case study scope*

## 4.4 Case Design

The Research Design Conceptual Map (Figure 7 pg.77) illustrates the research design discussed in this chapter while integrating theoretical underpinnings, findings from the literature review and my position as the researcher.

The selection of a specific type of case study design is guided by the overall study purpose (Thomas, 2016).My study had two aims: (1) to understand the relationships and experiences of PiMD and Police and HCPs involved in their safeguarding and (2) to identify factors and features of Police and HCP processes which facilitated or impeded safeguarding journeys. Hence, a case study that could allow exploration of the phenomenon of safeguarding journeys holistically while allowing focus on specific aspects and nuance within journeys.

Yin (2003) and (Stake, 1995), use different terms to describe a variety of case studies. Yin categorises case studies as explanatory, exploratory, or descriptive. He also differentiates between single, holistic case studies and multiple case studies. Stake proposes case studies as intrinsic, instrumental, or collective. After consultation with the literature and supervisory team, a holistic case study with embedded subunits was chosen. This allowed for exploration of the range of stakeholder perspectives and influence of Police and HCP processes on PiMD experiences. Yin (2003) suggests that the ability to look at subunits which are situated within a larger case is powerful. This research design involves dividing a larger phenomenon of interest (the case) into a subset of smaller meaningful units (subunits). Subunits can be used to compare similarities and differences within and across subunits to glean insight into the larger phenomenon of interest. Data can be analysed within the subunits separately (within-case analysis), between the different subunits (between-case analysis), or across all of the subunits (cross-case analysis). The ability to engage in such rich analysis serves to illuminate the case better.

To develop a rich analysis, careful organisation of the subunits of analysis is critical (Yin, 2014). With this in mind, I considered the alignment and purpose of the subunits of analysis against the aims of the research, theoretical proposition, and research questions.

The research conceptual map of this study presented, (Figure 7), illustrates the three subunits of analysis embedded in the holistic case study. Data collection from each subunit was organised in three consecutive phases. Participant demographic details for each subunit are presented in Table 3 and in more detail within findings in Chapters 5, 6 and 7. Decisions

regarding the selection of participants for each subunit is presented following a discussion on determining the data collection technique(s) and procedures.

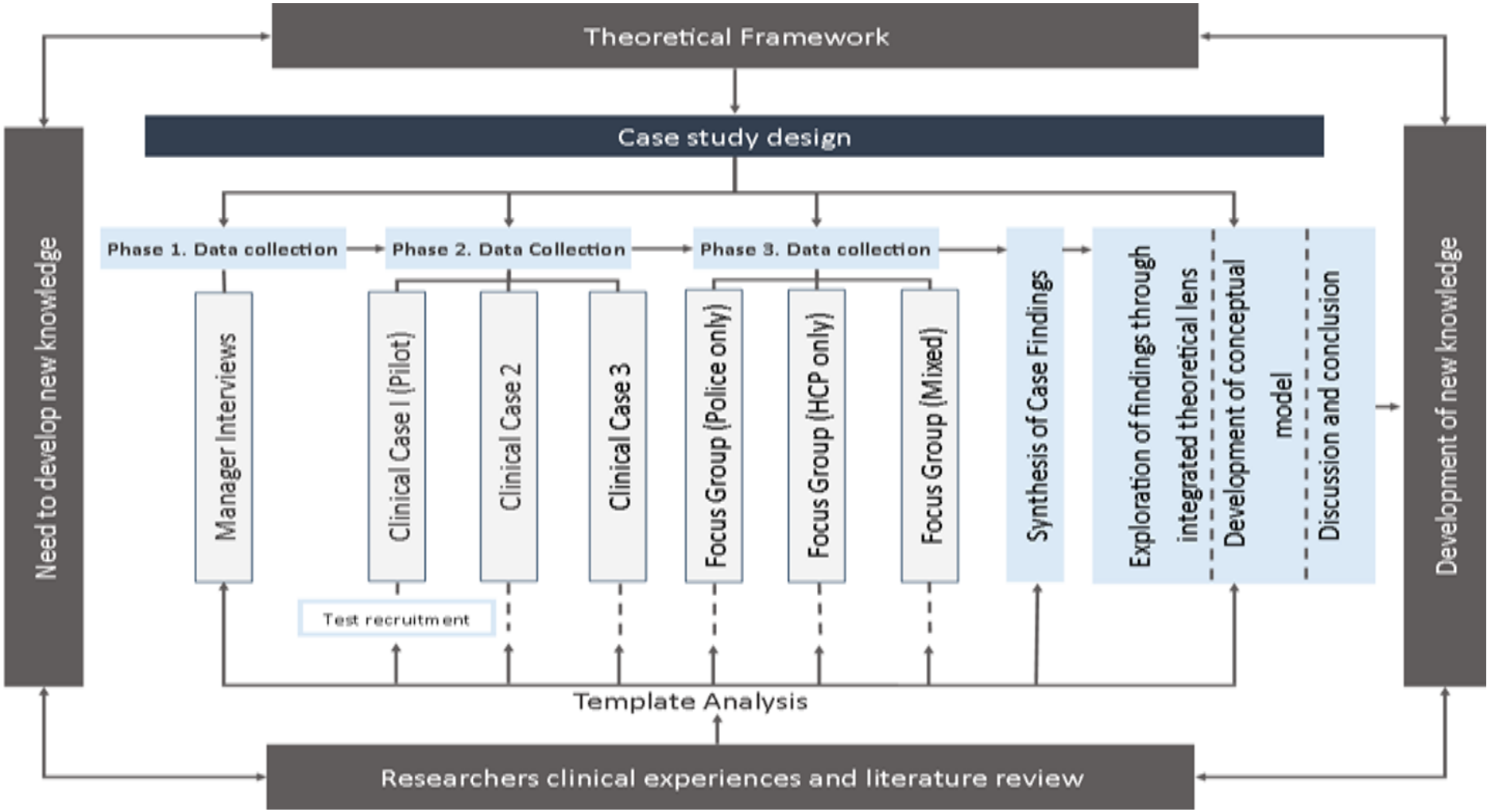


*Figure 7: Research design conceptual map*

### 4.4.1 Description of Embedded Subunits

In broadly keeping with social constructivist theory, these subunits were linked with findings from preliminary data analysis from each phase informing the next which I will discuss in 4.9:

#### *4.4.1.1 Subunit 1. Study Phase 1*

In this subunit, interviews (n = 12) were conducted with senior police and NHS managers. The subunit was bounded by role; that being senior managers working in emergency medicine, psychiatric services and out-of-hours G.P. services. This subunit was constructed to bring a depth of understanding to the influence of service capacity, priorities, governance, policies, political influence, relationships, and inter-agency cultures on PiMD safeguarding within Police and HCP systems. In subsequent subunits of analysis, I considered health and police practitioners' perspectives of PiMD safeguarding. However, I thought it pertinent to the holistic concept of the case study design to gain an understanding of influence from across all levels of the organisations. This first subunit brought an understanding of the broad landscape and specific factors influencing inter-agency safeguarding practice and relationships at the police and health out-of-hours service intersect. Findings from this subunit are presented in Chapter 5.

#### *4.4.1.2 Subunit 2. Study Phase2*

In this subunit, data from three clinical cases (named clinical case 1(n = 5), clinical case 2 (n = 5) and clinical case 3 (n = 5), each consisting of a safeguarding journey, were gathered. Semi-structured interviews with a PiMD, police officers and HCPs involved in keeping them safe were conducted. Clinical case boundaries reflected participants characteristics and contextual boundaries presented in Figure 6 pg.73. Exploration of these three clinical cases sought to identify nuance in safeguarding experiences from a range of contexts. An in-depth exploration of each clinical case, through the lens' of those involved, allowed for a deeper understanding of the experiences of PiMD and the impact of police and HCP safeguarding processes on their distress[2]. Drawing on the preliminary findings from subunit 1, I explored emergent themes with participants to support an understanding of each case. Cases were purposively selected for their variety in start and endpoints. In designing this subunit, I sought to gain a deeper understanding of participants' convergent and divergent perspectives and identification of areas of tension. A key focus was the exploration of the relationship between PiMD experiences of distress and the criminal justice and health system in which they sought support. Clinical Case 1 in this phase piloted the recruitment process (see Figure 7). The pilot

[2] This study will not claim to represent the voice of all PiMD. However, the inclusion of 3 in-depth cases allows the perspectives of the service interface, and previous safeguarding experiences to be included and, provides a richness and depth of knowledge to the multiple perspectives of safeguarding practice and care.

case (discussed in 4.7.4) aimed to inform modifications to the recruitment strategy but none were required. Findings from this subunit are presented in Chapter 6.

#### *4.4.1.3 Subunit 3. Study Phase 3*

This subunit involved three focus groups (FGs) and included operational police officers and HCPs working in clinical environments (n = 19). Police participants included police constable to the police inspector. The first FG was police officers only, the second HCPs only, the third mixed police and HCPs. The aim was to elicit professional experiences, assumptions, and expectations from the perspective of those in the field supporting PiMD. Combined, subunits 1 and 3 aimed to capture the safeguarding journey across police and health organisations. Findings from subunit 3 are presented in Chapter 7.

Careful consideration of the embedded subunit design and connectivity across the case allowed for a more in-depth exploration of participants individual experiences, perspectives, and nuance in their safeguarding journeys. As I will discuss later in this chapter, interview and focus group topic guides were partly informed and refined by themes emerging from preliminary data analysis of each subunit. In keeping with social constructivism and the holistic case study design, I was able to invite participants to bring their perspectives to evolving key themes and build on these. This iterative process was core to my approach to data analysis; Template Analysis, as discussed in 4.9. Thus, there was an ongoing process of exploring, building and layering new understandings. Key themes were constructed from across the whole case whilst seeking to capture the nuance and diverse perspectives of participants experiences (Eisenhardt, 1989).

## 4.5. Determining the Data Collection Technique(s) and Procedures

This study has already acknowledged the potential of CSR to facilitate single or multiple methods of data collection to investigate a research problem. As I have outlined, the trustworthiness of data can be achieved through multiple data collection methods (Thomas and Myers, 2015, Yin, 2009). Semi-structured interviews (subunits 1 and 2) and focus groups (subunit 3) were the chosen data collection methods. The rationale for the choice of these data collection methods will now be presented.

### 4.5.1 Semi-structured Interviews as a Data Collection Method

Semi-structured interviews were the primary data collection method. Thomas (2009), argues there is a continuum between highly structured interviews where the researcher dictates the direction of the interview and towards unstructured interviews where the interview is permitted

to go beyond the general interest topic. As the term suggests, semi-structured interviews lie between these two approaches. Here the interviewer develops pre-determined topics and open-ended questions laid down in an interview schedule informed by the research questions, and as I have explained, the emergent themes within the subunits. This allows flexibility to follow issues of unpredicted topics raised by the participants, yet still allows for some level of control by the researcher (Gerrish et al. 2015).

The flexibility this provided was essential in meeting my study aims given this study sought to understand a range of participants perspectives and consider the underpinning theoretical proposition (Yin, 2014, p.37). The limitations of this approach, such as time to plan and prepare were considered against alternative data collection methods, for example, questionnaires, which tend to be more reliable due to anonymity and could have been more economical due to the time taken to conduct the interviews(Green and Thorogood, 2004).

Nevertheless, semi-structured interviews allow for a relationship and rapport to be established between researcher and participant, which I deemed essential when potentially vulnerable people with a history of mental distress are involved in the study. Having a face-to-face controlled conversation allowed for identification of any distress during the interview whilst recounting their experiences. This can cover sensitive topics and requires respondents to talk spontaneously and expressively. Such openness allows for the richness, depth, and authenticity of participants' experiences to be recounted, and was central to the exploratory nature of the study aims.

Additionally, it allows the interviewer to answer questions about the study, check and summarise responses to ensure understanding and seek clarification to ensure rigour. As identified previously the relationship between researcher and those being researched can influence data generation. I believe semi-structured interviews were particularly valuable to this study in allowing me to seek clarification, challenge and probe topics arising and bringing co-constructed meaning central to the theoretical underpinnings of this study (Mishler, 1986, Brinkmann, 2014). For example, during a semi-structured interview with Jess, a PiMD participant, Jess talked of being transported in a police vehicle to custody. Given my understanding of police vehicles and procedures, I wanted to know how transportation was experienced from the perspective of someone in mental distress. Jess described how she tried to sustain a head injury by banging her head on the police van wall. By 'unpicking' and probing this conversation further, she described her feeling of distress as overwhelming and terrifying. She connected her heightening distress to the use of handcuffs and feeling of being trapped. By hoping to become unconscious and further self-harm, she described being able to escape

the enormity of her distress. Together we were able to co-construct meaning into the experience and bring richness to the narrative which may easily have been missed in structured interviews.

### 4.5.2 Focus Groups as a Data Collection Method

Three homo and heterogeneous focus groups brought a further lens to the study and supported a deeper understanding of findings in subunits 1 and 2. When used in this context, focus groups can help the researcher access a deeper understanding of the phenomenon. Building of in-depth understanding was achieved by sharing key themes emerging in my data analysis of previous subunits with focus group participants. This allowed me to explore the meaning those developing themes had for frontline officers and HCPs in practice. This was important as the social context in which discourse is produced in focus groups is qualitatively different to that of interviews. During focus groups, participants comment on each other's perspectives, manifest disagreement or ambivalence, and debate (Barbour and Morgan, 2017). The analysis takes into account the context of the discussion and how the group dynamic contributes to the results (Caillaud and Flick, 2017).

Largely, the focus group dynamics (see synopsis of focus group observations Appendix 6) meant participants interacted fairly well with each other. Despite some tension in the heterogenous focus group, the group dynamics allowed participant views to develop rather than my agenda being central. Bloor (2001), suggests that although guided by the researcher, focus groups allow themes to develop and encourage groups rather than individuals to voice their opinions. Each group allowed for in-depth exploration of the diversity of professional perspectives with participants rationalising their processes, frustrations, sense of agency, professional cultures and perspectives of the PiMD needs.

An example of this was in the mixed Police/HCP focus group. One question to the group related to Fiona, a PiMD participant from clinical case 2 who had been returned home when police believed she required inpatient care. A lively debate developed between an HCP and a police officer regarding the appropriateness of inpatient psychiatric care, highlighting the diversity in professional knowledge and perceptions of PiMD needs. This discussion revealed key factors such as diverse professional understanding of the nuance in mental health related emergencies as underpinning inter-professional tensions. This rich data would not have developed through individual interviews alone.

A limitation in this data collection method is that group dynamics may influence the conversation (Barbour and Morgan, 2017). Some participants may dominate and not allow

others to speak, or status differentials may deny some voices. This was the case in one of my police-only focus groups, where, despite seeking to exclude officers above the rank of police inspector, there were hierarchical dynamics within the group. This was resolved partially by directing my eye contact with other group members and steering the conversation to quieter participants.

After deciding on the research design, I then took steps to develop the research process. This involved identifying the study site, negotiating access to participants, selecting potential participants and ethical considerations.

## 4.6 The Research Process

Now I will explain how I selected and recruited participants to the study, providing a critical discussion of this process, identification of potential participants, screening and recruitment processes for each subunit of the study.

### 4.6.1 Negotiating Access to Participants and Identifying the Study Site

Setting case boundaries and negotiating study sites was an iterative process. I chose this site for two reasons. Firstly, I believed the city size would support the desired recruitment numbers and diversity of safeguarding journeys. The city is home to a large and busy NHS, E.D., a psychiatric hospital and an established out-of-hours G.P. service. Police Scotland serve the area with a large local policing Command Area and Police Custody Suite. Secondly, I made pragmatic decisions regarding travelling to sites, believing interviewing participants in one city would maximise my time available for data collection.

Initially I met individually with two senior NHS managers responsible for two of the study sites and the Police Area Commander (study gatekeepers) before applying for ethical approval to conduct the study (see 4.10.2). The purpose was to gain general support for the study and evidence of support for ethical approval (initial letter of support - Appendix 7). All three gatekeepers were enthusiastic and supportive of the study. Building positive relationships with gatekeepers and early foundational and scoping work proved crucial for the smooth running of the study, facilitating access to the research sites and recruitment of key participants (Holloway, 2017).

Following ethical approval, I again met with the three gatekeepers to negotiate the practicalities of data collection such as location and best timings to co-ordinate focus groups. This was to identify which police officers and HCPs were involved in the clinical cases (subunit 2), and PiMD clinical and criminal justice histories of previous safeguarding journeys.

Prior to recruitment and data collection, I presented the study aims, objectives and design to the area Police Strategic Command Group, chaired by the study area Police Commander, and key Health Managers from each area. I then shared copies of the study protocol, contact details of the supervisory team, proposed data collection timeline and the university ethical approval documents (discussed in 4.10).

### 4.6.2 Selection of Participants

Next, I had to develop a holistic case sampling framework for the subunits (Table 3), based on the theoretical underpinning and purpose of each subunit and what I believed to be manageable. This involved determining which PiMD, police officers and HCPs be invited to participate. Theoretical underpinnings; research questions; time and resources available; and the population being studied were considered (Parahoo, 1997). Selection of participants is often referred to as sampling, yet sampling is a complex issue in CSR as there are many variations of sampling strategies described in literature (Patton, 2014). Thomas (2013, p.61) argues the term 'sampling' does not apply to CSR, suggesting that sampling is often more aligned to experimental research. Thomas suggests the term 'selection' is a more accurate representation of the process of deciding who should be included in the case rather than suggesting the study is representing a sample of a population. Yet, the term 'selection' does not accurately reflect the different approaches I used in identifying participants across the three subunits. For the purpose of this thesis the terms sampling and selection are used interchangeably.

I wanted to include PiMD with different start and endpoints in their safeguarding journeys, thereby capturing the nuance in safeguarding journeys I had identified was missing in the literature. In addition, a range of professionals from various levels of Police Scotland and NHS organisations would ensure representation from governance and practice populations and reflect managerial and frontline views of safeguarding. Considering the design of each subunit, I deemed 40-45 participants in total to be an adequate number to explore the case and a target of 45 participants was reached.

Now I will present the participant sampling for each subunit. Firstly, the decisions regarding the senior manager (subunit 1) will be illustrated, followed by the PiMD, Police Officers and HCPs in the clinical cases (subunit 2) and Police and HCPs for the focus groups (subunit 3).

| | Identified | Agreed to participate | Participated |
|---|---|---|---|
| Subunit 1. Phase 1 | | | |
| Senior Managers | 4 contacted by researcher,<br>8 through snowballing techniques | 12 | 6 Police Officers - Inspector to Area Commander in rank.<br>6 HCP Managers- Band 7 to 9 and Doctors at Consultant level |
| Subunit 2. Phase 2 | | | |
| PiMD | 8 | 8 (4 removed in pre-screening)<br>1 failed to attend | 3 (3 clinical cases) |
| Police Officers | 8 | 8 | 8 |
| Police Staff | 1 | 1 | 1 |
| Doctors | 4 | 3 | 3 |
| Nurses | 0 | 0 | 0 |
| Subunit 3. Phase 3 | | | |
| Focus group police only | 4 contacted by researchers, 4 by snowballing technique | 8 | 8<br>Rank of Police Officer to Police Inspector |
| Focus group mixed police / health only | 4 contacted by researchers, 10 by snowballing technique | 14 | 8<br>Rank of Police Officer to Police Inspector<br>1 Mental Health Nurse |
| Focus group health only | 4 contacted by researchers, 4 by snowballing technique | 8 | 2<br>(1 Doctor,1 Mental Health Nurse) |

*Table 3: Subunit sampling framework*

#### *4.6.2.1 Sampling Participants Subunit 1 – Police and HCP Managers*

I chose a snowball sampling technique for the Manager interviews in subunit 1. Parahoo (1997), describes snowball sampling as a process in which the researcher deliberately selects at least two people to include in the study on the basis those selected can provide the necessary data. The characteristics of the individuals are used as the basis for selection. The selected participants then identify other potential subjects. A limitation of this type of selection is that referrals may be made to others who are perceived to have the same outlook, thus not achieving the multiple perspectives I was seeking. Reflecting on the views of those who participated, this was not the case in this study. Participants represented a wide range of clinical and policing areas, each providing a breadth of perspectives.

Guided by the case bounding discussed previously, participant managerial responsibilities were aligned to the city centre. The desired participant characteristics were occupational and experiential - people who held management positions in police or health services with broad understandings or responsibilities in safeguarding journeys.

I contacted four managers within the case whom I knew had managerial responsibilities in areas involving safeguarding. Recruited participants referred the remaining eight participants, thus securing the aimed for twelve for this phase with equivalent numbers of police (n = 6) and HCP (n = 6) participants to ensure equal representation in the research by each organisation. Police managers were from one professional grouping, being serving officers. Seniority in rank ranged from Inspector to Area Commander and were drawn from a range of services including local policing, those responsible for partnership working, and police custody. All but one worked within the study area. That person held national responsibility for mental health safeguarding and was included due to their work within the study area.

HCP manager participants represented a range of service areas including Emergency Medicine, Unscheduled Care Psychiatry, Unscheduled care G.P. Services and General Psychiatry. Characteristics ranged across experience and seniority (12 years to 42 years of operational, clinical and management experience). They were from nursing and medical backgrounds, ranging from Senior Nurse Managers, Consultants carrying management responsibility, and Service Directors. All had significant clinical experience with some continuing to have some clinical input in their senior role.

#### *4.6.2.2 Sampling Subunit 2: Clinical Cases*

Purposive sampling was used to identify PiMD and Police and HCPs involved in their safeguarding journey. The characteristics of the PiMD were set by the bounded characteristics

of the case in 4.3.2. As discussed previously, I had hoped to include PiMD who had different start and endpoints to their safeguarding journey, reflecting nuance in PiMD needs and contexts in which safeguarding occurred. However, I decided not to exclude people if they had a similar journey to other participants. I decided on three clinical cases as manageable and judged these would reveal a range of experiences and perspectives. I was fortunate to recruit participants with different safeguarding start and endpoints. I had hoped to recruit both male and female participants; however, all were female.

Additionally, HCPs involved in each clinical case were doctors, reflecting the legislative requirement for a medical officer to assess those brought within a Place of Safety and regional out-of-hours provision. These limitations are discussed further in Chapter 9. Police and HCPs were selected because of their involvement in each clinical case.

#### *4.6.2.3 Selecting Subunit 3: Police and HCP Focus Groups*

Similar to manager interviews, I chose a snowballing sampling technique for the selection of focus groups. Informed by research questions, the purpose of the focus group was to gain professional perspectives in the safeguarding of PiMD. I sought also to explore police and health service relationships whilst supporting PiMD, and similar or different perspectives and experiences within the heterogeneous and homogenous groups. The desired characteristics of participants for subunit 3 were occupational and experiential - people who were operational police officers from the rank of probationary constable to inspector with experience in supporting PiMD. HCPs were nurses or doctors of any level working in clinical environments involved in the care of PiMD within the case boundaries. For example, unscheduled care psychiatric services, liaison psychiatry, the E.D. or generalist psychiatry. I contacted four key people from a range of areas across the study sites. These participants then invited others to contact me and attend.

### 4.6.3 Recruitment

Recruitment for the study was conducted in three phases in order of each subunit, starting first with the manager interviews, then the three clinical cases followed by the focus groups. In total, recruitment and data collection took nine months. I will now discuss the recruitment for each phase of the study in the order conducted.

#### *4.6.3.1 Recruitment Phase 1: Manager Interviews*

Interest in the topic and willingness to participate was encouraging. Senior managers from both police and health services actively made contact with me to be part of the study, which

they heard about through organisational and professional networks. I found myself in a fortunate position of having to turn down participants due to study timelines and a desire to have equal representation from each organisation.

Most participants held higher degrees having completed postgraduate education before or during their current occupational role. Some participants had experience in working across both sectors, or in partnership roles, giving insight into both organisations and cultures. For example, one senior officer trained in social work before joining the police service. A Senior Nurse Manager also worked as a Police Special Constable. These dual experiences were important when considering how these managers viewed and made sense of their experiences.

#### *4.6.3.2 Recruitment Phase 2: Clinical Cases*

Recruitment for this subunit was more complex. It relied firstly on recruiting a PiMD participant who had experienced a safeguarding journey, then identifying the HCPs and police officers who had supported them, through the PiMD police and health files. The flow chart for recruitment for this phase is found in Figure 8, pg.89.

Before application to the Regional NHS Ethics Committees (REC) for approval to commence the study (discussed in 4.10), I had a preliminary discussion with Police Scotland regarding the recruitment processes of PiMD. As PiMD safeguarding journeys in this study started and ended with police, it was clear that Police Scotland would be the primary holder of information of potential participants who had come to their attention. It is the responsibility of the Police Scotland Concern Hub (formally known as the Force Referral Unit (FRU)) in the study area, to record details of people whom they believe to be vulnerable on the Police Scotland Interim Vulnerable Person Database (iVPD). Included would be PiMD supported by police officers through safeguarding journeys and referred to partner agencies. The iVPD was a central point from which to identify potential participants. Thus, a recruitment criteria and process (Appendix 8) was developed with Police Scotland in preparation for application for ethical approval to conduct the study by the various organisations. The recruitment strategy ensured the anonymity of potential participants until Police Scotland had obtained permission for the sharing of their contact details with me. My efforts in considering fully this process in theory before ethical review proved prudent as I was closely questioned on the process in my presentation(s) to the Regional NHS Ethics Committee discussed in 4.10.2.

Staff and officers of the Police Scotland Concern Hub in the study area identified potential participants from the selection criteria against the Police Scotland iVPD. To ensure Concern Hub staff were clear on process and criteria, I presented details of the study, selection criteria

and processes for recruitment at an ‘all staff meeting’ facilitated by the Concern Hub Police Inspector. This provided an opportunity for questions and discussion.

When a potential participant was identified by a member of the Concern Hub team, details of the individual were referred to the Police Scotland Adult Support and Protection Co-ordinator, Detective Sergeant or Detective Inspector within the team. If all study criteria were met, the individual was telephoned by the ‘checking’ officer or staff member. An overview of the study was provided from a script I had prepared. Permission to share their contact details with me was sought if they were interested in participating. The contacting officer confirmed the completion of processes in line with the agreed study recruitment process, in writing. To maintain confidentiality, only then were details of potential participants shared with me on a secure, Police Scotland protectively marked email.

The next process involved me contacting potential participants to conduct secondary screening for suitability and well-being, discussion of the study, and provision of participant information. Conscious of the potential fluctuation of mental well-being, I embedded a process of re-assessing participants’ suitability and well-being at each point of contact. The co-constructed process of screening was undertaken with each potential participant by talking through the interview process, an overview of what would be discussed and assessing the impact that may have on their current mental well-being. Collaboratively each potential participant and I considered the possible impact of participation. As an additional safeguard, any potential concerns were discussed with my supervisory team who hold extensive psychology and mental health clinical experience. Of the eight referrals made, I ‘screened out’ four candidates having come to a mutual decision with the individual that recounting their experiences may be stressful. One suitable participant agreed to participate, however, on three occasions did not attend the arranged meeting. The target number of three participants was reached and interviews conducted.

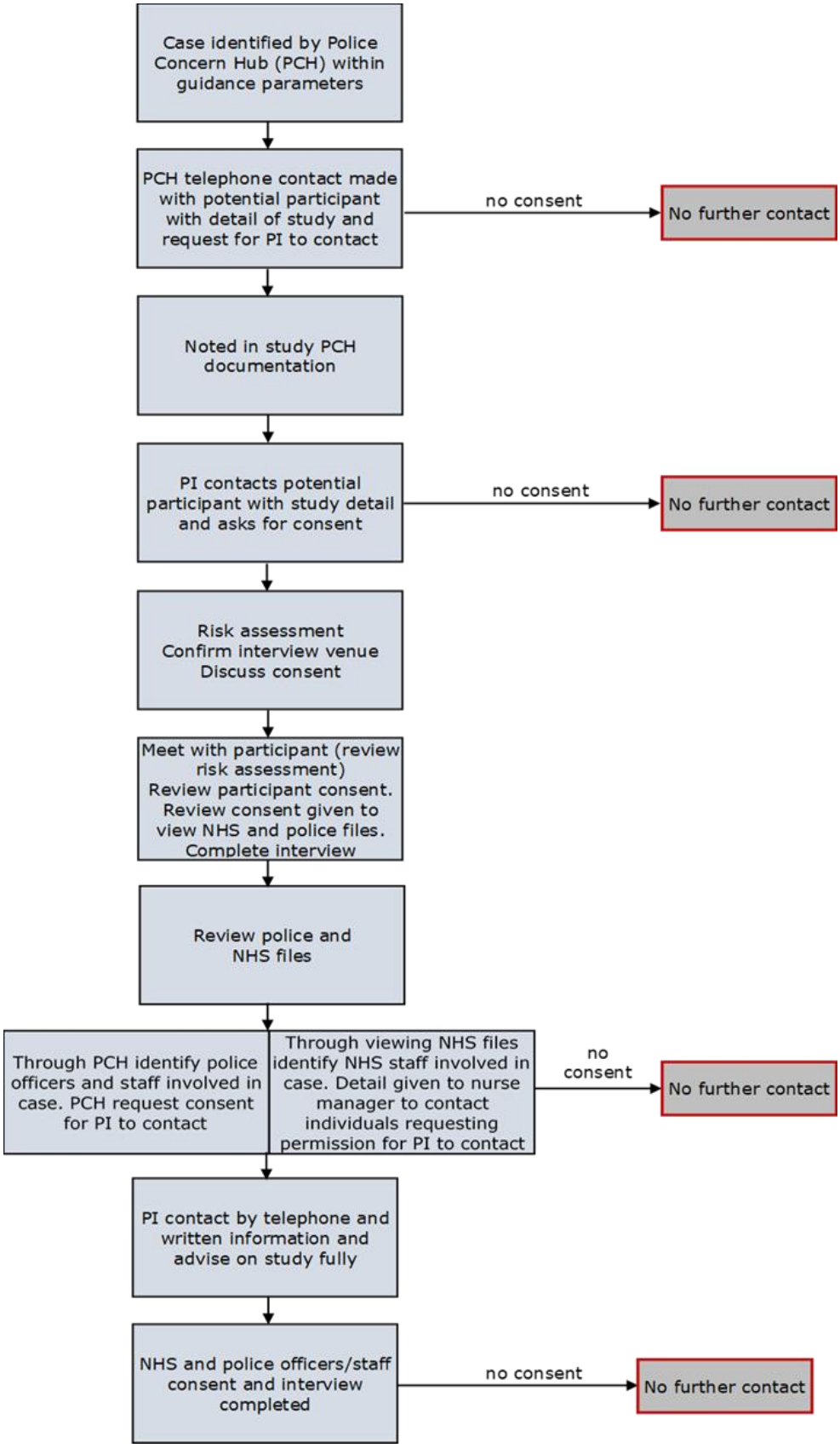


*Figure 8: Recruitment flowchart Subunit 2 Clinical Cases*

The procedure of screening peoples' suitability for the study could be viewed as contentious (O'Reilly and Kiyimba, 2015). It put me in a position of power, with a complex line between ethics and allowing participants space to voice their experiences. This process was debated at length within the supervisory team. I recognised, ultimately that I held the decision as to whether people would be invited to participate. Arguably, this is subjective and does not fit with the social constructivist approach to this study. However, I felt that the co-construction of this decision, with potential participants went some way to balancing participants inclusion in the study and ethical concern of doing potential harm as a result of participation.

Following the above process, identification and recruitment of the three PiMD participants in subunit 2 took six weeks.

One of the purposes of gaining permission to access PiMD participant police and health service records, was to identify the police officers and HCPs involved in their safeguarding journeys. This then allowed me to contact and invite them to participate in the study. I did so directly by secure email, providing details of the study and requesting their participation. Included were my contact details, confirmation of study and gatekeeper approval.

A potential threat to a 'complete' clinical case was that some professional participants, involved in the safeguarding journey, may not wish to participate or may have left the service. In consultation with the supervisory team, it was decided that the key participant for each clinical case was the PiMD. Thus, a clinical case would be included should only a PiMD be recruited. All but one professional agreed to participate in the study as that person had left the service and could not be contacted.

#### *4.6.3.3 Pilot Study*

Given the complex nature of the recruitment process and the potential vulnerability of PiMD as case study participants, I conducted a pilot clinical case to test the recruitment process. Within the design phase, it was decided with the supervisory team the pilot clinical case be included as one of the three subunits. Thus, it is the first of the three clinical cases. Pilot studies are often conducted in qualitative research to test processes prior to the full study being executed in the field. They are particularly valued in research involving vulnerable people (Pyer and Campbell, 2012), allowing for opportunities to identify possible risk to the individual not identified in the design phase (Kim, 2011). In this case study, the pilot study, situated in Phase 2, was developed with two aims. The first was to test and refine the proposed method for locating, accessing, and recruiting PiMD through the Police Concern Hub. This process supported the refinement of subsequent recruitment of Police and HCPs involved in each

clinical case. The second objective was to identify and mitigate possible risks in the proposed recruitment and data collection methods.

I assumed I would find some problems with processes. However, the pilot recruitment went to plan and supported the recruitment of the next two clinical cases. The process of piloting the recruitment for the clinical cases allowed staff from the Concern Hub to refine their potential participant conversations. It also gave me the experience to test the theoretical safeguarding procedures I had embedded in the study design and the recruitment process of professional participants involved in the clinical cases.

#### *4.6.3.4 Recruitment Phase 3: Focus Groups*

Similar to the recruitment of managers in Phase 1, I used a snowballing technique for recruitment to the focus groups (n = 11). I invited two key staff from Police Scotland and two from the NHS for each focus group. They then invited other participants who contacted me by email to gain more information about the study, focus group times and venues. All interested participants were re-contacted and reminded about each focus group two weeks ahead. Gatekeepers also promoted the study through their networks who forwarded me the contact details of those wishing to attend (n = 14).

I agreed with managers' dates and venues, at times and places most likely to attract the maximum number of participants. For example, outwith regular meeting times and when maximum staff were on shift. This was from 2 pm to 4 pm weekdays. Managers allowed participants to attend within their work time.

Recruitment to the focus group was much higher by Police than HCPs. Some HCPs were unable to attend due to an emergency at both HCP focus group scheduled times, potentially reflecting the challenges of conducting qualitative research with practitioners. The balance of professional roles for these focus groups was not ideal with a dominance of police officers over HCP's. These limitations are recognised and discussed further in Chapter 9.

### 4.6.4 Conducting the Interviews and Focus Groups

Information sheets, consent forms and topic guides were tailored to the data collection method and stakeholder participants, thus, differed slightly for those who had experienced mental distress and professional groups. Given the range of consent forms and topic guides for each phase, not all guides are included in the appendix. Two exemplars are found in appendices 9 and 10.

Before the interview or focus group, each participant received a participant information sheet which I reviewed with participants. Included was information on withdrawal from the study and study contacts should participants have concern about my conduct as a researcher. Consent to participate in the study was explained, signed by participants, and co-signed by myself. Each participant received a copy. To mitigate any literacy difficulties for PiMD, I also prepared an audio recording of the consent and participant documents to ensure participants understood the study and consent to participate. I was not required to use this process in the PiMD interviews.

Topic guides were used for the semi-structured interviews and focus groups (exemplars- Appendices 11 and 12). The interview and focus group topic guides were developed through engagement with the literature, reflection on the research questions and in discussions with my supervisory team. Using an iterative process during the research meant topics and prompts were added to the interview schedule which allowed me to explore emergent themes and ideas in more depth. Therefore, topic guides were revised during the data collection process, adding relevant questions arising from previous interviews, my reflections and preliminary analysis. For example, I had not included a question about supporting PiMD who were intoxicated during safeguarding when I had originally developed the topic guide. However, this was a key issue arising in most manager interviews in subunit one. A question about supporting people who were intoxicated was incorporated into subsequent semi-structured interviews.

## 4.7. Reflections on Conducting the Interviews and Dilemmas from the Field

In the previous chapter, I made explicit the ontological and epistemological perspectives underpinning this study. Creswell (2018) proposes the interpretivist researcher recognises the impact on the research of their background and experiences, which considers meaning as dynamic, and a product of reflection. Moreover, there is a growing body of literature towards researcher reflexivity and the 'emotional labour' involved in qualitative research, highlighting researchers are not merely 'tools' that record data (Aitchison and Mowbray, 2013, Seear and McLean, 2008, Bergman Blix and Wettergren, 2015). Rather, they are individuals bringing themselves and their lives into their research in a process that is complex and sometimes challenging.

Within this thesis, I discuss how my professional relationships both challenged and positively supported the development and conduct of this study. To promote transparency, I decided to tell participants something about my professional background at the beginning of each

interview. The purpose was to acknowledge my clinical experiences and dual identities as the impetus for the research. However, I wanted to be clear that my role in this interview was that of a researcher. This was a valuable reference point to return to in some interviews, with some participants cutting short their answers to a question, assuming I had an understanding of the point they were making. Potentially they may not have done so if I were not known to them or familiar with the area. For example, some respondents stated, 'you know exactly what I mean', or 'I don't need to tell you the kinds of problems that give us'. In one case, a participant stated 'we can speak about them off the record. When the tape is off'. Frustratingly, this suggested there was often richer information they were willing to share with me as a colleague, but not as a researcher. Although I frequently did understand the point raised, it was this rich detail I wanted to capture on the audio recording. I found I had to become skilled at returning to the question in a different way to press and probe for the depth of meaning. For example, I would weave the question back into a related topic and say “Just for my clarity, when we spoke about xxxxx earlier, were you referring to xxxxx? Can you tell me a bit more about that? It seems to be an important point related to xxxx”.

Dickson-Swift et al. (2009), remind researchers of the impact of undertaking qualitative research on sensitive topics. I felt confident about conversations with PiMD participants around suicidal behaviours, having developed these skills within my clinical practice. The literature suggested 'marking' myself as a mental health nurse and researcher, so supporting participants’ understanding, I had insight into the experiences they faced (Thompson and Chambers, 2012). On the other hand, as I will discuss in 4.10 relating to ethical considerations, there is potential to blur boundaries, with some participants possibly revealing areas of their lives freely as if it were a clinical discussion. An example of these blurring of roles and dilemmas is captured in an excerpt from my field diary (Figure 9) when interviewing Deb, the PiMD participant in clinical case 3:

I was halfway through the interview, and it was clear that Deb had limited insight into why she had been arrested. She questioned why, if she wants to kill herself, as the police said she had (she had no memory of this), she was taken to custody, rather than a hospital. Deb is unaware that she had refused to go to a hospital and was too drunk to be assessed. She recounted in detail, her fear and panic she had when handcuffed, triggering traumatic memories of being bound as a child. She alluded to sexual assault, stating, 'you are nurse, you know what I am talking about don't you?' I began to question if I had prepared Deb for such disclosure. I had anticipated and prepared her for recounting of a journey which could be painful. Was that enough for such a revelation? I took a practical decision to draw on clinical skills of checking resilience and self-protective measures used by Deb when such memories present at other times. She advised of a range of strategies she had developed and assured me she did not feel at risk.
Nevertheless, I had drifted into a clinical mode to ensure her safety. Or is this not a fundamental skill of a researcher keeping participants safe? This blurring of roles is uncomfortable. I will discuss with Colin tomorrow. I feel confident in her safety.

*Figure 9: Excerpt from field diary (Clinical Case 3)*

Another dilemma occurred when the first PiMD participant (Jess) related she was more at risk of suicide or self-harm when intoxicated. At the end of the interview, she suggested she would spend the study participation voucher on alcohol that night. She advised she would not have the money for this without the voucher. I put into place safeguarding processes before and during the interview having anticipated this. I did not know if participation in the study had given her access to funds that could potentially increase the risk of future self-harm behaviours. I had discussed reimbursement of participants with my supervisors and ethics committee: all agreed a £20 supermarket voucher of choice as appropriate. I pressed Jess further to re-assess her well-being post-interview. She advised she was not at risk and had safeguarding plans. However, she had just recounted with me experiences showing she had been highly vulnerable when drinking. The dilemma and irony being her involvement in the study could have provided the financial means to increase her risk. Although uncomfortable, competing notions of self-determination and personal choice on how to spend the voucher permeated this dilemma. I concluded the interview in checking the safety and emergency plans Jess would use when intoxicated. She reported she would ring the police or contact NHS24. Although I was satisfied with the safety plan, this once more involved the emergency services, and I could visualise the trajectory of this journey she had been on many times before.

Dilemmas have remained with me concerning this study. I felt I had thoroughly critiqued the literature and ethical guidance relating to compensation for research participants. Yet, despite

safeguarding efforts, the open desire participants had to tell their stories, and expressions of feeling valued through compensation for their time, I am left feeling uneasy. These concerns have brought deeper insights, and I will reflect on my approach to future research.

## 4.8. Data Collection and Management

Multiple authors discuss the importance of organising and managing data (Asmundson et al. 2002, Munro et al. 2005, Parahoo, 2014). The integrity of the study can be compromised if this is not given attention (Silverman, 2013).

Written consent and any hard copy papers were securely locked in the university. On completion of the fieldwork, I had gathered a large amount of audio recordings, field notes and police / health records data all of which required organisation and secure storage. A checklist ensured this was diligently conducted. Recordings from the fieldwork were transported from the site on an encrypted and secure password device. These were immediately downloaded on to the secure university R (research) drive and deleted from the recording device. Recordings were transcribed verbatim. I transcribed all but three audio recordings. Three were transcribed by a professional transcriber approved by the university to support my time management. Each transcription was carefully checked twice by me against the audio-recording to ensure accuracy, the anonymity of individuals and identifiable geographic areas and services.

All identifiable names and places were changed during transcription. Transcripts were formatted with page numbers and given a unique code which corresponded to the phase and case. Codes also corresponded to either police or health service participants, allowing for identification of participant groupings. The three women PiMD participants were given a pseudonym proposed by an office colleague. De-identified transcriptions were filed and stored within QRS NVivo 11 data management software installed on my laptop with secondary backup on the university secure server. Both were security password protected. A transparent filing system was maintained within this with transcriptions and field notes grouped within the phases and cases to which they belonged. During the data collection phase, the study was audited in February 2016 by the NHS R&D quality team as part of random quality checks. The audit checked data storage, protocols, and management passed with minor amendments.

## 4.9 Data Analysis

In this section, I discuss the data analysis process, including the use of Template Analysis (King, 2012). Template Analysis (T.A.) was used to thematically analyse these data. I selected

T.A. as an appropriate method as it affords a clear, systematic, yet flexible approach to data analysis (Brooks et al. 2015, Brooks and King, 2014). Template Analysis sits comfortably with exploratory CSR, the iterative processes within this thesis, and the broadly social constructionist framework underpinning the study (Brooks et al. 2015). In practice, analysis involves the iterative development of a coding 'template', which can, but not always, start with some a priori themes, and is responsive to novel themes evident in the data. In keeping with the T.A. flexible approach, I examined my data inductively. I wanted to be aware of participants' first-hand experiences, explore and be open to the data as themes 'emerged', while also considering my theoretical underpinnings, to help explain and elaborate these data. Template Analysis emphasises the use of hierarchical coding. Central to the technique is the development of a coding template, usually based on a subset of the data, which is then applied to further data, revised, refined and reapplied (King and Brooks, 2017). This was particularly well suited to the holistic case design with the connected embedded subunits of my study. The processes within Template Analysis allowed me to consider and build the key themes running through the holistic case, while still allowing the new themes to develop in each subunit. Thus, this approach aligned with the research questions and theoretical proposition.

Template Analysis is not a complete and distinct methodology; it is a technique used within a range of epistemological positions (King and Brooks, 2017). Although it makes use of codes and data coding, it is not highly prescriptive and is flexible in approach, allowing T.A. to be adapted to a range of underpinning study philosophies (Brooks et al. 2015). Waring and Wainwright (2008), point out that T.A. emerged during the 1990s from the work of Crabtree and Miller (1999) and Miles and Huberman (1994). It has gained credibility in the U.K. through the work of King and colleagues researching health and sociology related fields (Gibbs, 2012).

Although Template Analysis is flexible in that it is adaptable to a range of research methodologies, there is a structured approach to data coding. It lends itself to providing an audit trail which allows for the clear demonstration and explanation of how my themes were developed and how I arrived at my final thematic structure. This can help establish the quality of the final analysis of a study, something CSR can be criticised for (Thomas, 2016 p.67), by providing a means of recounting and explaining the decisions made throughout the coding process (Gibbs, 2012). I will now discuss the phases in conducting Template Analysis and how these were applied to my data.

### 4.9.1 Coding, Organisation of Data and Theme Development

There are six key phases in conducting Template Analysis, although analysis often involves cycling back and forth between stages because of its highly iterative nature (King and Brooks,

2017). The six stages are familiarisation with data; preliminary coding; clustering; producing an initial template; applying and developing the template; final interpretation.

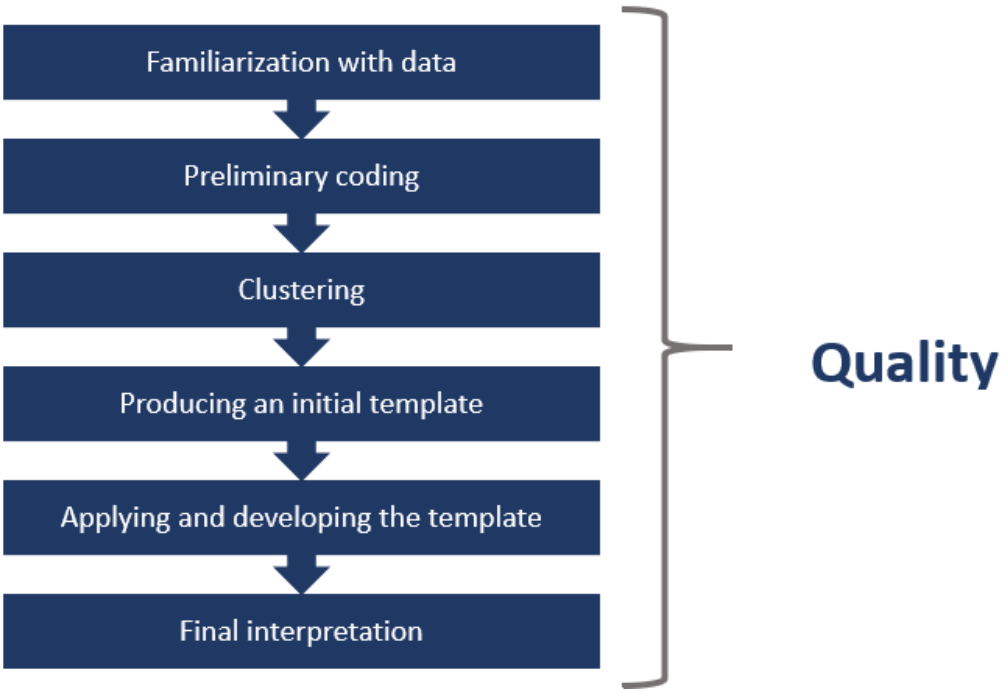


*Figure 10 Key phases in conducting Template Analysis*

### 4.9.2 Familiarisation with Data

A critical first step in generating a good thematic analysis is the researcher familiarising herself with the data (Brooks et al. 2015). I adopted several approaches to familiarisation of the data. Firstly, the process of transcribing and checking the transcripts against audio recordings. Transcription is more than just a process of transferring participants' spoken word into written forms. It is a valued way for researchers to get to know their data, gain a deeper understanding of their participants and commence preliminary analysis (Ritchie and Lewis, 2003). Furthermore, in checking each transcript for accuracy (at least twice) with the original audio recordings, I felt it was an important and useful first step in my data analysis.

The analysis and development of the template was ongoing throughout each stage of the data collection. For example, before commencing data collection for clinical cases, I re-listened to the audio recordings from managers interviews, taking further notes and listening for emerging themes. I then re-read the transcripts and reviewed the notes taken directly after the interviews. This process helped me re-familiarise with the data and start to consider a priori themes. Using NVivo 11 data software, I then wrote a short memo for each interview along with key points from my field notes. An example of one of these memos is in Appendix 5.

Bazeley (2013), suggests memoing provides researchers with a way of extracting meaning from data. Similar to Grounded Theory (Birks et al. 2008), memos in T.A. accrue as written ideas or records about concepts and their relationships; thus, continue questioning interpretation and constant comparison (Gardner, 2008). I found the process of memos particularly helpful as a reflexive process upon return to each phase of data collection. Memo writing became a priority for me with the data collection and developing template running in parallel. With my part-time study, memos became crucial to ensure the retention of my ideas which may otherwise be lost.

### 4.9.3 Preliminary Coding

King and Brooks (2017 p.28) suggest this stage is essentially the same process as used in most thematic approaches to qualitative coding data. This step involves beginning to move through the data to identify text that seems likely to help contribute to the understanding of the research topic. Rather than analysing all data on completion of the data collection, this process was ongoing. Using NVivo11 computer software, I read the text in each transcript closely, highlighting and memoing anything I believed relevant to the research questions.

This step also involves using preliminary comments to start defining potential themes. King and Horrocks (2010 p.150), define a theme as 'recurrent and distinctive features of participants accounts, characterising particular perceptions and experiences, which the researcher sees as relevant to the research question'. For example, at this point, I became more aware of the ‘lack of fit’ of PiMD in the clinical environments identified within the police and local emergency psychiatric plans. ‘Lack of fit’ became an early potential theme.

King and Brooks (2017 p.29) also suggest in the preliminary coding stage, the researcher may start utilising any a priori themes. These are themes defined at the outset of the research but used tentatively. To lessen the possibility of a priori themes having any unwanted ‘blinkering effect’ on the subsequent analysis, Brooks and King, (2014 p.4), suggest these should generally be limited in number. I used two in these early stages, which I developed from the literature review and theoretical proposition. These were ‘gaps in the journey’ and ‘co-morbidities’.

### 4.9.4 Clustering

The next stage involved organising themes into meaningful clusters, helping the researcher to think about how themes relate to each other within and between clusters. Groups were developed through hierarchical relationships and narrower themes nested within. At this point,

I began to notice there were lateral relationships between clusters, where themes permeated several distinctive groups. Brooks et al. (2015 p.204), refer to these as 'integrative themes. I found the concept of identifying these relationships particularly useful where shared spaces between themes emerged. For example, I started to recognise a cluster of themes around a theme named 'The Shunt'. This was drawn from a police manager interview. It captured the essence of the journeys of PiMD caught up in transitions between services. This cluster included 'managing intoxication', 'influence of policies' and 'medicalisation', as these appeared related to the 'push' of PiMD between services reflected in these data.

### 4.9.5 Producing an Initial Template

The next stage involved defining an initial coding template, which is a normal process of Template Analysis when working on a subset of data. King (2012), highlights that at this point, the researcher needs convinced that the selected subset (in this case, phase 1 manager interviews) captures a good cross-section of the issues and experiences covered. King cautions against becoming over-sensitised to material that easily 'fits' your template, neglecting material which cannot be encompassed as readily. On reflection, I recognise this was the case in working through my first six transcripts. However, as I became more accustomed to the data and process, I resisted urges to try to 'fit' data into existing themes or ignore data that appeared not to 'fit'. I used some of these emerging themes in the data to inform the interview schedule for phase 2. These were 'Intoxication', 'time' and 'no man's land' which was a renamed theme from 'lack of fit'.

### 4.9.6 Applying the Developing Template

A key feature of Template Analysis is its emphasis on hierarchical coding whereby groups of similar codes are clustered together to produce more general higher-order themes. Top-level or main themes may be elaborated through the use of subthemes, and there can be as many levels of coding as the researcher deems helpful in exploring the research questions. Once an initial template is formulated, the next stage in the analysis process is to go back to the data and apply it to fresh material.

I continued to develop the Template with data collected within and between each clinical case in phase 2. Here, new themes developed with these fresh data. Some themes were modified, and some became redundant or deleted (e.g. 'blaming'), others strengthened, becoming more dominant as additional data were analysed (e.g. stigma and dignity). In turn, emerging themes from the template helped inform the focus groups. For example, 'trauma' and 'diverse

professional perspectives'. This iterative process continued with phase 3 focus group analysis, which brought a new hierarchal theme 'between two systems'.

### 4.9.7 Final Interpretation

There is no fixed number of iterations involved in the application of successive versions of the template to the data. One of the benefits of NVivo11 software is there is an audit trail of iterations of the template, of which I had ten. The process of trying out successive versions of the template continued until it represented a rich, comprehensive interpretation of the data. I then returned to the subunits of the data (the three study phases) to develop overarching and subthemes for each phase making refinements to capture the "essence" of the themes. The iterative process of analysis, moving back and forth across case subunits drew out more in-depth meaning and relationships to link the holistic case.

As data analysis progressed, I identified within the manager data gaps in safeguarding environments for PiMD were a key issue. This, initially, was coded as a subtheme 'When it does not work' in Chapter 6. As the iterative process of analysis advanced, it was clear this was better reflected as a subtheme 'Working in opposition' discussed in Chapter 7. Thus, iterative theme development, integrated with my interpretations of the findings, played an essential role in understanding the depth of meaning in each phase and across the holistic case study.

Throughout, I shared my theme development with my supervisors. However, I still felt the themes did not firmly reflect the data in its totality. It was not clear what was going on 'beneath the data'. Brooks and King (2014 p.218) suggest that at times researchers should re-engage with the data and template with fresh eyes. Encouraged by my supervisors, I did so following a period of thesis writing. This proved to be an excellent learning point as a developing researcher. A synthesis of the findings (Chapter 7) and re-engagement with the literature has helped 'dig beneath' the findings to consolidate and capture key themes.

Although I felt I had completed the analysis, I found whilst writing the findings I continued to re-assess themes and refine the analysis. Braun and Clarke (2006 p.79), suggest that themes be assembled into a coherent and compelling story, convincing the reader of the worth and validity of the analysis. While working through this process and writing the qualitative findings, I adjusted and refined the overarching and subthemes across the three main subunits developed in the synthesis of the findings. King suggests presenting the template in a linear or mind map format (Figure 11).

### 4.9.8 Holistic Case Analysis

The next step involved integrating the study findings, which moves from simple description to explanation of underlying dynamics to build or elaborate theory within the case. Miles and Huberman (1994 p.91), describe this as ‘analytical progression' which moves from 'telling a first story' about the safeguarding journey, to constructing a ‘map‘ by formalising elements within the findings which are connected, and how they influence each other. Miles and Huberman (1994, pp 91-92), argue valid analysis requires to be focused enough to permit a full data set in the same location and arranged systematically to answer the research questions. I returned to my template, to consider the relationship between the subunits and holistic case, theoretical proposition, research questions, and conceptualised theoretical approach (Chapter 3).

Through my interpretation, I unpicked and developed the relationships between the data. Figure11: Example Template; highlighting relationships between the theme dignity- to build and elaborate the complex and rich portrait of the underlying dynamics, influence and relationships between the PiMD stressors and Police and HCP structural factors / human responses.

Finally, the dynamic story within my case was illustrated in a conceptual model (presented in Chapter 8). In line with this entire thesis, this was a highly iterative three model process taking eight months to complete. The models evolved from a less refined linear conceptualisation, similar to that of Stark et al. (2011), presented in Chapter 3, through to my final circular model reflecting the dynamic movements of PiMD safeguarding journeys at the intersect of two services.

1. **Managing the system**
    - 1.1. The workaround
        - 1.1.1. PiMD workaround
            - 1.1.1.1. No one to call on
            - 1.1.1.2. Reliability of police
        - 1.1.2. Police officer workaround
            - 1.1.2.1. Police custody as a means to an end
2. **Gaps in the system**
    - 2.1. Medicalised models
        - 2.1.1. Police unable to discharge care
    - 2.2. Inconsistencies in the level of sobriety to conduct M.H. assessment
    - 2.3. No safe space
        - 2.3.1. Privacy
        - 2.3.2. Dignity, humiliation, criminalisation
    - 2.4. The legislative gap in place of safety in a private dwelling
3. **Working in conflict**
    - 3.1. The shunt
        - 3.1.1. Tight service boundaries(health)
        - 3.1.2. Flexible service boundaries (police)
        - 3.1.3. Conflicting professional beliefs of PiMD need
4. **Time and timeliness**
    - 4.1. Out-of-hours calls for support
    - 4.2. Escalating distress
        - 4.2.1. Need for peace
        - 4.2.2. Intoxication
    - 4.3. Waiting
        - 4.3.1. Dignity
        - 4.3.2. Stigma and shame
    - 4.4. Resources
        - 4.4.1. Pressure on the clinical area
        - 4.4.2. Reliance on Police
            - 4.4.2.1. 'Babysitters'
5. **Distress cycles**
    - 5.1. Intoxication
    - 5.2. Aggression
    - 5.3. Entrapment
        - 5.3.1. Coercive procedures and custody
            - 5.3.1.1. (re) Trauma
            - 5.3.1.2. Dignity
6. **Professional Influences**
    - 6.1. Clinical knowledge and experience
        - 6.1.1. Inpatient care more harm than good
    - 6.2. Conflicting perspectives of PiMD need
        - 6.2.1. Repeat presentations
            - 6.2.1.1. No use of police discretion
            - 6.2.1.2. Risk-averse police culture
                - 6.2.1.2.1. Fear of getting it wrong
7. Risk positive approaches to PIMD clinical care

*Figure 11: Example Linear Template highlighting relationship between themes*

## 4.10 Ethical Considerations and Approval

### 4.10.1 Ethical Considerations

Ethical considerations of researching with potentially vulnerable people, has permeated this study and are discussed at different points throughout the thesis (in Chapters 1, 4, and 9). Here, I discuss how I approached ethics in relation to study design.

Ethical issues of researching with people who may be vulnerable required careful deliberation. Cohen et al. (2011 p.296), assert that the field of ethics in sensitive research is different from ethics in everyday research. It requires careful thought to balance beneficence and non-maleficence throughout the preparation of recruitment and data collection phases. Issues of informed consent, incentives such as those offered for the PiMD time (£20 gift voucher at a grocery store of their choice), and PiMD understanding of the study were critical to ensuring participants would come to no harm (Peirce and Smith, 2013).

The Royal College of Nursing (2011) state the purpose of ethical review is to ensure safety for research participants. Arguably, all research possibly could be harmful to participants and researchers (Long and Johnson, 2007). Therefore, governance is essential to ensure consent to participate is informed. There are processes to ensure anonymity for participants and prevent coercion to participate. Scrutiny of language used in participant materials should be clear and easily understood. Moreover, participants should be aware they may withdraw from the study at any time. Such governance also ensures secure storage of data and safeguarding processes for vulnerable people (Pyer and Campbell, 2012).

The recruitment of PiMD participants was considered in relation to the research design before, during and after data collection. These will be discussed following detail of the study ethics approval.

### 4.10.2 Ethical Approval

To conduct the study, four sources of approval / support to conduct the study were required: Robert Gordon University (RGU) School of Nursing and Midwifery Ethics Review Panel (SERP); the Regional NHS Ethics Committee (REC); NHS Research and Development; Police Scotland research support.

The region where ethical approval was sought has been anonymised in this thesis to protect the identity of participants. As I will now discuss, this was not straightforward and took nine

months in total for all four organisations to approve commencement of the study in July 2015 (Appendices 14,15,16,17).

Before applying for ethical review, I identified and met with NHS gatekeepers in Mental Health Services and the E.D. to help identify any ethical challenges linked to approval. As discussed earlier, I had met with the Police Scotland gatekeeper to discuss recruitment and data access. McFadyen and Rankin (2016), state that gatekeepers in research can influence research progress and access to participants based on their assumptions and preconceptions of the implications of the research. Thus, gatekeeper encouragement and interest in my study was judged important and facilitated through good communication and relationship building.

Ethical approval for the study was initially granted by Robert Gordon University SERP in November 2014. I then applied to the Regional NHS Ethics Committee using the Integrated Research Application System (IRAS). IRAS is a single system for applying for the permission and approval for health and social care / community care research in the U.K. Supported by one supervisor, I presented in person to the REC. My first application was not approved because of a number of recommendations made by the committee. These included informing the potential participant's G.P. that they will be taking part in the study. I was also asked to seek legal advice to ensure there could be no prejudicial effect in taking part in the study if potential participants had committed a criminal offence. I contacted the Crown Prosecution Service to ensure participation in the study would not unfairly impact on court proceeding through recounting of an incident. I was advised that would not be the case, but to offer to inform the participants legal agent that the interview was to take place. In my revisions of the PiMD participant information sheet, I included I would contact any legal representative and their G.P. regarding their participation should they wish me to. No participants asked me to do so.

With the first REC application unsuccessful, I informed the RGU Research Ethics and Governance committee of changes to the study. I made a second application to the REC using IRAS and a further in-person presentation. These amendments were approved in February 2015.

Next, I applied to the regional NHS Research and Development (R&D) team for permission to conduct the study in the NHS site areas. Approval granted, March 2015.

Police Scotland support for research was less complex than that of the NHS. This involved writing to the Area Commander to seek approval to conduct research in the Command Area.

This was granted. However, just before I was to start data collection, Police Scotland approach to research support changed. This was because Police Scotland centralised their research support process when the eight Scottish Police forces became one Force. I then applied for research support through a centralised process involving detailing the study and safeguards I had put in place. Approval to commence data collection was given in July 2015.

### 4.10.3 Approaches to Researching with Potentially Vulnerable People

Gerrish and Lacey (2010 p.32) highlight the importance of ensuring participants have a clear understanding of the study and are protected from harm. I was conscious of a number of issues which may arise in all types of research not limited to researching with potentially vulnerable people. Specifically, informed consent, confidentiality and blurring of researcher boundaries should be considered in all studies (Silverman, 2010). However, these issues can be particularly relevant to people who may be vulnerable because of complex health and social issues. These now will be considered in turn.

#### 4.10.3.1 Informed Consent

Gerrish and Lacey (2010 p.34), note there are specific features of informed consent which must be considered. Consent must be given voluntarily and can only arise when participants are given information about and comprehend what the research will entail and how findings will be used. Consent must be open-ended so participants can withdraw at any time during the research process. Thus, informed consent in research is an ongoing process, which requires much more attention than simply completing forms.

I have discussed in 4.6.3.2 the checkpoints I made with PiMD participants during recruitment and data collection to ensure they were fully aware of the research process. There is evidence of poor health literacy in Scotland with system failures to consider peoples information needs (Scottish Government, 2017b). However, the evidence supporting interventions to improve the informed consent process in low literacy populations is extremely limited (Tamariz et al. 2012). The study information documentation was written in layman terms to ensure clarity and ease of understanding, thus supporting informed consent. These documents were reviewed by two laypersons before recruitment to check these were easily understood. When gaining informed consent from my participants, I ensured they were able to understand the information, could understand what the interview would involve and the possible consequences. I also ensured they had time to consider the information and decide whether or not they wished to participate. I also prepared the detail of the consent documents in audio format. Participant information was dictated into MP3 format (provision was made for other formats to be made available) to

allow each participant to keep study information in auditory format should they so require. However, this was not required by any of the recruited participants.

Given consent is a continuing process, I regularly ensured participants knew they could stop the interview at any time, or that I might stop the interview if they were distressed. There were times during one interview the interview was interrupted by the participant's phone calls, but no participants asked to stop the interview early, or that I felt were distressed.

In relation to informed consent, given the evidence of co-existing substance use and mental distress issues from the literature review and my clinical experiences, I was aware there may be a possibility a participant may also use substances. To address this, I raised the topic of sobriety during participant pre-interview discussions and arranged interview times with them at a point they believed this was most likely. No participants were intoxicated during the interviews.

#### 4.10.3.2 Confidentiality, Disclosure and Blurring of Boundaries.

Complete confidentiality cannot be promised in research with vulnerable participants (Pyer and Campbell, 2012, Dhai and Payne-James, 2013), as researchers and nurses are obligated to report disclosures of harm (Stevens, 2013, Mackay and Notman, 2017). Participants needed to understand researchers may break confidentiality, and when and why this may be done. It is vital to clearly state limits to confidentiality as well as when and how a researcher would deal with disclosures of harm. During pre-interview telephone screening, and directly before the semi-structured interview, I advised participants of my duties to report any safeguarding concerns arising during the interview to the local authority. This duty lay within my responsibilities as a nurse within the Adult Support and Protection (Scotland) Act (2007). I advised participants I would make them aware if this were to take place. This was detailed within the study protocol and participant information guide (Appendix 13). This was not required within this study.

I was conscious that, in recounting their experiences, participants may become distressed. It was important that participants felt comfortable and supported when discussing sensitive experiences (Alexander et al. 2018). Yet, by making efforts to create rapport with participants, to support them to feel 'comfortable' in the interview setting, researchers can 'invite intimacy'. This potentially runs the risk of encouraging participants to say more than they may have originally intended, evoking distress and blurring boundaries (Miller, 2009). It is possible that boundaries can become blurred, thereby compromising the purpose of the interview, the validity of the study and the expectations of the PiMD. Possibly, participants can experience

this as exploitative and intrusive, potentially causing further harm (De Chesnay and Anderson, 2012).

My clinical experience gave me confidence in discussing sensitive issues with people. I felt capable of identifying and managing situations when people become highly distressed. In reality, during the interviews, no issues arose. I was conscious of keeping boundaries clear and remembering (in my own thoughts) this was a research interview, not a clinical discussion. In order to mitigate against the blurring of roles, I referred frequently to my interview schedule and personal prompt notes reminding me of my researcher role. However, practising as an ethical researcher was not without dilemmas and angst for me personally. In keeping with the broadly social constructivist approach in my research, enhancing the trustworthiness of my work, and as a mental health nurse where reflection is core to our practice, I will now present a reflection on ethics in this study.

### 4.10.4 Reflections on Ethics

Ethical challenges and possible threats to the study, because of my relationship with clinical practice, were a weighty consideration through the research method development phase. In this section, I reflect on the ethical questions I faced in the multiple identities as a researcher / nurse / colleague within this study and my approaches to resolving these dilemmas.

At an early point in the study, I become highly sensitive to possible negative consequences my practice relationships and familiarity with the topic could have on the trustworthiness of the study. Tension developed between the subjective assumptions I made as a practitioner and openness to new knowledge as a researcher. As a developing researcher with a desire to be transparent, I was concerned that potential bias could be criticised. I now recognise it is never possible to be fully transparent to participants, and that I could not and should not negate what I brought to the study. However, at the time, my focus on ethics became a struggle, and my preoccupation on this point of tension slowed the development phase. Looking back, this was a time of great learning for me of being a researcher rather than a nurse and academic.

Partially these difficulties were overcome through a better understanding of qualitative research theory, ethics, and practitioner research (Latimer, 2007), identifies the benefits and challenges of a researcher's relationships with their research, suggesting the desire for transparency by the researcher could be a positive rather than negative influence on the study. On one hand, the researcher’s relationship with the research can threaten the credibility or trustworthiness of the data. On the other hand, and in line with social constructivism, the researcher's nursing experience can bring an active medium through which data can be

collected and subsequently analysed, as a means of reciprocating with participants. Mantzoukas (2005), explored the relationship between bias, research, and reflective studies. He argues bias is not by definition, counterproductive if the researcher's bias is fully incorporated and apparent throughout the study - as I have tried to ensure. Adler (1990) agrees that being an 'insider' of the environment under scrutiny is not without its potential problems, such as bringing preconceived ideas about the social groups they study, into their work. However, there are also problems associated with being an 'outsider'. Floyd and Arthur (2012), suggest one danger of being an 'outsider' is that once the research has been completed and written, ethical concerns fade naturally into the background potentially leaving participants at risk of harm.

Possible negative or positive influence of my previous roles on my study forced me to critique perceptions of power and potential bias (Moule, 2015). The difficulty, or opportunity, lay in that I was neither an 'insider' nor an 'outsider'- with a complex mix of roles, police, and nursing professional identities, and a novice researcher.

To support an understanding of this conflict and to promote transparency, I reviewed the literature associated with insider / outsider research and discussed this at length with my supervisory team. Together we decided I should participate in, and record, a reflexive interview with a qualitative researcher. The reflexive interview supported my personal and professional understanding and helped me verbalise some of the ethical issues I had been pondering (Holloway and Freshwater, 2009). This process is strongly encouraged by Mantzoukas (2005), who suggests that for non-positivist studies, reflection is used to reveal the researcher bias, and should be included rather than excluded from the study.

The process of engaging in, listening and re-listening to my interview was revealing. Such insights 'laid bare' my own assumptions and facilitated a pathway for further learning via the literature. My reflection held two key points. Firstly, I held fairly strong views that health care colleagues lacked compassion for PiMD who self-harmed – a belief I had never verbalised previously, and one I no longer hold having completed the study. Secondly, I revealed there were parts of my nursing identity I had lost (and happily lost). I had taken elements of the policing identity. This was re-affirmed to me through the interview transcript of my recount of an introduction of me at a meeting by a Police Area Commander to senior officers. He said 'She's Ok. She's on our side. She wears a police uniform under that dress'. In relation to the study, both points raised my awareness of my biases. This allowed me to keep these in constant check throughout the data collection and analysis processes. It brought a critical self-awareness of my own assumptions and had important implications for how I approached

areas of the study, particularly in data collection and analysis. I developed a process of writing a brief summary of the dynamics of the interview or focus group to reflect on the researcher–participant relationship, to help learn lessons for future interviews as well as to inform my subsequent analysis. I shared these with supervisors during data collection and the early stages of analysis.

Corbin Dwyer and Buckle (2009) point out that rather than consider this issue from a dichotomous perspective, there exists a space between which I have tried to occupy since the early reflective interview. This allows researchers to move between the position of both 'insider' and 'outsider', rather than 'insider' or 'outsider'. This position can be unique and bring increased flexibility and understanding to explore the 'complexity and richness' of the research analysis. Through a reflexive process with supervisors, engaging in the literature and personal self-reflection, at the end of the study, I have learnt to manage and value the unique position rather than find it ethically burdensome.

## 4.11 Chapter Summary

This case study sought to understand the experiences of safeguarding journeys through the lens' of the three key stakeholders. Understanding factors, whether they be systems or human responses, impacting on these journeys is central to generating this new knowledge. Therefore, my approach was to generate data from a variety of sources and in a range of out-of-hours safeguarding contexts. From an organisational perspective, this spans health and police governance to frontline practice. In this chapter, I provide a thorough account of how I designed the research, considered ethical and safeguarding issues, and gathered and analysed these data towards meeting the research aims. I acknowledge this has involved making pragmatic decisions within the timeframe of part-time study, which I have articulated in my discussion and illustration of the conceptualisation of the research design in this chapter.

In the next three chapters, I present my interpretation of the study findings. As identified in this chapter, there were three subunits (phases) of data collection which ran consecutively. The three findings chapters are presented correspondingly. Chapter7 includes a synthesis of the key findings across the subunits. These findings chapters are organised in the following way:

- Chapter 5 Manager interview findings (Phase / subunit 1)
- Chapter 6 Three clinical cases findings (Phase / subunit 2)
- Chapter 7 Focus group findings and synthesis of holistic case (Phase / subunit 3)

# Chapter 5: Phase One – Police and HCP Manager Interview findings

## 5.1 Introduction

In this chapter, I present findings from subunit one (phase one, manager interviews). Firstly, I introduce the overarching theme and subthemes. A critical analysis of each subtheme will follow, supported by excerpts from the data. I will conclude with a summary of the findings of this initial phase of the study.

The purposes of manager semi-structured interviews presented in this chapter were twofold. Firstly, provide an understanding of the out-of-hours healthcare and police service interface supporting PiMD within the case study area. Secondly, present a governance perspective of inter-agency relationships and organisational processes in the care of PiMD.

Participants in this initial phase of the case study were senior Police Managers (n = 6) and senior HCP Managers (n = 6). In total, 19 hours of interview audio recordings were transcribed verbatim. Participants were interviewed in their workplace and each lasted between 1 hour and 1 hour 30 minutes.

Using an inductive approach, an overarching theme*, 'Managing and working the system'* was developed through data analysis and my interpretation. The overarching theme is underpinned by three subthemes being *'Service boundaries and blurring of roles', 'Inter and intra-agency policies and missing pathways: the impact on care'* and *'The service shunt'* (Figure 12).

## 5.2 Findings

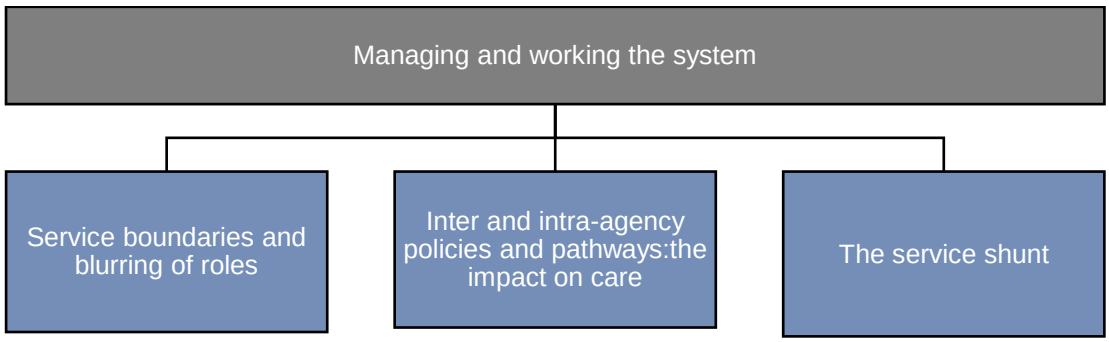


Figure 1: Overarching theme and subthemes Subunit 1 phase one

Critical analysis of the findings highlighted 'problems' at the police / health service interface in the care of PiMD. Professional relationships were respectful and positive; however, participants conversations were underscored by issues within intra-agency systems and structures in the care of people with mental health needs within, and between the two organisations. These issues were concerned with limited resources, debate over roles and responsibilities, competing organisational priorities, perceived lack of senior leadership and challenges in the transfer of care of people with specific mental distress needs such as those who were intoxicated.

I present the conditions under which inter-agency support of PiMD appeared to work well. More often, there appeared to be tensions at the service interface to work around and between structural gaps. This sometimes resulted in police and health services working in conflict.

The first subtheme emerging from the analysis was ***'Service boundaries and blurring of roles'*** and reflects participants' perspectives of inter-agency relationships and responsibilities in the care of PiMD. The second subtheme ***'Inter and intra-agency policies and missing pathways: the impact on care'*** illustrates the influence of interpretation, enactment of inter and intra-agency legislation, processes, and policies. The third subtheme ***'The service shunt'*** links to previous subthemes. Findings here highlight the difficulties in discharging care, and tensions in working within policies and legislation.

### 5.2.1 Service Boundaries and Blurring of Roles

In this subtheme, I present a critical analysis of manager interviews as to how police and out-of-hours health services intersect in the support of PiMD. Managers were asked about their perceptions of service boundaries, responsibilities and how they worked together across operational, clinical and governance environments.

#### *5.2.1.1. Inter-agency Relationships*

When asked about inter-agency relationships, participants were unanimous in the view that responses to mental distress incidents were an area of tension between health and police services. Three participants (one Police and two HCP managers) highlighted how they built a close, trusting governance forum between local police services and specialist psychiatric services to focus on co-operation and joint problem solving. The forum sought to address incidents involving police referral of people with mental health needs and incidents where people absconded from the psychiatric hospital. There was a sense the success of this forum

was because relationships were respectful and built on the leadership attributes of individual managers from both services. These attributes were discussed as a willingness to understand the challenges faced by the other organisation, honesty, and commitment to collaborate. All three participants discussed the time and effort they had invested to enable these relationships to flourish. An HCP manager recounted:

> *'I think partnership in general is taken very, very seriously. It needs to be. I think that there are very, very, good, positive working relationships. We meet regularly, operationally, tactically, strategically. People know each other' (HM1)*

A police manager echoes these comments suggesting value is placed on these relationships to address challenges in inter-agency working, highlighting the importance of open dialogue and trust between the two organisations:

> *'The interface that we have is really good. It is an open relationship. There is no issue between us bringing up problems or perceived bad experiences with each other. I know if I took something to the mental health manager, it would be looked into thoroughly. She would give an entirely accurate back-story behind it. Those relationships are important' (PM3)*

In this account, the police manager emphasised the importance placed on actively building and sustaining open, truthful conversations to support the resolution of inter-agency problems. This is highlighted in his point that clinicians and police officers have 'bad experiences' requiring investigation and explanation between partners. There is reference to the possibility of incidents having a 'back story' suggesting that in practice there may be different organisational interpretations, understandings, or perspectives of incidents. As I will present in Chapter 6, it is possible Police and HCPs do not always agree on the needs of PiMD and can be motivated differently in their practice.

The sense that senior manager collaborative working does not always transcend from policy to operational working, is alluded to in an interview with a senior police manager. The excerpt below illustrates active collaborative planning within organisational hierarchies, yet these are not always mirrored, and hard to enact in the realities of frontline working. As this interviewee points out, this is because of the realities of competing operational priorities:

> *'What you'll find from senior officers is there is a much more utopian feel. That things are much better because we immerse ourselves in community planning partnerships*

*and everything revolves from that. So, the world to me is very rosy. We are all working collaboratively. It isn't. Reality is it is not. We are still very much tied up with our own individual priorities etc. and that manifests itself and finds its way down to the street' (PM2)*

This manager identified an enthusiasm for idealistic cross-sector collaboration at a governance level. Yet, suggests that that inter-organisational day-to-day demands can distract from opportunities to enact governance ambitions for practice collaboration.

There were suggestions the challenges of siloed working were because of poor joined up thinking at governmental national and organisational leadership levels. Two managers (1 Police and 1 HCP) were animated about their experiences of joint national policy development. There was a perception that a lack of focus on police and health service resources in mental health care at a Scottish Government level hampered local inter-agency working. This was discussed as a lack of urgency within governmental and national health policy makers, and police leadership in progressing collaborative strategies and practice to support vulnerable people. The following two excerpts illustrate shared HCP and Police Manager frustrations of national governance leadership in enacting ambitions for innovative, cohesive partnership working. Firstly, an HCP Manager points to a need for stronger executive leadership and resources to address local partnership needs:

*'I think, it needs a real bit of holistic thinking, joint working and probably resource and finance that nobody's kind of got at the moment. We need to have real leadership. Take the bull by the horns and take it forward' (HM5)*

A Police Manager concurs, referring to the government led commission by Dr Campbell Christie, which makes clear recommendations organisations must work effectively in partnership to design and deliver public services that meet the needs of local people:

*'Christie needs to become alive and kicking. It won't change unless it changes right up at a governmental level' (PM2)*

Both managers expressed frustrations of a perceived lack of collective vision, blockage, or inactivity within senior leaders to support policy transformation at national and government levels. Thus, opportunities are hindered within local inter-agency partnerships. Funding constraints across public sector services, were viewed by participants as obstructing local innovations and partnership. As a result of health and police policy makers not collaborating

at a Governmental level, opportunities for local partnerships felt unsupported and outwith local leaders' control. There is a sense of a bigger problem which cannot be fixed at local management level. As I will outline in Chapter 8, these findings point to a tension between governmental aspirations and inter-agency legislation, focused on how services work together and resources available at local level.

Evidence presented so far suggests a disconnect across and through layers of inter-organisational systems to enact safeguarding policies to frontline resources and services appropriate to PiMD needs. Competing demands of core police and health services appeared to reinforce siloed working and expanded gaps in care.

Building on the above findings, I explored participant perspectives of their role, demands and priorities specific to police / out-of-hours referral points for PiMD within the local psychiatric emergency policies in the study site areas. This supported a deeper understanding of the organisation of out-of-hours responses to the care of PiMD and views of partnership roles in the safeguarding journeys of PiMD. A recurring theme in the interviews was a sense amongst interviewees from across both services, that they were not the right service to support PiMD, whose needs were not time critical. In this next section, I report on manager, participant responses to questions on their views of their organisations' role in supporting PiMD. As the findings I present suggest, demand on other areas of health and police service business can compete with safeguarding PIMD who are not viewed as an emergency.

#### *5.2.1.2 PiMD within E.D. Priorities*

One of the main issues raised throughout the HCP Manager interview was the inappropriateness of the E.D. environment to manage some PiMD who did not have a co-occurring physical health need. This excerpt highlights that in some circumstances the management of PiMD sits outwith, or on the perimeters of, their remit and expertise when there is no associated medical emergency:

> *'You know resuscitation is our main job. Dealing with seriously time dependent illness. Most mental illness is not time dependent. Unless they have taken an overdose. So, unless they medicalise it, they are not going to be a priority to us. Because that's what we're trained to do, and that's what we're here to do. We are not trained to be psychiatrists and we don't want to be either. To be perfectly honest, people who want to do emergency medicine don't want to be mental health specialists; it is as simple as that' (HM5)*

This account helps illustrate two points. Firstly, a perception that, at times, despite the E.D. being identified as a referral point in psychiatric emergency policies, the environment is not a suitable place for police referrals of some PiMD. Within this clinical environment, the focus and clinical speciality is aligned to time-critical, life-threatening emergencies. Therefore, only some PiMD who also have a medical emergency would be a priority. Secondly, in this manager's view, there are clear boundaries between the emergency medicine clinician and mental health specialist roles and skills. This suggests in emergency medicine, there is clarity of responsibilities in care management of PiMD. The E.D. is not perceived to be the 'right place' for police referral of some people and could explain the lengthy wait times and poor experiences of PiMD highlighted in Chapter 2.

#### *5.2.1.3 Unscheduled Care Psychiatric Services Priorities*

Similarly, an interview with an HCP Manager illustrates comparable service priorities and skill mix challenges, in unscheduled psychiatric services. In this excerpt an HCP Manager questioned the role of out-of-hours psychiatric services as being the appropriate service to manage PiMD who are perceived as not acutely mentally ill:

> *'I think there's always been a bit of conflict here. Because at the end of the day we're a specialist mental health service. So, you know, that's what we do. We come from that background. Dealing with serious mental illness. There's a long history of crisis services seeing people who aren't necessarily mentally ill but are in crisis by definition' (HM4)*

Like the E.D., this participant suggests this service has a defined clinical focus, being the care of people with serious mental illness. Here there is evidence some people will be in crisis but do not have a mental illness, therefore will not be a priority. Yet, they will still be brought by police to an area designed to treat serious mental illness. Potentially this is because there is nowhere else suitable. This suggests there is a gap in appropriate services for the needs of some PiMD.

#### *5.2.1.4 Out-of-Hours G.P. Services Priorities*

A third service identified in psychiatric emergency policies is the out-of-hours G.P. service who may be called upon by police to make an assessment in the PiMD home should they be unwilling to be transported to hospital. In such circumstances the individual's home is recognised as a 'Place of Safety' within the Mental Health (Care and Treatment) (Scotland) Act (2003). I recognised a similar pattern of questioning of role, response and resource priorities for out-of-hours G.P.s. In this discussion, the HCP Manager identifies that PiMD who

are not critically ill and being managed by police officers will not be a triaging priority. In such circumstances, competing medical emergencies must take precedence:

> *'It doesn't work so well when the person that the police are sitting with is not deemed to be quite such a dire strait as somebody that's collapsed with an MI or chest pain or whatever. So, that person will get priority' (HM12)*

Here the manager identifies competing priorities. Two factors are discussed which could potentially influence out-of-hours G.P. triaging. Firstly, and like the HCP manager's views, the PiMD clinical needs may not be as time dependant and serious as others in need of support. Secondly, the police are present. This suggests, if out-of-hours G.P. services are aware police are in attendance, the immediacy of the out-of-hours G.P. to attend is lessened. Potentially this can extend the time officers are required to remain with the PiMD. As I will go on to illustrate, police officers can also experience the management of PiMD, as outwith their priorities and role when HCPs are perceived to be too busy to attend.

In summary, these data suggest some PiMD may not be viewed by out-of-hours HCP managers as being seriously ill or a priority in the three key clinical areas identified in psychiatric emergency policies. Thus, there does not appear to be a suitable out-of-hours healthcare environment to provide timely support of PiMD needs, or where police officers can discharge care in a timely way. As I will now illustrate, police managers also identify their service as being inappropriate and ill-equipped to support PiMD, yet they are left to plug this gap which can lead to tensions at the inter-agency interface.

#### *5.2.1.5 Police Priorities in Responding to PiMD and Blurring of Roles*

Police officers appear conflicted in their roles and responsibilities in supporting PiMD. Police Manager participants recognised they had responsibility to respond to PiMD in crisis, however, the boundaries as to where these responsibilities ended was less clear. This lack of clarity, whilst filling a gap in community mental health care, finds the police officer role seep beyond emergency care. Here a police manager brings a police perspective to their role and responsibilities in the care of PiMD:

> *'The view on the street from police officers is partly a) it's not our job, and, b) they want to do the best they can for the person, and this is not always possible. Quite often there is sometimes discontent between health services, psychiatric services and the police' (PM5)*

Like HCP managers, there is evidence of clashes in perception of professional roles and responsibilities. In this interview, the manager explains this can result in operational tensions between the services. This discussion illustrates officers are willing to support to some degree, but for the most, the care of PiMD is outwith their abilities and police resources. Like the emergency medicine clinicians, this manager suggests police officers feel they do not have the skills or resources to respond to PiMD distress beyond a critical emergency. The use of the word 'partly' suggests officers may see themselves as having some role in the care journey, but overall, care of PiMD is perceived as sitting beyond police work. There was a sense that officers experience a gap in healthcare service provision, which they are reluctantly filling.

Each police manager talked about the police officer's role seeping into health care as a result of shortcomings in emergency out-of-hours health and social care services in the care of vulnerable people. Take, for example, an interview with a police manager who appears frustrated that police are being drawn away from core and traditional police business and into health and social care:

> *'We don't get ticks in the box for dealing with a vulnerable person. I am questioned as a very senior officer on house breaking, car crime, and violence. That's my bag, but I seem to be spending more time dealing with other folk's issues' (PM2)*

This could indicate fundamental differences between the objectives of health and criminal justice agencies. As this police manager suggests, police performance can be defined by crime statistics, rather than caring for vulnerable people. As I will argue in chapter 8, police performance indicators have changed in recent years since this data was gathered (2014). This results from a change of police leadership and policy which sees a much stronger focus on vulnerable people and less on crime statistics. Nonetheless, there are similarities with health care managers perceptions of role boundaries. The difference in the police interviews is that that police managers feel the boundaries are less clear for them and as a result their work can involve the care of vulnerable people. With this comes an erosion of their role as crime fighters.

My interpretation of 'dealing with other folks' issues' in the above account is that police officers feel they are picking up partner agencies roles. As I identified, care of PiMD was not viewed as core business for out-of-hours health services. As a result, police officers suggest there are no other services available. As this police manager reflects, police officers can feel there is nowhere else for people to turn to, thus PiMD call on police despite mental health care being outwith their role:

*'If we were to say, 'they're not our responsibility', where would that fall? I think at the moment we are generally carrying a burden that wouldn't primarily fall within our remit. Mental health is a health issue not a criminal one' (PM4)*

The term 'burden' suggests police services perceive PiMD demand unjustly. Yet, officers feel duty-bound to respond, despite acknowledged skills deficits. Such grievance against partner agencies was raised repeatedly in every police manager interview signalling a key point of inter-agency tension. Similar patterns of concern and resentment by police officers is recognised within the two subsequent phases of data collection. It is noteworthy the HCP manager identified a similar perspective of mental health care as falling outside their responsibility. Yet, they felt able to put a boundary around their role and service. This account would suggest police officers feel unable to boundary their role and have difficulties discharging a duty of care.

As a result of discussions of role shifting, I took the opportunity to explore the officer's motivation(s) to respond, given such firmly held beliefs that this work is perceived to sit beyond the police remit. Discussing this issue all police managers responded by explaining the police service and professional responsibility is rooted in a commitment to protect people. This was tied to police organisational culture, values, purpose and focus. Here one police manager captures the philosophy of public safety embedded in Police Scotland:

*'The base ethos of Police Scotland is keeping people safe, and that's our job. We do it in a million different ways. We are not in the business that says, 'sorry that's not our remit'. We are the 'can do' organisation we will sort things out for you. If someone is in need of protection, police will provide this. It will not be ignored or shifted on to other services' (PM6)*

These data contradict the previous discussions in this chapter suggesting the police role is focused on crime fighting. This account helps illustrate that police participants hold paradoxical positions. On one hand, there is a view that mental health responses and the care of vulnerable people sit outwith the police remit. That mental health care should be the responsibility of health services. Yet, on the other hand, this officer explains their role is deeply rooted in public safety. There is pride in the manager's description of police service abilities and acceptance of a wide-ranging remit, part of the Police and Fire Reform (Scotland) Act 2012 introduced in Chapter 1. The account suggests police officers are characterised by a willingness to accept, meet, and resolve challenges, and do not try to shift responsibilities to

another service. These data suggest that part of the role blurring, experienced by police, is because their work is ill-defined with little understanding where the role boundaries lie.

In summary, these data help illustrate there is evidence of some positive relationships between both organisations at a local governance level. Yet, a perceived lack of joint senior policy and organisational leadership appears to impact on resources to manage gaps in out-of-hours healthcare systems and police services to support some PiMD. A key point from these interpretations is that all three out-of-hours health services appear 'medicalised' with clear priorities and boundaries around each specialism. Services are organised to respond to medical emergencies or serious mental disorders. Some PiMD may have neither, finding them to be a poor fit within existing out-of-hours health care provision, and on the boundaries, or outwith, out-of-hours health care priorities.

In contrast, police roles and responsibilities appear less defined. Police manager discussions highlight that the role blurring is interwoven with strong public protection values and a perceived lack of alternative services to respond to PiMD, finding police services as 'service of last resort'. This can find officers 'duty bound' to respond, even though they feel ill-equipped. Potentially, as a result of police service ethos and culture of protection, reliability and dependability highlighted in my data, they have extended their responsibilities in public protection to plug a gap. PiMD could come to police attention because their needs fall outwith the focus of out-of-hours emergency services priorities. Therefore, on one hand, there is recognition of the importance of both organisations working together, yet on the other, gaps in health service structures appear to hinder care responses to PiMD. As the police managers pointed out, safeguarding responsibilities appear to have fallen to police officers.

In Chapter 1, I showed gaps in the policy landscape, guiding police and health services safeguarding, could impact negatively on the experiences of PiMD. In this subtheme, participants highlighted a disconnect between policymakers, national governance and practice. In this next subtheme, I build on these points through exploration of participants' views of the role and intersection of inter and intra-agency policies and legislation on practice and professional relationships in the care of PiMD.

### 5.2.2 Inter and Intra-agency Policies and Missing Pathways: The Impact on Care

A recurrent theme in the interviews was a sense amongst interviewees that current policies and organisation of health and police services were unresponsive to the needs of some PiMD. This subtheme illuminates gaps in the organisation of emergency health and police systems

and safeguarding policies which can find some PiMD 'fitted into' existing services and exposed to convoluted safeguarding journeys.

In the previous subtheme, there is acknowledgement that services are keen to work together at a local governance level. However, as indicated by some managers previously, there are elements of the safeguarding journey where they are working separately. All bar one participant identified tensions of working at the junction of cross-organisational policies introduced in Chapter 1. Interviewees talked of difficulties in working between a range of local inter-agency psychiatric emergency plans, safeguarding legislation and organisation, specific policies such as the Police Scotland Mental Health and Place of Safety Standard Operating Procedures (SOP), and Royal College of Emergency Medicine guidance. In this excerpt, an HCP manager suggests this disconnection may be because national policies and guidance are agreed at 'arms-length' from practice and local areas. Here the manager reflects on Royal College of Emergency Medicine guidance on how PiMD be managed within the E.D. and of the partnerships involved:

> *'These agreements and guidance are discussed with the College. But of course, the College is based in London. Guidance should always be tailored to the situation in which you're delivering it. But there's this expectation that an E.D is an E.D. Well no. If you've seen one E.D. you've only seen one E.D! Everybody has different ways of working. So, this idea that they're (police) going to turn up and we're all going to do it this way can't work' (HM5)*

This finding highlights the nuance in emergency medicine environments. This manager reflects a perception of a divergence between centralised guidance, local agreements, and operational realities. The manager identifies challenges of trying to work under guidance that does not consider the variety of localised out-of-hours services and skills mix. There is a sense of struggle to balance local knowledge and processes against national protocols which may not prove to be a good fit with some clinical areas. This example helps illustrate the experience in one of the health care environments in the study.

Yet, as I have illustrated in Chapters 1 and 2, the PiMD safeguarding journey is not linear. It can traverse four different inter-disciplinary healthcare environments: unscheduled care psychiatric services, out-of-hours G.P.s and the E.D. and two separate organisations. Within this, there is a raft of organisational and specialism specific, inter-agency, profession specific, national, local, and legislative policies and guidance shaping the journey. As I will now show, these can be complex, unaligned, intertwined and can compete. The impact on practice will

be explored further in Chapters 6 and 7 to help understand these influences on operational relationships and processes.

The previous subtheme highlighted HCP participants' viewed that often specific clinical areas identified in national and local policies are inappropriate environments for some PiMD. Yet, it is the broad national policies and legislation which underpins police referrals of PiMD to critical care services and designated Places of Safety. The following accounts illustrate the impact these policies have on out-of-hours health and police services.

#### *5.2.2.1 The E.D. Perspective of the Care and Management of PiMD*

There was a view by one HCP manager that the acute clinical environment was the wrong place for police-led referral for PiMD who did not have a time critical medical emergency. This was because the critical care clinical environment was neither designed for nor resourced to deal with non-urgent psychiatric referrals. This mismatch could have a negative impact on generalist emergency clinical environments.

Speaking on this point the HCP manager illustrates in more detail the nuance in police-led PiMD referrals and illustrates the challenges faced in supporting these:

> *'In a simplistic way, we deal with the medical problem and we don't really get involved. It's very time consuming to do the mental health stuff in a department that's supposed to have 4-hour targets. If they have some sort of self-harm that requires medical intervention, there is a very well-defined pathway for that. The second group are the ones who come in who primarily have a mental health problem. This immediately becomes obvious that they are not a medical problem. They are a mental health problem. That can be trying for us. Either we try to get them transferred or we have to wait for the psychiatrist to come up and see them. In those situations, the department is really being used as a holding bay. You know, we are not keen on that at all, but that's something we accept. But it's unnecessary'*

This interviewee highlights the E.D. is not resourced to support PiMD holistically where there are co-occurring mental distress and physical health needs. These appear to be dealt with separately contributing to lengthy wait times. As this interviewee explains, this can cause a breach in NHS targets and tensions in this pressured acute clinical area:

> *'We have a large number of breaches (E.D. wait time targets) because of waiting for the psychiatry guys to respond. They are under pressure as well. I suppose the third*

*group are the ones that are brought in by police, they really don't fit. So, they probably don't have a medical issue. Well, let us put it this way, they've got a mental health issue, but they don't have an acute health problem. So, we are not interested in them in general emergency medicine, I mean, well, I know that is a terrible thing to say. No, it's a truthful thing to say. We are under pressure, we are busy, we don't want to deal with these patients. We are not trained to deal with them, they come in here and actually they don't even need to be here, as a Place of Safety' (HM4)*

This manager captured the impact of PiMD referrals on emergency medicine environments. There is an identification of the variety of referrals, needs and available interventions in the care of PiMD. PiMD may be transferred by police for mental health assessment to unscheduled care psychiatric services at another hospital. Alternatively, PiMD and police officers would wait for a psychiatrist to travel to the E.D. to conduct an assessment. As the HCP manager highlights, this can see a busy E.D. used as a transitory holding space for police officers and PiMD awaiting assessment. Significantly, and important to this thesis, this illustrates that some PiMD referrals do not fit within either psychiatric or emergency medicine pathways. This suggests there is a missing service or pathway for some police referrals and potentially a need for a more appropriate referral point or Place of Safety other than busy E.Ds.

#### *5.2.2.2 The out-of-hours Psychiatric Services Perspective of Police Referral of PiMD*

Out-of-hours psychiatric services are also identified in policies and safeguarding legislation as a Place of Safety or referral point for Police. Like limitations in psychiatric care in the E.D., out-of-hours psychiatric service managers identified boundaries around the care they provide. At times, this can see Police transfer PiMD to E.D. for medical aspects of care. For example, when someone is intoxicated. The following quote by an HCP manager illustrates the further disconnection between policy guidance, service provision, legislation on services and the PiMD journey:

*'I've seen the most recent version of the Standard Operating Procedure for Police Scotland. They are clear if somebody's so drunk, you know, you can't talk to them, they should go to E.D. 'cause they're so intoxicated. So, we (psychiatric services) shift them up there. I can't imagine E.D. are welcoming them with open arms…you know, if they are that drunk. I just think its pass the parcel' (HM5)*

This account could suggest there are tensions between what is agreed at a national level and what is manageable or appropriate at a local level. Different levels of policy and local service provision adds complexity for both services. In this example, a redirection of people who are

intoxicated to busy E.D. reflects a further missing pathway or lack of an alternative safeguarding environment. The concept of “pass the parcel” suggests there is also a sense of trying to discharge care responsibilities onto another service. I will present this further in the next subtheme ‘The service shunt’.

#### *5.2.2.3 The Police Perspectives of the Impact of Safeguarding Policies*

Several police managers noted that the police response was resource intensive because often they had to work around the MHCT Act, gaps in alternative Places of Safety, and wait times for HCPs. Working within policy guidance and legislation, officers will transport PiMD to the E.D. They describe waiting for many hours until the PiMD is assessed. This mirrors the previous emergency HCP account, suggesting some police referrals as breaching the 4-hour wait time targets and using the E.D. as a holding bay. In this account, a police manager describes police officers’ feelings of despondency in being unable to leave, and highlights a perceived ‘minder’ role in the E.D.

> *‘I think they know their role is just to…I don't want to use the word babysit… but it is a babysitting thing. It is until somebody else can take care of them’ (PM4)*

This account reinforces a notion of ‘pass the parcel’ identified in the previous excerpt (5.2.2.2). There is a suggestion by this participant that police officers have trouble engaging emergency HCPs in a timely way, and thus remain responsible for safeguarding until HCPs are available. There is a sense that police officers feel ‘used’ somewhat by HCPs. This is aligned to shifting police roles and identity and perceptions of working at the discretion of HCPs, which I will discuss further in Chapter 7.

Similarly, a police manager discussed further difficulties in the timely engagement of HCPs, and additional demand on police resources when working around the MHCT Act, and police policies when called to a PiMD at home. An interviewee explained difficulties lie in cases when a PiMD refuses to be transported by police to out-of-hours psychiatric services for assessment. If the PiMD has not committed an offence and are not at immediate risk of life, police may not legally remove them from their home - from a Place of Safety (private dwelling) to another Place of Safety (hospital setting). Unable to leave the PiMD due to potential risk of harm, officers will make a request to out-of-hours G.P. services to conduct a mental health assessment in the home. As identified in the previous subtheme, this may not be viewed by out-of-hours G.P. services as a time critical emergency, thus officers may wait for some time for the G.P. to attend. These difficulties are illustrated in a police manager account, which captures the frustrations and experiences of officers:

*'The thing with the people in crisis in their own homes… generally the impact on the resources is the issue. It takes a long time to deal with. It is fairly obvious from the police officer point of view that the person needs help. Quite often, when we are called to someone's house when the crisis is very acute, and either are looking to fling themselves out of a window or are on the verge of self-harming. So, it ties us up for hours and has a knock-on effect on resources. Why is there not a more active, quicker action taken by health services? It is obvious what is going on. Why can't we get a police level quickness of response by health services? Just arrive, bang, deal with the issue in 10-15 minutes' (PM6)*

Here there appears to be a lack of understanding of the demands, agility, and limitations of G.P. out-of-hours services to respond quickly. There seems to be a perception health services rely on police services to manage mental health care until HCPs can attend. There also appears to be an assumption by the participant there would be an agreement between police and the HCP of the level of urgency and risk. As I demonstrate in Chapter 7, there are divergent professional perspectives of risk and PiMD needs which do not always find common ground.

#### *5.2.2.4 Police and Health Manager Perspectives of when Inter-Agency Policies work*

I do not wish to give the impression that all police / HCP managers viewed inter-agency policies and legislation as challenging to work around. Participants reported both positive and negative experiences of inter-agency working. There was an eagerness by some managers to talk about conditions when local joint policies support good practice. These are linked to established positive relationships identified in the previous subtheme within out-of-hours psychiatric services.

In this context, specialist psychiatric services provide out-of-hours assessments for people absent of a physical injury or intoxication. This discussion with an HCP manager illustrates experiences in this area:

*'I think when they (PiMD) are brought here by police …. we've done audits… they get seen relatively quickly. Very rarely do they have to wait over an hour. If they need admission, they get it there and then. We've never ever, ever, ever had a situation where we didn't admit somebody who required admission. It's not like in England where you hear people spending the time in police cells' (HM2)*

Here the health manager discusses an internal audit of police referrals, which the manager suggests, more frequently than not, in this health care environment, when police bring people for assessment they wait for a short time. This may be explained by the direct contact to mental HCPs with specialist knowledge, rather than G.P. out-of-hours services or generalist E.D.

Potentially if the person is known to the mental health services, mental HCPs will have access to an individual's full psychiatric notes, which is not the case in the other identified out-of-hours environments. The PiMD's willingness for assessment, sobriety and absence of any medical health needs can facilitate a swift response. Arguably, therefore, this is not a direct consequence of policy. Rather it is about the context of the environment, PiMD characteristics, staff, resources, relationships, how people understand and work together. However, as I will demonstrate in Chapter 6, police officer and PiMD experiences can vary in this clinical area. At times, they are not experienced as positively as the managers perceive them to be. Additionally, the audit discussed in this quote applies only to this specific area. This does not account for experiences of people in their own homes, the E.D. or police custody, nor of the journey prior to, or after assessment. Thus, this is not fully reflective of the safeguarding journey experiences.

In this subtheme, I have illustrated the policy and legislative landscape in which HCPs and Police care for PiMD is complex. At times it is unaligned nationally, locally and between organisations. Like out-of-hours health service structures identified in the previous theme, legislation and policies in which Police and HCPs work, appears to be organised around people with a medical emergency or serious mental health disorder. Hence, a Place of Safety being in E.D. or a specialist psychiatric service. Nonetheless, these data would suggest referral processes are not aligned to the PiMD needs and service capacity to respond in a timely manner. This is reflected in the participant's commentary regarding out-of-hours priorities and police waiting times.

This suggests current legislation and policies do not reflect the spectrum of PiMD needs. These can shape and change the trajectory of the safeguarding journey in a way that is resource intensive for both services. People can be transferred between clinical areas or wait for extended periods of time in busy health care environments. Yet, there are areas where inter-agency procedures do work and situations when management of PiMD has less impact on one service than the other. These are dependent on a range of circumstances including positive inter-agency relationships, leadership, aligned cross-agency procedures and agreements, sobriety and timely access to mental health or emergency care clinicians.

These data reflect that PiMD can be transferred by police or delayed between services. An aforementioned excerpt describes this as ‘like pass the parcel’. There is evidence of recurrent patterns of services ‘holding’ or ‘minding’ people. This is linked to the previous subtheme which identified some PiMD as sitting outside the priorities of the services identified as a Place of Safety. This reinforces concepts of inflexible or absent inter-agency policies and pathways that see a push between services to discharge care responsibilities. The first subtheme recognises that role expectations and conflicting organisational priorities can contribute to these processes and experiences. This subtheme extends these concepts to gain a deeper understanding of the relationship between gaps in broad safeguarding policies, the availability and appropriateness of clinical services to respond, and the impact of transfer and attempts to discharge care between services.

In the final subtheme in this chapter, I will draw predominantly on participants discussions of two key issues associated with the care and risk management within safeguarding journeys. Central to these conversations were issues in managing PiMD who were intoxicated and the safeguarding by police of those returned to their management after discharge from health services.

### 5.2.3 The Service Shunt

In previous subthemes, there is evidence interpretation of legislation and policies and the specific care needs, such as intoxication, can impact on the safeguarding trajectory. This subtheme considers how these factors influence the experiences of those managing care. The title for this subtheme derives from a police manager account where the term ‘service shunt’ was used to describe the movement of PiMD between services. It captures notions of a jarring, forced push and pull in order to find resolution to the PiMD’s needs in order to discharge care.

#### *5.2.3.1 Managing Intoxication and Mental Distress*

Alcohol intoxication, or the presence of alcohol, was viewed as bringing the highest demand and complexity to the management and assessment of PiMD. The impact of intoxication crossed multiple themes throughout the interviews. Central to this was debate over which service was most suitable to manage PiMD who were intoxicated. This was discussed in terms of perceptions of heightened risk of harm through alcohol use impulsivity, and negative impact on resources whilst awaiting sobriety. There was a resistance or inability for HCPs to assess mental health risk when the PiMD had consumed alcohol. Police managers identified this as delaying information of risk available to them, and resolution of the distress situation, thus impacting on police resources. Disputes over role in the management of the PiMD, whilst awaiting sobriety, saw frustration and a push back and forth of PiMD between services.

There was a sense that Police were left to manage people because there was nowhere else, and it was not a health service problem. This is reflected in the following excerpt by an HCP manager:

> *'I think the police are left with these individuals, but the trouble is they are left with them because nobody else wants them in this day and age, you know, should we (NHS) be the ones to bring provision for them in some way? Should it be a health provision? Well, is it a health problem?' (HM4)*

Within this quote, there is a sense that in previous years there may have been more flexibility between services to accommodate PiMD who were intoxicated. Potentially with the demands on NHS resources, the boundaries around what emergency services should provide has become more rigid. This suggests there is a push back and reliance on police to fill this gap in care as PiMD who are intoxicated do not 'fit' within health service provision. This links back to my earlier findings that out-of-hours health care is organised around people who are viewed by HCPs as time critical or seriously unwell. The point here is that there appears to be a further gap in service provision for some PiMD. As a result, those who are intoxicated may be accommodated by criminal justice services.

A common view amongst interviewees was there was no identified service wishing to take responsibility for PiMD who were intoxicated. Here a police manager points to a burden of additional responsibility in the management of PiMD who are drunk:

> *'That doesn't help with the elephant in the room which is the drunk. If they threaten to harm themselves, alarm bells go off. Nobody, and I've been around a fair while, nobody wants this population' (PM2)*

There is an inference that this is, and has previously been, an historical and problematic issue between, and within, the two agencies due to management complexity, and associated heightened risk. This police manager suggests that, in his lengthy experience, this has been an unresolved, recurrent challenge. However, 'alarm bells going off' is not solely associated with PiMD risk of impulsivity, or other harm related risk. Rather, apprehension is associated with expectations of a long and resource intensive period of management for officers.

The resource challenges and dilemmas associated with managing the care of PiMD who are intoxicated is underscored by an HCP manager. Highlighted below is an expectation that

police retain management of the PIMD until they are fit for mental health assessment, yet as this excerpt suggests there can be circumstances when police officers make referral whilst the PiMD is intoxicated:

> *'I think that's really difficult for each discipline. Doesn't matter where they are or where they pitch up. It's difficult because if they're really drunk there's not an awful lot you can do with them until they've sobered up a bit. I can't believe the police though. They still bring them here. We're saying they're so drunk we can't interview them! We've agreements that would be along the lines of, - If they're fit enough to be interviewed for a crime - we can interview them. If they're not capable, they must be put to a police cell or something. If I was a police officer, a police sergeant, I wouldn't want to let them go. If then something happened…. 'cause you know that is a risk being drunk and intoxicated… so it's very dangerous' (HM5)*

The account illuminates that this HCP appreciates the complications for both services of the management of PiMD who are intoxicated. Yet, if police refer the individual, there is an expectation they should continue to care for the PiMD. HCPs direct police to take the person away and return when the PiMD is sober and when "there's not an awful lot you can do with them". These data suggest that this healthcare environment is unable to support people who are intoxicated, and management of PiMD who are intoxicated is best placed with police officers. There is also suggestion in the above excerpt that there is an agreed inter-agency level of sobriety for referral to health services. Yet, the manager suggests officers present PiMD who are intoxicated outwith these parameters.

It is noteworthy the HCP participant in this interview suggests the risk to PiMD when they are intoxicated is high and 'very dangerous' and require close supervision. Potentially officers are seeking a safe environment providing close medical supervision until the PiMD is sober rather than waiting in a police vehicle for many hours. Local policies guide the transport of PiMD who are highly intoxicated, to the E.D. Yet, as already identified, a busy E.D. is unlikely to be a suitable place to bring intoxicated people to await sobriety, before transporting back to psychiatric services for mental health assessment. The HCP participant suggests a police cell or 'somewhere' under police management could hold a PiMD until sober. Five of the six HCP manager participants reflected a similar notion that police custody was a suitable environment to manage a PiMD who was intoxicated. This could reflect limitations in HCPs understanding of police resources, prevailing guidance, and expertise available to them to manage an individual who was at risk of self-harm and drunk. Alternatively, there is a belief that the historical use of custody to manage drunkenness was still considered a viable option. HCP

participants in this study did not appear to recognise that safeguarding an individual in police custody may be humiliating and potentially harmful. As I will discuss in the next chapter, this type of management can remove an individual of their liberty and dignity, and likely involve coercion.

A police manager provides a different perspective. Here he highlights a belief that custody should never be used in such circumstances:

> *'People in mental health crisis should not be taken to custody. I am absolutely firm on that. No one in my experience in mental health crisis, who is drunk, should be taken into a custody suite and put in a room with the door closed' (PM4)*

This police manager identifies that police custody is an unsuitable environment for safeguarding PiMD who are intoxicated. This is because there is a fear of heightening distress and potential self-harm because of intoxication and confined space.

A further important finding associated with the assessment of PiMD are inconsistencies in accepted levels of sobriety by HCPs to enable a meaningful assessment. Here a police manager talks about variation in HCPs approaches to assessment of PiMD and the impact this has on an operational officer's workload:

> *'It is a bit luck of the draw who they get on the day. Sometimes they get lucky and the person will be seen. Other times it is a no go, and they have to look after someone who is unwell and drunk till the doctor thinks they are straight enough. We just have to go away with them (PiMD) and come back' (PM6)*

Throughout the clinical case interviews and focus groups in the next phases of the study, it became clear there were several clinical arrangements by individual clinicians used to assess sobriety for fitness for mental health assessment. For example, some clinicians used an alcohol breathalyser to ascertain a zero Blood Alcohol Content (BAC). For others a drink drive limit was the indicator. Others suggested a more subjective assessment. In this case, finding a comparable level of cognition (being fit to be interviewed for a crime) can help officers recognise a level of capacity required for mental health assessment. A police manager argues that in other NHS Boards and areas of Police Scotland (outwith the study area), specialist mental health triage programmes have come to a more collaborative agreement for assessment. Here clinicians and officers agree that alcohol affects people in different ways and can see a wide range of BAC levels influencing capacity for assessment. In this NHS area, Community Psychiatric Nurses (CPN's) undertake a mental health assessment based

on the perceived individuals' level of impairment. This, in turn, has seen a significant reduction in the number of people returned to police management until sober. The police manager explains:

> *'I think it is different in different parts of the country. That can be difficult for our officers. We got over that (assessment based on BAC). There was a big shift in that mindset. The situation became quite clear from NHS management that, if the level of impairment or intoxication is not that severe, and a meaningful assessment or consultation can still take place, then one will. Over the six months, there were only four occasions where a person was so drunk, they couldn't be spoken to by the CPN' (PM6)*

There is evidence that in this NHS area (not the study site), there has been a shift in thinking regarding rigid (or inconsistent) criteria for sobriety to facilitate mental health assessment. What is important is that this approach has been adopted in national Police Scotland mental health safeguarding policies. Yet my findings suggest the approach has not been agreed by clinicians in local areas. Given police officers work across a range of NHS Boards, these data suggest they may experience inconsistencies in individual clinicians approaches to mental health assessment and intoxication.

Given the already identified lack of suitable safeguarding environments, inconsistencies in referral criteria bring an additional layer of complexity and contradiction for some police officers and clinicians working within this study area. A police manager highlighted that this finds the PiMD and accompanying police officers in 'no man's land', and potentially heightened risk. Meaning; the PiMD is still intoxicated, yet their risk because of self-harm behaviours is unknown. It is unclear when this may be assessed as there is no identified suitable safeguarding environment, thereby leaving limited opportunities for a timely resolution and officers searching for support. In this account, a police manager describes the shunt between services as police officers attempt to navigate the gaps and inconsistencies in safeguarding PiMD who are intoxicated and highlights the impact of processes on a PiMD:

> *'There was a female who wanted to jump off a bridge. We took her to the hospital She was drunk. They said they wouldn't look at her while she was drunk. Custody was the only option to keep her safe. We took her back in the morning, but she was still drunk. Then she said she wanted to, to kill herself, and she thought about taking pills. She'd thought about jumping off the bridge. For us, we thought it was mental health. She was not a criminal, no criminal record. Nothing at all. We said to her 'we're away to put you in a cell but the first thing we've got to do because you've intimated that you might*

*harm yourself, is to do a strip search'. We then subjected them (PiMD) to a strip search and put them in a cell. And that's our procedure. And there are many, many good reasons why we have to do that. But, you know, does that in anyway help the situation? I can assure you it didn't because she didn't want to be strip-searched' (PM4)*

This description reflects the realities for PiMD and officers where there is no safe place to be cared for until sober. In a previous excerpt, a police manager, identified custody should never be used to safeguard people. However, in this discussion, the manager suggests that often police officers have no other option. He expresses unease about subjecting an already vulnerable and potentially traumatised person to an intimate search to mitigate risk within the custody policies. Potentially officers could use discretion here. However, as I will present in Chapter 7 when officers are faced with decisions relating to mental distress, they align very closely to procedural guidance in order to mitigate any criticism of wrongdoing. Meaning; in some circumstances professional risk aversion can take priority over the needs of vulnerable people.

HCPs may feel unable to conduct an accurate assessment or manage safeguarding in an emergency care environment. These findings provide insights into systems with little flexibility to accommodate this group. This, in turn, potentially exposes PiMD to traumatising procedures and experiences within unsuitable environments-in this case, a custody strip search. As a result of 'protecting vulnerable individuals' and mitigating professional and organisational risk, Police and HCP may potentially be making people more vulnerable.

#### *5.2.3.2 The Homeward Journey with Police Officers following Discharge from Health Services.*

Difficulties in the management of PiMD can remain for police officers following HCP assessment. When participants were asked about PiMD discharge following mental health assessment, police participants raised this as a significant concern in safeguarding journeys. These signalled issues of ongoing risk management for police services because inpatient care was not deemed necessary by an HCP. Meaning; although the PiMD was assessed as not having a mental health disorder and requiring involuntary admission to hospital there remained a level of risk and concern for officers when the duty of care was returned to them.

One HCP manager acknowledged the difficulties non-admission poses for police officers. In this account, the manager talks about discharging a PiMD back to police officers following mental health assessment. This excerpt illustrates the limited options available following mental health assessment during out-of-hours periods. These options are restricted to admission to hospital, or being returned home alone or to a relative:

*'I'm not sure how we're ever going to get that right in a sense, because we are the people that must really frustrate the police. If they don't hit this, this, this and this, then they are not for admission. End of. Then we say - well there you go guys, take them away' (HM2)*

As this participant suggests, thresholds of a significant risk of self-harm and mental disorder must be met to consider admission ("hit this, this, this and this"). This point highlights the medicalisation of psychiatry on safeguarding journeys as discussed in Chapter 1. Those who do not reach the threshold for admission are discharged back to police management for a return home. Nevertheless, as already identified in Chapter 2, many people who express self-harm behaviours do not have a mental health disorder thus are unlikely to be safeguarded in hospital However, they can remain distressed and at risk of serious harm. The HCP in this account recognises how challenging it must be for officers, having been offered no further HCP intervention ('end of'), and unable to discharge safeguarding responsibilities to health services.

#### *5.2.3.3 Police Officers' Perceptions and Management of Risk*

A point raised by five police participants is that of limited communication by HCPs of the assessment or additional guidance, support, or joint planning to help officers on the remaining management journey. A lack of understanding of HCP assessment and limited mental health knowledge can see officers apprehensive in returning the PiMD home. Police officers can continue to observe risky behaviours which concern them and can result in revised safeguarding planning by officers.

In this account, a police manager describes an officer's experiences of weighing up perceptions of risk with limited understandings of the HCPs decision-making:

*'Even if someone is not deemed as having had a treatable mental health condition, they still have issues. They are still a potential risk to us. Generally, nine times out of ten, it means we need to drive them back to their house and leave them. That causes a bit of unease for police officers when they are the last professional body who has had contact with them, and we have not fully understood why they have been sent home. It is when they have to leave them alone. We might feel there is definitely still an issue here, but we have only been told there are no treatable mental health issues, and they will not be admitted. They are not drunk, but they still appear to be unwell.*

*They are still a risk to themselves. This is a grey area as there is no one to look after them. There is no answer to that' (HM5)*

This police manager participant illustrates two key points in this excerpt. Firstly, he suggests there is a gap in care to support people who are not considered to require inpatient care, yet not safe to leave alone at home. Police officers can remain concerned for the PiMD. Despite an HCP assessment that the PiMD does not reach criteria for inpatient care, leaving that person alone comes with a level of professional and organisational risk. However, as this interviewee points out, often there are no other referral options for police officers. Secondly, the excerpt suggests communication of HCPs assessment is often limited. Police officers, at times, do not understand the HCP decision to return the PiMD home and thus do not understand risk. Left with this dilemma, officers will seek internal police support to resolve the risk. Contrary to policy guidance and earlier findings that custody is unsuitable, officers may transfer the person to custody. A police manager explains:

*'We won't take chances, we'll say - well if there's a chance they've not been very well, then we'll generally default to custody. There is no in-between NHS and the police. This is your best option to deal with them, you know. There is no halfway house' (PM5)*

This important point shows a gap in care between hospital and home. Similar to the care of PiMD who are intoxicated, there is a missing pathway for some PiMD which can find them safeguarded in police custody rather than in health services. There is evidence of risk-averse police culture, and a further gap in joint inter-agency information sharing, decision-making and safeguarding environment options. These factors point to a relationship between the structural gaps and how people work within them. The human element in this relationship will be explored further in Chapter 7.

The option to use custody as a safeguarding environment does not completely mitigate risk for police services. Like managing a person who is intoxicated, transferring someone to custody for safeguarding can simply transfer risk and dilemmas to another area of police business. In this excerpt, a police manager explains:

*'We then have a decision to make…is there legislation that allows us to take their liberty away and keep them in a cell? The upside of keeping somebody in a cell is they can't jump off the bridge. The downside is then we take on a slab of risk in case they do something in police custody. That's something we don't want. Just locking*

*somebody up doesn't really get the risk negated. It changes and shifts the risk for us to another part of the police service' (PM4)*

Although the person is deemed safe, in that, custody can limit the immediate access to lethal methods of harm (such as jumping off a bridge), this comes with a cost in taking the individuals liberty away, possibly impacting their human rights. Important to this thesis, although the HCPs did not feel obliged to use their legislative powers to bring involuntary detention in hospital, this police officer suggests they feel compelled to use police powers to safeguard the PiMD in custody after a mental health assessment. Potentially, this could be for several reasons. Police officers may observe an escalation in self-harm behaviours after HCP assessment. Alternatively, there may be a context-specific risk in the PiMD community, which concerns the police officers such as no available support from family or friends. Furthermore, as the interview in the earlier excerpt pointed out, police officers may not trust or understand HCP assessment. Potentially these findings could suggest police and HCP view risk differently, with different perceptions of PiMD, professional and organisational risk.

The police officer manager in the previous excerpt suggests risk has only temporarily shifted from local policing officers to custody officers. The risk appears partially framed around fears of breaching legislative powers of detention, risk that the person may self-harm in police custody and weighed up against professional risk highlighted earlier in this chapter. As one police interviewee pointed out, the risk is associated with the police officer's concerns of being the 'last professional body who has had contact with them'. This alludes to special investigations associated with the death of a person 48 hours after police contact conducted by the Police Investigations and Review Commissioner (PIRC). The fear of such an investigation may go some way to explain such risk-averse measures.

By way of contrast, HCP managers in these interviews did not appear so compelled. These findings suggest HCPs may have a different perception of risk and feel able to transfer any potential risk back to police officers. Yet, as this interviewee highlights, when no other routes to manage risk in the community are available, more coercive measures will be adopted to manage organisational and professional risk of an individual completing suicide following discharge from police officer management. The mitigation of individual and professional risk may therefore be strong motivators and drivers of the safeguarding journey trajectory. These concepts of professional risk and motivation for referral and discharge are explored further in subsequent phases of this study.

In sum, this subtheme has focused on two key factors on the safeguarding journey; these being the care of PiMD who are intoxicated, and the onward journey post mental health assessment. These data illustrate for some PiMD these journeys are not linear and can involve being managed in the criminal justice system. There is a push back and forth between services to discharge care responsibilities, limited options for care, gaps in alternative safeguarding environments, and variation of professional perceptions of risk. These factors can influence the safeguarding trajectory. Significantly, there are inconsistencies in acceptable levels of PiMD sobriety to conduct an accurate mental health assessment. Such inconsistencies can contribute to transfers between services. Yet, one of the noteworthy findings in this subtheme is, as a result of these gaps and inconsistencies, police custody can be used to manage risk. This could suggest that HCPs and police officers are primarily reactive to risk rather than the direct needs of the individual. Consequently, there is a sense there is no space in the system to support this population, responsive to their needs.

## 5.3 Chapter Summary

In this chapter, I presented a critical analysis of Police and HCP managers' accounts in the first phase of this study. These interviews provided a useful foundational understanding of the nature of the police/out-of-hours health service interface in the care of PiMD. Several key points identified were brought forward for exploration into the next phases of data collection.

Firstly, out-of-hours health care, safeguarding legislation, policies and mental health assessment appear to be organised around medicalised problems and serious psychiatric disorders. Such policies can shape Police referral into an out-of-hours health care system with competing demands, which does not appear equipped to support PiMD needs. Failings in this system, and how Police and HCPs respond to these shortcomings, appear to find the management of PiMD falling to police services. Relationships between these failings can create situations perpetuating a cyclical journey for PiMD through the criminal justice and out-of-hours health services.

Secondly, these accounts have shown there are circumstances where the service interface works well at a strategic level, but only in certain circumstances in practice. These circumstances are dependent on certain conditions and contexts. This is most likely to occur when the PiMD is sober, where there are no co-occurring medical conditions, access to expertise in mental HCP assessment, and is outwith the person's home environment. Agreed organisational processes are a poor fit beyond such circumstances and present legislative and resource challenges which impede smooth transitions of care. A lack of alternative

safeguarding environments can find police officers reacting to organisational and professional risk and driving the use of police custody to keep people safe.

Particularly problematic conditions are when police officers remain concerned for an individual's safety post mental health assessment and for those who are intoxicated. What is significant from these findings, and a key point emerging from the interviews is that there is evidence of a breakdown in the joint policy agreements for the care of PiMD who are intoxicated. Both services understand the heightened risks, yet there is a clear lack of appropriate safeguarding environments available in either service. This, in turn, sees a push back and forth between services to accept risk responsibility. The findings illuminate no suitable pathway of care for this group, with PiMD displaced between services. It shows services trying to work around guidance and available resources yet do not take into account what is best for the individual.

Finally, my interpretation of these findings is that there is a sense of disconnect between governance ambitions for inter-agency collaboration and the realities of operational working. Despite positive professional relationships, services appear to work in conflicting ways. HCP managers appear clear and firm about their core business and service boundaries. By way of contrast, police managers reflected undefined boundaries and an organisational culture which has seen police services absorb mental health responses in the community. There is a sense that the safeguarding of PiMD has become caught up in these gaps and boundaries. Managers provide a bleak overview of the service interface which appears crisis and risk driven, and 'going through the motions' by policy, rather than finding lasting resolutions for the PiMD.

In the next chapter, I extend these findings by critically exploring the experiences and perceptions of those directly involved in safeguarding journeys. These phase two (subunit 2) findings explored experiences of three women who experienced mental distress safeguarding, and the professionals involved in their care. This subunit seeks to provide a deeper understanding of the experiences of PiMD looking for support, and how Police and HCPs respond to their needs whilst intersecting with the shortcomings identified in this chapter.

# Chapter 6: Phase Two – In-depth Clinical Case Interview Findings

## 6.1 Introduction

In this chapter, I present a critical analysis of the data from subunit 2 (phase 2) of the study. Here I report on accounts from three clinical cases. These individual clinical cases involve three women who came to police attention in mental distress and the Police Officers and HCPs involved in their safeguarding. These data bring together experiences of people with lived experience of mental distress, and professionals' perspectives, illuminating the multiple viewpoints of safeguarding journeys and illustrating the nuanced experiences of those involved.

The semi-structured interviews in this phase were conducted three months after the initial coding template of the managerial interviews was conducted. Emerging key themes from the manager interviews drew my attention to organisational processes, gaps in care for PIMD who were intoxicated, competing priorities, gaps in service structures and inter-disciplinary relationships identified in subunit 1 (phase 1). This second phase extends these findings to support understanding and the interplay of expectations, relationships, experiences of mental distress, and operational Police Officers and HCPs involved in safeguarding journeys.

In addition to an exploration of the safeguarding journey at the centre of each clinical case, I was interested in each participant's previous experiences of seeking help and support. Given this study is underpinned by a broadly social constructivist theoretical approach, previous experiences may have shaped how participants viewed their social worlds. Being socially constructed, these may have a bearing on current and future help-seeking behaviours and care management perceptions, relationships and experiences.

Table 4 presents a breakdown of the participants interviewed in each clinical case; the woman; police officers attending to them; and the HCP involved in their care. In order to maintain anonymity, the women were given pseudonyms. Professionals were allocated a code reflecting their profession and clinical case in which they were involved. For example, P1C2 relates to police officer 1 in case 2. HC3 refers to the health care professional in case 3.

| Case | PiMD | Health | Police |
|---|---|---|---|
| 1 | Jess | G.P.<br>(HC1) | 2x Police Constables<br>1x Police Call Handler<br>P1C1, P2C1, P3C1 |
| 2 | Fiona | FY2 Doctor<br>(HC2) | 2x Police Constables<br>1x Police Sergeant<br>P1C2, P2C2, P3C2 |
| 3 | Deb | Out-of-hours G.P.<br>(HC3) | 3x Police Constables<br>P1C3, P2C3 P3C3 |

*Table 4: Semi-structured interview participants per clinical case*

The women were interviewed at home and professionals, their workplace. In total, 21 hours of interview audio recordings were transcribed verbatim. 15 interviews were conducted over three cases, with each interview lasting between 1 hour and 1 hour 30 minutes.

This chapter opens with a summary of three safeguarding journeys drawn from the three clinical cases central to this phase, thus providing a background to the findings. Synthesised detail of each case has been drawn from my field notes, data from the interviews, and the womens' police and medical files. 'Clinical case trajectory' notes within the appendix summary highlight specific characteristics and context of the individual safeguarding journeys (Appendix 18).

Each clinical case presents a snapshot of different safeguarding journeys with a variety of 'start and end points'. These cases reflect a range of contexts and factors influencing the trajectory of the safeguarding journey. The mapped safeguarding journey for each woman is presented at the end of Chapter 1 (Figure 1 pg.19). This is followed by a summary of the social and psychological backgrounds of each woman.

| Case | • Start / • End Point | Safeguarding Journey<br>Context Summary |
|---|---|---|
| **1**<br>**Jess** | •Home only • | • Jess calls NHS24 from her home stating she wished to self-harm.<br>• NHS24 request immediate police response.<br>• Officers stay in attendance until an over-the-phone mental health assessment conducted by out-of-hours G.P.<br>• Police manage the distressing episode in Jess's home.<br>**Total time of safeguarding journey 4 hours** |
| **2**<br>**Fiona** | • Public place → Out-of-hours psychiatric service → home • | • Police called by Fiona's mother saying her daughter had left home wishing to complete suicide.<br>• Police found Fiona on a carpark rooftop and persuaded her to come to safety.<br>• Fiona transferred by police to Out-of-hours mental health services.<br>• Police stay in attendance.<br>• Fiona returned home after a mental health assessment.<br>**Total time of safeguarding journey 7 hours** |
| **3**<br>**Deb** | • Home → police custody→ home • | • Police called by Deb to her home during a domestic incident. Deb highly intoxicated and says she wishes to complete suicide<br>• Officers stay in attendance. Out-of-hours G.P. attends but unable to conduct assessment due to Deb's intoxication.<br>• Deb arrested to enable safeguarding in police custody. Returned home the next day.<br>**Total time of safeguarding journey 14hours** |

*Table 5: Summary of clinical cases*

The Social and Psychological backgrounds of the Women Participants.

**Jess** lives alone in a small one bedroom flat, rented from the city council and located in a small block in the city centre. She has a long history of self-harm and periodic engagement with health and social care services from the age of 14. Jess left school at 16 and has experienced long periods of unemployment since then. She is quite isolated in her community, with her parents living 40 miles away. Although supportive, Jess's parents set boundaries around her calls when she feels unable to control her self- harm behaviours, meaning Jess does not call on them for support at times of crisis. Jess states she does not have many friends or relationships with neighbours, explaining she has 'burnt bridges' when intoxicated or in mental distress. She has experienced multiple violent and abusive relationships with men.

**Fiona** lives with her parents in an affluent suburban area of the city. She has a long history of self-harm, intoxication and violent behaviour since aged 15. She studied at university, leaving in second year due to increasing self-harm. Fiona works periodically in the banking sector, but currently is on long-term sick leave due to her low mood. Fiona has periods of engagement with outpatient psychiatric services. Although She has friendship groups, most friends are in long term relationships and only see her periodically. Fiona states she finds it difficult to sustain any close relationships. Her parents are supportive; however, they find it difficult to manage Fiona's behaviours and have called on police officers when Fiona is intoxicated and violent.

**Deb** lives alone in a small one bedroom flat, rented from the city council, located in a large block in an area of deprivation within the city. She is in a long-term relationship with a man who often stays over at weekends. Their relationship is often violent following periods of heavy alcohol use,yet, Deb states, on the whole, the relationship is loving with both Deb and her partner reliant on each other for companionship. Deb works in a local shop but is currently on long-term sickness leave due to her low mood. She has an adult daughter who lives 100 miles away although their relationship is fairly good, the daughter is unable to support her mother due to her own mental health needs and the distance between them. Deb is isolated in her community as a result of the frequent violence between her and her partner. She is proud of her home, investing much of her time and money in keeping it clean and tidy.

## 6.2 Findings

Findings from the three clinical cases are presented collectively. I present a range of views expressed from across those involved in the three safeguarding journeys, so building a deeper understanding of professional viewpoints, the women's needs, service priorities and policies and professional practice influences. Using an inductive approach, I now present an overarching theme and three subthemes developed from analysis of these data (Diagram 13).

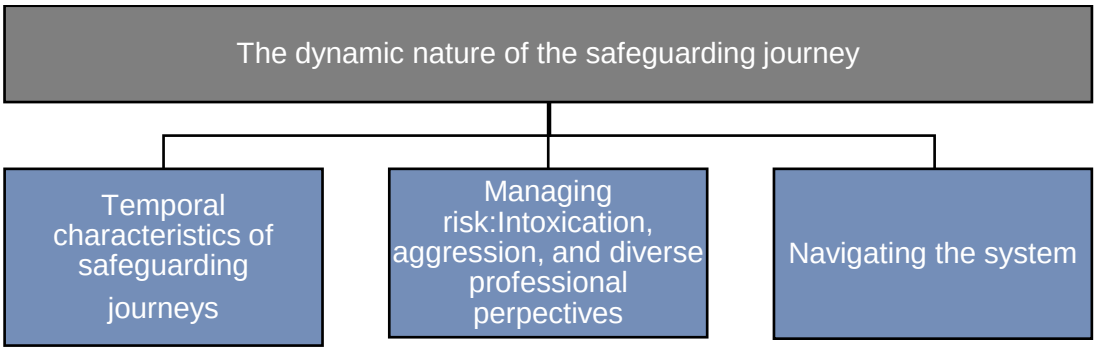


*Figure 2: Overarching theme and subthemes phase 2*

### 6.2.1 Summary of themes

The overarching theme in this phase was an original a priori code identified early in the analysis - ***'The dynamic nature of the safeguarding journey'***. A recurring theme in the interviews was a sense amongst interviewees that there was a relationship between external factors, such as shortcomings in the system, and PiMD participants' experiences of distress. Individual factors (e.g. impulsive behaviours whilst intoxicated), organisational factors (e.g. police custody safeguarding procedures) and environmental factors (e.g. hospital waiting areas when chaperoned by police) were inter-related and viewed by all three women as influencing their experiences and the course of their safeguarding journeys. These Inter-related factors and experiences are reported under three underpinning subthemes: ***'Temporal characteristics of safeguarding journeys'***, ***'Managing risk: Intoxication***, ***aggression, and diverse professional perspectives'*** and '***Navigating the system'.*** As I will show, there is an interplay between the subthemes, which reflect the dynamic nature of safeguarding journeys.

The first subtheme ***'Temporal characteristics of safeguarding journeys'*** concerns participants' accounts of the importance and meaning placed on time throughout safeguarding journeys. Participants discussed time in a variety of ways. For example, the urgency of timely distress support, the timing of distress calls, the impact of waiting time for HCP assessment, and time as a resource.

The second subtheme, '***Managing risk: Intoxication, aggression, and diverse professional perspectives'*** developed through my analysis of professionals' responses of managing risk across safeguarding journeys. Prominent in the data were three key, inter-related risk management factors shaping the safeguarding trajectory and participants experiences. Firstly, the womens' experiences of mental distress, intoxication and being safeguarded by police. Secondly, professional participants' experiences of management of intoxication and aggression during safeguarding. Thirdly, and linked to intoxication and aggression, this subtheme presents findings of the influence of diverse professional understandings of risk during safeguarding.

The final subtheme '***Navigating the system'*** emerged from the analysis of participants discussions of their experiences, and responses to system shortcomings across their safeguarding journeys. A theme recurrent in the interview data was a need for the women, police officers, and to a lesser extent, HCPs, to work around out-of-hours health and police systems to ensure safety. This subtheme presents the impact on participants and the trajectory of care through navigating the system.

## 6.3 Temporal Characteristics of Safeguarding Journeys

In the previous chapter, the findings suggested policies and out-of-hours health services are organised around medicalised problems and highlight a missing pathway or service for those who do not have time-critical emergencies. The findings in this section built a picture of how participants experienced shortcomings or gaps in the system. Central to these findings was the relationship between PiMD experiences, and how professionals work within shortcomings or gaps.

In this subtheme, I present my interpretations of participants' accounts of the importance and relevance of time across the safeguarding journey. All PIMD participants identified time as having both impact and meaning on their experiences during or after safeguarding and this was discussed in two ways.

Firstly, time in relation to timeliness and timelines of the safeguarding journeys. For example, professional participants identified time as influencing their actions, decision-making, perceptions of inter-agency relationships and junctions on the timeline of the safeguarding journey. The women discussed time in relation to the need for an urgent response, timing and timeliness of out-of-hours help-seeking and experiences of waiting.

Secondly, professional participants identified time as an essential resource.

### 6.3.1 Timing, Timeliness, and the Timelines of Response

The majority of participants agreed timing and timeliness of safeguarding responses had an important meaning as to how safeguarding journeys were initiated, progressed and experienced.

Talking about issues of cyclical out-of-hours responses to mental distress, Jess's G.P. suggested there was a relationship between the timing of distress calls to police and the influence of night-time alcohol intoxication. Like Fiona and Deb, experiences of mental distress and out-of-hours help-seeking tended to co-occur with episodes of evening and weekend drinking. This was viewed as influential in perpetuating night-time, rather than daytime, self-harm behaviours, and initiating support through available emergency services:

> *'Because alcohol is involved; any sensible thing you say during the day goes out the window. The way and time she needs to seek help changes with alcohol' (H1C1)*

In this account, the G.P. suggests daytime conversations about distress coping strategies are ineffective when Jess has been drinking alcohol. 'The way and time…' suggests, that for Jess when she is sober, she can manage her distress differently. However, alcohol use can influence negatively on her internal coping strategies, the timing of self-harm behaviours, and to whom she turns for help.

Jess confirmed this impression in her interview while talking about difficulties in controlling urges to self-harm in the early hours of the morning when she has been drinking thereby influencing the timing of when and whom she calls. In this account, she comments on her feelings of distress and need for calm, stemming from difficulties in accessing immediate HCP support at a time she needs it. In this account, Jess explains how she works around a lack of community based out-of-hours health services. This, in turn, finds her navigating emergency services in order to get a police response:

> *'Sometimes when I've had a drink, I'm feeling really, really low and bad and stuff, erm, it's usually when there's nothing, you know, it's like about 2, 3 o'clock in the morning. So, there's nothing else there. That's another reason why I phone the police. I know they're not qualified to help people like me, but it's kind of the only solution really. If I was able to speak to a nurse at that point or just, you know, like speak to somebody*

*that could've like calmed me down and reassured me. Instead of having to get the police up here' (Jess)*

Despite recognition that police officers may not be best suited to support her needs, these findings illustrate prompt access to out-of-hours health support is important to some PiMD. Jess finds she is unable to access HCP support when she needs it. She works around the system to access police to help manage her anxieties and has an awareness of their availability and will respond to bring resolution to her distress. This evidence chimes with manager perceptions of police officers filling gaps in health service provision as identified in Chapter 5.

A common view held by police interviewees in all three cases was that, although police fill a gap and bring a swift response, their presence may reduce the urgency for HCP support. Therefore, they are unable to discharge care. An officer who attended to Jess on this and other occasions, suggests her help-seeking calls to NHS24 will trigger an emergency police response. This officer suggests that once police attend, health services are unwilling to provide timely support to allow police officers to discharge care and attend other police work. When no longer triaged by HCPs as an emergency, officers waited for four hours in Jess's home for HCPs to re-engage:

*'She is at the top of the queue when she phoned NHS24. She gets police attendance immediately and then; apparently, that is the end of medical treatment when she gets two cops. She then goes to the bottom of the queue again and has to wait 4 hours plus, for them to get back. The impression is they've prescribed two police officers. As if it's a medical treatment and then they consider their job done and wash their hands of it. They wait for us to call them again and put us at the bottom of the queue again. Well hold on, I'm not the patient. I didn't call you, this person called you, and you've sent me here to make sure she's safe. She is safe. Now that we know she's safe, can we continue her treatments? Well yeah, we can continue her treatment three, four hours from now when we decide to contact you back 'cause we're too busy doing other things'. That's the impression' (P2C1)*

In this account, these data highlight a sense that this officer feels aggrieved by HCPs when the police prompt response is not reciprocated by HCPs. There is a sense police officers are used or 'prescribed' as part of the treatment, thus reducing the urgency for a follow up medical response. Police officer feelings of being used as a triaging tool for HCPs may be compounded when, according to the police files, four hours after the police arrived, Jess's 'over the phone'

mental health assessment was brief, lasting four minutes. In short, these data suggest that for Jess, police have addressed her immediate distress and safety needs. However, police officers feel unable to discharge responsibilities until an HCP conducts an assessment. In other words, there appears to be an impasse at this point in the safeguarding journey for police officers. This could contribute to inter-agency tensions.

An alternative perspective on the timeliness of HCP triaging is presented in an interview with the out-of-hours G.P. who visited Deb. This account brings detail to the realities when managing multiple competing medical emergencies. Here he reflects on the context of his workload on the evening police request him to conduct a Place of Safety (POS) assessment for Deb, who was highly intoxicated and threatening suicide:

> *'Suicidal thinking makes us nervous, but imagine you're doing home visits at night. You have about four visits, two of them are people with possible sepsis, unwell and they might die. One of them has cancer, in a lot of pain. Then you see this drunk woman. So, they (police) can't really come over pissed off when you put it in context' (HC3)*

In this account, the G.P. acknowledges suicide risk yet this is balanced against competing critical care he must provide to others that evening. He highlights the risk of mortality for others and his decision to triage Deb and the escorting police officers, after others. Comparatively, given the limitations on out-of-hours G.P. time, and the realities of being able to respond in a meaningful way, people who may be alone and with more time-critical medical needs must take precedence. The risk of serious harm for Deb is reduced significantly; given police bring assessment and management on the scene. Similar to the officer attending Jess in the previous account, there is a sense of poor communication and lack of awareness of service demands and the circumstances in which they each work. Put simply; these findings suggest a lack of resources and consultation between the two services to manage PiMD in a way that recognises the time demands on both emergency services.

The three cases reflect a variety of experiences for PiMD in the liminal space between an immediate police response and HCP assessment. In each case, police spent a significant time waiting for HCP support. In these three cases, this ranged between 4 and 14 hours. Waiting with police held a different meaning for each woman. This was dependent on the context of the environment in which they were 'minded'. For example, whether it was in custody, home, or a healthcare environment.  A common view was of embarrassment and lack of dignity in the publicity of their encounters with police. In this account, Fiona reflects on feeling humiliated

when seen, escorted by police, in a public place. Here Fiona talks about her experiences of a four-hour wait in a police car, at the psychiatric hospital with officers:

> *'There were three cars (police) there in the queue. I've heard people wait there for up to eight hours. I remember a police officer took me there before. So, I knew from before there could be a whole days' worth of wait before people can see you. It's awful. You are waiting in a police car. It isn't great. It would be good to have somewhere else…not a public waiting room either. You're just kind of sitting in a car in a queue. Not ever knowing how long you're going to be there. I know they are short-staffed, so you have always got that in the back of your mind' (Fiona)*

This account suggests that transportation and waiting with police officers for health assessment can be stigmatising for PiMD. Lengthy wait times, particularly sitting within a marked police car, extends and intensifies visibility. Not knowing the extent of the wait appears to contribute to shameful experiences and distress. This resonates with Deb's experiences. She asked officers to drop her off at a distance from her home after her arrest and overnight safeguarding in custody. By walking the remainder of the journey to her house, she hoped her neighbours would not see her leaving the police vehicle:

> *'They drove me hame (home). I was shocked they gave me a lift hame. I told them to drop me off at the top of the road so as no one here would see me' (Deb)*

The negative publicity and stigmatisation of a police chaperone, and lengthy wait time in public waiting rooms or police vehicles, appear to have important implications for how PiMD experience the safeguarding journey. This suggests periods of waiting with police officers, or returning home, be managed more discreetly.

In contrast, for Jess, the lengthy wait time spent with officers in the privacy of her home, brought a space for calm and control. This saw her urge to self-harm dissipate and recover. In this circumstance, the officers' presence appears appreciated. This suggests the context of wait time in police attendance can have a different meaning for PiMD. Jess discussed time with police officers as valued in keeping her calm and secure. In this account, she reflects on previous experience of police officers bringing her security in police custody:

> *'I was feeling very, very anxious, and I wanted to self-harm. If you have a look over there (points to the kitchen area), my kitchen drawer. I'd pulled that out trying to find a knife. My neighbour phoned the police. I got taken into custody. I get put in this blue*

*suit (suicide prevention garment). I get checked like every 45 minutes, half an hour, you know. Like, one of the ladies will shout through 'are you okay?', yep. It was terrifying, but at least I knew I was safe. In the early hours, in the morning, a doctor came and spoke to me and just asked why I was like that. I usually get given a Valium. I felt embarrassed that I had to be in that situation, but at the time I needed it' (Jess*)

These data contrast with the findings in Chapter 5, which reflected critically on custody as a poor environment for PiMD. However, Jess talks of the importance of 'time out' to her safety, within a controlled environment, when unable to self-control urges to self-harm. Although Jess found elements of the experience terrifying and embarrassing, she brings an alternative perspective to police interventions in her protection. My interpretation of these data is that, although Jess identifies the enforced safeguarding as necessary, potentially the value lay in the provision of time, feelings of being supported, direct access to a police HCP, and controlled space where others managed her safety. This comes balanced against being frightened, a loss of dignity and embarrassment of being kept safe in a 'suicide suit'. This illustrates the overwhelming nature of distress and the need for relief. It also reflects failings in the system central to this thesis. Custody may bring a controlled environment to support safety, yet according to these data, it can come with a price for the PiMD.

Nonetheless, in this circumstance, it was the only option available. This suggests a lack of alternative safeguarding environments outwith the criminal justice and emergency health systems to support PiMD needs with dignity.

### 6.3.2 Time as a Resource

All professional participants spoke of the importance of time as a resource. HCP participants discussed caring for PiMD within a system which was already time poor. Police officer conversations focused more on the impact of time taken to respond to PiMD on other areas of police business (for example, transporting to and waiting at the hospital and transporting home).

#### *6.3.2.1 Waiting Time*

An interview with an officer supporting Fiona illustrated the impact on police resources while waiting in a queue during out-of-hours, in the psychiatric hospital Here, eight officers were waiting at the hospital with four PiMD; highlighting the lack of police availability to respond to other calls:

*'there were three police cars in front of us with other patients, therefore, we would likely be there until the completion of our shift. So, that was the reality. That meant every unit there, was unavailable for the rest of that time' (P1C2*)

In all three cases, police participants identified 'writing off' officer shifts and being unable to respond to other calls while waiting for HCP assessment. The description of chaperoning PiMD in this excerpt conflicts with the HCP manager's discussions of fairly short police waiting in Chapter 5. This suggests there are circumstances where operational officers' experiences differ from the perceptions of senior managers of wait times.

Like the police officer's perception of being drawn away from competing police work, the HCP (FY2 Junior Doctor) attending to Fiona that day, talked about the impact and demand of police referrals on his workload. Here he talks of being drawn away from inpatient priorities to assess a PiMD brought to unscheduled care psychiatric services. As he explains, these can be lengthy, yet there is a conscious effort to attend to these promptly:

*'In my mind seeing a PoS is high up on the agenda as people are waiting. You are not going to do six Kardexes rather than see the PoS, as there is a clear difference there. But it can be a bit more challenging, as there are only two junior doctors on, and one is up in the general hospital at the E.D. That leaves just one. If you are in the middle of seeing a ward patient or even just started seeing a new patient, which we often are, especially at the weekend, you are not going to back out of that. That can take about an hour and a half. A full assessment of a new patient with a full psychiatric assessment, never mind the physical stuff on top of it, is easily an hour to two hours. Here you are in something for a long time' (HC2)*

This excerpt brings an HCP perspective on the impact police referrals of PiMD have on out-of-hours health services. Here there is an understanding that PiMD and police are waiting to be seen. Contrary to some police officers' perceptions identified earlier in this chapter, there was an awareness people are waiting. Efforts were made to see them promptly above other routine tasks. The HCP highlights that responding to PiMD is a priority over routine ward-based work.

Nevertheless, with limited staff, there are competing inpatient responsibilities for HCPs. These can demand time and focus without interruption. With the doctor unable to attend to police referrals promptly, PiMD and police may have an impression that they were of less importance. These data suggest for this doctor, this was not the case. From an HCP perspective, they

were prioritising important tasks, getting on with their job, with the resources available to them. The queue of police referrals found this FY2 doctor conducting four back-to-back assessments, each lasting a minimum of one hour and illustrates the impact of police referrals on HCP resource. In this case, police referred mental health assessments drew the HCP away from the wards and the care of people with serious mental health issues. My interpretation of these data suggests that inter-agency systems and processes, whilst responding to PiMD, impacts both organisations.

This can have a knock-on effect, and unintended consequences on time resources of all involved, not only police officers. Considering the impact on public sector resources, these findings reinforce a key argument in this thesis that there is evidence of a systems problem between health and police. Inter-agency policies are not aligned to practice realities, resources and the needs of PiMD.

An interview with Jess's G.P. also highlighted the significance of time as a health care resource. I conducted this interview after an attending police officer participant highlighted a history of a high number of police concern reports sent to Jess's G.P. and local authority Adult Support and Protection Team (Social Work). These concern reports followed multiple police-led out-of-hours responses to Jess seeking support to prevent serious self-harm. Some of the police reports appealed for a cross-sector approach to disrupt a cycle of intoxication, distress and reduce demand on police and emergency out-of-hours health services. The Adult Support and Protection Social Work correspondence reflected Jess did not reach the legislative criteria for support as she did not have a mental health disorder. Her G.P. file showed 76 records of distress episodes involving police and health services within 12 months. Most interactions reflect the same pattern of out-of-hours calls to police or NHS24, two police officers attending, and lengthy waits for HCP engagement by which time her distress had settled. I was curious to understand the G.P.s perspective on engagement with Jess and responses to police correspondence. Here he talks about time pressures on primary health services as a significant barrier to a follow up daytime face-to-face appointment with Jess or inter-agency collaboration to disrupt cycles of repeat out-of-hours emergency responses:

> *'This is just an example. These are the people who have called today to speak to a doctor (9.20 am. G.P. shows call list on the computer screen). There are already 40 people called in the last one and a half hours who are trying to get a house call or just speak to a doctor to get advice. That gives you an idea of the demand. If she (Jess) was in the middle of that and is a frequent attendee, she will get downgraded. Or a*

*police concern report. It will not be seen. So, it is just to let you see what she is up against in relation to getting an appointment' (HC1)*

The call volume reflects the demand for the G.P.'s time. Identification of Jess as a frequent user of G.P. services suggest access may be limited in fairness to appointment requests by other patients. Therefore, timely engagement with Jess after her out-of-hours safeguarding experiences will be less of a priority than that of other people wishing daytime support. Placed in this context, it appears that follow up engagement is difficult when people are no longer in crisis, and their needs are considered less urgent than others. In this case, the G.P. was motivated to work with other services to help disrupt recurrent patterns of distress and out-of-hours responses. However, the daily demand for a busy G.P. practice did not appear to allow time for any flexibility to engage with inter-agency collaboration. Put simply, despite inter-agency policies guiding information sharing of concerns for people who may be vulnerable; there appears little flexibility in primary health care to engage with cross-sector working in order to disrupt recurrent out-of-hours safeguarding journeys.

In this subtheme 'Temporal Characteristics', I have shown that, in the context of these clinical cases, time plays a vital role throughout the safeguarding journeys, experiences and interactions between the women, HCPs and Police. Taken together, these data highlight a relationship between PiMD feelings of urgency to be kept safe, timing and type of out-of-hours calls for support, Police and HCP triaging, competing time demands, and out-of-hours resources. These inter-related factors can contribute to the safeguarding trajectory during and after the immediate emergency response. In the context of this thesis, the findings from these three cases bring focus to the compounding effect of resource-intensive responses, on already time-poor police and health services, and the PiMD. This suggests there is a need to develop a deeper understanding of the broader impact of safeguarding journeys on public sector resources.

In the previous chapter, my interpretation of the findings suggested that police and health service policies, legislation and out-of-hours services are organised around medicalised problems and show a missing pathway or service for those who do not have time-critical emergencies. The findings in this next section illustrate how shortcomings in safeguarding systems play out in practice. In this next subtheme, I build on the dynamic nature of the safeguarding journey through the exploration of the impact of intoxication, aggression, and the perception of risk within safeguarding journeys.

## 6.4 Managing Risk: Intoxication, Aggression, and Diverse Professional Perspectives

This subtheme evolved through recognition of the relationship between PiMD intoxication and aggression, professional perspectives of PiMD needs, and police and health service organisational risk. All participants viewed these inter-related factors as influencing the course of the safeguarding journey. For the women, risk when intoxicated was associated with managing escalating distress behaviours, and police officer responses to their intoxication and aggression. Also, two divergent and often conflicting discourses emerged in professional participants experiences, perceptions and responses to PiMD risk of serious harm. These appear to work in opposition, resulting in inter-professional tensions and convoluted safeguarding journeys.

### 6.4.1. Intoxication, Aggression and Managing Risk: The Influence on Distress Behaviours

Chapter 5 found inconsistencies in local and national policies as a factor influencing inter-agency responses to PiMD who were intoxicated. Intoxication coupled with aggression were recurring issues arising from the data in this phase. Participants' discussions focused on two main areas. Firstly, the influence of intoxication and distress on the loss of control and aggressive behaviours and secondly, the professional response to the management of risk when the PiMD is distressed, intoxicated and aggressive across the safeguarding course.

All three women identified that intoxication could influence their control, impulsivity, urges to self-harm, and aggression to themselves and others, raising the likelihood of coming to the attention of the police. For example, Deb initially called the police to her home during an episode of heavy drinking and domestic abuse. During this time, she intimated her suicide intent. However, because she was so highly intoxicated, the out-of-hours G.P. was unable to conduct a mental health assessment. With no other choice available, this forced officers to use police custody to keep Deb safe which, in turn, increased Debs' anxiety and aggression towards officers.

Furthermore, to manage her safety, officers used handcuffs to manage the risk of serious harm, which further elevated Debs' anxiety and aggression. These factors, when viewed together, reflects a relationship between intoxication, distress, aggression, gaps in structures and methods to manage risk. These points will be explored further in the next section where Fiona talks of similar previous experience of alcohol and self-harm as a catalyst for aggression towards police.

#### *6.4.1.1 Fiona's Experience of Distress, Intoxication, and Aggression*

An interview with Fiona illustrated that for her, thoughts of self-harm during heavy alcohol consumption could act as a catalyst for aggressive outbursts and loss of control. In this account, she reflects on an incident when she was highly intoxicated and wishing to self-harm. For Fiona, a call to police was viewed as the quickest way to manage her safety when she no longer felt unable to do so:

> *'Self-harm and drinking. I was just in a massive state. It's been like that a couple of times, where I have been aggressive, like throwing stuff and things. But I have been extremely distressed. If you phone a doctor to come out, you will have to wait a long time, and they wouldn't be there on time. As I said because I was in immediate danger, they (police) are probably the first people you could think that could appear on the scene as quick as possible' (Fiona)*

This highlights that Fiona has an insight into the heightened level of personal risk associated with self-harm and intoxication, and urgency to bring control. Linking back to the previous subtheme associated with timeliness of support, Fiona did not view a call to an HCP as bringing the timely safety a police response could deliver. Thus, police attendance brings the immediate control Fiona seeks.

However, as the next excerpt will show the combined factors of intoxication, aggression and police involvement at this point, can change the trajectory of the safeguarding journey from a health service referral towards the criminal justice system. Here, Fiona recounts an incident when police were called directly for support, yet because she was intoxicated, aggressive and was unsafe to be left alone, she was arrested and managed in custody:

> *'There are times where I have wanted to hurt myself and been aggressive. They (Police) were like…' well, you can't stay at home'. I've said I have nowhere else to go. Then, of course, because I had some drink in me, it just escalated and… erm, I ended up having my hands tied behind me and slammed against a police door. Taken to the cells like a criminal been like strip-searched, cavity searched' (Fiona)*

Fiona's account illuminates that under certain circumstances, distress and intoxication behaviours, professional responses to risk and systems gaps can shift the trajectory of the safeguarding response into the criminal justice system. There was evidence of police officer tension in being able to leave Fiona at home when she is at risk of harm, against police responses to her aggressive behaviours. These factors combined appear to escalate to arrest,

bringing exposure to coercion and police custody processes such as strip-searching. On one hand, Fiona was aware of a need to call the police to prevent serious harm. Nevertheless, her intoxication and aggression compromised her distress management. Although Fiona was kept safe from self-harm, there is evidence of exposure to trauma because of the custody environment and safeguarding processes discussed in Chapter 5. These data point to a connection between the complexity of PiMD distress behaviours and police procedures in order to manage safety. Taken together, these data can help pinpoint several factors shaping the course of the safeguarding journey and experiences of the PiMD.

### 6.4.2 Diversity of Professional Perspectives of Risk - Debs experience

As the interviews in this phase of the study progressed, I became more aware of the nuance in HCP and police officers' professional perspectives, interpretations and approaches to risk shaping responses on the safeguarding route. These were underpinned by professional tolerance to risk, processes to manage risk and knowledge of self-harm and suicide risk management.

The diversity in professional understanding reflects tensions between police officer perceptions of individuals need for safety in hospital against the HCPs assessment of PiMD to be returned home by police. In this account, a police officer discusses experiences of attempts to transfer a PiMD to inpatient care whom he has judged to be at serious risk of harm:

> *'I'm not medically trained, so I need that reassurance that I can leave that person in their care. Have I taken people there who have been admitted who I believe needed to be admitted? Yes, and it does work well in some cases. But I've also taken people I believe should be admitted and they are not. That concerns me. I know it's not going to be me that's made that decision, but ultimately you do feel a certain degree of responsibility for the people you're taking in. If I deem a person does not need to go there, then I would not take them. So, it does sometimes feel that you are being contradicted' (P2C2)*

There are inconsistencies within this account. On one hand the officer talks about a lack of medical knowledge as being a catalyst to seek health expertise and understandings of risk. Thus, an HCP can provide an informed decision of risk of harm. There is an acknowledgement that health services have decision-making responsibilities to admit someone to the hospital (or not). This officer suggests that at times, when police officers perceive there is an obvious need for inpatient care, then the transfer of care and responsibility can work well.

On the other hand, the police officer suggests there are times when he referred people he believes to be at serious risk, whom HCPs deem fit to be returned home. The police officer states this feels like his professional judgement is disputed. My interpretation of this finding is that police officers are seeking medical reassurance to reduce the risk burden, yet do not always trust or believe a health assessment if it opposes the officer's perception of risk. In other words, police officers acknowledge they have no medical expertise and discharge responsibility for risk and medical assessment to health services. Yet, despite having no medical knowledge, there are times they do not believe the assessment if it contradicts their own. Potentially the police response here is attributed to frustrations of being unable to discharge a duty of care and the dilemmas they face in returning PiMD home, discussed in 5.2.3.2.

An alternative explanation may be linked to findings in Chapter 5. These identify that HCP decisions for inpatient care are influenced by mental health legislation and organisational priorities. Potentially people may display behaviours which police officers believe are because of mental health disorder, yet often HCPs identify this is not the case. Under such circumstances, HCPs may assess there are no legal grounds to make compulsory detention, or inpatient care could be detrimental to the PiMD's recovery. This may suggest police officers are unaware of the clinical and mental health legislation parameters within which HCPs work. An interview with the out-of-hours G.P. attending to Deb highlights this point. He reported that, at times, police officers misunderstand or can be confused by their decisions. The discussion here is in the context of people who are sober and known to services. In such cases, a therapeutic, risk positive approach may be taken when hospital admission is deemed unsuitable. This can bring tensions between police and HCPs:

> *'There's a measured psychiatric element, stemming from when we could, and should, intervene. This is not something I can prevent, and the responsibility lies with them (PiMD). They stomp off unhappy saying 'I'm going to go kill myself. I say 'fine, okay', because I can't prevent you from killing yourself. I don't think you're ill. I think you're just threatening me'. They split us (police and HCPs). They split us. So, the police may become risk-averse. Police are more protective, whereas the doctor becomes more dismissive. We (HCPs) say 'You're playing, you're at it'. They're (police) protecting them, and we are in dispute' (H1C3)*

In this statement, the G.P. highlights three key points. Firstly, the legal boundaries in which he works. He suggests the PiMD is not ill in the sense he could use legislative powers within the

MHCTA to prevent harm. This reflects recognition of the boundaries of the professional legal framework the G.P. works within.

Secondly, he points to professional perspectives and approaches to care. The G.P. transfers the responsibility of risk back to the PiMD, thus recognising and enforcing therapeutic boundaries. He suggests this positive risk decision may be misinterpreted as uncaring by police officers, rather than being rooted in clinical decision-making.

Thirdly, the out-of-hours G.P. brings the individuals behaviour into focus, resulting in an added dynamic of professional conflict and risk perspective. In this account, the G.P. refers to PiMD "projection" of risk onto others including the G.P. and police officers. He suggests differences in interpretations of risk, potentially, can be because of a polarising three-way interplay between PiMD, Police and HCPs. My interpretation here is that the G.P. is highlighting individual behaviours where there is a perceived purposeful 'splitting' of professional teams by the PiMD, resulting in divergent views of risk. Put simply, in some cases, PiMD behaviours can (positively or negatively) reinforce professional views of risk. Here the G.P. acknowledges threats of suicide as stemming from behavioural traits, rather than an intent for serious harm. As such, he resists a risk-averse response, such as inpatient safeguarding, which could reinforce such behaviours. He chooses instead to take a risk-positive approach by setting behavioural and therapeutic boundaries. Potentially this approach is not communicated or understood by police officers, thus causing inter-professional tension.

In contrast to the G.P.s approach, police officers feel unable to be risk-positive when safeguarding PiMD. Potentially this is linked to a risk-averse police culture I will discuss further in Chapter 7. In this excerpt, a police officer who supported Deb states:

> *'We can't be risk positive, 'cause to be risk positive, you have to be able to back that up. I only have this training, this experience, this knowledge. All you can say is 'well, this is nothing to do with police work'. My experience is police work' (P2C3)*

This participant proposes police officers find it difficult to engage in risk positive ways of working with PiMD, where the risk associated with self-harm sits outside police officers professional knowledge. The officer suggests potentially there are opportunities to be risk-averse in areas of policing where they have the expertise and can justify their actions. This way of working, however, does not apply to the risk stemming from mental health incidents.
There are, however, boundaries to risk positive approaches by HCPs. This can occur when HCPs feel unable to defend their professional decision-making. The out-of-hours G.P. reports

that under such circumstances, risk management is a pushback to police officers. Although usually confident in assessing psychiatric risk, he identifies a caveat on risk assessment when someone is intoxicated:

> *'The difference is when I do the home visits for someone, and they are drunk, I can't really be confident about assessing them. Then I have to pass the buck (to police). Then I feel bad about it, but then I have no other options because I have to protect myself too, medically, legally…' (HC3)*

The G.P. suggests that a lack of confidence in some assessments forces the responsibility of risk back to police officers. The risk is framed in a medicolegal protection perspective where there is a personal and professional threat. Although he apologises for consciously returning the risk to police, he states he has no option. This suggests professional risk is a factor for both professions. It can bring variance to the safeguarding journeys and tensions to the police / health service interface.

These excerpts illustrate why it is hard to find common ground in professional responses to PiMD risk. The diverse professional understanding of mental health needs and working within the parameters of professional knowledge and risk, illuminates a further dynamic in the safeguarding journeys and inter-agency relationships, while supporting PiMD. Thus, these data underscore the relational influences of a range of factors appearing not to be accounted for in safeguarding policies.

The safeguarding of Deb is an example of a situation when professional and organisational risk was too high for both the HCP and Police. With the G.P. unable to conduct a mental health assessment because of Debs' intoxication, and with no further safeguarding options available to them, the attending police officers arrested Deb, to use police custody to keep her safe. Although this was a means to an end, the attending police officer interviewees talked about this as being deeply uncomfortable and fraught with dilemmas. In this excerpt, the officer reflects on Deb's experience of safeguarding in custody:

> *'In custody, every half an hour she gets checked, they have someone at the door, and they've not done anything wrong. This is just wrong. They shouldn't be there' (P3C3)*

The moral tone of this description reinforces a sense of compassion and an expression of organisational wrongdoing. The secure custody environment is highlighted as being appropriate to manage those who have offended. In this case, Deb is viewed as being in the

wrong place, having 'done nothing wrong'. The suggestion that PiMD should not be safeguarded in custody strengthens a perception t the safeguarding system is flawed when police are forced to construct safe spaces, because of gaps in the system to support vulnerable people.

Deb's interview highlights the impact of systems gaps and professional responses to risk on those who are already vulnerable. She had no memory of wishing to die, or of offending, and could not understand why she had been kept overnight in custody. The episode she described as distressing, triggering traumatic childhood memories:

> *'If I was going to hurt myself, and I was in a 'mental' frame of mind, they should never have locked me up. It makes me worse. Reminds me of the past, and makes me want to harm myself' (Deb)*

In this account, Deb appears to distrust the police explanation of safeguarding motives. She questions the justification of the use of custody if she had been mentally unwell and highlights her resentment of police for placing her in a situation which made her more vulnerable to self-harm. Potentially, this could have a lasting negative impact on her relationship with police officers. Deb identified the experience of being handcuffing and confined to a cell as re-traumatising, bringing back memories of being tied, and locked up, during historic sexual and physical trauma. This suggests that as a result of gaps in the system, people can be re-traumatised in order to keep them temporarily safe. This experience potentially could have an impact on future self-harm behaviours and contribute to, and reinforce, cyclical engagement with services.

In summary, building on Chapter 5, this subtheme brings focus to the relationships between intoxication, aggression, risk and gaps in the system. These can change and shape the safeguarding course. This could impact negatively on the PiMD, bringing them into the criminal justice system, and acceptance of risk oscillating between services. The findings suggest intoxication alone can shape decision-making. However, other determinants such as aggressive behaviour during intoxication can significantly impact on some PiMD experiences.

Such factors can bring an added layer to how and why PiMD come to police attention and can change the context of the safeguarding journeys. Furthermore, there is evidence of a clash of risk positive and risk-averse professional understanding. These appear to contribute to inter-agency tensions. Within this, there is a failure to find a safe and dignified space for PiMD who are intoxicated or aggressive. This can see people who have called on services because they

are distressed, exposed to traumatic procedures. This suggests that managing professional risk can take priority over the needs of PiMD. Although further investigation is needed, my data suggests, limitations in inter-agency options to manage risk can contribute to a cycle of self-harm and alcohol, help-seeking, risk management, re-traumatisation and potential further self-harm.

## 6.5 Navigating the System

Turning now to the final subtheme in this phase, in this section, I present findings of a recurrent theme arising in the womens' and police officers' accounts of navigating the out-of-hours system when seeking safeguarding support.

### 6.5.1. The Workaround: Jess's Experience

In her account of help-seeking in the first subtheme of data findings, Jess suggested the overwhelming nature of her distress can be a driving factor to seek out-of-hours professional support. Like Fiona, Jess suggests prompt in-person HCP support to manage her distress is unavailable. Drawing on past experience, she suggests that by dialling 999 police will respond swiftly, remain with her, and become conduits to HCPs. This way of working around the system has become normalised for Jess at times when she believes she is at risk of harming herself. In this account, she explains how she manages the out-of-hours emergency systems to direct police officer support of her immediate needs:

> *'So, I just phone the police. They will come here and stay here for many hours. They wait for somebody from the NHS psychiatric people, for one of them to phone, so that I can speak to them. When they (police) come up here I've got them in front of me, you know. Whereas it's not just a voice on a phone' (Jess)*

The direct and conscious call to police implies Jess can navigate the system and command a response. Thus, she highlights her ability to work around several system gaps. Firstly, the police officers physical presence, authority and commitment to remain with her, was reported as bringing a calming influence and disrupting escalating self-harm. Secondly, there is a sense the police presence directly communicates the seriousness of her distress more effectively than a phone call to HCPs alone. Drawing on earlier findings, an important point here is that the urgency of the need to call on police to bring peace and calm appears to take precedence over any risk of potential trauma of safeguarding in police custody. Potentially, this could point to the significance and intensity of distress and pressing need for safety experienced by some PiMD.

The police officers attending Jess on this, and other occasions, recognise the part they play in filling a gap in services for some PiMD. In this account, an officer acknowledges the methods Jess adopts to work around the system. He points to police and NHS24 policies which state if an individual suggests they are suicidal then an immediate police response will be provided:

> *'She says she is feeling suicidal If nobody attends, then she is going to harm herself. That gets an immediate response from us, albeit that I've never seen her injure herself or have injuries. We attend there, and we are met by Jess, who's happy enough to let us in. She has two male cops, I mean there's no signs of harm, what do you diagnose her with? Loneliness? That's what it's almost like, you know. She has burnt her bridges, and there is no one to leave her with' (P2C1)*

In this account, the officer recognises Jess can 'dial-up' or engineer a police response at a point of her choosing. There is a sense that although there is a police willingness to respond to emergency calls where there is a risk to life, this officer appears to feel 'used' or controlled by Jess as a result of her social rather than mental health issues. This officer does not appear to recognise the overwhelming distress Jess talked about as the catalyst for her call to police. Having never seen serious self-harm, this participant proposed that the police company and relationship relieved feelings of loneliness, rather than preventing a serious threat to life as expressed on the call.

Also, there was also recognition that even if Jess was settled, there were no options to discharge safeguarding to a family member. Like the other women, Jess said her friends and family no longer offered to sit with her, as they no longer tolerated the frequency of her distress behaviours. These data could suggest there is a lack of flexibility in the system to support this population before situations when distress becomes intolerable. As I will now show, the triggering of a police response can amplify further gaps in the system, which can see police officers accepting a duty of care and a need to navigate police and health policies and structures.

Most officers interviewed held a view that the time they spent at a call with a PiMD was dependant on when HCPs responded to their requests for support, thus potentially enabling them to discharge care.

In Jess's case, despite her quickly settling and saying she had no intention to self- harm, attending officers reported they felt unable to leave. This was because police policies guide

officers to remain with the individual until an HCP assessment identified they were no longer a self-harm risk. Like police participant experiences in the other two cases, there was a view police officers had little control over the length of time they would wait, this being determined by HCPs. In this account, an officer discusses his frustrations of being unable to discharge care and being caught up in an inflexible interdependent system:

> *'We're a public resource for everything else as well. Our only job is not to facilitate, or just be, you know, the tail wagging at the end of the mental health people. We, we have other jobs! We are just assisting here. I don't see how it can take over three hours, with us sitting at things like that. Then expect mental health to just ignore us. Which is what it comes across as. I'm phoning you. Make that assessment. I'm not allowed to' (C1P2)*

The police officer uses the term 'the tail wagging at the end of the mental health people' suggesting he experienced his time as being directed by mental health services with HCPs being the key to allowing him to discharge care. This is important given that the literature review reported in Chapter 2 identifies police as gatekeepers to mental health services. However, police participants in this study talk about gatekeeping control sitting with HCPs, or other parts of the police organisation such as custody. Most police officer participants highlighted the trajectory of the safeguarding journey as being inflexible and one where often they were met with closed doors of support. In Chapter 5, the subtheme 'The service shunt' (pg.126) shows the pushback and movement between services in order to discharge care. As I will show, although officers can request support from HCPs, they can be turned away (in the case of intoxication), redirected or made to wait for extended periods. In this account, an officer describes some practice realities and his frustrations of navigating through a system trying to find a safe place or assessment for the PiMD in his care:

> *'We take them to the mental health hospital We are turned away. They are taken into police custody and told she is not coming in here. She needs to be assessed. Taking her back to the hospital and saying we can't have her. It becomes a bun fight' (P2C3)*

This excerpt emphasises the scope of journeys the officer must take in order to find support and discharge care. This appears complicated by a lack of safe environments, which can displace people between police and health services. This officer highlighted neither system is equipped to support some PiMD. My interpretation of these findings is that the safeguarding journeys for some PiMD are extended because police officers need to navigate and can be

caught up in a ridged system when trying to find support. Within this, it appears services may be protecting their environments by deflecting back to other safeguarding responsibilities.

As highlighted in an earlier section, there were times the women navigated the system to gain police officer support to help control the escalating risk of serious self-harm. However, as I illustrated in the last point, the remaining journey where escorted by police officers, can be experienced as unwieldy and outwith their control. All three women discussed these experiences in terms of loss of control, dignity and security. Speaking on this issue, Fiona captured her experience of displacement and being exchanged between services:

> *'We are just kind of treated like something to decant. I think, from one place to the next. I suppose handed on, person to person to person' (Fiona)*

Within this excerpt there is a sense that the process of transporting people between services is de-humanising. There is a suggestion of a loss of control, as a passive 'object' to be shifted until accommodated. This objectification draws back to an earlier chapter, where two managers described the inter-agency management of PiMD like 'pass the parcel' or 'shunt'. There was also a sense of a loss of dignity as a result of being a commodity to 'decant'. Loss of dignity has been found already to be important in PiMD experiences in early discussions associated with waiting and in exposure to police custody processes. These data suggest people can also experience their displacement between criminal justice and health systems as undignified.

All three women agreed there were aspects of their safeguarding journeys which were valued. However, each reported exposure to additional stressors during safeguarding. For Jess, this was attributed to a need to navigate systems. For Fiona, it was the publicity of lengthy wait times with police, stigma and dehumanisation. For Deb, exposure to frightening and undignified custody processes. As Deb reported:

> *'Being locked up and the like. You feel like scum. Like I say, it brings everything back in tae yer heed. Aye, nae in a good way, if you get my drift. I jist felt worse. I started drinking when I got hame' (Deb)*

These data suggest potentially, for some PiMD, safeguarding journeys bring added stressors which could contribute to their anxieties. These stressors appear to reinforce feelings of unworthiness, loss of control and need to escape, reported earlier as a catalyst for the initial calling for support.

In summary, taken together, these data reinforce the evidence around a relationship between peoples' feelings of distress, their need for support and shortcomings in the safeguarding journey. This association could contribute to repetitive cycles of self-harm behaviours intoxication and aggression. Although PiMD report being powerless to manage their safety in distress, there are examples of people retaining a sense of agency to work around the system to direct the type of response they need.

By way of contrast, these data also suggest that once people engage with police officers, they experience having limited choice and little control over what happens in the remaining parts of their safeguarding journey.

## 6.6 Chapter Summary

Interpretation of the data presented in this chapter has enriched understanding of the foundational findings presented in subunit one. In Chapter 5, I reported that police and health service out-of-hours organisational processes could be inadequate and ill-fitting to support PiMD without a time-critical emergency or serious mental health disorder. This chapter built on these findings by exploring PIMD's experiences of seeking help within the police and emergency health systems while attempting to escape stressful situations

Viewed through the multiple lens' of PiMD, operational police officers and HCPs, the clinical cases reported in this chapter illustrate the nuanced and dynamic nature of the safeguarding journeys of those involved. Exploration of these experiences illuminates a range of inter-related individual and external factors which can interact with police and health out-of-hour emergency health care system shortcomings. These can shape the course and experience of the safeguarding journeys.

Accounts within these clinical cases underscore the importance the women placed on access to a prompt, professional response to manage their safety and escape distress. Although police involvement brought a rapid response, access to HCPs was slow, finding the women chaperoned and managed by police officers for extended periods. This was because of HCP workload, triaging time-critical emergencies, a lack of alternative safeguarding environments and co-occurring issues such as intoxication, which could compromise mental health assessment. Although there were instances when PiMD valued the safety which police presence brought, police involvement could come at a price. This was because of the lack of appropriate health or police environments in which the women could be kept safe and police

and NHS risk management procedures. In some circumstances, exposure to these factors contributed to distress and re-traumatisation, thus reinforcing a cycle of shame, further intoxication, and potential further self-harm.

All participants viewed alcohol intoxication as a critical factor influencing the course of safeguarding journeys. Firstly, intoxication was reported by the women as contributing to their distress, impulsivity and aggression. Intoxication also influenced help-seeking behaviours, the timing of calls for support and relationships with police.

Secondly, HCPs and police participants reported that inconsistencies in inter-agency processes and a lack of safeguarding environments could influence the management of PiMD with co-occurring distress, intoxication, and aggression. Intoxication restricts HCPs ability to evaluate the potential risk of serious self-harm. This, in turn, can compromise police officer understanding of self-harm risk of those in their care.

These findings revealed an interconnected 'grey area' in which HCPs and police officers work, when managing people with co-occurring distress and intoxication. These factors can drive convoluted safeguarding journeys, poor experiences for PiMD and contribute to inter-agency tension.

Thirdly, navigating gaps in unscheduled health care and police service structures while balancing and managing risk, presented some or multiple challenges for PIMD, Police and HCP participants. For the women, these inter-related factors linked back to a need for prompt support which brought police involvement. Police officers articulated this could find them managing challenging and risky behaviours and forced to make difficult decisions to balance public safety against the individual's wellbeing. Unlike other areas of policing, officers appear reliant on HCPs to inform risk of serious harm and manage onward care. When HCP assessment is unavailable to them, or conflict with police officer beliefs of risk, PiMD and police officers can be pushed back and forth between services. At worst, these data show that when police are unable to discharge care, they can be forced into ethical dilemmas of safeguarding people in police custody and finding PiMD exposed to undignified police risk management procedures.

Together, my findings suggest there is an interplay between individuals' responses to mental distress and structural or systems shortcomings in police and health services. The lack of flexibility in inter-agency procedure alongside the nuance of PiMD needs can create a situation where PiMD can be exposed to added stressors. These factors are particularly problematic

when PiMD are intoxicated. These findings suggest some people who do not have a serious mental health diagnosis ‘fall through the gaps’ in policy and legislative thresholds and daytime services, perpetuating the crisis-driven, cyclical experiences of PiMD and emergency services. Thus, the current inter-agency systems of communicating concern for PiMD can fail to connect in a way that supports partnership working and safeguarding at the heart of inter-agency policies

The next chapter moves on to present findings of the final phase of this study which facilitated inter and cross-agency conversations. Three operational Police and HCP focus groups build on findings from Chapters 5 and 6 to build on understanding how Police and HCPs work within this ' grey area' of practice. Building on the earlier phases, these focus groups consider the influence of structural and of human responses such as professional cultures, have on safeguarding journeys.

# Chapter 7: - Phase Three – Focus Group Findings

## 7.1 Introduction

In this chapter, I present a critical analysis of findings from three focus groups conducted in the final data collection phase (phase three). Focus group participants were HCP's working in clinical environments, police officers, and police staff working in an operational policing. Drawing on emergent themes from previous phases as a framework, the purpose was to contextualise and enhance my understanding of the findings. In particular, those findings concerned with relationships, occupational influences and the experiences of those supporting safeguarding journeys, central to the overall case study. I will conclude this chapter by presenting the six key arguments developed from the synthesis of the findings from across the three subunits of this holistic case study.

## 7.2 Focus Group Participants

Details of the groups and participant codes are found in Table 6. For example, a police officer within the mixed police / health focus group is coded as PHFG P2 (Police / Health Focus Group police officer number 2). In both focus groups, which include HCPs, some participants from the E.D. and other areas of mental health services who indicated their intent to attend, were unexpectedly called upon to provide emergency ward cover or attend emergencies at the time of the scheduled focus group. Consequently, there was a lower than anticipated number of HCP participants attending. HCP participants were based within psychiatric services where police officers refer PiMD who do not have a co-occurring physical injury. Therefore, the views of HCP participants in these data reflect the experiences of those in this context.

An excerpt from my synopsis of observations of the focus group dynamics, drawn from my group facilitation notes, is found in Appendix 6.

| Focus Group and Venue | Professional Mix | Police Participants | HCP Participants | Total Participants |
|---|---|---|---|---|
| 1<br>Police Office | Police<br>Police constables, police staff, police sergeants, police forensic physician, and a police inspector | 12 | 0 | 12<br>Coded PFG 1-12 |
| 2<br>Psychiatric Hospital | HCP<br>Mental health nurse<br>Doctor | 0 | 2<br>(8 accepted) | 2<br>Coded HFG 1 and 2 |
| 3<br>Psychiatric Hospital | HCP<br>Mental health nurse | 8 | 1<br>(5 accepted) | 9<br>Coded PHFG-P1-8<br>(Police) |
| | Police<br>Police constables, police staff, police sergeants, a police inspector | | | PHFG-H1<br>(HCP) |
| | | | | Total<br>23 |

*Table 6: Focus group participant and identification coding*

## 7.3 Findings

Using an inductive approach, an overarching theme and three subthemes were constructed. These are presented in Figure14, followed by a summary of the theme and subthemes.

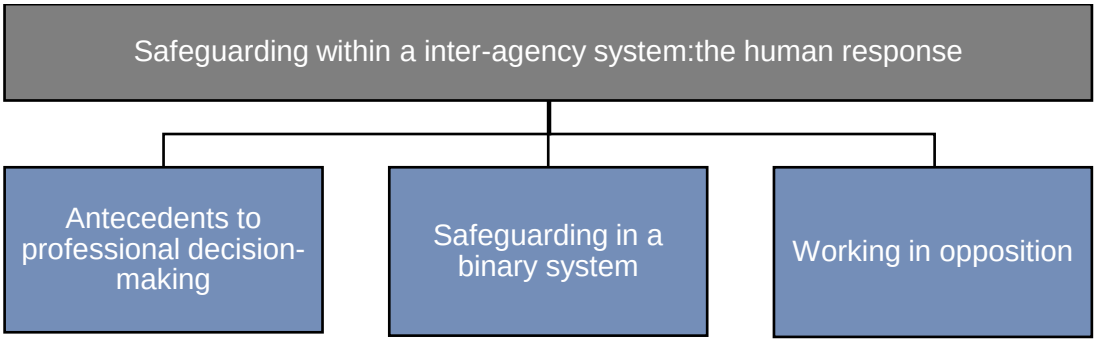


*Figure 3: Overarching theme and subthemes Subunit 3 phase three*

### 7.3.1 Summary of Themes

The synthesised findings from the focus groups are collated under three interlinked subthemes underpinning the overarching theme '***Safeguarding within an inter-agency system: the human response'***. The overarching theme illuminates that, along with system shortcomings, additional human responses are influencing safeguarding journeys. By human response, I mean professional responses to PiMD needs, professional knowledge, identity and occupational culture. How professionals responded and made decisions was influenced by the system itself, inter-agency dynamics and relationships at the Police / HCP intersect. Three underpinning subthemes are illustrated in Figure 14. '***Antecedents to professional decision-making'*** illuminates the importance and meaning placed on professional knowledge by participants and their understanding of risk, nuance within self-harm behaviour, decision-making and inter-professional relationships. The second subtheme, ***'Safeguarding in a binary system'*** reflects participants' experiences of working in a system which may criminalise PiMD through exposure to criminal justice systems, or inappropriately medicalise through psychiatric labelling and inpatient psychiatric care. The final subtheme, '***Working in opposition'*** describes participant perceptions of failings in the system and their human responses to these failings. This has created a situation where police and health practitioners can work against each other, and thus perpetuate cyclical responses, which can overlook the PiMD at the centre.

## 7.4 Antecedents to Professional decision-making

Diverse professional perspectives around mental health assessment and PiMD needs were particularly prominent in the focus group data. Antecedents to occupational decision-making associated with mental health assessment were coded 116 times across the three focus groups transcripts and were the most frequently occurring code within the focus group data. The antecedents were coded as: clinical knowledge; experience in supporting PiMD; professional perspectives of PiMD needs; professional culture.

In Chapter 6, I presented different professional viewpoints of risk, a lack of alternative safeguarding spaces, and that there is no agreed understanding of immediate needs of PiMD, as regards potentially shaping safeguarding journeys. The influence of these factors on professional practice was explored within the focus groups. Two reported problems emerged within participants discussions. Firstly, some police participants argued there were circumstances when HCPs could misjudge some individuals need for inpatient care. Thus, police officers reported they were left to deal with people they believed to be still at risk of harm. In the same vein, HCPs talked about feelings of police officer distrust of their decision-making.

Secondly, all groups highlighted the issue of increasingly high numbers of people coming to police attention referred for out-of-hours emergency mental health assessment, as placing pressure on both services. However, HCP participants highlighted that many were not seriously at risk of harm. Both circumstances appeared to contribute to inter-agency tensions and lengthy safeguarding journeys. In this section, I report on participants discussion of antecedents to professional practice influencing these two issues.

When people were returned home, there was a sense many police officer participants distrusted HCP assessment, suggesting they were doing a disservice to some PiMD. Two police officers mentioned this issue openly, suggesting they often had people returned to their care following mental health assessment whom they judged to be at serious risk of harm. Police officers also reported they felt forced repeatedly to return people for assessment or use police custody as a safeguarding environment, confirming police managers perceptions reported in Chapter 5. One officer stated:

> *'We take folk there that need to be in hospital. They are openly telling us they want to kill themselves! How obvious does it need to be? And they (HCPs) just say take them home. A blind man can see they are not right! So, we get them home, and two hours later they are ringing us, and we are back at their door. If they (HCPs) just got it right the first time, it would be better on everyone and save everyone's time' (PFGP3)*

HCP participants also raised this point in their focus groups, talking in negative terms of their experiences of police officer referrals. These comments centred around experiences of pressure from police officers to admit people to hospital and professional distrust by police officers of HCP clinical judgements. Talking on this point, this HCP pointed out that the nuance of mental health presentations and the complexity of clinical judgements may be beyond the scope of police officer's knowledge of mental health issues. As he suggests, mental health

assessment requires profession-specific education and experience. However, given the limited mental health understanding held by most police officers, they may potentially misinterpret PiMD need for inpatient admission:

> *'Well, they (Police) are not sitting in medical school or nursing school doing three to five years of reading around diagnosis and mental illness. They would have to have a lot of mental health knowledge to know what they are assessing. For example, someone with a schizoid personality can present as serious schizophrenia. I suppose it takes them to trust our judgement that we are saying no (to inpatient admission) for a reason' (HFG2)*

Within this excerpt, there is a sense of irritation by the HCP, of police officers' lack of trust of the HCPs depth of knowledge. Given officers often talked about having no mental health expertise as a catalyst for their referral and the need to seek clinically informed judgement of risk and management, this HCP appeared annoyed by officers' suggestions they misjudge diagnosis.

Potentially, the need for police officers to trust HCPs stems from HCPs inability to share and explain their assessment in order to maintain patient confidentiality. Thus, the element of professional trust is an important antecedent to effective inter-agency safeguarding practice. This appeared missing in the context of mental health assessment with HCPs experiencing doubt in their professional integrity and trust in their clinical judgements. In turn, it seems to contribute towards inter-agency frictions recurring throughout the focus group conversations.

The reasons for divergent occupational views of PiMD needs, risk and management, were further explored within the HCP focus group. Although participants recognised this could be associated with levels of mental health education and experience, HCP participants suggested tensions lie in the intersection of other diverse aspects of occupational knowledge. For example, one HCP participant suggested decision-making was influenced by occupational and cultural differences associated with how police officers and HCPs think about, and approach risk:

> *'They (police) come up against us saying you have misjudged it this time. Maybe not in that language. Nevertheless, they are maybe wondering that according to the education they have had, that this person is suicidal and this person needs to be in a hospital We are saying, well, there are lots of different types of suicide and suicidality. Even we as health professionals struggle with that, and it is very subjective. A police*

*officer's world is a very objective world. You break the law, and you get arrested. Whereas we deal in a world of grey. Very subjective ideas. I wonder if it is challenging for them to deal with that?' (HFG3)*

These comments seem to provide a further potential explanation for police officers' distrust in mental health assessment and may be attributed to differences in occupational worlds and approaches to practice. The suggestion here is that the subjective approach to diagnosis and assessment by many mental HCPs may not align well with the more objective way of working by police officers based on facts and observations.

Alongside limited understanding of mental health issues, objectivity may restrict police officer interpretation of self-harm behaviours. By way of contrast, the HCP in the above excerpt suggests mental HCPs knowledge and clinical decision-making as highly subjective. There was recognition of the broad scope in suicidality, with the complexity of risk factors challenging agreement between clinicians in the same field. The HCP describes their professional know-how as working in a 'world of grey' where clinical decisions are not defined simply by a range of symptoms and observations. The HCP brings feelings, perceptions, and concerns obtained through engagement with the PiMD to the assessment. Therefore, a mental health assessment is not an objective process, so, a lack of congruence in types of occupational knowledge applied to assessment, may contribute to disagreement on PiMD needs.

HCP's perceive the police world as 'very objective'. Talking on this issue, a police participant pointed out that in other areas of their work, there are opportunities to use discretion, subjective thinking and justify actions. However, in the context of mental health safeguarding, police officers may not hold a level of confidence or ability to defend their decisions, thus following protocols and referral to mental health services becomes their default position. In this excerpt, the police participant explains these processes in practice:

*'In most areas of policing, if I went along and made a decision, I can say that is what it is. Now, the person could complain about it, a supervisor of mine could come around and say this is nae (not) right, but generally you are quite safe. Because you have followed the process. If I think there might be a problem, I have to do something with this problem. I have looked at you. I have assessed you. You're fine. But, without being a medical professional I cannot decide you are safe to stay here by yourself. It just doesn't happen. I have to find someone to look after them. Most have burnt their bridges so there are no relatives, so that is a no go. I have to arrest them, or I have to*

*take them to the psychiatric hospital As long as I get someone to say there is not a problem, and nothing goes wrong, then that is OK' (PHFG4)*

These comments suggest this officer experiences a sense of agency and confidence in other areas of his work, yet professional agency or discretion is missing in circumstances when supporting PiMD, where there is a lack of support options available to police and the PiMD. Even though this officer may feel confident the individual is safe, he would still transport that person for assessment, given this type of professional judgement is assumed to be out-with his realms of ability. As such, there is a procedural need to look for internal or external approval to support safeguarding decisions should something 'go wrong' and avoid deviation from police safeguarding policies. In this context, safety appears to apply to the police officers defence of his professional judgement, rather than the safety checking of the PiMD. According to these data, it is possible another antecedence to police referral for mental health assessment is; officer sensitivity to adherence to procedures in cases of mental distress; a need to mitigate professional risk and do 'something' with the 'problem'.

The notion that police officer referral of some PiMD is motivated by risk aversion rather than the individuals' needs, is linked to a point raised in the HCP focus group. Participants spoke of the stress placed on out-of-hours services by police referrals of those who were not considered by HCPs as psychiatric emergencies. In this excerpt, an HCP participant discussed patterns of police referrals within a recent Place of Safety audit. The HCP suggests a reduced level of tolerance for organisational risk by police officers can contribute to increasing numbers of people referred by police who are returned home:

*'See with the PoS audit. The numbers have gone up. I think hugely. But the proportion admitted, sorry, I mean the actual numbers detained are exactly the same. So, for me, it really indicates that their level of tolerance is changed. About 80% of people are returned to the police' (HFG -H1)*

These data suggest this HCP recognises a relationship between police officer professional risk reduction and referral for mental health assessment. This perception indicates that a shift in police sensitivity to risk can partially drive the increasing number of PiMD referrals who do not require hospital inpatient care. This is important when considered alongside previous findings, which suggest PiMD can experience the transfer to health services by police as undignified.

My interpretation of these findings is that there are antecedents, based on professional practice, knowledge, and inter-agency relationships, which have a bearing on the referral and outcomes of mental health assessment. Although related to shortcomings in the system found in earlier chapters, these antecedents are human influences (or responses) associated with trust, depth of professional knowledge and responsiveness to risk. The next subtheme links to these points and draws on participants' discussions on transferring a duty of care of PiMD between criminal justice and health services.

## 7.5 Safeguarding in a Binary System

This subtheme developed through divergent and often conflicting police and HCP discourse across the three focus groups around managing some PiMD in a two-way system between criminal justice and emergency health services. In these conversations, participants talked of the shifting role of police officers from law enforcement to caregivers in response to shortcomings in emergency health services. A key point in this subtheme is that through the discussions, it became clear that safeguarding was limited in both criminal justice and emergency health services. Neither were equipped to support some PiMD needs following a first police response. This subtheme highlights participants discussions of experiences working to support people displaced between the two systems.

### 7.5.1 Shifting Roles

A common viewpoint of police participants was that calling the police to respond to the majority of mental health incidents had become the first course of action for NHS24 and PiMD. Building on the commentary of police officer managers in Chapter 5, most police participants suggest their role had moved beyond an emergency response bringing initial control before handing over to health services, to one of managing mental distress incidents from start to close. In their accounts, two participants discussed why they believed their role had evolved in this way. In this excerpt, a police officer participant discusses how he believes police officers meet the expectation of PiMD immediate needs:

> *'It's about the response, and about having someone they can talk to at that moment. Being able to talk to someone. A face-to-face response, which they will get from police. They will not get that from services like NHS24 or out-of-hours emergency health services' (PHFG2)*

In this discussion, the participant echoes commentary by Jess, (PiMD), within the clinical case interviews in Chapter 6. She highlighted the dependability on the police and the importance of

immediate face-to-face contact when unable to control her urges to self-harm. This officer concurs, suggesting it is about someone who will respond at the moment, who will be available to talk. The emphasis in the officer's discussion is that it is 'someone' who is dependable, not necessarily a police officer that a PiMD requires. Importantly, the police officer's critique of a health response highlights the impression that police feel they have adopted the role of health carers. Critically, police officers' discussions centred on what care they believed PiMD need, and the gaps they fill by bringing a caring response. This is an interesting point given the caring role is a shift from one of keeping law and order, usually attributed to the public's perceptions of the police. As another police participant put it when talking about caring for PiMD:

> *'What they need is someone to sit with them, talk with them, and actually care. We do' (PFG6)*

This commentary illustrates an adapting and melding of the police officer role. According to these data, police officers suggest they bring the human qualities of listening, care, and compassion to distress situations thus filling a void left by HCPs. What is missing from these conversations, and could have been explored further, is an understanding if police officers view that these are human qualities which police officers bring naturally to mental distress situations, or has the listening and caring role evolved because of the enforced long waiting times with PiMD when unable to discharge care quickly to health services.

The notion of the police officer role blending into health care, by bringing care and compassion to keeping PiMD safe, was raised within the HCP focus group. In this discussion, a mental health nurse talked of the evolving police officer role in responding to PiMD. Here he suggests the language and actions police officers use in keeping people safe could reinforce to PiMD that the police officer / health care roles are merging and shifting:

> *'You wonder if, over time, they (PiMD) have developed a different relationship with police. Or identify police differently now because the experiences they have had with them are not through crime. It is through concern for their wellbeing and safety. So, the police have said things like 'I am here to look after you'. 'I am worried about you' in order to gain an alliance with them. Similar language to what we use. So maybe the police have looked different to them. Maybe they do not look like people who are there to enforce laws and deal with criminality. They are there to look after them' (HFG1)*

The suggestion PiMD could view the police officer role as 'distress carer' is significant in understanding the safeguarding journey. It is important to bear in mind that this is one participant's perception. However, taken with the previous excerpts of police officers perceptions of what PiMD need, it is possible PiMD view police officers as those who will listen, and be there for them because of the language they use. Potentially, this may explain why, in recent years, PiMD have come more often to police attention. Further, this may explain why, when a PiMD looks to the police to bring initial support, there is an increase in police transportation of people to health services for mental health assessments.

Police officers also expressed concern about discharging care of PiMD, to health services during out-of-hours periods once they had become involved. In this next section, I present data of participants' conversations highlighting their experiences of a push back and forth of PiMD between criminal justice and health services.

### 7.5.2 Criminalising and Psychiatric Labelling

When asked about transferring care between police and health services, divergent and conflicting discourse emerged between most police officers and HCPs, confirming findings in the previous phases of the study. In short, people could become criminalised or psychiatrically labelled. What I mean here is that people whose distress is not because of mental disorder can be inappropriately admitted to inpatient psychiatric care. Participants in all focus groups talked about the inter-disciplinary conflict they experienced in trying to keep people out of each of their systems to prevent harm.

Police officers, when talking of attempts to keep PiMD out of the criminal justice system, suggest it was difficult to move people on to health services once they became involved. This resulted in a tussle between criminal justice and health services as to who was best suited to deal with the PiMD. The view held by this police officer was that discharging care was particularly difficult to psychiatric services outwith routine hours:

> *'The psychiatric services have always been difficult, whether it is a capacity issue or an organisational attitude, but they really do not like new business full stop. Or they like it to be in an ordered way, time and place of their choosing. They don't like out-of-hours. It is a battle' (PH FG6)*

The notion that transfer should be in an ordered way alludes to the idea that psychiatric hospital admission is something which is considered and taken seriously by HCPs. For this officer, 'battle' type experiences reflect the acute nature, pressure and dilemmas officers

suggest they feel confirms inter-agency tensions discussed in previous chapters when seeking HCP support to keep the individual safe. An interesting point raised in this excerpt is that this participant suggests that psychiatric services are unwilling to admit people to hospital because of issues within the service, such as inpatient capacity rather than inpatient care being something the individual does not need. The notion inpatient care may not be the right course of action for PiMD was missing from the police focus group discussions. Rather, there was an assumption that inpatient care would remove the immediate risk of self-harm for both individual and police officer.

Exploring the notion that professional knowledge impacts on perspectives of PiMD needs, I raised the above point of police officers feeling inpatient transfer felt battle-like with the health focus group. Talking on the issue, a doctor responded saying she was aware of the pressure police officers felt to discharge responsibility for people to health services. However, drawing on their professional knowledge and bringing individuals' needs to the forefront, all clinicians felt strongly that admission to a psychiatric hospital could be detrimental to some people:

> *'On one hand I can understand why it upsets them (police) and why, if someone says they are suicidal, then we should keep them here to keep them safe to prevent suicide. However, on the other hand, I find it quite frustrating, because admitting people in this situation is so detrimental to them. We have it in our faces all the time. The people we have done a complete disservice to and are in a complete and utter state now. I actually find, because I have spent so much time with the patient that they are really understanding, and really OK with going home. But police are not' (PHFG -H1)*

In this statement, the HCP suggests she understands why officers would assume inpatient admission was the best option to mitigate the risk of harm. However, she makes two important points in this statement. Firstly, confidence and her trust in her joint assessment with the PiMD, that they are safe to return home. She again identifies police as distrusting this assessment despite both the PiMD and HCP agreeing they are safe. Secondly, she acknowledges the potential long-term harm to the PiMD, which can happen as a result of exposure to inpatient care when it is not necessary. In this case, drawing on her professional experience, she suggests taking a risk-averse response and facilitating inpatient care can be a disservice and harmful to the individual

The notion that harm can be caused by taking away someone's liberty to enforce safeguarding chimes with the traumatising experiences of custody management discussed by the women in Chapter 6. Although police officers recognised police custody was a poor environment for

safeguarding, they did not appear to appreciate the possible harm of enforced or even voluntary inpatient psychiatric care. Rather, it was the immediacy of dealing with the 'problem' which took precedence. The longer-term impact on the individual went unrecognised yet, was a strong motivator for HCPs in keeping people out of hospital.

These data suggest diverse professional knowledge and experience can influence tensions at the intersection of services associated with the immediacy of PiMD safety and opportunities to discharge care. People can then oscillate between police and health services. There was a strong sense from participants there were only two accessible services to respond to PiMD during out-of-hours; being health or criminal justice services. Nevertheless, building on the managers' interviews in Chapter 5, these focus group findings underscore the view that elements of the criminal justice and health services are ill-fitting. 'Shoehorning' safeguarding of some PiMD into either service as a means to an end may potentially be harmful to some PiMD.

Moving now on to the final subtheme, which links to the two previous subthemes, in this section, I present findings from participant conversations of the influence which systems shortcomings and professional behaviours can have on safeguarding practice and which can find police and HCPs work in conflicting ways.

## 7.6 Working in Opposition

Previous subthemes recognise the influence of human responses due to the professional knowledge and beliefs of PiMD needs on professional practice. In this subtheme, participant perspectives of the impact these human responses and systems gaps discussed in earlier chapters, have on safeguarding journeys and police and health service resources, are discussed. Collectively, these can find services working in conflicting ways. Working in and between these systems gaps can perpetuate the cyclical nature of crisis-driven interventions and contribute to unexpected consequences on inter-agency practice in which the PiMD as an individual gets lost as staff navigate the apparent options available to them.

### 7.6.1 Perpetuating the Distress Cycle

Participants from both disciplines discussed situations where they felt they worked against each other. Issues raised in the previous subthemes such as a lack of trust of clinical decision-making, diverse perspectives of risk and limited options to discharge care, could also find police and HCPs stuck in a cyclical way of working. There appear limited opportunities to disrupt cycles of distress through police emergency response and presentations to mental

health services. For the most, police officer participants spoke of failings in health services to respond in a different way to break cycles of repeat presentations of PiMD. Only one officer questioned the police response. He suggested police officers should rethink repeatedly trying to discharge care to health services when distress was not associated with a health problem. This was met by criticism by some fellow officers who argued mental distress must be responded to in health services to avoid criminalisation of PiMD. Commenting on the need for police officers to reconsider their approach of repetitive attempts to discharge care to health services, this officer stated:

> *'There is one person we have brought into the psychiatric hospital eighteen times over two months. I do not know how many times they (HCPs) can say there is no treatable mental health condition here to police. But we still just keep bringing them back in again and again. There were three times in one day. It is clear that we need to challenge the behaviour here rather than try to pass the problem on' (PHFG- P5)*

The case described in this account is an example of the inflexibility of current processes to manage PiMD in a limited two-way system. This can find both services stuck in patterns of referral, working in opposition, and the individual caught up in the middle. This was the voice of one officer questioning the legitimacy of continued referral to psychiatric services, to address distress, not associated with a mental disorder. The officer suggests that in such cases there should be a different approach, one which sees the PiMD challenged on their behaviour within the criminal justice rather than the health system. This key point highlights the positioning of PiMD between two services and gaps in care. Moreover, it underscores a system which reinforces cyclical care experiences for PiMD which do not meet their needs, nor that of police officers or HCPs.

In addition to PiMD being in distress cycles, police officers and HCPs appear caught in a cyclical pattern not meeting their needs. There was a sense in the police focus group that, like the above excerpt, should police officers refer the person frequently enough, then health services will eventually be 'won over' and convinced there is a mental health issue and refer for inpatient care. Potentially, this reflects the difficulty police officers experience when they feel there are no other avenues open. A further reason for repetitive presentations is that of police officer sensitivity to a risk-averse police culture highlighted throughout the study findings. Talking on these two issues, a police participant said:

*'It is a culture thing that has gone on for years. The more we struggle with resources, the more we are getting to the point that we are not going to be able to go to these calls. But the police being the police say we are afraid to give up the ball. We still sit there. We have taken them (PiMD) to someone, and they say no, it's not mental health. But we are not happy with that. We are looking for a different answer, and we will just sit with them, and sit with them, as that is the culture' (PFG-4)*

In this officer's view, police can be persistent in their belief that mental health services should support the individual. On the surface, this can be interpreted as a police officer's determination to break through health service barriers to get a service of PiMD. This point links back to a police manager's discussion in Chapter 5 of an embedded police culture of occupational reliability and dependability to get a job done. However, this inflexibility in approach and lack of questioning of the appropriateness of inpatient care appears to come at the expense of the PiMD, and police and health service resources. Thus, this way of working underlines a relationship between human responses to knots in the current system which maintains police officers in cyclical patterns of response to PiMD.

Building on these discussions, I asked further about peoples' experiences of working at the intersection of police and health services during safeguarding, and of outcomes of current processes on resources. In this next section, I present findings of participant discussions of unintended consequences of current safeguarding practice.

### 7.6.2 Unintended Consequences of Inter-agency Practice

When asked about inter-agency working, participants were unanimous in their views that the current safeguarding system placed burdens on both services. By far, most of the accounts suggested the disproportionate burden of responsibility for PiMD sat within police services. However, police responses to PiMD through referral to health services, had a direct influence on health care environments. Impacts were more subtle than the time taken in mental health assessment. HCPs reported there were situations when multiple police referrals during out-of-hours periods could have the unintended consequence of negatively impacting on other clinical environments. The HCP comment below illustrates there can be an impact on acute psychiatric wards when medical staff respond to police referrals of people who may not need emergency psychiatric care:

*'One night I was working on the ward, it was hectic. We had four people on obs (patients requiring constant observation through one to one nursing care). There was only another nurse and me on the floor. I needed the doctor to see a really unwell*

*patient. But because he was tied up doing police POS assessments, he could not come. While we were trying to manage the patient, another high-risk patient absconded. We could not leave the ward. Our policy is to call the police given we now have a high-risk missing person. But all the cops were out the front of the hospital or up at A and E waiting with people who were not really ill! Ridiculous!' (HFG2)*

As this account illustrates, there can be an accumulative impact on both services of multiple police referrals reaching beyond the PiMD needs, to other aspects of services. In this circumstance, a 'knot' in police and health resources found a doctor drawn away from acute clinical areas, and police tied up at health services. So, simultaneously this situation contributed to, and hampered response to, a critical incident. These situations are likely unpredictable and unintended consequences of inter-agency policies designed to respond to community based mental health issues. However, as this HCP points out, there is an irony in enacting inter-agency procedures to support collaborative working, which can result in failures of other co-operative emergency responses.

A further unintended consequence raised in the police / health focus group was that of the impact of a limited two-way system on the PiMD. When responding to the system, police and HCPs can lose focus of their response to the individual. Talking on this, a mental health nurse brings focus to the individual's experience. In this excerpt, the nurse stresses a lack of person-centeredness and humanism in care, can find the individual reduced to being viewed as a problem to be managed:

*'The whole scenario, the whole environment that we are in now, is that, quite often, the person in the centre really is completely forgotten, in terms of their existence as a person. They are just a problem to be solved and an issue to get rid of. They pick up on that. And if you look at that and the lived experiences that people have had right through the system, they are rebounding off services without ever hitting a solution' (PHFG-H1)*

It appears while the focus is on resolving incidents, managing resources and inter-agency tensions, the individual and their need can be overlooked. Confirming Fiona's story of being 'decanted' in the previous chapter, the PiMD becomes a temporary crisis-driven 'problem' to be shifted between services. This HCP points out that PiMD can absorb this. These data suggest inter-agency co-ordination for the PiMD can be unwieldy, unpredictable and unresponsive to long term needs. Potentially, this experience is opposite to the control and safety PiMD suggest they seek highlighted in the previous chapter. As a result, although not

an intention of police and HCPs, the person-centeredness or 'existence as a human' can be lost because of inter-agency wrangling through the human responses to inter-agency systems.

## 7.7 Focus Groups Summary

This theme *'Safeguarding within an inter-agency system: the human response'* confirms and builds on the previous two chapters findings highlighting inter-agency system shortcomings by explaining what influences human responses of operational police and HCP practice on safeguarding PiMD.

Three key findings emerged:

Firstly, there appears to be some occupational difference in understanding PiMD needs between the two disciplines which can cause inter-agency tension and contribute, potentially, to the cyclical nature of responses for PiMD, police and HCPs in different ways. There are antecedents, such as occupational belief of individuals' needs and occupational culture, which can have a bearing on police and HCP decision-making, practice and relationships. Central to this are the clinical knowledge and experiences held by HCPs. These allow for the identification of nuance in mental health presentations and an individual's ability to self-manage their distress and safety without inpatient care. Nevertheless, police officer distrust and tension in inter-agency relationships can occur when this assessment does not match with police officers' evaluations.

Secondly, supporting PiMD is limited to a system in which neither the criminal justice nor emergency health systems are equipped to deal with some PiMD needs. Human responses to limitations in this system has created a situation where police officers have adopted the role of distress caregivers in the community, yet they can find it difficult to discharge their care responsibilities onto health services. This is because HCPs can view the medicalisation of inpatient psychiatric care as equally harmful to some people who do not experience a mental disorder. Likewise, police officers view the criminalisation of people to keep them safe as potentially harmful. Such a binary system can find PiMD oscillate between the two services without having their needs met and driving demand through both services. Thus, the relationship between how professionals respond, and the two-way system in which police and HCPs work, can have a significant impact on the safeguarding experiences of PiMD.

Finally, whilst working in, and responding to system gaps, the PiMD may unintentionally be overlooked. There are circumstances where police and HCP seem to be working in opposition thereby perpetuating cyclical safeguarding journeys for some PiMD, and cyclical responses

from police and health services. When safeguarding journeys are partly driven by a police officer's sensitivity to a culture of risk reduction and a need to deal with the 'problem', the humanness of the individual can inadvertently be lost.

## 7.8 A Synthesis of the Holistic Case Findings

In this section, I present the six key arguments developed from the synthesis of findings from across the three subunits of this holistic case study which will be discussed in the next chapter in the context of relevant empirical and theoretical literature.

- Evidence from this study suggests limitations in the current inter-agency safeguarding model can fail some PiMD. When reliant on criminal justice and a medicalised model of emergency and psychiatric care to respond to people whose distress does not stem from a mental disorder, some PiMD can be displaced between both services. A lack of services, appropriate to their needs, can expose people to undignified, dehumanising, stigmatising, and at times, traumatising processes. The inter-agency safeguarding model in which this study is focused, seeks to provide the appropriate intervention, prevent harm and be least restrictive to the individual. Yet, aspects of this model can be ill-fitting for some PIMD. Responding to this poor fit, police officers and HCPs can shift PIMD between criminal justice, emergency medicine and psychiatric services. In short, there are several stressors PiMD can experience across the safeguarding journey, which may contribute to their distress. My findings suggest a need to develop service models and legislation which move beyond the confines of criminal justice and overly medicalised emergency care for PIMD. A contemporary model, supporting dignified care and trauma-informed safeguarding, could be more responsive to a broader scope of distress needs and help disrupt distress cycles.

- My findings illuminate gaps in current legislation, policies and processes. A lack of alternative referral routes and opportunities for police officers to discharge care can increase demand on out-of-hours emergency health and police services. This evidence has a broader application to NHS efforts to reduce E.D. wait times and Police Scotland improved responses to vulnerable people at the first point of contact. The Scottish Government Mental Health Strategy (2017) identifies one of the eight priority areas as being to improve access to mental health services and make them more efficient and safer. These data suggest people can remain at risk because their needs are not met.

- In some cases, PiMD can be vulnerable as a result of engagement in the system. Although there have been efforts to prevent unnecessary inpatient psychiatric care,

de-criminalise mental health responses and reduce the use of police custody as a Place of Safety, this study suggests there are circumstances where police custody is still used in safeguarding. Often this can be as a 'means to an end' in situations when people are intoxicated, aggressive, unwilling to leave their own home and unsafe to be left alone. People can also feel criminalised because of the publicity of police involvement.

- Taken together, the findings suggest there is a relationship between PiMD behaviours, structural gaps, and human responses of HCPs and police officers. For example, there is evidence of divergent approaches to risk, professional knowledge and organisational cultures. These can work against each other and contribute to cyclical distress journeys for PIMD, police and HCPs. The PiMD may inadvertently be overlooked within these cycles. Government ambition for inter-agency working and joint police and health policies (Police Scotland, 2016, Scottish Government, 2017), do not consider these relationships.

- This study identifies PiMD can be required to work around systems to gain support, a lack of alternative safeguarding environments for PiMD who are intoxicated, and inconsistencies in the agreements for levels of sobriety to conduct a mental health assessment. The safeguarding journey is more complex, undignified and traumatic for PiMD who are intoxicated. This suggests a need to develop clear guidance and alternative safeguarding environments to support PiMD safety, dignity, prevent criminalisation, psychiatric labelling and reduce demand on police and emergency health services.

- Shortcomings in the broader health and social care system can hinder opportunities to disrupt distress cycles for some people. Demands on G.P. time can make timely daytime follow up of out-of-hours safeguarding episodes difficult. Absence of a mental health disorder, for example, schizophrenia or depression, can find people outwith the thresholds for collaborative inter-agency support and case management within the ASP Act. Together, these processes can contribute to missed opportunities to help people find solutions to self-manage their distress and support recovery. The lived experience of support by police and out-of-hours HCP services for some PiMD only partially matches up with their immediate and long-term needs.

In the next chapter, six key arguments are framed around three research questions, and discussed in the context of appropriate empirical literature.

Also, I consider the relationship between the system and human responses and the impact on both the support available and stressors for PiMD through the inter-related theoretical lens of Defeat and Entrapment Theory (Gilbert and Allan, 1998), The Cry of Pain model (Williams and Pollock, 2001), and Starks Conceptual Model of Suicide (Stark et al. 2011), introduced in Chapter 3.

# Chapter 8: Discussion

## 8.1 Introduction

In this chapter, the key arguments of the study will be discussed in relation to the wider empirical evidence. The research questions outlined in Chapter 2 provide the structure for the discussion.

I will reintroduce the inter-related Defeat and Entrapment theory Gilbert and Allan (1998), The Cry of Pain Model (Williams and Pollock, 2001) and the Stark et al. (2011), Conceptual Model of Suicide, presented in Chapter 3. I will discuss the limitations of these theories in relation to my own findings, and introduce my conceptual model, adapted and informed by elements of the above authors work, underpinning my discussion.

## 8.2 Theoretical Considerations in the Elaboration of Findings

In Chapter 3 (3.3), I presented the theoretical approaches with relevance to the findings of this study. The three inter-connected theoretical and conceptual models of suicide and self-harm (stated in the above Introduction). I presented the elements and concepts of each theory or model relevant to the findings in this case study, (Chapter 3 Figure 5 pg. 65) and are judged to be a useful frame to guide the discussion of the findings.

My findings identify a relationship between the individuals' experiences of distress, shortcomings in police and health service systems and the human responses brought to bear by occupational culture, and diverse professional perspectives of PiMD needs. In some circumstances, such as when the PiMD is intoxicated, the systems gaps and human inputs can contribute to an individual's distress, and cyclical safeguarding responses of PiMD, police and HCPs. These go unaccounted for in the current literature. Collectively, elements of the above theoretical frame can help explain these relationships and experiences.

A useful element of Gilbert and Allans' (1998), work, is the focus on the internal and external factors which contribute to feelings of defeat and entrapment. These can help explain the catalyst for help-seeking through emergency services and experiences of increasing distress during safeguarding. The work of Williams and Pollock (2001), and Stark et al.( 2001), bring a useful lens to the 'Stressors' and 'Factors affecting support' within the safeguarding journey brought to bear by Police and HCP processes and responses. Specifically, Stark draws attention to the relationship between external factors such as Mental Health Service availability, and stressors such as social and political exclusion. Drawing on key elements from

these three works, within the context of Police and HCP responses to PiMD, can help bring an understanding of individuals' experiences of safeguarding central to the research questions.

There are limitations to this theoretical frame. Unaccounted for in these models, which my study addresses, is the recognition of stressors, which can present as a result of the available support; police and out-of-hour emergency healthcare. In the context of my study, my findings suggest support availability can both reduce and contribute to feelings of distress, escape and helplessness at different points within the safeguarding journey. Thus, it is important to extend this theoretical framework to recognise the cyclical nature, relationships, and impact of support on reducing or adding to distress. Although police officers and HCPs work to keep people safe, my findings suggest the realities of safeguarding journeys, where two services intersect, can be convoluted, often cyclical and can in some contexts, bring unintended additional stressors. Consequently, the current theory and models I have drawn upon do not fully support an understanding of the flux of distress as a result of inter-agency systems and human responses.

There were elements of the chosen theoretical frame I did not use. This was because they sat outwith the scope of my study. For example, Williams and Pollock (2001), identify positive future thinking as a key rescue factor. This did not present, nor was explored in my interviews. The Stark et al. (2011), model goes beyond stressors and factors affecting support to identify contributory factors in decisions to self-harm and likelihood of death. These were outwith the boundary of the case study, which was focused on safeguarding journeys, thus not evident in my findings.

In Chapter 4 (4.6.8), I discussed my approach to the integration of the findings within this holistic case study. This analytical progression moves from 'telling a first story' about the safeguarding journey, to constructing a 'map' by formalising elements within the findings which are connected, and how they influence each other (Miles and Huberman, 1994). This must be focused sufficiently to permit the synthesised data to be viewed collectively and arranged systematically to answer the research questions. The current study synthesised data, and relationships between subunits and the holistic case, theoretical proposition, research questions, and conceptualised theoretical approach (Chapter 3) are considered.

Thus, the dynamic story within my case study is illustrated in a conceptual model (Figure 15), illustrating the relationships between structural and human responses and an individual's stressors during safeguarding journeys.

Thinking holistically about this model is important as it underscores the nuance in safeguarding journeys as experienced by participants. Before discussing my findings in relation to this model, I will describe briefly the structure and relationships within my conceptualisation.

Central to the model is the PiMD. Surrounding them are potential internal and external stressors, experienced by the PiMD, informed by my findings and Defeat and Entrapment Theory (Gilbert and Allan, 1998). Internal stressors are for example, the 'need to find peace from escalating distress' and timely support. Aligned to and surrounding these are external stressors, brought to bear by the context and nature of the individual's distress; for example, 'publicity of distress and intoxication'. Theory helps to explain the relationship between the individual's distress (internal and external factors) and the impact of the support brought to bear by Police and HCP inputs. Working outwards, and surrounding these, are inter-related factors affecting support informed by Starks' work. In the context of my findings, these are police and health systems factors and human responses. Connecting to all three elements is the outer cyclical features of stress, helplessness, and escape potential. Informed by the work of Williams and Pollock (2001), these highlight how stressors and factors of support can find people move in and out of distress cycles and potentially contribute to the risk of serious self-harm.

Conceptualising safeguarding experiences in this way helped me understand the relationships and movement of cyclical distress journeys, which can find PiMD, Police and HCP within patterns of distress and response. Although there is relational overlap, I aligned these elements within the model thematically. For example, working from the core outwards to the left of the model – the external stressor 'exposure to restraint' compounds internal stressors of 'feeling entrapment and aggression'. Stressors are further heightened through police system factors such as 'processes to manage aggression' and human responses such as a 'risk-averse police culture'. Collectively these reinforce helplessness, stress and escape potential thus impacting on risk of further self-harm. The two-way arrows illustrate these factors can also work back and inwards, relating to '(Re)traumatisation' (from previous experiences) and 'feeling dehumanised' thus contributing to further distress.

I will now discuss my findings in relation to my conceptual model (Figure 15). The subheadings in this discussion link with stressors and factors within the conceptual model.

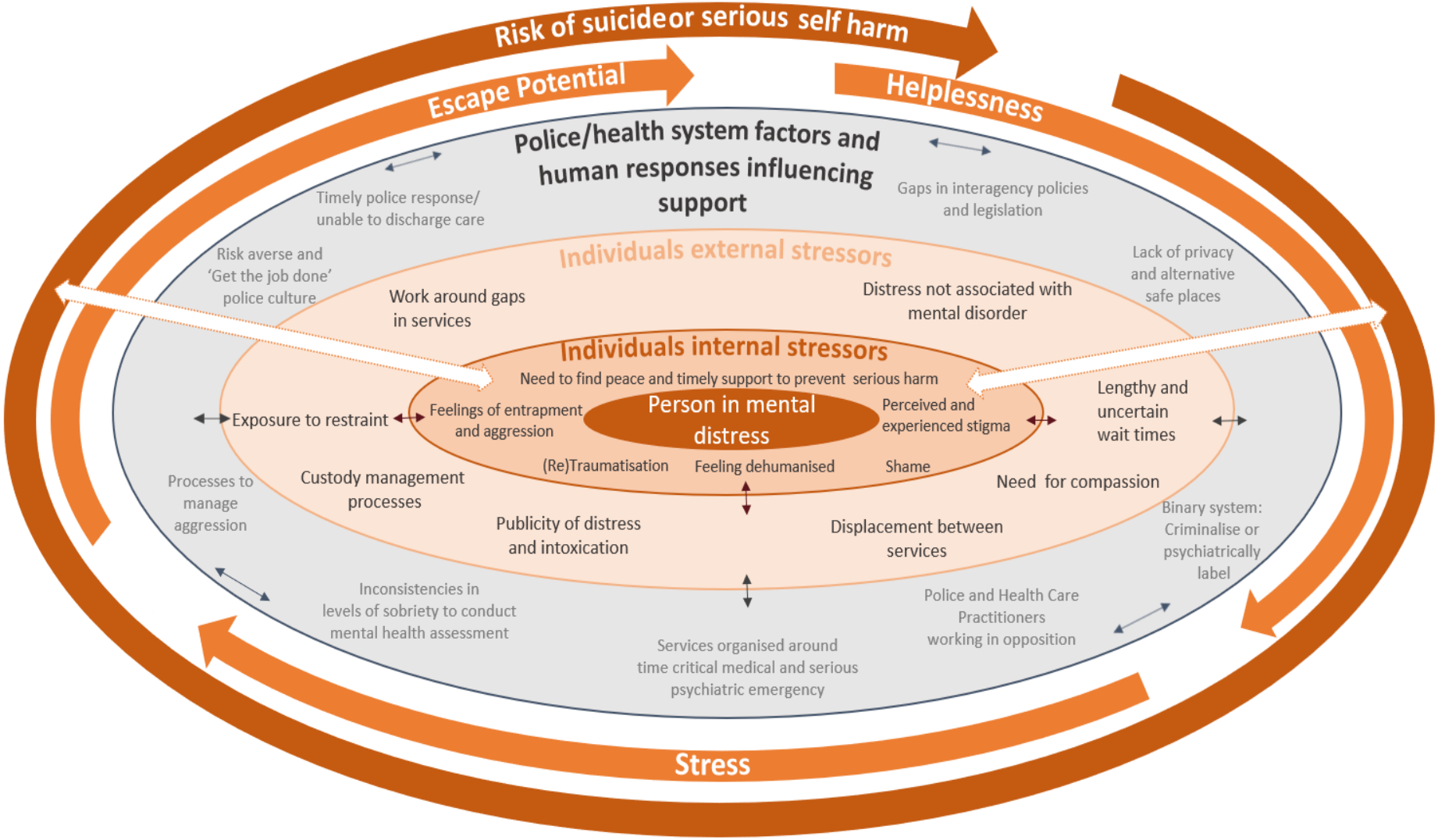


*Figure 4: The relationship between structural and human responses and stressors in the safeguarding of people in mental distress; a concept model*

## 8.3 What are the Experiences of People who seek help through Police and Healthcare Practitioners when they are in Mental Distress?

The first question in this study sought to determine the experiences of PiMD in help-seeking via the Police and HCPs. The womens' experiences of being kept safe varied depending on the context in which help-seeking took place. Experience differed if the person was kept safe in their own home, transported to out-of-hours health services, or safeguarded in police custody. Experience also differed if the PiMD was sober or intoxicated. In this section, I draw on elements of the conceptual model to guide the discussion.

### 8.3.1 Timely Support to find Peace and Safety

A key feature shared within two of the womens' interviews[3] when talking about seeking support, was of a pressing need for physical safety, help to manage escalating thoughts of serious self-harm, and peace from their distress. The swift police response was viewed as crucial in bringing this type of support for two main reasons. Firstly, police officers were viewed as reliable and available to respond quickly when HCPs could not. Secondly, they brought a physical presence and authority when the women felt they were unable to keep themselves safe.

A key narrative within the womens' interviews was trust that police would attend when called on for support. Similarly, the commitment for a consistent, prompt response, was highlighted in interviews of police officers attending the three women. Officers discussed a dependable, quick response to emergency calls as routine practice for those at risk of self-harm. Included in this type of response were frequent callers such as Jess, whose needs were viewed often by officers as non-urgent. Fallon (2003) echoes the importance of reliability and trust of support givers during help-seeking, to prevent self-harm. Fallon's (2003), qualitative grounded theory study found people rely on contact with HCPs to help intervene in order to stay safe during self-destructive behaviours. By way of contrast, in my study, HCPs were viewed as unreliable by the women in the context of being prompt first responders. Instead, it was police officers who were viewed as the dependable, only option when they were in crisis.

Fallon (2003), highlights people adopt strategies to negotiate access to mental health care when emotions become overwhelming and self-destructive behaviours become likely. My study highlights that, learning from previous experience, people did so through police services when they felt HCPs would not be available promptly. The women talked about working around

[3] These points did not arise as strongly in Deb's interview as she has little memory of this first point in her journey due to intoxication

service gaps by intentionally triggering an emergency police response through NHS24 or directly via an emergency call to police. Gaps in access to support before crisis point, are highlighted in a synthesis of evidence by Paton et al. (2016).

Consistent with my findings, Paton suggests there are few options, other than the police, for an in-person presence to manage mental distress behaviours in the community. PiMD purposively working around the system is unaccounted for in the current literature. My data highlights that police officers occupy a primary and important position in being accessible and consistent to PiMD to manage their self-harm behaviours.

In my case study police officers were not perceived by the women as bringing mental health care per se; rather it was the physical presence of a police officer as law enforcers, which brought a sense of management to a situation in which the women felt out of control. For example, as Jess explained, police officers could disable lethal means of harm such as removal of knives and remain in attendance for many hours until HCP assessment. This would suggest PiMD perceive police as important in managing mental distress and keeping people safe, brought about by their ability to respond quickly alongside the authority they bring to safeguarding.

Collectively, these data pinpoint an important relationship between the sense of urgency for support experienced by PiMD and feelings of availability, trust, and reliability of police.

The flip side of this was a view there are gaps in health systems with a *lack* of reliability and availability of out-of-hours HCPs. As Gilbert and Allan (1998), suggest, levels of stress and feelings of entrapment occur when the flight is blocked. Access to prompt support is considered as a buffer from suicidality to individuals in the face of stressors (Johnson et al. 2011). Likewise, Stark et al. (2011), highlight that access to mental health services is a key factor influencing escape potential with a lack of availability of services outside working hours increasing the risk of harm.

Yet, the relevance of accessibility to other front-line services in blocking or easing self-harm behaviours is often missing, or minimised as 'social support', in other theoretical or conceptual models (Karthick and Barwa, 2017). The police officer role appears understated in health and safeguarding literature and absent from theoretical models. My findings suggest police officers fill an important space and a critical role in reducing feelings of entrapment and potential serious self-harm when called on for support. Thus, their role should be included as a key support in the conceptualisation of risks to serious self-harm.

These data highlight a further significant external stressor unaccounted for in Starks' work and therefore important to include in my conceptualisation. People were required to work around systems to gain police support. Although police officers can relieve feelings of entrapment and halt potential serious self-harm, the pathway is not clear.

Local police and NHS psychiatric emergency plans identify a pathway to healthcare support for PiMD following a police response. Nevertheless, as I will now discuss, there are circumstances where PiMD can experience elements of the remaining police / HCP response as either supporting or contributing to their distress. Therefore, there is a tension between the need for immediate relief from distress brought by the police, against the potential added stress brought to bear by further police and HCP inputs.

### 8.3.2 Lengthy Waiting and Publicity of Safeguarding Journeys: Shame, Criminalisation, and Calm

In this study although the women perceive police officer attendance as bringing safety, the wait for HCP assessment with police officers was lengthy and linked to the context of where the wait occurred.

Fiona had a lengthy wait time with police officers at the psychiatric hospital where she felt her self-harm and behaviour was 'public'. She felt waiting in a police vehicle and being constantly chaperoned by police in a public waiting area was embarrassing, stigmatising and criminalising. The lack of privacy, compounded by the police involvement, added to her embarrassment of her self-harm.

Similarly, Owens et al. (2016), qualitative study reported people who self-harmed avoided the E.D. whenever possible, based on previous poor experiences of public shame and stigma. When forced to seek emergency care, Owens suggests people did so with feelings of unworthiness, thus perpetuating a cycle of shame, avoidance, and further self-harm. The present study illuminates the shame of self-harm brought to bear by police involvement in other clinical areas. It is therefore essential for police officers and HCP's to consider peoples' privacy and wait times throughout the safeguarding journey to ensure discretion and dignified support.

Deb's memories of the lengthy wait time for HCP assessment in her home were scant, due to intoxication. However, she talked of the shame she felt in her community brought about by the publicity of removal from her home, and being returned home, by police. To avoid further

embarrassment, Deb asked officers to drop her at a distance from her home so she was not seen leaving a police vehicle. These findings help us understand the impact of the stigma of police involvement during safeguarding where there is the added humiliation of perceived criminalisation. Stark et al. (2011), highlight stigma associated with self-harm as an external stressor in their conceptual model. These data underscore the notion that stressors associated with self-harm stretch beyond that of mental health stigma.

According to my data, self-harm can be linked to other forms of stigma and shame through police safeguarding. Stigma through police intervention during safeguarding has received little attention in the literature. These findings raise further questions about the nature and extent of stigma through police involvement and of the need to consider the broader impact gaps in systems, and how out-of-hours safeguarding impacts on an individual's social recovery.

Notwithstanding, there were circumstances when waiting with police was experienced more positively. In contrast to waiting with police in public spaces, less shameful experiences occurred in the privacy of the person's home. This was only possible if the person had no physical injuries, was sober and could engage in HCP assessment with an out-of-hours G.P. For Jess, the time spent waiting for HCP assessment with officers, was experienced as caring and brought calm and peace.

These findings link to my police focus group data highlighting a belief that time police officers spent talking and listening to PiMD, reflected care and attention missing in safeguarding because of the absence of HCPs. This suggests, there are contexts in which chaperoning by police officers can be experienced in a less stressful way. Previous studies have not explored the context of what happens during positive experiences of police attendance to PiMD, in the privacy of their home, or what prevents transportation to health services or arrest. These findings invite opportunities for further research and consideration of the context and environment in which people are kept safe with dignity whilst awaiting assessment.

These findings are based on the experiences of three women so should be treated with caution. My data suggest stress associated with police involvement and waiting is lessened when managed more discreetly.

### 8.3.3 Place of Safety or an Unsafe Place?

Police custody should only be used to keep PiMD safe as a last resort (Bradley, 2009, Police Scotland, 2018). The current study illustrates that police custody is used because of gaps in HCP and police systems. This includes when police believe a person was still at risk from self-

harm behaviour after a mental health assessment or when PiMD were intoxicated or aggressive. Police custody was used for Deb because she was unsafe to be left at home, yet too intoxicated to be assessed by the G.P. and refused to be transported to the E.D. All three women discussed previous traumatic experiences of police vehicle transportation and police custody during safeguarding.

My data suggests experiences of safeguarding in police custody, contrasts with the concepts of feeling safe and managing distress. All three women described their experiences as confusing, humiliating, frightening and undignified. For the most, this was because of exposure to custodial procedures to support safety. For example, they reported the use of handcuffs and removal of clothing in exchange for a disposable self-harm prevention suit. Strip searches were undertaken by officers looking for concealed self-harm lethal methods, such as blades to prevent potential self-harm.

The women highlighted these procedures felt punishing, increased their anxiety, agitation, and distress, making them feel more vulnerable and unsafe. Distress because of police custody procedures are highlighted in earlier qualitative studies exploring peoples' experiences of police custody as a Place of Safety in England (Riley et al. 2011, Jones and Mason, 2002). These studies report that people felt like criminals and de-humanised because of the removal of personal possessions. Jones and Mason (2002) identified people felt custodial procedures stripped them of a sense of being an individual in the real world. This created a feeling of being 'out of touch with normality' and feeling 'not quite human'.

Unlike my findings, Jones and Mason, (2002) and Riley et al. (2011), do not discuss people being strip-searched by officers. Such invasive procedures reported by my participants contributed to them feeling de-humanised. This is an important finding highlighting the need to balance intrusive measures to prevent potential self-harm in custody against increasing the distress of those being kept safe. These key points suggest that, although people have been removed from a situation in which they could self-harm, the custody environment and procedures they are exposed to in order to prevent injury, can be distressing and feel unsafe. Consequently, this reinforced the distress for which they originally called on police for support.

In short, custody is not seen as a safe place for PiMD and humanness of the individual can become lost in processes. A lack of appropriate safe spaces during out-of-hours periods appears to have inadvertently created a situation where people who have sought safety through health and police services, can be exposed to harm through the act of safeguarding.

This suggests there is a pressing need to develop alternative processes to keep people safe outwith the custody environment.

There were situations when the women calling on support were arrested, and held in custody, due to intoxication and aggression towards police. This was because they perceived themselves to be a ‘problem’ to police, with no other means of managing their intoxicated, aggressive self-harm behaviour. They explained that when their intoxication and distress was unmanageable in the community, police resorted to force to restore order. Police officers discussed similar management difficulties and dilemmas in clinical case interviews and police focus groups. Intoxication, impulsivity, and aggression are interlinked to self-harm (Timmins et al. 2019, Heffernan et al. 2003, Borges et al. 2017, Lau et al. 2004). As Stark (2011), points out, it can also be due to feelings of entrapment. My data suggests there was no alternative process to respond to, or support PiMD, displaying aggressive behaviours when intoxicated outwith the criminal justice system. Yet, custody is experienced by the women in this study as traumatising and undignified. This could help explain serious self-harm behaviour during and after release from custody, (Cummins, 2008), potentially reinforcing the repetitive cycle of aggression, intoxication and police safeguarding contact. This suggests a problematic relationship between the need for police to maintain law and order, alternative safe spaces, and the need to provide compassionate care and safety in such circumstances.

People run the risk of arrest when seeking support for self-harm when intoxicated. My data suggests PiMD can become ‘offenders’ partly due to there being no other place or way in managing their safety, intoxication and aggression. It is important to note under such circumstances, people would not be documented in custody records as a 'Place of Safety’ under the MHCT Act and Mental Welfare Commission data discussed in Chapter 1 (Mental Welfare Commission, 2018). It would be recorded as an offence.

This could provide some explanation to the reported reduction in recent years of police custody being used as a ‘Place of Safety’. Potentially, the safeguarding of PiMD in custody is concealed inadvertently through recording of other offences. Again, these data being the experiences of three women, may limit somewhat these exploratory findings.

However, my data invites further investigation of the scale of a problem, and experiences of a specific group of people managed in police custody. This population may be unaccounted for in police custody data where their calls for safeguarding have become complex due to alcohol and aggression and are managed under offences such as a breach of the peace.

Recognition of the complex and uneasy tension between escalating feelings of entrapment, intoxication and aggression and keeping people safe against exposing PiMD to further distress through restraint during transportation, undignified custody management procedures and the custody setting emerged. These findings are not identified in current literature and point to a gap in structures and processes to respond to PiMD who are aggressive in a supportive and protective, rather than criminalising, manner. In this next section, I discuss the immediate and longer-term impact of this gap on people resulting from the trauma of exposure to custody.

### 8.3.4 (Re) Traumatisation and Dehumanisation

The women reported exposure to the previously mentioned police custody safety processes, as (re) traumatising, embarrassing, and frightening. This was illustrated in Deb's account of her history of self-harm linked to childhood sexual trauma. Handcuffing, being locked in a cell and unable to escape triggered memories of abusive experiences as a child and adult. Triggering such memories found Deb wishing to further self-harm and drink alcohol on her release from custody. These echo experiences of trauma survivors based in mental health settings as reported by Sweeney et al. (2018), who suggest re-traumatisation occurs when something in a present experience is evocative of past trauma, such as the inability to stop or escape a perceived or actual personal threat. Evident forms of re-traumatisation include seclusion, restraint, body searches and round-the-clock observation. The processes and experiences in mental health settings, described in Sweeney's work, mirror those described in the experiences of police custody by the women in my data.

Similarly, the womens accounts chime with trauma-informed literature from other custodial settings. Miller and Najavits (2012), in their review of the literature of trauma-informed practices in prison settings, suggest custodial environments are designed to house perpetrators, not victims, and are full of unavoidable triggers such as 'pat-downs' and strip searches. This suggests the police transport, custody environment and procedures can contribute to re-traumatisation. Thus, it is argued the use of police custody does not match the needs of PiMD to feel safe or reduce feelings of distress. Rather, these findings suggest police secure transportation and custody safeguarding procedures can contribute to distress cycles in which police respond.

These data highlight new understanding of the re-traumatisation of a specific population; PiMD safeguarded through custody processes to prevent self-harm. The current study highlights this gap and points to a tension between preventing self-harm in crisis and contributing to long-term harm to vulnerable people. There appears to be a balance struck between the crisis nature of keeping people safe at that moment, against the lasting impact of 'protective' custody

processes on those already traumatised. The current study shows there is a crucial need to build in systems to avoid custody safeguarding under any circumstance. Also, there is a need to develop trauma-informed practice and processes for the custody setting, such as recognising the symptoms of past trauma and actively seeking to avoid re-traumatisation for those at risk of self-harm in custody.

Aligned to custody experiences, my data suggests other safeguarding processes can be experienced as dehumanising. These findings stem from interviews with Fiona, police officers' supporting her safeguarding and police managers. Police participants reported that people could be treated like an object or a problem to be solved, passed between services which did not meet their needs. Fiona reported this added to her feelings of low self-worth and distress. Dehumanisation is raised in mental health care literature relating to areas of seclusion and restraint (Brophy et al. 2016), and more broadly in mental health discrimination literature (Thornicroft et al. 2010). However, issues of dehumanisation in safeguarding PiMD is widely missing in policing and health literature. In contrast to other work by Williams (2001), and Stark et al. (2011), traumatic or dehumanising interaction with those bringing support is not identified as a stressor. It was therefore important to include re-traumatisation as a result of gaining support within the conceptualisation of serious self-harm in my conceptual model.

In summary, and answering the research question in this section, these new findings illuminate an essential relationship between peoples need for relief from their distress, structural gaps and the immediate and long-term impact on PiMD experiences of safeguarding journeys involving police and health services. These novel findings are unaccounted for in the current literature (Paton et al 2016, Stark et al 2011, Fallon 2003), and highlight that although PiMD value the initial police response to calls for support, they can be exposed to lengthy police escort wait times for mental health assessment, and at worst, undignified and traumatising experiences of safeguarding. These experiences are in stark contrast to the needs of people to feel safe, protected and treated with dignity. This is not only in terms of future risk of self-harm, but also in terms of PiMD's ongoing and future relationships with police (Wooff and Skinns, 2018), and health services. Given the cyclical traumatising experiences reported in this study, it is essential that police officers' and HCPs recognise and consider the emotional fragility of those entering and released from their care.

Feelings of shame and humiliation can contribute to defeat and entrapment thus potentially easing movement towards suicidal ideation (O'Connor and Kirtley, 2018). The humiliation experienced by some women in this study could negatively influence further self-harm and future calls for support.

Importantly, even though aspects of their previous safeguarding had been challenging, the women in this study did seek support through police services when unable to manage their distress. This is because they felt there were no other options available. Williams (2001) argues entrapment can be influenced by negative memory bias which can act as a barrier to accessing support and feelings of hopelessness. These new findings address a gap in the literature in the context of out-of-hours distress experiences involving police during mental distress incidents. Extending the work of O'Connor and Kirtley (2018), my findings point to the importance of recognising the cumulative effect of repetitive trauma, shame and humiliation as internal stressors through engagement in police and health services, on potential future help-seeking and risk of serious self-harm. The impact of repetitive distress journeys and negative experiences is not fully understood.

## 8.4 How do Organisational Processes, Partnerships, and Cultures influence care journeys of those in Mental Distress?

The second question this study sought to understand was how health and police service processes, partnerships, and cultures shape PiMD journeys. The key factors arising from the data analysis are embedded in my conceptual model under 'Police / Health system and human responses affecting support'. Three of these inter-related factors will be discussed in this section.

Firstly, and linked to the women's experiences in the earlier section, there was evidence of variations within, and between, services in agreed levels of sobriety to conduct mental health assessment leading to inter-agency tensions and convoluted safeguarding journeys. Secondly, criminal justice and health services, when organised around serious mental illness and time-critical medical emergencies, were a 'poor fit' for the women in this study who found themselves displaced between services. Finally, my data suggests safeguarding journeys can be shaped by occupational culture associated with managing risk.

I will now discuss these points in turn.

### 8.4.1 The Impact of Inconsistencies in Measuring Sobriety to Conduct Mental Health Assessment

There is an established link in the literature between alcohol and the risk of serious self-harm (Borges et al. 2006, Cooper et al. 2005, Hawton, 2016). The Stark et al. (2011), conceptual model, recognises this relationship across settings. An unexpected finding emerged from my

analysis of police officer and HCP interviews and focus groups was that of inconsistencies between services of agreed levels of sobriety for mental health assessment. This was surprising given the strong relationship to suicide and risk assessment. Such inconsistencies were confusing for referring officers and assessing HCPs alike. When coupled with a lack of safe and discreet places to manage PiMD awaiting sobriety for assessment, PiMD were exposed to numerous transitions and rebounding between services, and management in busy environments such as the E.D. or police custody.

Across the study setting, four levels of sobriety were viewed as suitable by police and HCPs for PiMD to take part in mental health assessment. Three such levels of sobriety were assessed using a breathalyser to identify blood alcohol content (BAC). These were total sobriety or two different drink-drive limits. A fourth subjective test, based on an individual's ability to understand and answer questions, was also used by some HCPs and embedded in the Police Scotland Mental Health standard operating procedure (SOP). The lack of clarity on the level of sobriety required for mental health assessment contributed to inter-agency tensions and the uncertainty and unpredictability of how, where and for how long police officers managed a PiMD.

Such inconsistencies resonate with the literature, which reflects a lack of consensus and clinical guidance. An Irish retrospective study by Elgammal et al. (2015), sought to examine in what circumstances emergency medicine HCPs request BAC. Elgammal's study suggests that, in most cases, a breathalyser was used to determine BAC to ensure complete sobriety before psychiatric assessment. What is not clear from Elgammat's study is why this level was chosen or what happened to people awaiting sobriety.

In my study, some HCPs assessed the ability to engage in mental health assessment by applying the legal drink-drive limit, evidence for which is unaccounted for in the existing literature. It is noteworthy that within the data collection period for my study, the legal drink-drive limit in Scotland was reduced to almost zero. However, for some HCPs, the practice of refusing assessment for those over the new, and lower, drink-drive limit remained. This suggests an arbitrary level of sobriety has been drawn from legislation associated with impaired driving, rather than underpinned by evidence of cognitive capacity for mental health assessment.

Police participants interviewed within the clinical cases and focus groups suggested their referral of people who were intoxicated to health services for mental health assessment was guided by Police Scotland policy, using a subjective measure of intoxication. Officers reported

that in their experience, peoples' cognitive capacity could vary when under the influence of alcohol. Thus, some presented with high levels of alcohol in their system yet still could understand questions. Olson et al. (2013), in their observational study, explored objective and subjective decision- making of sobriety with emergency medicine HCPs. Based on outward signs, HCP's in this study estimated intoxication in people (n = 384) attending the E.D.

Participants interpretations of intoxication did not correlate well with BACs, meaning HCPs could assess someone as sober, yet BAC indicated high levels of intoxication. This was especially true for people with chronic alcohol problems, where their tolerance to alcohol can mask visible signs of intoxication (Brick and Erickson, 2009). This is important in the context of my study as it suggests the way people present, and their capacity for assessment can vary. Some people who appear highly intoxicated yet have low blood alcohol levels, may be excluded, or accepted, for assessment dependant on subjective or objective measurements chosen by HCPs.

In the current study, those refused assessment by HCPs were transported and chaperoned by police officers into the E.D. or managed in a police vehicle or police custody, to await sobriety. Thus, approaches to sobriety can impact upon further police transfer and transportation of PiMD, waiting time with police, and undermine dignified care. This suggests there is an uneasy relationship between inconsistencies in organisational processes, evidence-based clinical guidance, individual professional approaches to assessment, and peoples' experiences of care. The rationale for the chosen level and approach to measuring sobriety appears driven by HCP individual preference rather than agreed evidence-informed, inter-agency policies.

Partnership referral agreements and clinical guidance in the assessment of PiMD who are intoxicated, has received little attention in the literature. As these findings suggest, variation in assessment can have a significant impact on peoples' experiences of being kept safe. These data suggest a need for clinical guidelines and standardised practice which would help the dignified treatment of PiMD and reduce operational tensions between police and HCPs.

Managing PiMD awaiting sobriety for mental health assessment within current systems, was also found to have a significant impact on police and health service resources. Police officer participants in the clinical case interviews and focus groups highlighted they could spend up to an entire shift managing PiMD in the E.D., psychiatric hospital wait area or their homes.

This was illustrated in the police officer experiences in the three clinical cases. For these police officers, lengthy wait times awaiting mental health assessment was perceived as drawing police officers away from frontline policing duties. The HCPs, in the manager interviews and clinical case interviews, thought police referrals of PiMD who were intoxicated contributed to breaches of NHS 4 hour turn around target times, and increased demands on out-of-hours G.P.s. This suggests the use of clinical environments to manage PiMD who are intoxicated, can cause blockages in police and health systems, and make additional demands on emergency health services.

These findings resonate with studies in England, where the time taken for sobriety for mental health assessment in the E.D. is reported as ranging between, almost 7 hours and 9 hours 36 mins (Borschmann et al. 2010, Docking, 2009). Zisman and O'Brien (2015), in a large English retrospective study of PiMD brought into the E.D. by police, found that in most cases (69.5%) E.D. target times were breached because of intoxication. In the context of my study, this underlines practice challenges at the police and health intersect. These do not appear to work for either service. The findings point to a need to consider alternative safeguarding options for this group, which are not reliant on police officers, is cognisant of the impact on clinical services, yet supports the safety of PiMD.

The impact of intoxication on safeguarding journeys is more complicated than whether the PiMD is fit to be assessed or not. According to Stark, mental health care availability is a key factor affecting support and risk of serious self-harm. My findings suggest intoxication can restrict availability of mental health care and impact significantly on police and out-of-hours health service resources.

Drawing on my holistic conceptual model, the relationship between gaps in the system to support PiMD awaiting sobriety and individual stressors becomes clear. When mental health assessment is unavailable due to intoxication, and the PiMD is managed elsewhere, such as the E.D. or police custody, added stressors come into play. Examples of this would be, the publicity of distress, lengthy wait times and potential exposure to traumatising custody processes. Therefore, inconsistencies in processes in assessing sobriety to access mental health assessment all have a part to play and should be considered within the system factors and human responses affecting support of those at risk of serious self-harm.

### 8.4.2 Displacement of PiMD between Criminal Justice and Health Services

I highlighted that current out-of-hours health and criminal justice systems are ill-fitting for the needs of some PiMD. Now, I will consider how these gaps are experienced from the

perspectives of police officer and HCP participants, and why these gaps displace PiMD between the four safeguarding environments identified in this study; the E.D., the individual's home, unscheduled-care psychiatric services and police custody.

Despite local partnership emergency psychiatric plans naming the E.D., psychiatric hospital and out-of-hours G.P.s. as police referral points for PiMD, most HCP participants indicated they felt responding to some PiMD sat low on their clinical priorities. This was because some were not viewed by HCPs as 'time-critical' or associated with serious mental illness. Mental distress was often associated with social or psychological needs rather than emergency care. During 'normal-hours' working, community psychiatric nurses, third sector or social services can provide support. Perceived to be unavailable at night or at weekends care, fell to emergency services.

This may go some way to explaining lengthy wait times and poor experiences of PiMD as discussed in Chapter 2. Resonating with the findings of the current study, the Sondhi et al.(2018), large mixed-methods study based in London suggests the E.D. environment can be non-therapeutic, frightening and intimidating for PiMD. Sondhi, argues assessment processes in the E.D. are too clinical procedural and lacking a mental health therapeutic focus.

In my study, the busy clinical environment organised around medical emergencies, was ill-equipped to support people who did not have a co-occurring physical emergency such as overdosing. Thus, despite the E.D. being identified as a police referral point, the E.D. is unsuitable for PiMD with non-medical needs.

Similarly, mental HCPs felt police referrals to unscheduled psychiatric care of people viewed by HCPs as not seriously mentally ill, as drawing them away from their acute, inpatient psychiatric services. In this specialist area, mental HCPs highlighted they were ill-equipped to deal with PiMD who were highly intoxicated or had co-occurring medical needs. Consequently, police referrals of some PiMD transported to the E.D. suggests this referral point could be inappropriate for PiMD with specific needs.

In the same way out-of-hours G.P. services highlighted competing medical emergencies, a lack of capacity to deal with serious psychiatric emergencies and those who were intoxicated as restricting their abilities to respond to PiMD in their home when referred by police officers. Nevertheless, the individual's home is identified as a 'Place of Safety' under the Mental Health Care and Treatment (Scotland) Act (2003) ((Scotland) Act 2003) as a safe place to manage PiMD.

According to my findings, missing in these arrangements are processes to provide support for some PiMD who refuse to leave their home, which avoids arrest. This failing was illustrated in the case of Deb. The G.P. was unable to assess Deb due to her intoxication, and she refused to be transported to the E.D. These circumstances are unaccounted for in policy guidance and with no other options available to them, police officers applied criminal charges to remove Deb from her home into police custody to keep her safe. As explained in 8.3.4, this process can be traumatic. Furthermore, the police officers involved highlighted in their interviews that, for them, this gap finds them with a difficult dilemma; exposing people to unwarranted force, and places them in a position of doing an unlawful act in the removal of a person from their home against their wishes. This underlines serious implications for PiMD well-being and police practice.

Operational police and custody officer participants report being deeply uncomfortable with working around mental health legislation and police policies. They argue the use of force to remove someone distressed from their home, and exposure to custody. as being harmful, abusive, demeaning and resource intensive. Nevertheless, officers felt powerless to manage safeguarding in any other way, thereby highlighting gaps and a lack of flexibility in the health and criminal justice system to support this group.

Understanding officers' experiences of working within this gap in Scottish safeguarding legislation is missing from the literature – something this study addresses. Although working within a different legislative framework, there is evidence in England of similar situations where police officers have used custody to safeguard PiMD who are intoxicated (Scott, 2015). In a discussion of human rights law, Scott (2015), highlights such practices generate unacceptable breaches of human rights. Scott argues law reform is the only way to kick-start adequate provision of appropriate Places of Safety.

Although this is not an area the current study set out to explore, the findings suggest gaps in health care provision and legislation identified in the current research, in which coercion is part of safeguarding, reflects similarities in breaches in human rights. Through extending the literature, these findings highlight a complex gap in Scottish mental health legislation and police and health service joint psychiatric emergency planning. Therefore, it, becomes essential to understand the gaps in services and how these impact in safeguarding practice to examine and challenge safeguarding legislation.

Overall, several gaps appear in out-of-hours health and criminal justice services in order to manage PiMD holistically. This can find people displaced between services and place a demand on police officers seeking to discharge care. A mismatch between identified police referral points and out-of-hours emergency health services, and PiMD needs, may explain why some police officers remain concerned for peoples' safety after discharge from out-of-hours health services. Similar concerns were reported by all three women who highlighted that there were times when they had been discharged from the E.D. or unscheduled psychiatric services, where they felt remaining at risk of self-harm. My data underlines a gap in out-of-hours care for people whose distress is not associated with a mental health diagnosis. It also suggests there is no safe place for PiMD sitting between inpatient care, the E.D. and home.
Where there are gaps in legislation when 'Places of Safety' and police referral points are organised around emergency medicine or serious mental illness, people can be displaced between services. This thesis highlights a need for alternative referral assessment, non-clinical safeguarding processes and spaces beyond criminal justice, emergency medicine, out-of-hours G.P. and inpatient psychiatric services.

### 8.4.3 Occupational Culture as a Driver of the Safeguarding Journey

In this study, Police contact with PiMD was disproportionally high across the safeguarding journey, a key driver being a risk-averse police culture. "Risk" manifested in *all* police officer and focus groups interviews across the three study phases.

This was described as a fear of 'getting it wrong', and in part was because police officer participants recognised they were not mental health experts. Therefore, they relied on referral to HCPs to support their decisions. Officers suggested this was often a 'tick box exercise' used to shift accountability to HCPs should someone self-harm following police intervention. English police officers recognise similar practices. Thomas and Forrester-Jones (2018), mixed-methods study, suggests that where an officer is advised by an HCP not to detain a person under mental health legislation, the HCP assessment can indemnify them should an individual go on to harm themselves after police intervention. Potentially, such risk-averse practices could help explain the significant increase in police referrals to health services in Scotland (Mental Welfare Commission 2018).

However, my findings extend beyond the work of Thomas and Foster-Jones (2018), to suggest there are circumstances when HCP assessment is insufficient to divert the management of risk from police officers. As I highlighted earlier, police custody may be used in circumstances where officers did not trust - or were unconvinced by - HCPs decisions not to detain a person in hospital This is important because, although police officers in this study identified as having

limited mental health knowledge, some felt compelled to safeguard people in custody when they did not agree with HCP expertise. These findings contrast those of Thomas and Forrester-Jones study, (2018), which suggests HCP assessment alone can remove police officer liability, should the PiMD harm themselves when they returned home.

My findings suggest that at times, officers feel HCP assessment does not entirely remove accountability for police officers' decisions, because they do not agree with the HCP decision. Therefore, risk aversion and indemnity for their actions can remain a crucial motivator in police practice. This risk-averse police response may be linked to the earlier point of a gap between inpatient care and home, which can find people unsuitable for inpatient care, yet still be perceived to be at harm's risk.

Although officers expressed concern for the PiMD, underpinning a risk-averse culture was a concern of reprimand from senior officers, and fear of scrutiny from within the organisation should they fail to keep someone safe. As such, officers reported adhering to police policies, even if they believed it was the wrong thing for PiMD. For example, the previously discussed strip-searching of PiMD safeguarding in custody.

Whilst intra-organisational criticism was viewed as partially driving officers decisions, there was evidence also of a fear of public and regulatory body criticism. Officers explained their risk-averse behaviours were reinforced by fear of external investigation by The Police Investigations and Review Commissioner (PIRC). Similar to a Nursing and Midwifery Council investigation, a PIRC investigation was described as a harrowing experience and something to be avoided at all costs.

Thus, internal and external governance can directly influence how police keep people safe. Carson (2012), in a critique of reviews of professional risk-taking, suggests little can be expected to change in practice unless there are significant changes in the manner that professionals' risk decisions are reviewed when harm occurs. This is important when considered alongside the re-traumatising experiences of the women discussed in 8.4.4. Therefore, there is a need to address firstly the driving fear of professional criticism and scrutiny to disrupt the distress cycle and prevent serious harm.

Taken together, as I have in my conceptualisation, these findings point to a relationship between risk-averse police practice to avoid criticism of causing significant harm, and the less overt actual harm caused as a result of risk-averse police practices in the women's narrative. The value, therefore, in viewing experiences through a range of lens' - as this study has done,

is the exposure of relationships between these factors unaccounted for in the literature (Thomas and Forrester-Jones 2018), This study does not claim to be a voice for PiMD; however, it does illuminate new evidence of a relationship between peoples' behaviours and experiences during mental distress and gaps in safeguarding environments. Also, inconsistencies in approaches to mental health assessment of people who are intoxicated which is limited in existing literature (Mental Welfare Commission 2018, Hawton, 2016).

## 8.5 To What Extent do Expectations and Relationships between Police, People in Mental Distress and Health Practitioners' impact on Support and Safeguarding?

Most professional participants in this study acknowledged the responsibility in keeping PiMD safe during out-of-hours in the community, falls to the police. Police officers, as first responders were able to react quickly to those seeking support in the community. However, there was evidence of inter-professional tension associated with the remaining safeguarding management and responsibilities. This was discussed in three ways.

Firstly, most police officers reported an imbalance between their public safety and law enforcement roles with a significant amount of their time involved in care responsibilities. This was perceived to be unsustainable under current police budgets, potentially finding police officers questioning the current way of working with HCPs in safeguarding. Secondly, out-of-hours safeguarding takes place between health and criminal justice services, thus limiting options beyond these two systems for support where there is no serious mental health issue, or offence. In part, this links to the third point. HCPs and police officers could hold different beliefs of, and approaches to, PiMD risk and safety. A lack of shared understanding of PiMD needs found services working in contradictory ways contributing to convoluted and cyclical safeguarding journeys. These inter-related points will now be discussed.

### 8.5.1 Police as Safeguards and Law Enforcers

Most police officer participants highlighted in interviews and focus groups that protecting the public was at the forefront of police purpose, focus and values (Police Scotland, 2019). As the Police and Fire Reform (Scotland), Act (2012) first principle states, 'the main purpose of policing is to improve the safety and well-being of persons, localities and communities in Scotland'. While responsibility for the safety of PiMD was undisputed by most police participants, all officers highlighted they felt their role in responding to PiMD had moved beyond their expected initial public safety practice, into core police business. This shift brings

tension in balancing the role of a police officer, where they have responsibilities for individual and public safety, law and order and protecting human rights.

This multifactorial role, coupled with difficulties in discharging PiMD care to out-of-hours health services, created circumstances where police officers were challenged to respond as law enforcers to PiMD who also displayed disorderly behaviours.

Police officers described situations where PiMD became aggressive to them during safeguarding interventions. Aggression, intense anger, feeling out-of-control and rage are associated with entrapment (Li et al. 2018, Clarke et al. 2016), and help explain aggressive behaviours of some people who self-harm attended to by police. Several authors suggest police are not sufficiently prepared or trained to successfully manage situations involving PiMD who behave aggressively (Brouwer, 2005, Cotton and Coleman, 2010).

As a result, officers can resort to traditional approaches such as highly directive, authoritarian communication styles, used to engage and resolve other aggressive encounters in their work. Such an approach can be ineffective in certain situations, leading to an escalation of violent behaviours, thereby requiring more coercive tactical options, such as handcuffing and arrest (Brouwer, 2005, Godfredson et al. 2011).

In contrast to the evidence above, the womens' and operational officers' descriptions of their experiences of management of intoxication and aggression differ from that in the literature. For the most, officers described using 'soft skills' such as de-escalation communication to manage aggression and avoided hand restraint at all costs. For the most, handcuffs were used in circumstances where there was a need to manage safety, for example, when Deb tried to jump from the moving police vehicle.

Aggression appeared to escalate when it became clear there was no available support through health services, and police custody was the only choice. Officers in this study appeared to understand and moderate law enforcement approaches to aggression in safeguarding incidents. Furthermore, the escalation of aggression at a point when health services were unavailable strengthens the notion of a relationship between entrapment and aggression. These findings suggest restraint and the use of custody was used as a means to an end, rather than a traditional policing response to disorderly behaviours and point to a relationship between entrapment, police responses and gaps in the system.

Despite the traumatising and undignified experience, this study also shows PiMD experienced elements of police response as compassionate. For example, their willingness to wait for many hours for HCP assessment in the privacy of the individual's home.

In part, officers staying in attendance may be explained by the risk-averse police culture discussed in 8.5.2. Nevertheless, several police officer interviews highlighted a belief that their patience and attentiveness to PiMD brought care and compassion to safeguarding mental distress situations. Similar findings are highlighted by The Mental Welfare Commission (2018), in their report into 'Place of Safety' monitoring. This report commends Police Scotland for their care, compassion and professionalism in supporting PiMD. Williams and Pollock (2001), highlight the importance of compassionate responses to PiMD, suggesting rejection as a key internal stressor contributing to the likelihood of suicide. Cole-King et al. (2013), in their discussion of pragmatic, evidence-based interventions for HCPs to reduce suicide, suggest a compassionate approach is by far the most useful positive interaction for reducing such a stressor. Cole-King highlight adverse reactions such as feeling unheard, can cause people to feel hostile, unsympathetic and uncaring, putting engagement at risk. Applying this theoretical frame in a policing context is mostly missing from the current literature. Thus, although the lengthy wait times with police officers can be a stressor as I have argued, these data suggest that when delivered with care and compassion, there are opportunities to reduce the stress impact.

Several officers within the focus groups advocated for withdrawal from mental health safeguarding as they believed this to be outside the immediate police role. For example, through chaperoning PiMD in the E.D. officers viewed that by 'pushing back' on health services they could re-balance an unequal partnership and reclaim their policing role in law enforcement. Officers reported they felt 'used' by health services for security purposes and were pushed to the end of the queue until HCPs were available to attend. They articulated this as 'babysitting' for health services. They suggested they found HCPs had discretion over the use of an officer's time and role.

This was evidenced, in a description by one officer, of HCPs 'prescribing' two police officers, as part of treatment until HCPs could attend. What is important here is that some senior officers suggest they were no longer able to sustain this level of support to HCPs. As previously established, police officers occupy an essential space in immediate safeguarding, and a significant part of the remaining safeguarding journey because there is no one else. If police officers were to restrict their resources, the gap in services would be greater and potentially increase entrapment and less opportunity for escape, for some PiMD.

Therefore, an imbalance in professional responsibilities highlighted in this study has important consequences for HCP and police partnership relations. Moreover, a potential retreat into organisational silos suggests a possible deepening and widening of failings in a system in which PiMD have limited options to prevent serious harm.

### 8.5.2 Working in Opposition

There was a sense, because of the gaps in systems and different professional responses to PiMD, that police and health services may work in contradictory ways. The PiMD appeared to get caught up and lost within this relationship, at times being pushed back and forth between services.

Services working in opposition were influenced by professionals' perceptions of the individual's needs and risk of self-harm. An example from the current study focus groups was of one PiMD being returned by police officers to unscheduled care psychiatric services 18 times in four weeks.

Definitions of vulnerability across health and police literature are at best fragmented (Enang et al. 2019). Enang et.al international scoping review of police and health care perceptions of vulnerability, identifies that models for assessing and understanding vulnerability across the two services lack uniformity. Police interpretation tends to be context-specific, meaning police consider vulnerability from the perspective of the impact from, and on, the broader community. Enang et.al suggest HCPs tend to hold a person-specific perspective, meaning the focus on vulnerability is centred on symptoms and behaviours of the individual.

Potentially, there could be other factors at play such as those already discussed, for example a risk-averse police culture. Yet, viewing vulnerability through different professional lens' can result in police / health responding to PiMD in conflicting ways. Caught up in the middle, the PiMD can experience the stressors discussed previously in this chapter. The current study illuminates an essential gap in the shared assessment of PiMD needs, which could collectively consider individual and community perspectives drawn from both disciplines to better understand PiMD needs and risk of harm.

Aligned to different diverse concepts of vulnerability, I identified a lack of shared professional understanding or philosophies of the PiMD role in self-management and recovery from their distress. For example, mental HCP participants articulated the PiMD relationship and history with HCP's as being central to their assessment and decision to return the person home.

Mental HCPs alluded to a ‘strengths-based’ model of care and philosophy of person-centeredness, person and social recovery.

Central to the HCP assessment was understanding what the PiMD brought to their recovery, for example, knowledge from previous experiences and the clinician's role in supporting an individual's capacity to keep themselves safe without inpatient care. By way of contrast, police officers expressed a more reactive safeguarding approach based on perceived immediate risk and PiMD 'deficit'. Previous history and relationships with the PiMD appeared less critical to police officers, with the uncertainty of risk driving their response. This was illustrated in a police participant interview in Chapter 6. When responding to Jess, even though police officers had never seen her harm herself, they reported this potentially, could be the time serious harm occurred. This appears more aligned to traditional approaches to mental health care where there lacked recognition of the individual's role in person and social recovery, and re-empowering those who have been dis-empowered by mental distress or psychiatric services or both (Barker, 2001, Bird et al.2012).

Police and HCP dichotomous philosophical perspectives did not appear to be acknowledged between services. There was little evidence of planned and shared responses for PiMD who frequently sought police and HCP support. Therefore, these differences could potentially contribute to the cyclical nature of police referral / assessment / and return home.

Finding common ground in partnership assessment of risk is not uniquely a mental distress safeguarding issue. Similar inter-disciplinary differences have been identified in applying a strengths-based approach to working with offenders with mental illness (Vandevelde et al. 2017). A critical review, Vandevelde and colleagues argue that within forensic mental health, there has been a paradigm shift and narrowing of the divide in which different disciplines (psychiatry, criminology, and law) approach risk and recovery. Instead of focusing on offenders’ “deficits”, incapacities or problems, there is an adoption, within each discipline of strengths-based approaches to enable people to develop resilience.

However, there remains fundamental differences in the objectives of driving each discipline (van Dijk et al. 2019). This was reflected in my data, where police officers objective was to resolve an immediate crisis through linkage to inpatient care, against HCPs objective to prevent unnecessary admission to inpatient acute psychiatric care, thus promote recovery in the community. Therefore, different interpretations of strength and deficit can contribute to inter-agency tensions.

Vandevelde et al. (2017), propose that an assessment of an individual's strengths and difficulties should start from an holistic, inter-disciplinary point of view. In contrast, the current case study suggests that, overall, these two disciplines have not moved towards a shared understanding of risk and strategies to enable the PiMD to escape the distress cycle. Understanding different occupational objectives, perspectives and approaches are sparse within emergency police / health safeguarding literature. The findings from this case study have implications for the development of person-centred shared assessment, planning and building relationships around keeping people safe which are inclusive of the PiMD, Police and HCP perceptions.

Aligned to strengths-based theoretical and practice approaches to mental distress, Cole-King et al. (2013), view that in order to reduce stressors, HCPs should encourage and empower people to take back responsibility for staying safe. Thus, HCPs can instil a sense of self-efficacy and personal control and enhance resilience.

Personal control, in which they felt able to take responsibility for their actions, was mostly, absent from the womens' narrative in the current case study, mainly because police officers took responsibility for keeping them safe. In contrast, HCPs spoke about supporting people to enhance and manage their distress to avoid hospitalisation and return home. However, these attempts for empowerment were countered by police officers' risk-averse approach, which saw people frequently returned to health services or managed in custody when they did not understand or agree with the HCPs decision. This highlighted, a lack of understanding of partnership responses to PiMD and may result in HCPs and Police working in conflicting ways. Failure to reduce stress may limit escape potential of PiMD, reinforce helplessness and the distress cycle.

Challenges and tension in partnership responses to PiMD between police and health agencies resonate within the policing literature, with evidence of efforts to improve police / health partnership co-operation(Herrington, 2012, Bartkowiak-Théron and Asquith, 2015, Wood and Beierschmitt, 2014) (Herrington and Pope 2013, Bartkowiak-Theron 2011, Wood et al.2011). Tension in police / health relationships are less evident in mental health nursing or emergency medicine literature, suggesting a relatively one-sided perception of problems in partnerships (Heyman and McGeough, 2018).

Like the findings in this study where police officers felt they carried the burden of responsibility for PiMD, demand and a perceived shift in roles appears to be felt more acutely in policing practice, rather than that of healthcare. In this study police officers felt aggrieved by the

perceived erosion of their law enforcement role, and inclusion of mental health care into police work which they feel evolved without negotiation, partnership brokering or recognition of other demands. Recognition of inter-agency tensions and realignment between services to stop them working in opposition is required alongside reform, an articulation of resources and responsibilities in partnership commitments between Police Scotland and Mental Health strategies (Police Scotland, 2016, Scottish Government, 2017).

### 8.5.3 Safeguarding in a Binary System: Psychiatric Labelling and Criminalisation

Current out-of-hours safeguarding of PiMD is managed between health and criminal justice systems, with Police Officers and HCPs holding key roles in safeguarding. However, my findings highlight aspects of this two-way relationship having impact on PiMD experiences and, in some cases, inadvertently criminalise or psychiatrically label people through seeking to manage them in psychiatric services. In part, this is because the needs of PiMD who do not have a serious mental health disorder or have not committed an offence are unaccounted for in multi-agency psychiatric emergency planning. This suggests a need to broaden out-of-hours systems and policies towards more pragmatic safeguarding solutions where police can discharge care outwith health services and people can be kept safe without being viewed as a psychiatric or criminal justice problem.

Avoiding 'criminalisation' by police diverting PiMD to mental health services, is laid out in Scottish Government policies (Scottish Government, 2017c). However, the current study shows people may 'bounce' between police and mental health systems with diversion into health services or the criminal justice system, as being harmful and incongruent with some PiMD needs.

Literature points to police as gatekeepers in deciding should a person with mental health needs who has come to their attention, enter the mental health  or criminal justice systems (Borum et al. 1997, Franz and Borum, 2011, Fry et al. 2002, Chappell and O'Brien, 2014, Compton et al. 2006, Wells and Schafer, 2006, Lamb et al. 2002, Broussard et al. 2010).

Potentially, reflecting local policies and the , my data suggests this is not the case in this study area and is more complicated for people who do not have a serious mental illness or medical emergency. Although police may expect mental health services to be more appropriate than the criminal justice system to safeguard PiMD, it would appear HCP's are often the gatekeepers to mental health services, not police officers. PiMD may still be diverted back to the criminal justice system, via mental health services.

All police officer participants viewed the de-criminalisation of PiMD as necessary and custody as the worst place to manage anyone with mental health needs. In contrast, most HCP participants interviewed suggested police custody as a suitable place for PiMD who were drunk because acute psychiatric and critical care environments were unsuitable. Yet, consistently the literature reflects custody as an unpleasant and inappropriate place to safeguard people with mental health problems (Mouko et al. 2015, Riley et al.2011).

In England, the Crisis Concordat highlighted significant concerns over the use of police custody as a 'Place of Safety' (Paton et al. 2016), and have developed "zero tolerance" of custody for safeguarding (Gibson et al. 2016). The Independent Police Complaints Commission (IPCC) (Docking, 2009) concluded that a hospital E.D. provides a better environment than police custody for those in mental distress. It is unclear in this report if this includes PiMD who are intoxicated or aggressive, and what options there are for their safeguarding. It is possible neither health, nor criminal justice services, may be ideal and there is a need to reconsider alternative bespoke safeguarding spaces for some PiMD.

Unaccounted for in the literature (Fry et al 2002, Lamb et al 2002, Chappell and O'Brien, 2014) is the possibility that the diversion by police to mental health services for some PiMD, may be unwarranted, potentially harmful and stigmatising. New evidence presented in my study suggests some people can be referred repeatedly by police to mental health services, despite HCPs confirming there being no evidence of mental disorder or treatment they can offer. HCPs reported significant pressure by police officers to detain people in acute psychiatric care. This is problematic because, as the focus group HCP participants explain, inappropriate hospitalisation can expose people to restraint and personal restrictions which could be disempowering, traumatic and negatively impact on recovery – comparable to experiences described by the women of police custody safeguarding. Thus, despite efforts to decriminalise PiMD, ‘fitting’ people into inpatient care in order to keep them safe, can inappropriately expose people to psychiatric labelling and potential harms.

Several authors question the appropriateness of current medicalised service models in providing meaningful care for people who self-harm, calling for a rethink of how care to some PiMD can be provided (Simpson, 2006, Barker and Buchanan-Barker, 2004). The current study highlights a gap in safeguarding literature in the care of those who self-harm (Bradley, 2009, Campbell, 2013, Paton et al 2016) and raises important questions about the limited nature of the binary out-of-hours safeguarding system and the relationship between the criminal justice and health services in supporting PiMD and the stressors these bring to bear on peoples’ experiences of safeguarding. The focus for many years was on de-

institutionalising mental health care into the community, then in recent years, effort to divert people from the criminal justice system to mental health care. Nevertheless, my research illuminates that although criminalisation of PiMD is detrimental to their recovery, a diversion into mental health services may also be harmful. Therefore, a key finding is a need to broaden out-of-hours multi-agency psychiatric emergency plans beyond the current two-way criminal justice / mental health services.

## 8.6 Chapter Summary

These three sections, organised around the research questions and supported by my conceptual model, illustrate the relationship between the PiMD internal and external stressors, elements of policing and out-of-hours systems, and the human interaction of Police and HCPs involved in safeguarding.

Considering these relationships holistically, has allowed for the identification and understanding that there is nuance within the needs of PiMD and the ways Police and HCPs work which are unrecognised in current policies and processes.

Linking back to the 'Map of Local psychiatric emergency plan pathways and safeguarding journeys within the study area' presented in Chapter 1 (Figure 1 pg. 19), this thesis submits that if out-of-hours systems and human responses work well, people can be kept safe in a dignified way and are more likely to escape a distress cycle. However, in situations where the systems and structures are ill-fitting, people can become entrapped in this cycle and remain at risk of harm. This study has addressed elements within these relationships and underscored opportunities to disrupt distress cycles and rethink out-of-hours inter-agency safeguarding practice.

Having identified the ways the research questions have been answered, the final chapter concludes by reviewing the research approach and discusses the strengths and limitations of this study. I also consider the extent to which the study met its aims and presents an overview of how this thesis contributes to the key empirical and theoretical literature. I provide suggestions for future research, inter-agency education, policy and practice. In closing, I will reflect on my role in this study.

# Chapter 9: Conclusion

## 9.1 Introduction

In this concluding chapter, I review the research approach and discuss the strengths and limitations of this study. I consider the extent to which the study met its aims and present an overview of how the thesis contributes to the key empirical and theoretical literature. I provide suggestions for future research, inter-agency education, policy and practice. Finally, I reflect on my role in this study.

## 9.2 Review of the Research Approach

On completion of this study, it was important to take a critical reflective and retrospective look at the theoretical underpinning of the research, review limitations and strengths of my approach and consider the rigour and trustworthiness of the study.

### 9.2.1 Review of Theoretical Underpinning

Meeting the aims of this study was enhanced by the use of theory as outlined in Chapter 3. Defeat and Entrapment Theory (Gilbert and Allan, 1998), and the Cry of Pain Model (Williams and Pollock, 2001), helped explain and provide deeper insight into the relationship between individuals' distress experiences and the influence of Police and HCP inputs. Importantly, I believe the use of these theoretical lens' can help reposition the individual and their experiences of mental distress as central to the safeguarding journey. This study contributes to the policing and mental health safeguarding literature and explains why PiMD can be overlooked within the complexities of safeguarding journeys as a consequence of systems gaps and human responses. Defeat and Entrapment Theory illuminates the need for people to seek support through emergency services to gain peace and prevent serious harm. It also helps us understand the tension brought to bear by engagement with these services in which elements of safeguarding can be experienced as traumatising, stigmatising and undignified, thus reinforcing cycles of distress.

Understanding the data and thinking about this in a holistic way allowed for an extension of this earlier work, into a specific context. Thus, building new knowledge through the conceptualisation of relationships between individuals' stressors and police and HCP safeguarding.

Drawing on the work of Stark et al. (2011), helped contextualise my findings and provide deeper insight into the complex nature of safeguarding in a way that is applicable to HCP and Police Officer practice. The context of safeguarding journeys and relationship with professional responders influence the experiences of those in mental distress. Uncovering the perspectives of key stakeholders, and thinking of these collectively, has illuminated this.

My findings concur with Stark and colleagues work in acknowledging a range of factors in distress, including service availability. Stark states factors such as social isolation increases the likelihood of defeat, entrapment and 'no rescue', which are core to the Cry of Pain / Entrapment model. Where my findings differ is that unlike Stark and colleagues work, who point to mental health service availability, I considered the influence of police officers and out-of-hours emergency health services as factors in alleviating or contributing to feelings of defeat and entrapment. Police service availability can bring initial 'rescue'. However, my findings suggest a range of police and health service systems gaps and human inputs within safeguarding journeys, can bring additional stressors to PiMD. These can contribute to cyclical distress journeys for PiMD, police officers and HCPs.

Drawing upon a broadly social constructionist approach for this study allowed for these findings to be better understood within the current safeguarding environment and policy context. As described in Chapter 1, mental health, safeguarding and policing legislative landscapes have resulted in change over the last two decades, influencing how Police and HCPs practice. The findings highlighted limitations within out-of-hours police and healthcare resources and the tensions experienced by both in terms of their role identities as safeguards. The current system can find Police and HCPs inadvertently exposing people to harm in their attempts to protect those who may be vulnerable. Thus, a broadly social constructionist approach enables a better understanding of the findings within this current context.

As discussed in Chapter 3, using qualitative methods allows detailed investigation of real-life phenomena. I believe CSR enabled an in-depth exploration of a range of perspectives set out in the study aims. Case studies are described as 'tailor-made' for exploring processes, experiences and behaviours that are little understood, so were relevant to this study (Eisenhardt, 1989). In conducting this study with PiMD, Police Officers and HCPs, I captured a diverse range of views and experiences which, when considered holistically, illuminate the relationship between the systems and human responses on safeguarding journeys.

Qualitative CSR can be criticised for lacking generalisability of the findings (Thomas, 2016). Therefore, I implemented a number of approaches to ensure my research was conducted in

a rigorous and trustworthy manner. Defining and bounding the system in which safeguarding journeys occur, established a comprehensive approach to understanding a somewhat nebulous concept. I presented a variety of perspectives and contexts to frame the problem in Chapter 1. A robust review of the literature identified gaps in knowledge of the experiences of PiMD responded to by Police and HCPs during out-of-hours where inpatient care is not required, and of the inter-agency safeguarding processes to support PiMD.

I used a combination of methods to gather data from those who experienced safeguarding journeys; PiMD, Police Officers and HCPs. I propose my decision to consider this event from governance, practice and lived experiences brought richness and depth to these findings. Each clinical case was nuanced with different start, mid and endpoints, a broad age range, different police engagement contexts, and different assessment points. The findings have provided insight into different safeguarding journeys.

### 9.2.2 Approach to Interviews and Focus Groups

Within a broadly social constructionist framework, reflexivity provides an understanding of relationships between the researcher and participants (Cheek et al. 2015). I will now reflect on my approach to the interviews and focus groups

In Chapter 4 I reflected on the ordered way in which one police officer talked, as if he was participating in a police meeting rather than a research interview. It is possible participants were portraying themselves in a particular manner to protect reputations, both personal and of the organisations they represent. It seems feasible this may have influenced the information they provided. However, after a period of rapport building at the start of interviews my perception is that most HCPs and police officers shifted into a more relaxed and open conversation. Mostly, participants did not exclude their experiences of deviating from policy when there was no other option, or of adhering so strictly to policy that it exposed PiMD to potential harm. The narratives presented in the findings reflected their current reality of demands imposed on them and a multitude of other factors influencing their role in supporting PiMD at the intersect of two services, influenced by current policy and practice and guidelines they try to work within.

I wanted to ensure the voices of the three PiMD participants were heard. In retrospect, it would also have been useful to have spent additional time with the women to further explore their experiences of distress before they called for support and after they were returned home. I believe this would have provided a richer and more complete understanding of a distress journey. However, I was conscious it was tiring for participants to recount their stories. I was

careful not to exceed the time of one hour thirty minutes I had suggested the interview would take. Regardless, I was aware the women were keen to tell more of their experiences. If I were to conduct the study again, I would spend time with the women in a different way by conducting two interviews, spaced over a week to capture further detail and the depth of their stories. However, I submit my interpretation of the womens narratives presented in this thesis reflect their views and experiences.

Being reflective of the research process, I now recognise I could have explored further the political dimensions of the Police Officer and HCP roles in the social recovery of PiMD. In relation to mental health, social recovery alongside personal recovery is usually made when there are considerations of social inclusion, exclusion, or stigma (Ramon, 2018), with self-determination believed to play a key role in the recovery of those with mental health needs (Davidson, 2016).

It was not until the synthesis of my findings and application of the theoretical lens, I fully recognised the influence of diverse professional views of the individual's role in their personal and social recovery, as a stressor. My findings uncovered how systems and how professionals work in opposition as influencing distress. However, it would have been valuable to deepen this through exploration of professional ideologies of the PiMD role in disrupting distress cycles. Unlike most HCPs, police officers did not support the empowerment of PiMD towards becoming agents of their recovery. Rather, they appeared to take the view PiMD should passively wait for the police to 'save' them and clinicians to make them better. Now on completion of the study, I believe it would have been valuable to invite Police to see PiMD in an empowering way and explore further how this relates to their risk-averse practices and policies. This potentially could have brought a further depth of understanding of working in opposition and barriers or facilitators to distress cycles.

Access to PiMD research participants was negotiated through the Police Scotland Concern Hub and may have influenced how they viewed me. Although I highlighted in the participant information sheets that involvement in the study would not favourably or unfavourably influence future dealings with Police or HCPs, participants may have believed police officers or HCPs were associated with the research. Therefore, they may have responded in specific ways as a result, potentially limiting the openness of their narratives of encounters with police officers and HCPs. However, I judge the participants told stories which reflect their experiences.

It was my intention to recruit the same number of manager participants from each sector. However, following Phase 1, the police officer participant number was higher than HCP. That higher number may have allowed their views to come through more strongly. Nonetheless, their willingness to participate may have been linked to their perception of a disparate amount of police resources involved in out-of-hours mental health safeguarding.

### 9.2.3 Reflection on Analysis

Qualitative research is often criticised for lacking credibility, due to its subjective nature (Miles and Huberman, 1994). As explained in Chapter 3, I chose Template Analysis because of the fit which a broadly social constructivist approach to this study and the embedded reflexivity and audit trail it supports (Brooks et al. 2015). As highlighted in Chapter 3, I used field notes, memos, a reflective diary and discussions with my supervisory team to constantly build and refine my analysis. This was particularly valuable given periods of time away from these data as a part-time doctoral student.

I am aware of the importance of developing autonomous and innovative work at doctoral level and recognise my overall responsibility for data analysis. On reflection, I could have sought further opportunities for integrating a team-based approach to Template Analysis. If I were to conduct the study again, I would develop a more inter-disciplinary team approach to coding, template building and analysis. That said, the thorough inter-disciplinary supervision I have received, particularly in the synthesis of my findings, has been critical in checking and challenging my interpretations.

### 9.2.4 Issues of Rigour and Trustworthiness

I implemented a number of methods to ensure that my study was conducted in a rigorous and systematic manner. In Chapter 4, I set out the research questions, theoretical proposition and details of pragmatic data collection decisions to construct the boundaries of the case. I remained within the case bounds in my recruitment of appropriate participants. On being approached by further participants to be involved in the study it was agreed with my supervisory team I had a substantial data set and could become overwhelmed with data. Therefore, in part, rigour was enhanced by adherence to the planned research design, despite the temptation to engage in further data collection, an element of the research I particularly enjoyed.

CSR allowed for ongoing analysis of findings in each subunit of the holistic case. This process allowed me to extend and explore the findings of previous phases and to validate or identify

alternative perspectives and practices. The holistic case design with three subunits supported the construction of deeper understanding of the complex interaction in which people were kept safe. I believe using focus group participants in the final phase, to check and explore the findings in more depth, strengthened the research and enabled me to further develop the theoretical ideas.

Holloway (2010), highlights that sharing qualitative research findings with participants is perceived as an essential methodological moral and ethical procedure. Member-checking can enhance study credibility and trustworthiness by asking participants to check the transcript of their interview thus potentially enhances accuracy of the data. However, I decided not to share the transcript with participants. Potentially, in so deciding, I may have missed opportunities to support or challenge the precision of the transcript or reconstruct their narrative through deleting extracts they felt no longer represented their experience.

Goldblatt et al. (2011), in their reflection on the process of sharing qualitative transcripts with research participants argue, member-checking can invite new perspectives not necessarily reflecting those depicted in the original interview. Given the part-time nature of my doctoral study, a period had elapsed between the interview, transcribing and opportunities to return to participants. Therefore, I chose not to share the transcripts to mitigate against any difference in perspectives as a result of this time-lapse, which may have altered meanings captured in the original interview. I did, however, have several opportunities to share and check the conceptual ideas with HCPs, police officers and researchers involved in this field. I believe this process enhances the trustworthiness of my findings.

## 9.3 Extent to which the Study met its Aims

This thesis was concerned with the relationship and interplay between structural factors and human input within PiMD out-of-hours safeguarding journeys in a large city in Scotland. Previous research has focused on particular aspects of the safeguarding journey, novel models of collaborative practice, or experiences of specific disciplines. Peoples' experiences during safeguarding journeys, or the influence of policing and healthcare responses to keeping PiMD safe, is poorly understood. Several insights of the safeguarding journey have been uncovered.

Findings from an in-depth exploratory holistic case study, with three embedded subunits addressed the study research questions. These findings identify shortcomings in out-of-hours police and health systems in meeting their needs and keeping some PiMD safe following their

initial calls for support. Although unintended, system shortcomings and human responses can find aspects of PiMD safeguarding being overlooked, exposing them to stigma and undignified processes. PiMD, Police and HCPs can be caught up in repetitive distress cycles.
This study was timely given the significant governmental national and international interest in the intersect of mental health, emergency medicine and policing. By answering the research questions, this thesis has identified areas for future research and extended the existing theory and literature. This work can inform inter-agency, mental health, police and emergency health care practice, and policy and education to develop appropriate, dignified and efficient safeguarding of PiMD.

### 9.3.1 Consideration of Study Limitations

Throughout this thesis, I acknowledge my past experience as a practising mental health and adult nurse in both health and police services. This influenced how I developed and implemented the research. As a result of my own experiences, it is possible I asked questions, considered ethics, made assumptions and interpretations which reflect my professional background. Notwithstanding that, I believe that being a part-time doctoral student, alongside rigorous supervision, has enhanced the reflective approach to this research. I have continuously challenged and questioned assumptions from my professional identities and personal values.

A limitation of this study is that all PiMD participants were women. The findings may have differed had there been gender balance. The literature suggests gender has significant effects on the paths to formal healthcare for those with mental health needs (Tannenbaum et al. 2016). Women appear more alert to symptoms of distress and can act upon these before they become a more significant threat to their safety (Albizu-Garcia et al. 2001). Potentially, the all-female participant group is more reflective of those engaging in unscheduled care safeguarding in this study area. Indeed, the majority of PiMD who indicated an interest in participating in the study were female. However, on reflection, if I were to repeat this study, I could extend the recruitment period and seek a more balanced gender selection, with two male and two female participants.

A further limitation is this qualitative study was conducted in a single city in one area of Scotland thereby potentially limiting the transferability of the findings. However, the cross-sector focus and perspectives of key stakeholders have relevance to a broad audience. Where case studies generate new thinking, the validity does not entirely depend upon the cases from which it is drawn (Hodkinson and Hodkinson, 2001). So, although there are limitations in the transferability, I propose these findings are relevant to a range of contexts; for example, given

the range of approaches reflected in the literature and evidence-based guidance, it could be assumed inconsistencies in agreed levels of sobriety to conduct mental health assessment is problematic beyond the study area.

In relation to transferability during my doctoral training, I presented my study at a number of national and international multi-agency conferences (Appendix 19) and received positive commentary about the relevance of my study in safeguarding, inter-agency psychiatric emergency, unscheduled care policy, police, mental health and emergency medicine practice. Although there are legislative, policy and practice difference in policing and HCP responses to mental distress in the UK and internationally, feedback from my presentations highlighted elements of my study as having relevance in a range of contexts. For example, police officers in the U.S.A and Australia recognised similarities in their practices as potentially contributing to distress, and of the experiences of shame and stigma of PiMD in being chaperoned by police officers.

### 9.3.2 Consideration of Study Strengths

A key strength of the study was I sought to bring a variety of perspectives and contexts to understand the problem identified in Chapter 1. In so doing, it underscores the influence of police input in mental distress incidents, often absent in health and social care literature. As discussed in 9.2., I believe the broadly social constructivist theory and elements of inter-related suicide and self-harm theory and my conceptualisation of the findings, brings the PiMD experience central to the safeguarding journey which is also missing from safeguarding literature.

The research design, complex ethical considerations and combination of methods to gather data has brought strength to the study and provides me with an invaluable range of skills reaching beyond this thesis. The structured, phased approach allowed for ongoing analysis of findings in each subunit of the holistic case. Thus, I believe, this iterative approach, my attention to transcribing, organising, analysing each account and reflectivity throughout has been crucial to the strength of this qualitative research. Adding to this, a further strength of this PhD has been the expertise of the cross-disciplinary supervisory team. The knowledge mix, from nursing, psychology, sociology and criminology research continuously challenged me to consider relationships and broader cross-disciplinary perspectives. It has been a valued check on any potential bias, and my development as a researcher.

As I highlighted, I came to this research with clinical experience in both adult, and mental health nursing and public protection in police services. These multiple identities have been a

benefit and a challenge. There were times throughout my personal doctoral student development I have grappled with being both an 'insider' and 'outsider' in this research. However, overall, I feel my cross-disciplinary experiences and relationships have been a key strength of this study. I believe that locating myself in the thesis, my reflective approach with supervisors, and keeping a research diary have ensured the integrity of my research. Thomas (2016), argues, a key determinant of the quality of a piece of case study research is the quality of the insight and thinking brought to bear by the researcher. Specific elements of my clinical experience supported data collection. For example, conducting interviews in people's homes, police offices and hospital settings were comfortable territory for me. I believe my familiarity with the topic and relaxed conversation style helped build rapport with participants and brought richness to discussions. I understood the context of police and healthcare practice which allowed me to interpret and understand the experiences discussed by participants.

## 9.4 Key Contributions

Below are the key contributions of this work to the empirical literature and theory development.

### 9.4.1 Contributions to the Empirical Literature

Key findings:

- There is a relationship between peoples' feelings of entrapment, aggression due to intoxication and inter-agency safeguarding. Engagement with emergency services can bring initial safety. However, gaps in inter-agency systems and human responses can contribute to distress. Subsequently, people who call upon police to be kept safe can be exposed to police escorted transportations, police custody and exposure to coercive processes such as handcuffs and strip-searching.
- People can be unintentionally overlooked and exposed to stigma and undignified care because of a risk-averse police culture and gaps in safeguarding environments and legislation. This is particularly problematic for those who are unable to engage in mental health assessment due to being intoxicated in a 'Place of Safety'eg,. a private dwelling and who refuse to travel.
- Inconsistencies in healthcare practitioner approaches to the mental health assessment of people who are intoxicated can result in people being exposed to multiple journeys between services or being safeguarded in police custody.
- Difference in professional approaches and understandings of PiMD needs and limitations within a binary police / emergency health care system can see services work in conflicting ways and contribute to cyclical distress journeys.

To my knowledge, as at 2020 this is the first in-depth study in Scotland to explore the experiences and relationships between PiMD, Police and HCPs during the out-of-hours safeguarding of people who do not have a diagnosis of a serious mental health disorder.

My approach to viewing their experiences and relationships holistically provides an in-depth account of the relationship between peoples needs, behaviours, policies, and diverse occupational cultures and perspectives. The findings shed new light on safeguarding journeys of a population who are unaccounted for in current safeguarding policies and legislation.

In addition, this is the first study to explore the entire 'looped' safeguarding journey, including experiences after a mental health assessment. Previously, the focus in other studies has been on single or dual aspects of the journey such as initial contact with police or experiences and perspectives in the E.D. or police custody. This study highlights a gap in environments to keep people safe that sits between inpatient care and returning home. They can fall through this gap or be managed within the criminal justice system rendering them vulnerable to self-harm, exposed to trauma, stigma and a lack of dignity.

Also, this study provides an in-depth account of how PiMD are kept safe. It moves beyond Police / E.D. referral to consider the range of contexts in which help-seeking, police engagement and mental health assessment may take place out-of-hours.

Furthermore, by identifying the factors and stressors in out-of-hours safeguarding of PiMD and relating them to the PiMD experience, my study identifies points at which Police Officers and HCPs may be able to intervene in order to reduce distress, stigma and undignified care.

Finally, to my knowledge this is the first study to highlight the experiences of PiMD who are intoxicated in a ‘Place of safety’ i.e. a private dwelling, and who refuse to travel. It illuminates the dilemmas and pressures on police to engage in potentially unlawful acts in order to ensure PiMD safety. This study contributes to understanding the impact of this legislative gap and how people are kept safe in such circumstances.

### 9.4.2 Theoretical Contribution

The present study and conceptual model developed from these findings extends and addresses current theory in the context of safeguarding PiMD coming to police attention. Building on Starks work, underpinned by suicide and self-harm theory, the holistic conceptual model illuminates the distress journey as one that changes and is influenced by the support available. This contrasts with the ordered way in which other authors present the diagrammatic

conceptualisation of stressors and factors influencing suicide and self-harm[4] (Stark et al. 2011, O'Connor, 2010, Rasmussen et al. 2010). My conceptualisation illustrates that the realities of safeguarding journeys for PiMD are convoluted, often cyclical with a range of factors and stressors influencing different aspects of distress journeys.

As my findings suggest, although police officers and HCPs work by responding to policy and professional knowledge in a procedural way, there are several circumstances in which safeguarding takes place which is unaccounted for in police and health policies. In this study both professions worked around gaps as best they could. There was multiple input across the journey from two diverse occupational cultures and sources of knowledge which can shape PiMD experiences and distress behaviours. The relationship with these factors and PiMD individual internal and external stressors is crucial to the holistic understanding of safeguarding journeys.

Theoretical perspectives of inter-agency responses to PiMD can be criticised for lacking peoples lived experiences (Maclean et al. 2018) or being focused on responses by only one discipline (Jacob, 2013, Watson et al. 2008a). These limit our understanding of the complexity of human responses to distress and inter-agency working. My conceptual model places PiMD experiences of mental distress central to the context of out-of-hours police and HCP responses. My findings suggest that is not always the case within safeguarding journeys when PiMD can be overlooked. Thus, the current study suggests new theoretical conceptualisations of distress experiences. The proposed model, therefore, offers a basis for further theoretical development. It also provides a useful practice framework for policy makers, clinicians and police officers to improve safeguarding practice through understanding PiMD behaviours, and Police and HCP accessibility, responsiveness, dignity and quality of treatment in the criminal justice and out-of-hours health systems.

## 9.5 Recommendations

Since the commencement of this doctoral study, Scottish Government Ministers set up a Board bringing together leaders in Health and Criminal Justice delivery partners, to make progress on several cross-sector challenges including improving collaborative public service responses to distress and information sharing to support people with complex needs. This

[4] I recognise the accompanying narrative within other authors work does not suggest distress is a linear or ordered process. Rather it is the conceptualisation in diagrammatic form which can appear linear. Unlike my model this does not necessarily reflect the cyclical convoluted experiences of distress brought to bear by the police and health systems and human inputs illuminated in my study.

study has several important implications for future collaborative approaches towards supporting PiMD policy development and practice, which can inform these aspirations.

### 9.5.1 Recommendations for Policy and Practice

- Findings from this study have important implications for trauma-informed Police and HCP practice and recommends consideration of policies or practices and how these can be adjusted in line with trauma-informed care. This study highlights a relationship between feelings of entrapment, intoxication, aggression, and gaps in inter-agency safeguarding. Police officers can find situations where an individual is distressed, intoxicated and aggressive and cannot be assessed by health services. Where no other options are available, police custody is used as a safeguarding space, meaning people who have called on police to be kept safe are exposed to police escorted transportations and coercive processes such as handcuffs and strip-searching.
- This study argues the current binary system of criminal justice and mental health care is insufficient to support this population. PiMD can be criminalised, or 'fitted into' the health system. Such processes can reinforce cyclical episodes of distress. A key policy priority for the safeguarding of some PiMD should be to develop a third system involving social care and a third sector to meet the needs of some PiMD more appropriately.
- There is a specific gap in safeguarding legislation and police policies to support people in mental distress in their own home who are unwilling to be transported by police to health services or cannot be assessed in their homes by a GP There are opportunities to consider adjustment of inter-agency safeguarding policies or practices to support this gap.
- The findings suggest a need for alternative multi-agency environments which are safe, accessible and dignified, thus, supporting people who do not require inpatient care but are unsafe to return home because of self-harm or intoxication. Potentially, this would reduce stigma and embarrassment, and reduce demand on the E.D. and other out-of-hours health services and reduce the police presence in people's homes and secondary care systems.
- There is a need to develop NICE guidelines on an agreed level of sobriety to conduct PiMD mental health assessment. Inconsistencies in health care practitioner practice in the mental health assessment of people who are intoxicated can find people exposed to extended police escorted safeguarding journeys.

### 9.5.2 Recommendations for Nursing and Police Education

- The study findings have several implications for nurse education: in particular, the undergraduate nursing curriculum. There are elements of this study which map across five of the seven platforms of the Nursing and Midwifery Council Future Nurse: standards of proficiency for registered nurses (Nursing & Midwifery Council, 2018). For example, in Platform 4; *Providing and evaluating care*. In outcome 4.11 *Demonstrate the knowledge and skills required to initiate and evaluate appropriate interventions to support people who show signs of self-harm and / or suicidal ideation.* By drawing on the current thesis, there are opportunities to develop undergraduate nurses' theoretical understanding of the impact of police and health systems and human responses on PiMD. The conceptual model and clinical cases can help bridge transition from theory to practice supporting nurses to be cognisant of peoples experiences before and after leaving their care, thus be more responsive to PiMD needs and person-centred care.
- There is a need to incorporate an understanding of experiences of distress and safeguarding journeys within police officer education, thereby supporting police officer understanding of PiMD behaviours and the impact of police processes on safeguarding journeys. This thesis will be of interest to inform theoretical and practice-based police education, underpinned by realistic scenarios which apply to Police Scotland.
- This thesis contributes to inter-disciplinary public protection education by drawing on findings of professional motivation in practice, diversity in professional knowledge, legislative constraints, and occupational cultures. There are opportunities to consider the impact of the systems gaps and human responses discussed in this thesis. Findings from the current study and my contextual model can help reveal professional perspectives and expectations, service priorities and unintended consequences of system and human inputs during safeguarding. As such, there are opportunities through inter-disciplinary education to improve safeguarding practice, and professional relationships at the police / health intersect.

### 9.5.3 Recommendations for Future Research

The Scottish Government Health and Justice Collaboration Improvement Board (Scottish Government, 2018), seeks evidence applicable to the Scottish context, to support the development of inter-agency solutions to improve PiMD experiences of unscheduled care, reduced police presence in secondary care systems and reduced E.D. / front door

attendances. This is an area of strategic importance to the Mental Health Strategy for Scotland 2017-2027 (Action 13) (Scottish Government, 2017c) and the Police Scotland 2016 – 2026 Policing Strategy (Police Scotland and Scottish Police Authority, 2017), as it is of compelling interest in inter-agency plans for the reform of mental distress pathways. A natural progression from my work would be in the following areas:

- Further work is required to establish the impact of intoxication on care pathways of PiMD and can be explored through mixed-methods study. A quantitative element by linking routine health and police data could establish care pathways and outcomes for PiMD who are intoxicated and attended to by police. A qualitative element could extend the current case study by identifying opportunities for alternative safeguarding environments and processes.
- Stakeholder focus groups (emergency medicine, psychiatric and substance (mis)use, clinicians and police) and a systematic review of the literature could usefully explore clinical practices associated with the level of sobriety to conduct a mental health assessment. In so doing, there are opportunities to develop new knowledge associated with clinical decision-making in situations where there is a need to keep people safe; balanced against the capacity to engage in assessment and clinicians legislative and ethical judgements.
- Qualitative research involving people frequently being supported on out-of-hours safeguarding journeys is limited in existing literature. Evidence of those who have been intoxicated and aggressive or safeguarded in custody is particularly limited. It is imperative to extend this case study to gain a deeper understanding of these experiences to inform dignified care, methods to reduce re-traumatisation and safe and effective inter-agency processes during and after release from police custody.
- There are significant gaps in the understanding of the impact of 'Place of Safety' experiences of PiMD / Police/ HCP in a private dwelling. A deeper understanding of the impact this context has on experiences of PiMD, professional decision-making and impact on resources may inform proposed MHCT Act reform.
- The issue of how HCPs and the Police respond to people who are distressed, intoxicated and aggressive, could be usefully explored in further research. An exploratory study could examine HCP and police officer dilemmas identified in this study. Specifically, such a study could develop a new understanding of how police officers balance their role; HCP responses to distress which consider social recovery; managing law and order against the needs of people who are aggressive in response to feelings of entrapment.

## 9.6 Dissemination of Findings

I highlighted that throughout my doctoral training I have presented elements of my study at local national and international conferences through papers and poster presentations (Appendix 19). I will present the final findings at an international conference in 2021 and submit my literature review and findings for publication in peer-reviewed journals.

## 9.7 Closing Reflection of my Role in the Research

From a personal perspective, at the beginning of my studies I felt isolated within the nursing research community. When discussing my study with nurse researchers, I felt somewhat detached - a nurse wishing to embark on cross-disciplinary research involving police within the care of people in mental distress. Nevertheless, I believe the uniqueness of this inter-disciplinary study is also a strength of this thesis. As a nurse, researching across two disciplines has been a privileged and valuable doctoral research training opportunity. This study puts the police response at the heart of the experiences of PiMD. Thus, part of the specific contribution this thesis brings is a nursing voice within police research and vice versa.

The most valuable lesson has come at the end of this thesis when I reflect how much there is yet to learn and uncover in inter-disciplinary self-harm research. Returning full circle to Chapter 1 where I position myself in this thesis, I discussed a young woman I cared for who went on to complete suicide days after discharge following a violent sexual assault. At the time, the attending police officers and I shared our fears for her vulnerability, yet we did not escalate our concerns. Despite the significant progress made in safeguarding, I am not convinced that the outcome would be different some 37 years later. There remain significant gaps in our knowledge and practice, inviting the development of innovative cross-disciplinary research to ensure appropriate systems, services and support is a priority for people at risk of serious self-harm.

Nonetheless, I feel there is a readiness and commitment for change. During the six years of this doctorial journey, there has been significant policy and practice interest in mental health legislative reform. There is the emergence of police, health and social care policy and practice collaborations, co-constructed with people with lived experiences, to better support people in mental distress. There are also new cross-disciplinary research partnerships across policing, health and social care. As a board member of the Global Law Enforcement and Public Health Association and member of the Police Scotland Mental Health Governance Group, I've had the privilege of contributing to national and international debate, policy development in law

enforcement and mental health throughout this doctorial training. I feel there is optimism for the future of compassionate, safe and dignified care of people experiencing mental distress.

***PostScript***

I have completed this PhD in the midst of the coronavirus disease 2019 (COVID-19) pandemic. This was not a factor in the research; however, I believe this thesis has particular relevance for how PiMD are supported and managed by Police and HCPs, in this and future pandemics. COVID-19 is having a profound effect on population mental health in general, exacerbated by fear, self-isolation, and physical distancing (Pierce et al. 2020). This thesis highlights gaps in the system prior to the pandemic limiting support for some PiMD and finds people transported to busy public clinical areas or police custody. Furthermore, my study illuminates police officers spend extensive amounts of time in people's homes, hospital waiting areas or waiting in police vehicles with PiMD; all of which can potentially contribute to PiMD distress, and potentially, to PiMD and frontline workers exposure to the COVID-19 virus. Thus, this thesis highlights aspects of safeguarding policy and practice which should be considered in approaches to infection control and mental distress support brought to bear by the COVID-19 pandemic.

Internationally, the consequences for mental health and police services are already being felt, e.g., increased workloads and practitioner well-being (Laufs and Waseem, 2020, Lersch, 2020). Positively, services are developing new ways of working, such as developing expertise in conducting psychiatric assessments and delivering interventions remotely e.g., by telephone or digitally (Gunnell et al. 2020).

The challenge during this pandemic and beyond is the requirement to understanding safeguarding journeys - something this thesis addresses - in order to re-imagine safe and effective collaboration between disciplines. This thesis has shown, police officers play a central role in mental distress care, therefore it is imperative that criminal justice research is included in multi-disciplinary mental health research. Therefore, this study supports a call for action for mental health multi-disciplinary research priorities for the COVID-19 pandemic (Holmes et al. 2020).

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# Appendices

## Appendix 1 - Terms and definitions used in this thesis

Mental distress

A variety of definitions and terms for mental distress have been suggested across nursing and police literature (Payton, 2009). Some definitions are risk focused, for example 'people at risk of harming themselves and others'. Definitions can also be derived from a service perspective which describes how people come to the attention of services. For example, suicidal ideation, threats, gestures, self-cutting or interrupted self-harm attempts. Given this study is focused on the experiences of PiMD, and professionals who seek to support them, I have chosen a definition reached collaboratively between people with lived experience and professionals. This definition captures a sense of despair and isolation which permeated the narratives of PiMD participants in this thesis:

> "Mental health crisis as an overwhelming experience; something that is more than the person can deal with and not one's normality. It can mean having nowhere to turn or having exhausted all one's coping strategies ''
>
> MIND(2011)

The above definition highlights the immense pressure people experience whilst in distress. Also contained within this definition are feelings of isolation, being out of control and need to seek external support. As a result, police and emergency health services are frequently called on to help manage these overwhelming feelings.

Self-harm

For the purpose of this thesis I use the term self-harm within the context of mental distress. Self-harm and suicide are two different, yet related phenomena. Despite often having different meaning, previous self-harm is a significant risk factor for completed suicide (Norman, 2013). As such, both terms are used interchangeably across the literature with debate over the naming of these acts (McAllister, 2003).

I define self-harm as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. Thus, it is an 'umbrella term' which includes suicide attempts as well as acts where little or no suicidal intent is involved (e.g. where people harm themselves to reduce internal tension, distract themselves from intolerable situations, as a form of interpersonal communication of distress or other difficult feelings, or to punish themselves.)

Safeguarding journey

Having defined the context of mental distress in this thesis, it is necessary to clarify exactly what is meant by the term 'safeguarding journey' used throughout this study. A variety of definitions exist to conceptualise transitions through service, such as clinical pathway, care pathway, integrated care pathway, critical pathway, or care map, (De Bleser et al.2006). Yet, these do not easily translate into police processes where terms such as operational or procedure tend to be used. Thus, I decided to deliberately use a broad term, appropriate to both services, signalling that there is no clear attribution to either policing or health care.

The term safeguarding has been criticised in the literature as being paternalistic (Cornish and Preston-Shoot, 2013). Pilgrim (2017) notes, that care imposed on an individual can be considered coercive and an abuse of power. I had also considered the terms 'protection'. Stewart (2011) distinguishes between the terms 'safeguarding' and 'protection'. Protection tends to focus on the needs of individuals who are experiencing harm and/or abuse or at risk, suggesting a one-way process. Safeguarding on the other hand, is described as proactively seeking to involve the whole community in keeping an individual safe and promoting their welfare, essentially a preventative, co-productive approach (Mandelstam, 2013). The term safeguarding therefore signals that all three key stakeholders have a role in preventing serious harm, including the PiMD.

'Safeguarding' also highlights the influence of public protection legislation driving how services worked together. It is important to note that terminology specific to each discipline appears at certain points in the thesis, particularly in the literature review where I report on approaches and studies.

By using the term 'journeys', I seek to reflect the non-linear experiences of PiMD whilst being kept safe. When people's needs are complex, and care crosses both services, PiMD did not 'fit' within a sequential or straightforward pathway reflected in police or health service policies. There was an interplay between gaps in systems, and responses of professionals working within those gaps. The trajectory of how people moved between services fluctuated and changed dependant on a range of factors, for example if the PiMD was intoxicated or aggressive. Thus, the term 'journeys' articulates the indirect nature of people experiences

Systems and human responses

In this thesis I refer to systems, structures and human responses. In terms of systems and structures, in this context I mean the network of police and health services, and how these are organised to support PiMD. In particular I refer to the medicalised model of unscheduled care,

inter-agency safeguarding policies and legislation, and safeguarding environments. In terms of human responses, I refer to organisational and professional cultural sources of knowledge and inputs brought to bear on safeguarding journeys

## Appendix 2 - Literature review key search terms

| Literature review key search terms |
| --- |
| 1 (Mental health distress), 2 (police OR Law enforcement), 3 nurses OR health care, 1 OR psychological distress*, 1 OR psychiatry*,1 and safeguarding * 1 and 2, 1 and psychiatric health*, 1 and safeguarding, 1 and experiences*, 1 and pathway*, 2 and 3 and,2 and Psychiatric Service users*, 1 and Mental Health Service user*, 2 and Psychiatric Clients*, 1 and Mental Health patients*, 1 and Mental Health Patients and experiences *, 2 and mental health management *,(MH "Emergency Medical Services") OR (MH "Emergency Services, Psychiatric") OR (MH "Emergency Service, Hospital") OR "accident and emergency" or casualty or "psychiatric assessment", 2 and inter-agency or inter-agency or inter-professional or inter-professional or multidisciplinary or multi-disciplinary or cross sector or cross-sector Mental health crisis, 3 (Self-Injurious Behaviour and suicidal behaviour ), 3 and alcohol *,2 and alcohol *, 1 and Mental Health Nursing*, and law enforcement *, 1 and police*, attitude*s,3 and Risk Management., police and mental health risk management,1 and support,1 and Mental Health Service user*s, 1 and 2 and care *, 1 and police and experiences *1 and nurses and experiences * 1 and health practitioner and experiences* 1 and out-of-hours OR unscheduled care, 2 and culture, nursing and culture, health and culture |

## Appendix 3 - Literature review data extraction summary tables

| Theme 1. Safeguarding and care experiences of people in mental distress | | | | | | | |
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| **Authors** | Country | Objectives | Research Type | Research Method | Sample Size | Results | Key findings |
| **BRUFFAERTS et al. (2006)** | Belgium | To examine patient and system characteristics of first-time ("incident") vs. recurrent ("recurrent") use of a psychiatric emergency room (PER | Mixed methods | A semi-structured interview based on the Minimal Psychiatric Data form, a standardized and validated psychiatric patient registration form used to gather information on patients' demographic and clinical characteristics and mental health service use | N= 3,719 | About 64% (n=2,368) were incident and 36% (n=1,351) were recurrent users. The PER was the first treatment setting ever for 50% of the incident users. Incident users were most likely over 69 years or referred by a health care professional. They were less likely to have a personality disorder or to have used inpatient or outpatient services in the past. About 44% were admitted, 38% referred for outpatient treatment, 9% referred to the outpatient crisis-intervention program, and 9% refused any follow-up. | The Psychiatric emergency room was a first treatment setting ever for 1 in 3 patients. Incident and recurrent users differed in sociodemographic characteristics, pathways to care, service use, and the presence of a personality disorder. They did not differ in axis 1 disorders, comorbid mental disorders, or pathways after care. |
| **DIGEL VANDYK (2018)** | U.S.A. | Explore the experiences of persons who frequently present to the ED for mental health-related reasons. | Qualitative | Interpretive Description A using semi-structured interview and a simple sociodemographic survey | N= 10 | Frequent presenters to the ED for mental health-related reasons feel compelled to come to hospital. For them, every visit is necessary, and dismissal of their needs by ED staff is interpreted as disrespect and prejudice. | The participants felt compelled to come to hospital. For them, every visit was necessary, and dismissal of their needs by staff was interpreted as disrespect and prejudice. |

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| | | | | | | A lack of adequate discharge planning upon release from the ED appears to perpetuate further ED use, especially when safe transportation home is not available. | Further training and sensitization to the needs of individuals in psychiatric crisis is required for hospital security staff, who are often involved in volatile interactions with these individuals. |
| **BRUNERO et al. (2007)** | **Australia** | **To determine the clinical characteristics of people with mental health problems who frequently attend an Australian emergency department (ED)** | **Quantitative** | **A retrospective clinical audit of presenter characteristics** | **N= 868** | **12.5% attended at least twice. The entire frequent presenters group had their second presentation within the first month and 10 (77%) had all their presentations within the first 6 months. The occasional repeaters had their second visit to the ED within the first month 65% of the time, and all visits within 6 months.** | **Younger people appeared more prominently in the frequent presenters group this group also contained more mood/anxiety diagnoses than the other groups. Frequent presenters were more likely to be self-prompted arrivals and less likely to arrive via ambulance or police** |
| **SPENCE et al, (2008)** | Canada | To investigate the repeated use of the E.D by men with a history of suicidal behaviour and substance abuse to understand the needs and | Qualitative | Semi structured interviews, patients, ED staff and family physicians | N=25 patients N=17 ED staff members | The ED was viewed as a last resort despite seeking help. Frustration was felt by both patients and staff regarding difficult communication, especially during an acute crisis. Of the health care workers interviewed, 77% also stated that these patients had negative experiences. Staff felt that patient visits were | All patients reported that they had previous negative ED experiences that impacted their ability to seek and find ongoing care, especially after being identified as "frequent flyers." Recognizing the limitations of the setting, ED staff should attempt to optimize their interactions with these patients. |

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| | | barriers to care. | | | | stressful because of their repetitive nature and the difficulty conducting assessments, especially when there were competing demands for their time | |
| **KUEHL et al,. (2012)** | **New Zealand** | **To describe the number, characteristics and management of patients who presented to an emergency department (ED) with intentional self-harm and then represented for any reason within 1 week, over a 1-year period.** | **Quantitative** | **A retrospective records review from one New Zealand ED over 12 months.** | **N=48** | **A group of patients re-presented to ED within days following ISH. Of concern was the risk of further serious ISH which was evidenced by increased inpatient admission numbers. A significant number of patients (54%) were involved in challenging incidents, demonstrating they were distressed, experiencing a mental health crisis and possibly were at risk to self and/or others.** | **While patients with mental health issues often report that general staff have negative attitudes toward them,17 some doctors have reported feeling helpless in addressing the emotional aspects of self-harm. A decreased level of consciousness, assumed of some patients post overdose, can also make a mental health assessment in ED difficult.** |
| **JOUBERT et al, (2012)** | Australia | To examine the psychosocial precipitating factors of people presenting to the | Quantitative | 2 stages- Clinical Data Mining and Action Research | N = 72 | The majority of patients (78%) received their care in the ED, with 12% requiring admission to a ward for management of a medical condition. Of the 72 patients, 68% were | 62% of presentations to the ED occurred outside of regular business hours. Depression was present in 92% of cases (using Beck's Depression Inventory). Patients largely do not follow up on referrals |

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| | | emergency department (ED) due to attempted suicide. | | | | discharged to their home, 11% to another acute hospital, 6% to an inpatient psychiatric facility, and 11% discharged themselves against the advice of the treating team. | or return to their primary care physician as advised |
| **WATSON et al, (2008)** | U.S.A. | To explore police encounters from the perspective of persons with mental illness | Qualitative | Using procedural justice theory as a sensitizing framework- in-depth semi-structured interviews | N=20 | Two major themes emerged from our interviews with people with mental illness. First, the respondents are fearful of the police and second, the behaviour of the police during these encounters affects the corresponding experiences and behaviour of the respondents | Participants came into contact with police in a variety of ways, two main themes emerged. First, they feel vulnerable and fearful of police, and second, the way police treated them mattered. |
| **WISE-HARRIS et al. (2017)** | Canada | To explore perceived need for and experiences of ED utilization of frequent users with mental health and/or addictions challenges | Mixed methods | Quantitative surveys in-depth, qualitative interviews | Quant surveys (N = 166) and in-depth, Qual interview (N= 20) | Participants presented to hospital for mental health (35 %), alcohol/drug use (21 %), and physical health (39 %) concerns A perceived clash of viewpoints among patients, community service providers, and ED personnel as to the appropriateness of the ED as a point of care for mental health and substance use crises | Participants described their ED visits as unavoidable and appropriate, despite feeling stigmatized by hospital personnel and being discharged without expected treatment |

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| **CLARKE et al,(2007)** | Canada | To determine mental health patients and their families satisfaction with care received in regional EDs with particular emphasis on their evaluation of the role of the psychiatric emergency nurse. | Qualitative | Eight focus groups | N=27 clients, n=7 family members N=5 stakeholders | Themes identified were waiting in the ED, attitudes of treatment staff, diagnostic overshadowing, 'nowhere else to go', family needs, and a wish list for ideal services. | Many of those currently coming for help because there is nowhere else to go. Need for safe, respectful, and holistic care that recognizes each client as a worthwhile individual with complex medical and mental health needs. |

| Theme 2. Intoxication, self-harm, and aggression | | | | | | | |
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| **BORGES et al, (2006)** | International | To study the risk of non-fatal injury at low levels and moderate levels of alcohol consumption as well as the differences in risk across modes of injury and differences among people with alcohol dependence | Quantitative | A case–crossover method to compare the use of alcohol during the 6 hours prior to the injury with the use of alcohol during same day of the week in the previous week. | 10 E. Ds around the world (n =4320) | The risk of injury increased with consumption of a single drink (odds ratio (OR) = 3.3; 95% confidence interval = 1.9–5.7), and there was a 10-fold increase for participants who had consumed six or more drinks during the previous 6 hours. Participants who had sustained intentional injuries were at a higher risk than participants who had sustained unintentional injuries. Patients who had no symptoms of alcohol dependence had a higher OR | Since low levels of drinking were associated with an increased risk of sustaining a non-fatal injury, and patients who are not dependent on alcohol may be at higher risk of becoming injured, comprehensive strategies for reducing harm should be implemented for all drinkers seen in emergency departments |
| **LARKIN et al, (2014)** | Ireland | To examine factors associated with severity of self-cutting and in particular the association between severity of self-cutting and prospective | Quantitative | All index self-cutting presentations to emergency departments in Ireland over 5 years were grouped by treatment received and compared on the basis of demographic and clinical characteristics | N=59,155 | Receiving more extensive medical treatment was associated with male gender, being aged more than 15 years, and not combining self-harm methods. Receiving less extensive treatment conferred a higher risk of prospective 12-month repetition, even after controlling for demographic and clinical characteristics. Repeat self-harm presentations by those | Significant differences in demographic and presentation characteristics across self-cutting treatment groups. Patients who received less extensive treatment for self-cutting were more likely to repeat self-harm within 12 months Repeated presentations among those whose index act of self-cutting required more extensive |

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| | | repetition of self-harm. | | | | with more severe self-cutting in an index act were less prevalent but were more likely to involve high lethality methods of self-harm. | treatment was more likely to involve high-lethality self-harm. |
| **GRIFFIN et al, (2017)** | International | To establish the role of alcohol in self-harm as well as to identify associated factors, in order to best inform service provision | Quantitative | Comparative data on hospital-treated self-harm from both the National Self-Harm Registry Ireland and the Northern Ireland Registry of Self-Harm. | N=24 513 | 19 831 (58%) were made to EDs in Ireland and 14 598 (42%) to EDs in Northern Ireland. Approximately 52% of the sample were female and 44% were aged between 25 and 44 years. The most common method of self-harm recorded was intentional drug overdose (71%). The only other common method of self-harm was self-cutting, present in 23% of acts. Fewer than one-third (29%) were repeat presentations and 31% were made by residents of urban areas. | Alcohol was present in 43% of all self-harm acts, and more common in Northern Ireland (50 versus 37%). The factors associated with alcohol being involved were being male, aged between 25 and 64 years, and having engaged in a drug overdose or attempted drowning. Presentations made out-of-hours were more likely to have alcohol present and this was more pronounced for females. Patients with alcohol on board were also more likely to leave without having been seen by a clinician |
| **DOWNES, et al, 2009)** | Australia | To describe the characteristics of patients with acute behavioural | Quantitative | Retrospective review of acute behavioural emergencies that required response | N=122 | 71 male patients (58%) who accounted for 143 CB activations. The primary problems were deliberate self-poisoning or self-harm | Acute behavioural disturbance is a common occurrence in ED, the frequency of these events is |

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| | | disturbance and their emergent treatment in an ED with a structured team approach | | from the Code Black (CB) Team (duress response team) in the ED | | (38%), alcohol and illicit drug intoxication (33%) and psychiatric, organic illness and drug withdrawal (29%). One hundred and eight (89%) patients had a past history of alcohol/illicit drug abuse or psychiatric illness. Indications for CB activation were threatening harm to others or behaving violently in 67% of cases | significantly higher than previously quoted in the Australasian ED literature. Underlying causes were predominantly organic in nature, and a team approach appears to be invaluable in managing these incidents |
| **ZISMAN & O'BRIEN, (2015)** | England | To identify the demographic profiles, circumstances of detention and assessment outcomes of all individuals detained under Section 136. The study explored the relationship between alcohol and/or drug use, the process and outcomes. | Quantitative | This retrospective cohort study | N=245 | Threatening to self-harm (n = 100, 44.8%) was the most common reason for assessment. Of the 245 patients assessed, 108 (44.1%) were found to be intoxicated with drugs and/or alcohol. | Intoxication resulted in longer assessment times and a decreased likelihood of admission to hospital ($p < .000$). |

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| **MAHARAJ, et al, 2011)** | Australia | To identify any differences between patients referred by police compared with patients referred from other sources, to a psychiatric hospital in Australia | Quantitative | retrospective audit | N=200 | The two most common reasons for the involuntary referral of patients by police were bizarre ideas (33%) and threats of suicide (28%). When 101 patients referred by police were compared with 99 patients from other sources, police referrals were three times more likely to be diagnosed with a mental and behavioural disorder because of psychoactive substance use, less likely to be diagnosed with a mood disorder, and less likely to be diagnosed as psychotic. | Police referrals were more likely to have worse functional scores; exhibit aggressive behaviour; spend fewer days in hospital; more likely to be admitted to the psychiatric intensive care unit, and to be secluded. The most important predictor for a police referral was drug or alcohol problems. |
| **MORPHET et al, (2014)** | Australia | To identify the causes and common acts of violence in the ED perceived by three distinct groups of nurses. | Quantitative | Delphi technique | Round 1 n=157 Round 2 n= 132 Round 3 n=158 | Long waiting times, drugs and alcohol all contributed to ED violence | Triage nurses indicated that ED staff, including security staff and the triage nurses themselves, can contribute to violence |
| **DOYLE et al, (2007)** | Ireland | To describe the experiences and challenges that nurses | Qualitative | 15-item semi-structured questionnaire | Forty-two ED nurses | Participants in this study identified risk assessment as part of their role but did not focus on psychosocial assessment or psychological management of this | Challenges experienced included a lack of appropriate communication skills and insufficient resources within the ED to adequately care for this |

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| | | encounter when caring for patients who present to the ED with suicidal behaviour. | | | | patient group. Feelings of sympathy and compassion were reported towards patients; there was often a prior judgement of the perceived 'genuineness' of the presentation. | vulnerable patient group. |
| **LORD & BJERREGAARD (2014)** | U.S.A. | To determine (1) the nature of interactions between police-referred calls to the mental health mobile crisis unit and (2) to determine the outcomes of these calls and the factors that might influence the outcomes. | Quantitative | Comparison between law enforcement–initiated calls and those initiated by other agencies/individuals | N= 3,635 | Significant differences in the type of PMI calls from law enforcement–referred calls to MCUs are found; the PMI are twice as likely to be violent, intoxicated, psychotic, mood-order diagnosed, and in emergent need of care | Law enforcement–referral calls primarily deal with persons with serious mental illness (PSMI) and who are in crisis. Without appropriate and immediate mental health intervention, law enforcement officers might have to resort to physical restraint and arrest |
| **MAHARAJ, et al, (2013)** | Australia | Explore nurses' experience of caring for | Quantitative | Semi structured interviews | N=9 | The theme expecting 'the worst' was constituted by the sub-themes of: (i) 'we are here to care for whoever | Ethical issues related to stereotyping of patients brought in by police and labelling as 'the worst' |

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| | | police-referred patients to psychiatric hospitals. | | | | they bring in'; and (ii) 'but who deserves care?' The theme balancing therapeutic care and forced treatment was constituted by the sub-themes of: (i) 'taking control, taking care'; and (ii) 'managing power'. | patients, and what this may mean in terms of subsequent treatment. A lack of operationalized models of care and clinical guidelines for managing the range of patients including those with dual diagnosis. A lack of resourcing and expertise, and failure of continuity of care and collaboration between specialist services such as substance use services. |

| Theme 3. Professional perspectives and responses to PiMD | | | | | | | |
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| **MCALLISTER et al, (2002)** | Australia | To develop and test a scale to identify relevant dimensions of ED nurses' attitudes to clients who present with self-injury. | Quantitative | Questionnaire (ADSHQ) were drawn from a literature review and focus group discussions with ED nurses. The tool was piloted with 20 ED nurses not working in the target agencies. | N=352 | Four factors that reflected nurses' attitudes toward these clients were related to; nurses' perceived confidence in their assessment and referral skills; ability to deal effectively with clients; empathic approach; and ability to cope effectively with legal and hospital regulations that guide practice | There was a generally negative attitude towards clients who self-harm. Correlations were found between years of ED experience and total score on the ADSHQ, and years of ED experience and an empathic approach towards clients who deliberately self-harm. |
| **SUMMERS & HAPPELL, (2003)** | Australia | To ascertain the level of psychiatric patient satisfaction with the services received in the emergency department of a Melbourne metropolitan hospital. | Qualitative | Telephone interview. A structured questionnaire was used to seek information from patients regarding what was helpful, and what was not helpful, about their treatment, and sought any feedback that could improve the service. | N=136 | High level of satisfaction, particularly with the availability of staff with psychiatric qualifications and experience to provident treatment, support and care. The major areas of dissatisfaction identified by patients included: lengthy waiting times, lack of privacy in the triage area and negative attitudes of general staff. | Need for triage guidelines to be tailored to the needs of mental health patients and for emergency department triage staff to be appropriately educated to adequately triage these patients. |
| **CONLON & O'TUATHAIL, (2012)** | Ireland | to measure emergency department nurses' | Quantitative | The 'Self-Harm Antipathy Scale', a validated questionnaire, was | N=87 | Nurses show slightly negative antipathy overall, indicating positive | Judgmental attitudes and manipulation in the self-harming behaviour. |

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| | | attitudes towards deliberate self-harm. | | administered to a random sample of nurses in four emergency departments | | attitudes towards self-harming patients. Attitudes were significantly different in accordance with a nurse's age. Education and social judgment also contribute to the way nurses view, interact and make moral decisions regarding self-harm patients | Nurses were frustrated with patients frequently returning to hospital. Moreover, the results of this study show that the nurses do not feel adequately trained to respond, and many have doubts about the degree of support that may be available to them in this area. They also feel that self-harm is the responsibility of the mental health services, and consequently it will indeed be difficult to shift the major responsibility for responding to self-harm patients to generic hospital-based staff |
| **CHAPMAN & MARTIN, (2014)** | Australia | Explore staff perceptions about caring for patients who present to the emergency department following deliberate self-poisoning | Qualitative | Two open-ended questions | N=186 | Three themes emerged from the data representing staff perceptions about caring for patients who deliberately self-poisoned and included depends on the patient, treat everyone the same, and skilled and confident to manage these patients. | Staff reported mixed reactions to patients presenting with deliberate self-poisoning. These included feelings of empathy or frustration, and many lacked the skills and confidence to effectively manage these patients. |

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| **COMMONS TRELOAR & LEWIS, (2008)** | Australia | To assess the attitudes of mental health and emergency medicine clinicians towards patients diagnosed with borderline personality disorder. T | Quantitative | Questionnaire | N=140 | Statistically and clinically significant differences were found between emergency medical staff and mental health clinicians in their attitudes towards working with borderline personality disorder. The strongest predictor of attitudes was whether the clinician worked in emergency medicine or mental health. This was followed by years of experience and specific training in personality disorders as significant predictors of attitudes to self-harm | Mental health clinicians who provide ongoing management and treatment for BPD have more positive attitudes to working with this patient group, and this may be influenced by their more sustained level of care. Emergency medicine clinicians are required to provide urgent medical attention to the patient with BPD following episodes of self-harm and this may result in such professionals having a greater difficulty in maintaining an empathetic attitude to such patients |
| **BETZ et al, (2013)** | U.S.A. | To examine the knowledge, attitudes, and practices of emergency department (ED) providers concerning suicidal patient care and | Quantitative | Survey | N=631 | Providers expressed scepticism about the preventability of suicide, despite evidence that suicide prevention measures can prevent deaths. A minority of providers reported screening most or all patients for suicidal ideation | Providers expressed gaps in their skills and practices related to risk assessment and provision of referral resources Individual beliefs can also be a barrier to care of suicidal patients |

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| | | to identify characteristics associated with screening for suicidal ideation (SI). | | | | | |
| **MCCANN et al, (2006)** | Australia | To assess if accident and emergency (A&E) nurses attitudes towards patients with deliberate self-harm, and to assess if nurses' age, length of A&E experience, or in-service education influence their attitudes towards these patients. | Qualitative | Questionnaire | N=43 | Most nurses had received no educational preparation to care for patients with self-harm. Over 20% claimed the department either had no practice guidelines for DSH or they did not know of their existence; one-third who knew about them had not read them | Older and more experienced nurses had more supportive attitudes than younger and less experienced nurses. Nurses who had attended in-service education on DSH had more positive attitudes than non-attendees. |
| **FRIEDMAN et al, (2006)** | England | To investigate the attitudes of accident and emergency (A&E) staff towards patients who | Qualitative | questionnaire | N=117 | The staff held a belief that self-laceration was an important problem but felt unskilled in managing patients. Evidence of unhelpful attitudes amongst some staff. This is particularly true for more | Staff without previous training, a longer period working in A&E was correlated with higher levels of anger towards patients and an inclination not to view patients as mentally ill. A&E staff were keen for |

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| | | self-harm through laceration. | | | | senior staff without previous DSH training, who, as a group, were less sympathetic to this group of patients. | further training and wanted a higher proportion of patients to be seen by specialist mental health services. |
| **THOMPSON et al, (2008)** | England | To explore community psychiatric nurses' experiences of working with people who self-harm | Qualitative | Semi-structured interview | N=8 | Participants described struggling to conceptualize self-harm behaviour and generally reported finding working with people who self-harm stressful particularly in terms of managing the emotional impact upon themselves and the boundaries of their professional responsibilities in relation to managing risk | The therapeutic relationship was viewed as crucial and a variety of coping methods to manage the impact of the work, which had largely developed through 'on the job', experience were described. |
| **LEE, (2006)** | Australia | To prospectively examine the characteristics mental health patients brought in by the police | Quantitative | Descriptive study | MH n=2334 and n=452 of those were police presentations | 12 themes relating to police presentations were identified research: presentations; departure time; time in department; diagnosis; mental health history; forensic history; alcohol and other drugs use; community mental health; admission rate; length of stay in emergency department; outcome of the presentations; length of stay in hospital. | The length of stay of mental health police presentations is nearly twice as longer than the non-police mental health presentations (median 21 days) 75% of the police presentations arrived after hours (1700—0830 h, Monday—Sunday). Only 25% are during business hours |

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| **LEE et al, (2008)** | Australia | To determine the frequency profile and characteristics of consumers of mental health services brought in by police to an emergency department (ED) | Quantitative | A multivariate logistic regression analysis | N=542 | Results indicated that police presentations are likely to be young males who are unemployed, have past and present alcohol and other drugs use, present after hours, and are admitted to hospital as a result of their presentation. These consumers are likely to have a presenting problem of a psychotic disorder, less likely to have a presenting problem of depression and/or anxiety, and given a triage code of three or higher. | Police presentations to EDs with mental health issues are an indicator of significant impact on health services, especially with the current overcrowding of EDs and the associated long waiting times |
| **BOSCARATO et al, (2014)** | Australia | To explore mental health consumers' experiences with formal crisis services | Qualitative | Semi-structured interviews | N=11 | Most participants preferred family members or friends to intervene. However, where a formal response was required, general practitioners and mental health case managers were preferred; no participant wanted a police response, and only one indicated a preference for CAT team assistance | While the preferred mode of crisis response was informal, when involving the provision of support from family members or friends, if a formal crisis response was needed, participants wanted this to be timely, consistent, respectful, humane, and nonthreatening, and if involving police and mental health clinicians, they wanted this to occur in a coordinated manner |

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| **MARTIN & THOMAS (2015)** | Australia | To examine police encounters with people experiencing mental disorder | Qualitative | Semi-structured interviews | N=25 | Officers singled out people with personality disorder and expressed frustration, anger, powerlessness and resignation with their referrals of this group to health services. Officers reported that E.Ds were reluctant to assess people with P.D and when they did assess them stated that the person did not meet criteria for admission to mental health services, or if admitted, they were quickly discharged | People with personality disorder were reported to take up considerable police resources. When police were told by mental health professionals that there was nothing they could do about people experiencing personality disorder, then the question from police was what was to be done with them |
| **GODFREDSON et al, (2011)** | Australia | To explore (1) the frequency of contact between the police and people experiencing mental illness; (2) the way in which police officers' knowledge and the sources of information used relates to various | Qualitative | Survey | N=3,534 | Police reported that a considerable amount of their time each week was spent dealing with people they believed to be mentally ill. These encounters were reportedly associated with considerable practical difficulties for police, both in terms of knowing how to deal with people experiencing mental illness and how to best find appropriate supports for them | The most common results of their encounters were instigating a mental health apprehension, followed by arrest, but decision-making was influenced by the differential weight police placed on different sources of information received at the scene. |

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| | | dispositions; (3) the signs, symptoms and behaviours that police officers consider are associated with mental illness; and (4) the challenges police face in this respect when performing their duties | | | | | |
| **MCLEAN, N. & MARSHALL, 2010)** | Scotland | To investigate police officers' views on their roles in dealings with people with mental health problems and with mental health services. | Qualitative | Semi-structured interviews | N=9 | Recurrent themes identified were: emotional aspects of dealing with people with mental health problems and with services, impact of incidents on police resources and on people with mental health problems, success through collaborative working with health services and failure in its absence. | police officers interviewed expressed compassion and understanding of people with mental disorders. Difficulties experienced when called to resolve situations involving the mentally ill, there may be no indication for arrest, but they may be unsuccessful in securing care or hospital admission for the individual |

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| **AL-KHAFAJI et al, (2014)** | Australia | To describe the characteristics and outcome of patients brought to an emergency department by police under Section 10 of Mental Health Act | Quantitative | Retrospective medical record review | N= 164 | Patients were predominantly male (58%) with median age of 35 years. The most common presenting complaint (65%) was threat of self-harm. No sedation or restraint was used in 61%. Sixty seven percent were deemed safe for discharge home while 26% were admitted to a psychiatric ward (equally divided between voluntary and involuntary admission). The predominant discharge diagnosis was self-harm ideation or intent (35%). Median ED length of stay was 156 min (inter-quartile range 79–416). | Most patients brought to ED by police under Section 10 provisions were for threat of self-harm and did not require sedation or restraint. The majority are discharged home. Further work exploring less restrictive or traumatic processes to facilitate psychiatric assessment of this group of patients is warranted. |
| **REES et al, 2016** | England | to explore paramedics' perceptions and experiences of caring for people who self-harm | Qualitative | Semi-structured interviews | N=11 | Two emerging themes: Firstly, professional, legal, clinical and ethical tensions, linked to limited decision support, referral options and education. The second theme of relationships with police, revealed practices and surreptitious strategies related to care and detention, | Paramedics van be conflicted by clinical, legal and ethical care of people who self-harm. To facilitate attendance at hospital paramedics can coerce and collude with police. Whilst this may appear distasteful, dishonest, unprofessional, unethical or illegal, conditions that cultivate |

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| | | | | | | aimed at overcoming complexities of care | such practices need to be questioned. |
| **FRY et al, (2002)** | Australia | To examine the relationship between mental health services and police and people who have mental health problems, are suicidal or are drug- and/or alcohol affected | Qualitative | Survey | N=131 | More than 10% of police time is spent dealing with people with mental health problems. Nevertheless, police felt unsupported in this role, unprepared for it and torn between the competing demands experienced in their work. A lack of confidence in dealing with suicidal people and a belief that work with mentally disturbed people does not constitute valid police work | There are difficulties relating to: inadequate training and education; deficiencies in services/resources; time and resource over-utilization; communication, liaison and feedback problems, and frustration related to accessing mental health facilities/services. It is argued that police work involving mentally disturbed people is a valid and necessary role that complements law enforcement |
| **SCHULENBERG (2016)** | Canada | To explore the ways in which the decision-making process and use of discretion with people with mental illness (PMI) reflects a systematic procedural bias that can | Mixed methods | Observational data analysed (1) binary variables were calculated and the chi-square statistic used to assess whether the differences between PMI and non-PMI were statistically significant. (2) Using three binary logistic regression models and (3) thematic analysis | Data from 637 hrs of 'ride-alongs' with police officers | Regardless of mental health status, a citizen who is under the influence of alcohol or drugs increases the likelihood of criminal charges and citations. Evidence of indirect and direct pressure to resolve PMI-related calls in an expedient manner. | Patterns in police response strategies, including behavioural indicators officers use as criteria for determining mental health status, procedural challenges with limited resources or information, and complications endemic to PMI encounters that culminate in constraints on officers' decision-making autonomy. |

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| | | directly or indirectly contribute to criminalization of the mentally ill. | | | | | |
| **COTTON (2004)** | Canada | To identify and quantify those attitudes that may influence the discretionary behaviour of police in their interactions with people with people they believed to mental illness | Quantitative | Questionnaire | N=138 | Police officers are in the untenable position of having a social expectation to ''do something,'' while at the same time, having no clear reason to arrest and knowing full well that a visit to the local emergency room is unlikely to lead to admission or treatment, unless the individual in question is acutely homicidal or suicidal. | Police officers appear to have attitudes similar with those of the public, and do not ascribe to punitive and isolationist attitudes that might lead to the apprehension of mentally ill individuals without a clear reason for such action. They are interested in obtaining more information about working with and understanding individuals who are mentally ill. |
| **VAN DEN BRINK et al, (2012)** | The Netherlands | To examine the extent to which these individuals are disconnected from mental health services, and whether the police response has | Qualitative | Retrospective review of police records | N=336 | Half of people with mental health needs coming to police attention (N=162) were disengaged from mental health services, lacking regular care contact in the year prior to the crisis In the month following the crisis, 21% of those who were previously disengaged from services had | Police play an important role in linking these individuals to services. There may be room for improvement, as more than half of the individuals who were disengaged from mental health services were not connected with services at the time of crisis. |

## Appendix 4 - Exemplar of literature quality appraisal

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Critical Appraisal Skills Programme

Paper for appraisal and reference: Watson (2008) Defyning Negative Expectation:Dimensions

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: Goal of the research is clear and highly relevent to the integrative review. This paper is focusesd on people with mental health needs encounters with police. Exactly as stated in title

2. Is a qualitative methodology appropriate?

Yes ✔ | Can't Tell | No

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Exploration of peoples experiances. In depth semi structured interviews Procedural Justice theory used as a sensitizing framework

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ✔ | Can't Tell | No

HINT: Consider
- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Very clearly sets out research design. Recruitment, participant characteristics clear

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

| | |
|---|---|
| Yes | ✔ |
| Can't Tell | |
| No | |

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Very clear. Explained how recruitment was mangeaged, selection

5. Was the data collected in a way that addressed the research issue?

| | |
|---|---|
| Yes | ✔ |
| Can't Tell | |
| No | |

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Set out how interviews were conducted and who by. Clearly states how this was done

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Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

| | |
|---|---|
| Yes | |
| Can't Tell | ✔ |
| No | |

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: Unclear. Research details provided but no understanding or relationship to particpants

Section B: What are the results?

7. Have ethical issues been taken into consideration?

| | |
|---|---|
| Yes | ✔ |
| Can't Tell | |
| No | |

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: University ethics highlighted.

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Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

| | |
|---|---|
| Yes | ✔ |
| Can't Tell | |
| No | |

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Processes of coding , theme development clear. Discusses how anaylsis was conducted and how agreements were found

9. Is there a clear statement of findings?

| | |
|---|---|
| Yes | ✔ |
| Can't Tell | |
| No | |

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: very clear and links back to the research question. Good discussion. Validation with three anaylists

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ✔
Can't Tell
No

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Processes of coding , theme development clear. Discusses how anaylsis was conducted and how agreements were found

9. Is there a clear statement of findings?

Yes ✔
Can't Tell
No

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: very clear and links back to the research question. Good discussion. Validation with three anaylists

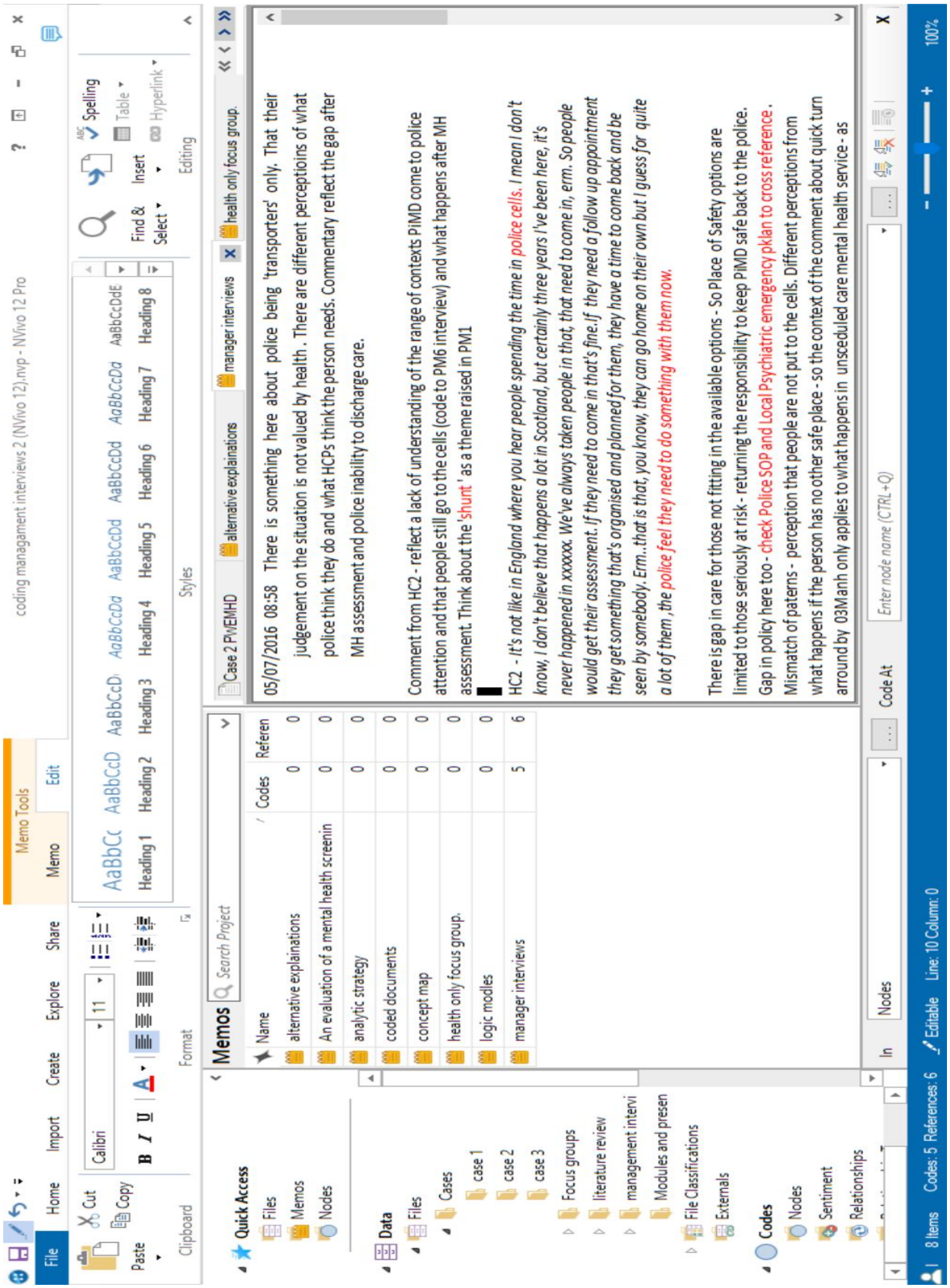
## Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments: To some extent. Particiapnts discuss feeling frightened and vulnerable. This may be associated with armed officers which is not relevent to Scotland. need to be treated humanely, heard and treated with dignity is highly relevent to the local context. Clealry sets out recomendations. Excellent paper

# Appendix 5 - Example of memoing from NVivo 11



## Appendix 6 – Synopsis of observations of the focus group dynamics

The focus group dynamics were noteworthy. I feel it is important and meaningful to my findings, to reflect how participants from the two professions talked about the focus group topic, about one another and how they expressed and reinforced their viewpoints.

Within the police only group, there was a sense of urgency, grievance and frustration. This was centralised around a perception of a lack support and pushback from HCP's. Although there was recognition of demand on health services were working to capacity, there was a generalised perception of an unsolicited redistribution of HCP's responsibilities into police work. There was a sense that their story was important and needed to be told.

The majority of participants talked spontaneously with participants often 'queuing' to talk, reinforce and build on other conversations and ensure their perspectives were heard and noted. Only two novice officer participants requiring prompting. This may be explained by awareness of rank and more experienced officers leading the conversations. The focus group was time bounded, however, the majority of participants wished to talk for much longer and asked to extend the time available to emphasize and record detail they felt important. There was a sense that this is a highly contested area of police work with few platforms to have their experiences heard.

Comparatively, I observed police participants within the mixed HCP/police focus group were less united as a profession. Two officers were particularly vocal with highly frustrated undertones. They suggested Police Scotland leadership has failed operational police officers who now find their work dominated by mental health care rather than police work. Yet, one police officer reflected insights into health service perspectives. He acknowledged empathy for the unscheduled care and inpatient based HCP's, recognising challenges of low staff numbers and demand. This brought a tension and debate between fellow officers with undercurrents of 'side taking' with HCP's and a lack of loyalty towards fellow officers The HCP in the group jokingly made comment that he felt 'ganged up' against and needed to defend his position.

I observed the HCP only focus as calm, with agreement throughout. Yet, participants were irritated by the absence of colleagues who had failed to attend the focus group as arranged. They stated that police attendance in the unscheduled care environment was a frequently discussed and persistent problem. This is reflected in the HCP focus group opening conversations:

“This is so disappointing. We have junior doctor meetings, and we speak about this issue ALL the time. It is a BIG thing.” (HFG2)
“Yes, we speak about this on the wards all the time. Yes, it is a real issue” (HFG3)

I found this noteworthy given until this point in the data collection, the majority of professional challenges, frustration and resource demands were focused around police experiences. Until now, the HCP voice had felt passive.

I drew from dynamics across all three focus groups, that inter-professional tensions expressed in the semi-structured interviews were also felt across most focus group participants. These were more palpable in the police only group and less direct in the mixed and HCP groups. Yet these frustrations were not focused on individuals. Rather the attention was on processes, roles, expectations, and the impact this has on the cyclical outcomes for many PiMD and service delivery.

## Appendix 7 - Police Scotland gatekeeper letter of support

RE: Inga's Phd - Email of Support

xxxxxxxxxxx@scotland.pnn.police.uk]

You replied on 09/01/2014 15:55.

Sent:09 January 2014 15:36

To: xxxxxxxxxxx.

Cc: xxxxxxxxxxx Inga Heyman (fns)

**PROTECT - MANAGEMENT**

***Inga,***

***Please find below some text. I trust it is sufficient for your needs.***

***"To Whom it May Concern,***

***On 4 November 2013 I met with Inga Heyman, Lecturer at the School of Nursing and Midwifery, Robert Gordon University in Aberdeen.***

***In the wake of this meeting during which she outlined her PhD proposal around aspects of vulnerable people, mental health and inter-professional education, I can confirm that I am content to act as an External Advisor for her during the period of her PhD research.***

***In terms of resources, relevant Officers from xxxxxxx Division of Police Scotland will also be able to provide her with additional advice and guidance as her research evolves. I do believe this has much relevancy for my organisation and valued partners and with that has the potential to be of some real value."***

***Yours faithfully,***

*xxxxxxxxxxxxMBA, MSc, BSc (Hons)*
Local Policing Commander
XXXXXXXXXXXX Division Headquarters
XXXXXX Street
XXXXXX, XXXXXX

Tel: xxxxxxxxxx
Email: XXXXXXXX@scotland.pnn.police.uk

## Appendix 8 – Recruitment criteria and process sheet for Police Scotland Concern Hub (Formally known as FRU)

Guidance for Force Referral Unit (FRU) officers and staff in contacting potential study participants.

This study has been reviewed and approved by Police Scotland. It has also been reviewed and approved by The RGU School of Nursing and Midwifery Ethics Review Panel, The [redacted] Research Ethics Committee and NHS [redacted] Research & Development Office.

**Aims and objectives of study**

The principal aim of this study is to understand the service pathways and interface, following emergency mental health assessment, between police officers, health service practitioners and those in mental health distress who initially present to, and are returned to, police services for subsequent management.

The principal investigator in this study is Inga Heyman who is a lecturer in mental health nursing at Robert Gordon University and PhD student

This study is taking a case study approach which includes in-depth investigation of three cases. I am interested in cases where an individual in mental health distress has come to the attention of the police, are taken to health services and are returned to police care following mental health assessment, or before if mental health assessment cannot be conducted. I will be studying the interface and pathways between police, the at-risk individual and health service practitioners in this experience. I will also be conducting:

- Interviews with health and police managers and key personnel such as the FRU.
- Focus groups with police officers and staff and health practitioners to better understand the challenges and facilitators that impact on how they deal operationally with those in mental health distress.

**How can you help?**

Through the FRU and operational police officers I need to identify three cases. I am hoping these will come to your attention through concern reports or on the VPD. The criterion for a case is as follows:

- The potential participant resides in [redacted]
- The first point of contact with services is through the police. This could be for example through a call by the person at risk or another to the control room, the service centre or officers identify someone at risk in the course of their duties. It could be in the person's home or in the street. It does not matter as long as the first point of contact is the police.
- They have not come to police attention on this instance because of a criminal matter.

- They do not have a severe and enduring mental health problem.
- Being drunk or intoxicated with other substances at the time of the incident does not exclude participants from the study
- The police must have transported them to health services [redacted] but they are returned to police care for onward management. This might be because they are assessed as not requiring an intervention, they are intoxicated, or their assessment is compromised in some way.
- They are over 16
- Police deal with their onward management. This could be for example, transported home, to a relative or to the cell block as a last resort place of safety. The study will include those who have been charged with Breach of the Peace simply to keep them safe. This does not matter as long as the police are dealing with the disposal

You should not give any identifying information to me at this point. The potential participant must remain anonymous until the point they have agreed for you to provide me with their contact details.

I am hoping you will be able to identify potential study participants through the iVPD, through concern forms or any logged calls.

**What happens once you have identified someone?**

If you identify anyone who is within the criteria you would then contact them by telephone to seek their verbal permission for me to contact them and tell them more about the study.

**What should I say on the telephone to an identified potential participant?**

After you introduce yourself please explain that a researcher from Robert Gordon University is studying the experiences of people who have come in contact with the police and health services when they are in need of help due to mental health distress. The researcher would be keen to hear about their experience.

Ask if it would it be OK if you gave the researcher their contact details allowing her to call them and tell them a more about the study. Explain that at this point I would only like to talk to them about the study, they are not agreeing to anything. They do not need to be involved if they do not wish to. If after speaking to the researcher they are happy to participate in a one hour 30 min (approximately) interview the researcher, they will be provided with a gift voucher to the value of £20 to recompense for transport costs to the interview, the participant's time and any related inconvenience. However, the purpose of you contacting them is to simply get their consent for me to call them to explain about the study. You should then record the outcome of the phone call on the attached form titled 'Verbal consent for Principal Investigator to contact potential participant'.

I would also like to interview the police officers and health staff involved in each case. I will ask for their contact details too once the identified person who experienced mental distress gives consent for me to do so.

Should you identify anyone please contact me on the details below. This can be by telephone or email (using police protected markers). I will visit the FRU on a weekly basis to answer any questions. However, I will not be able to discuss potential cases with you should that influence any possible recruitment. As stated, would like to explore **three cases.**

I really appreciate all your help. This study is the first of its kind in the UK and has been informed by my experiences whilst working for Police and health services. I hope that this will help shed some light on the pathways and interface between police, those in mental health distress and health service to helps support policy development, resource allocation and multiagency education.

Thank you very much for taking the time to do this. I am aware you are always very busy.

Kind regards

Inga Heyman

## Contact details

School of Nursing and Midwifery
Faculty of Health and Social Care
Robert Gordon University
Garthdee Campus
Garthdee Road
Aberdeen
AB10 7QG
Tel 01224 262644
i.heyman@rgu.ac.uk

# Appendix 9 – Consent form Person in Mental Distress

**CONSENT FORM**
**Those Who Have Experienced Mental Distress**
**A study of the interface and pathways between police, those who have experienced mental health distress and emergency health services**

**Participant identification Number:** **Case number:**
Name of Researcher: Inga Heyman

Please initial the boxes

1. I confirm that I have read and understand the information sheet dated ……. (version …….) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw or stop the interview at any time, without giving any reason, and without my legal rights being affected. ☐
3. I agree for the interview to be audio recorded. ☐
4. I understand any personal information that is recorded will remain confidential unless the researcher believes that I or others are at risk of harm. ☐
5. I understand that the data collected during the study may be drawn from my health and police records and will be viewed by the researcher. I give permission for the researcher to have access to these records. ☐
6. I understand that the findings from this study may be used in conference presentations, reports and publications. However, I will not be individually identified in any of these formats ☐
7. I agree to take part in the study. ☐
8. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from Robert Gordon University, from regulatory authorities or from the NHS Trust/Health Board, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
9. OPTIONAL
   In addition I give permission for the researcher to inform my G.P and/or legal representative (if awaiting court proceedings related to this incident) of my participation in this study (please delete as appropriate) ☐

| Name of participant | Date | Signature |
|---|---|---|
| | | |
| Researcher | Date | Signature |
| | | |



# Appendix 10 – Consent form Health and Police Managers

ROBERT GORDON UNIVERSITY ABERDEEN

# CONSENT FORM

## Police/health service manager and key personnel interview

**A study of the interface and pathways between police, those in mental health distress and emergency health services**

**Participant identification Number:** Name of Researcher: Inga Heyman

Please initial the boxes

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. ☐
3. I agree for this interview to be audio recorded. ☐
4. I understand any personal information that is recorded will remain confidential within the parameters detailed in the information sheet. No information that identifies me will be made publicly available. ☐
5. I understand that the data and findings collected during the study may be used in conference presentations, reports and publications. ☐
6. I agree to take part in the study. ☐

| Name of participant | Date | Signature |
|---|---|---|
| _____ | _____ | _____ |
| Researcher | Date | Signature |
| _____ | _____ | _____ |

# Appendix 11 – Topic guide clinical case interviews

Topic guide: Those in mental health distress interview

### Introduction

***Aim: to introduce the research and set the context for the proceeding discussion.***

- Introduce myself, background and RGU
- Introduce the study: for my PhD, it is about the pathway and interface between those in mental health distress, police and health services
- Talk through key points:
- Purpose of the interview
- Length of the interview
- Understand that individual may get upset and aim to support if this occurs
- Can stop at any time if you need a break
- Can come back another day to finish
- Voluntary nature of participation
- No questionnaire, more like a conversation
- Recording of the interview
- Can stop at any point
- Confidentiality and how findings will be reported
- No right or wrong answers, just say what you think
- Gift voucher
- Participants can withdraw at any time form the study
- Any questions
- Information sheet identify and literacy difficulties and read through if consent form in need be. Participant to initial boxes and sign if in agreement

**Aims and objectives of study**

The principal aim of this study is to understand the service pathways and interface, following emergency mental health assessment, between police officers, health service practitioners and those in mental health distress who initially present to, and are returned to, police services for subsequent management.

***Aim: to explore the respondent's pathway and experiences in the identified case of contact with police and emergency health care staff***

- What initiated the call to the police?
- Who was involved at the time of police contact?
- Why were the police called and not another service?
- Interactions with police before incident, at the time of the incident, and since
- Interactions with emergency health services before incident, at the time of the incident, and since
- Whether needs addressed, how, when and by whom or why not
- What was helpful, what was not?
- What went well/not well in their experience?
- What things that would have made it easier?
- Opportunities to speak to/ ask questions of colleagues in the other service relating to the case
- How would you describe the outcome of that incident?
- Have you contacted police whilst in mental health distress in the past? If so under what circumstances and what was that experience like?

***Aim: What are the barriers, and facilitators, for those involved in this pathway to achieving a positive outcome?***

- What is perceived as a positive/ negative outcome for you in a similar situation?
- Respondent's impressions of gaps in the service
- What could be done to make you experience better in the future or prevent you requiring services again?
- Whose responsibility is it to provide this care?
- What is the most important thing that can be done for people in a similar situation?
- What gets in the way?
- Do you think there is any gap in services to support you when you sought help, if so, what are they?
- If you needed help in a similar circumstance in the future what would you do?
- If services could be better, and what would this look like in their view

Other issues respondent would like to raise?

**Close**

Thank you for your participation.

Check all consent details are signed

Ensure expenses monies are provided

Ensure participant is not distressed by interview and safe to leave

Offer details of support services

Ensure participant has contact details for researcher and supervisor.

## Appendix 12 – Topic guide focus groups

Topic guide: Focus group police only/health service only /mixed

### Introduction

***Aim: to introduce the research and set the context for the proceeding discussion.***

- Introduce myself, background and RGU
- Introduce the study: for my PhD, it is about the pathway and interface between those in mental distress, police and health services
- Information sheet and consent form – **initial boxes- not tick**
- Talk through key points:
- Purpose of the focus group. Be specific about the exact type of cases being studied
- Length of the focus group
- Can stop at any time if you need a break
- Voluntary nature of participation
- No questionnaire, more like a conversation
- Recording of the focus group
- Can leave focus group at any point
- Confidentiality and how findings will be reported
- No right or wrong answers, just say what you think
- Try to let one person speak at a time
- Participants can withdraw at any time form the study
- Can provide detail of the transcribed focus group if required
- Any questions?
- Allow participants to introduce themselves

**Aims and objectives of study**

The principal aim of this study is to understand the service pathways and interface, following emergency mental health assessment, between police officers, health service practitioners and those in mental health distress who initially present to, and are returned to, police services for subsequent management.

***Aim: to explore the pathways and interface between those in mental health distress who come to police attention and emergency health care staff***

- Why do you think those in MHD come to police attention initially? What do you think initiates a call to the police/individual coming to police attention?
- Why were the police called and not another service?
- What pathways are possible? Starting points and then directions?
- Who is involved at the time of police contact?
- What your experience was of interacting with those in mental health distress?
- What factors influenced the decisions you make in working with those in mental health distress

- From a practice perspective, what is your experience of engaging and interacting with police /emergency health services?
- Whether you think there are gaps in the services for those in need of emergency mental health care what could be done to enhance care.

***Aim: What are the barriers, and facilitators, for those involved in this pathway to achieving a positive outcome?***

- What is perceived as a positive/ negative outcome within this pathway?
- What facilitates a good outcome in their experience?
- What elements influence a negative outcome
- Whose responsibility is it to provide this care on the pathways
- Participants ideas of an ideal pathway
- Most important thing that could be done to improve pathways
- From a practice perspective, what barriers exist within and between
  a. Services b. Those in mental health distress?
- What facilitators to a positive outcome between services/and service users?
- What else helps?
- What gets in the way?
- Any barriers/ facilitators from a management/strategic perspective?
- Do you think there is any gap in services for help seekers, if so, what are they?
- What would make it better?
- Are you aware of any key developments within your organisation or out with that would support and improved outcomes for service users and practitioners?
- Are you aware of any areas of best practice or innovations relating to such cases that would help you in your work with this specific group?

Other issues respondent would like to raise?

### Close

Thank you for your participation.
Check all consent details are signed
Ensure participants have contact details for researcher and supervisor.

## Appendix 13 – Participant information sheet PiMD interviews

# Information sheet: Those who have experienced mental distress

You are being invited to take part in a research study. You have already heard about the project from Police Scotland and verbally by the researcher, Inga Heyman (PhD student, Robert Gordon University). Before you decide whether or not to participate, it is important to understand why the research is being done and what it will involve. Please take time to read the following information carefully (Part 1 tells you the purpose of the study and what will happen if you take part. Part 2 gives you more detailed information about the conduct of the study). Talk to others about the study if you wish. Feel free to ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

## Part 1

### *What is the purpose of the study?*

This study aims to try to better understand the service pathway and interface, following emergency mental health assessment, between police officers, health service practitioners and those in mental health distress who initially present to, and are returned to, police services. The study is in partial fulfilment of the researcher's PhD

### *Why have I been invited?*

The Police have identified you as someone whom they brought to health services.
A sample of those who have been brought by the police to NHS emergency mental health service is required to participate in an interview with the researcher.
Understanding the experiences of those who have been in the care of these services is essential to help develop guidance and education for those working in health care and the police.

### *Do I have to take part?*

No, it is up to you to decide.
Whether you take part or not will not influence, either positively or negatively, any further care or interactions you have with either the police or health services.
To the researcher will go through this information sheet with you, which you will be able to keep. You will then be asked to sign a consent form to show you have agreed to take part. If you do decide to take part, you are still free to withdraw at any time and without giving a reason.

### *What about my expenses?*

A £20 gift voucher will be provided along with travel expenses to recompense for any costs to attend the interview, your time and any related inconvenience.

### *What will happen if I decide to take part?*

If you decide to participate, you will firstly go through the consent to participate information sheet. Once you are clear that you understand what is involved in the study you will be asked to sign the consent form which confirms you are agreeing to be part of the study.
You will then take part in an interview with the researcher Inga Heyman. Interviews will be carried out either at The Robert Gordon University or another public service building such as a health centre close to your home, whichever you would prefer, and at a time convenient for you.
The interview will last about 1 hour and will be recorded (with your permission). You can stop the interview at any time. You can also withdraw from the study at any point should you no longer wish to participate.

You will be asked about:

- your experiences of how you came in contact with the police
- what you experience was of interacting with the police
- What was your experience of health services?
- Your needs and whether they were met.
- Whether or not you think there are (or not) gaps in the services for those in need of emergency mental health care and if so, what could be done to enhance care?

The researcher who will carry out the interview is a trained mental health nurse.
The researcher would like to review what happened at the time of this incident and, with your permission, will examine what was noted in your police and health records in relation to presentation to services relating to mental health distress. The researcher is not wishing to examine other areas of your police or health records.
Interviews are also being carried out with police officers and health staff involved when you were brought to services. Additionally, the views of health and police managers will be sought to get their general perspectives on police and emergency health services when someone is in mental health distress.
Information that is collected from all the interviews will be used to help develop education and policies to help police and health services to better understand the experiences of, people who have experienced mental health distress, police and health staff when someone requires emergency mental health services. The findings of this research will be shared with study participants.

### *What are the possible benefits and disadvantages of taking part?*

There may be some risk of participants becoming upset due to the sensitive nature of the topic. The researcher will support you through the process and, if you think you need it, will guide you to gain support through your G.P. other health professional or telephone support services such as the Samaritans. Details of support services will be provided to you should you require them at a later date.
There will be no direct benefit in relation to your interactions with police or health services should they choose to or not to participate.
It cannot be promised that the study will help you personally, but the information collected will be used to guide the care of others who require police and health services whilst in mental health distress

### *Will my taking part in the study be kept confidential?*

Yes, all information that is collected during the research will be kept strictly confidential according to the Data Protection Act 1998. Names and contact details will be stored separately from other data collected. Your name will never be used in any reports, papers and

presentations arising from the research. Data will be stored for 5 years and will be destroyed when it is no longer needed for the project. Anonymous data may be shared with other researchers.
If for any reason the researcher knows or believes an individual to be at serious risk of harm or pose a risk to others through the course of this study, she must report this to the relevant authority such as the individuals G.P, local authority or police.
With your consent we will advise your G.P that you are participating in the study.
Should you have been charged with Breach of the Peace and kept in police custody for safeguarding during the incident at the focus of this study, the researcher will advise your legal representative (if you have one),with your consent, that you are taking part in the research. Advice obtained from the Crown Office states participation in this study will not impact on criminal proceedings.

This completes Part 1. If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## Part 2

### *What if there is a problem?*

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the researcher's supervisor, Dr Colin Macduff at The Robert Gordon University. His telephone number is 01224 262935 and his email address is c.macduff@rgu.ac.uk

### *What will happen to the results of the research study?*
On completion of the study a report will be written, results will be published in medical, nursing and police journals and reported at one or more conferences. Participants will be given the results of the study in a summary report. You will not be identified in any report or publication. Any direct quotes will be anonymised

### *Who is organising and funding the research?*
The research is being undertaken by Inga Heyman, a lecturer and PhD student at The Faculty of Health and Social Care at The Robert Gordon University, Aberdeen.

### *Who has reviewed the study?*
This study has been reviewed and approved by the RGU School Ethic Review Panel (SERP) The North of Scotland Research Ethics Committee and NHS Grampian Research & Development Office.

### *What happens next?*
Please get in touch with the researcher if you have any questions about the research or about this invitation to participate. If you do decide that you would like to take part, please contact the researcher by phone or email. You will then be contacted with more information about the next steps.

### *Contact for further information:*
Inga Heyman, School of Nursing and Midwifery, The Robert Gordon University
Telephone: 01224 262644 or e-mail i.heyman@rgu.ac.uk

## Appendix 14 – Robert Gordon University Ethics Review Panel approval

ROBERT GORDON UNIVERSITY ABERDEEN

FACULTY OF HEALTH & SOCIAL CARE
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG
United Kingdom
Tel: 01224 263059
Fax: 01224 263053
Email: v.maehle@rgu.ac.uk
www.rgu.ac.uk

Inga Heyman
Lecturer/PhD student
School of Nursing and Midwifery

Date: 15th March 2015

**Research proposal number:** 14-15

**Research proposal title:** Black, white and grey – a study of the interface and pathways between police, those in mental health distress and emergency health services

Dear Inga,

The School of Nursing and Midwifery Ethics Review Panel has now reviewed the above research proposal. Please find details of the outcome and recommended actions below.

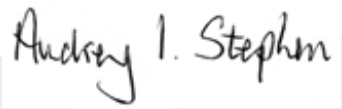
| | | |
|---|---|---|
| X | Proposal approved | You may go ahead with your research, providing approval from any relevant external committee/s has been obtained.* |
| | Proposal approved subject to amendments. | Please review and amend all relevant documents in the light of the comments given, then forward them to the Convenor who will give final approval. |
| | Proposal not approved: significant ethical issues as yet inadequately | Please review your proposal in light of the issues identified. If you require further clarification or discussion please contact the Convenor. You are welcome to re-submit your proposal when the issues of concern have all been addressed. |
| | Proposal referred to RES and/or the University Ethics sub-committee. | Some proposals require consideration and input from colleagues out with the School of Nursing and Midwifery. We will keep you informed of progress in this regard, and involved in the process as appropriate. |

* Where research involves NHS staff or patients, approval through the NRES system must be obtained. Members of the School Panel can advise on this process if necessary.

Thank you very much for providing additional information addressing the points arising through ethical review of your study. We are now pleased to provide approval for your study to proceed. Please do not hesitate to have further discussion with SERP should any issues requiring ethical clarification arise as you carry out the research.

We wish you well as you move forward with this important study.

**Signatures of Panel member**



**Position held:**

Research Fellow/SERP Convenor

**Signatures of Panel member**

**Position held:**
**Lecturer**

If you require further information please contact the Panel Convenor, Audrey Stephen, on 01224 263150.

When you have completed your research project, please send a copy of your final report to:

Dr Audrey Stephen
School of Nursing and Midwifery
Robert Gordon University
Garthdee Road
Aberdeen
AB10 7QG

Email: a.i.stephen@rgu.ac.uk

# Appendix 15 – Regional NHS Ethics Committee (REC) approval

**NRES Committees -**

Telephone:
Facsimile:
Email:

28 April 2015

Mrs Inga Heyman
School of Nursing and Midwifery
Robert Gordon University
ABERDEEN
AB10 7QG

Dear Mrs Heyman

**Study title:** **Black, white and grey - a study of the interface and pathway between police, those in mental health distress and emergency health services.**
**REC reference:** **15/NS/0008**
**IRAS project ID:** **172615**

Thank you for your letter of 27 April 2015. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 13 March 2015.

**Documents received**

The documents received were as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Interview schedules or topic guides for participants: NHS/Police Manager and Key Personnel Interview | 3 | April 2015 |
| IRAS Checklist XML: Checklist 28042015 | | 28 April 2015 |
| Letter of Response | | 27 April 2015 |
| Lay Person Confirmation of Understanding | 2 | March 2015 |
| Link for Audio | | 28 April 2015 |
| Participant Consent Form: Those who have experienced mental health distress | 3 | 27 April 2015 |
| Participant Information Sheet (PIS): Those who have been in mental health distress | 3 | April 2015 |

| *Document* | *Version* | *Date* |
|---|---|---|
| Participant Information Sheet (PIS): Police/Health Practitioners and Mixed Police and Health Practitioner Focus Groups | 3 | April 2015 |
| Participant Information Sheet (PIS): Police Officers involved in case | 3 | April 2015 |
| Participant Information Sheet (PIS): Health Practitioners involved in case | 3 | April 2015 |
| Participant Information Sheet (PIS): NHS Managers and Key Personnel | 3 | April 2015 |
| Participant information sheet (PIS): Police Managers and Key Personnel | 3 | April 2015 |

**Approved documents**

The final list of approved documentation for the study is therefore as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Covering letter on headed paper | | 24 February 2015 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only): Non-NHS insurance | 2 | 1 August 2014 |
| GP/consultant information sheets or letters: Letter for GP | 1 | February 2015 |
| Interview schedules or topic guides for participants: Topic guide PWEMHD | 2 | January 2015 |
| Interview schedules or topic guides for participants: Topic Guide focus groups | 2 | January 2015 |
| Interview schedules or topic guides for participants: Topic guide practitioner in case. Police/Health | 2 | January 2015 |
| Interview schedules or topic guides for participants: NHS/ Police Manager and Key Personnel Interview | 3 | April 2015 |
| IRAS Checklist XML: Checklist 28042015 | | 28 April 2015 |
| Police Origin and Police Management Map | 1 | January 2015 |
| SERP table of changes application 1 | 1 | 24 February 2015 |
| Guidance for Force Referral Unit to recruit | 2 | January 2015 |
| Letter advising legal representative of client involvement | 1 | February 2015 |
| Force Referral Unit - Verbal Consent for PI to contact potential participant | 2 | January 2015 |
| Recruitment map | 1 | January 2015 |
| Letter of unfavourable opinion NRES Project 1 | 1 | 13 January 2015 |
| Letter of Response | | 27 April 2015 |
| Lay Person Confirmation of Understanding | 2 | March 2015 |
| Link for Audio | | 28 April 2015 |
| Participant Consent Form: Police/Health Manager | 2 | 27 January 2015 |
| Participant Consent Form: Case Study Practitioner | 2 | 27 January 2015 |

| *Document* | *Version* | *Date* |
|---|---|---|
| Participant Consent Form: Focus Group | 2 | 27 January 2015 |
| Participant Consent Form: Those who have experienced mental health distress | 3 | 27 April 2015 |
| Participant Information Sheet (PIS): Those who have been in mental health distress | 3 | April 2015 |
| Participant Information Sheet (PIS): Police/Health Practitioners and Mixed Police and Health Practitioner Focus Groups | 3 | April 2015 |
| Participant Information Sheet (PIS): Police Officers involved in case | 3 | April 2015 |
| Participant Information Sheet (PIS): Health Practitioners involved in case | 3 | April 2015 |
| Participant Information Sheet (PIS): NHS Managers and Key Personnel | 3 | April 2015 |
| Participant Information Sheet (PIS): Police Managers and Key Personnel | 3 | April 2015 |
| REC Application Form: REC Form 26022015 | 172615/744847/1/873 | 26 February 2015 |
| Research protocol or project proposal | 2 | January 2015 |
| Summary CV for Chief Investigator (CI): Inga Heyman | 1 | 24 February 2015 |
| Summary CV for supervisor (student research): Colin Macduff | 1 | 24 February 2015 |

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**15/NS/0008** **Please quote this number on all correspondence**

Yours sincerely

**Senior Ethics Co-ordinator**

Copy to: Robert Gordon University
NHS R&D Department

## Appendix 16 – Research and Development Management approval – NHS Scotland

**Research and Development**

Mrs Inga Heyman
Robert Gordon University
School of Nursing and Midwifery
Robert Gordon University
Aberdeen
AB10 7QG

Date 08/07/2015
Project No 2015RG003

Enquiries to
Extension
Direct Line
Email ermissions@nhs.net

Dear Mrs Heyman

**Management Permission for Non-Commercial Research**

**STUDY TITLE:** Black, white and grey - a study of the interface and pathway between police, those in mental health distress and emergency health services.
**PROTOCOL NO:** v2, January 2015
**REC REF:** 15/NS/0008

Thank you very much for sending all relevant documentation. I am pleased to confirm that the project is now registered with the NHS Research & Development Office. The project now has R & D Management Permission to proceed locally. This is based on the documents received from yourself and the relevant Approvals being in place.

All research with an NHS element is subject to the Research Governance Framework for Health and Community Care (2006, 2nd edition), and as Chief or Principal Investigator you should be fully committed to your responsibilities associated with this.

**R&D Permission is granted on condition that:**

1) **The R&D Office will be notified and any relevant documents forwarded to us if any of the following occur:**
   - **Any Serious Breaches in (Please forward to**
   - **A change of Principal Investigator in or Chief Investigator.**
   - **Any change to funding or any additional funding**

2) **The R&D Office will be notified when the study ends.**

3) **The Sponsor will notify all amendments to the relevant National Co-ordinating centre. For single centre studies, amendments should be notified to the R&D office directly.**

We hope the project goes well, and if you need any help or advice relating to your R&D Management Permission, please do not hesitate to contact the office.

Yours sincerely

**Non-Commercial Manager**

cc: Professor Rita Marcella, Robert Gordon University
Dr Colin MacDuff, Robert Gordon University
Research Monitor

**Sponsor**: RGU

## Appendix 17 – Letter of study support- Police Scotland

**OFFICIAL**

Date: 7 September 2020

Your Ref:

Our Ref: KLC/IH

Inga Heyman
School of Health and Social Care
Edinburgh Napier University
Sighthill Campus
Edinburgh
EH11 4BN

POLICE SCOTLAND
Keeping people safe

POILEAS ALBA

Kirsty-Louise Campbell
Head of Strategy and Innovation

Corporate Services
Fettes Avenue
Edinburgh
EH4 1RE

strategyandinnovation@scotland.pnn.police.uk

Dear Inga

**Letter of Support - 'PhD research, Black, white and grey - a study of the interface and pathways between police, those in mental health distress and emergency services'**

Thank you for your continued interest in Police Scotland and your research focusing on the police and health intersect. Police Scotland have a key interest in how research and evidence can help inform the delivery of policing; both now and in future. We are committed to developing as a learning organisation through strengthening existing partnerships with research organisations, in addition to building new and interdisciplinary relationships regionally, nationally and internationally to the benefit of service improvement.

As your PhD with Robert Gordon University, School of Nursing, Midwifery and Paramedic Practice now approaches conclusion, may we take the opportunity to confirm our support to this study to understand the service pathways and interface, before, during and following emergency mental health assessment, between police officers, health practitioners and those in mental health distress who initially present to, and are returned to, police services for subsequent management.

We are keen to encourage knowledge exchange and consider and discuss findings. I would like to wish you every success; and we look forward to receiving a copy of your PhD and highlight report in due course.

Yours sincerely

*PP Judith Northin*

Kirsty-Louise Campbell
Head of Strategy and Innovation

scotland.police.uk @PoliceScotland PoliceScotland

**OFFICIAL**

## Appendix 18 – Synthesis of clinical cases

| CASE 1 – JESS. |
| --- |
| Jess is a 23-year-old woman who lives alone. She often feels anxious and has difficulty controlling urges to self-harm. This is exacerbated by periods of problematic drinking. She frequently relies on emergency services to support her during these times. Evenings, weekend, or when she has no credit on her phone are times when she is most likely to contact NHS24 or dial 999 for police support.<br>At midnight on a weeknight, Jess called NHS24 stating she was anxious and thinking of self-harming. She had been drinking alcohol. NHS 24 contacted the police control room requesting police attend the address.<br>Jess is well known to police services who have attended multiple times previously. On this evening police resources were particularly stretched. Officers responded quickly given the immediate threat of self-harm. Jess had not self-harmed and settled quickly when the police arrived. As Jess had been drinking and had no physical injury, officers were unable to transport her to unscheduled MH services or the E.D. (as per local psychiatric emergency plan). An out-of-hours G.P. services assessment was arranged via NHS24 in order to assess risk of harm and need for alternative safeguarding. Both officers remained in attendance for three hours awaiting G.P. contact. Given demand for their time, their sergeant contacted health services to hasten the response. One hour later an out-of-hours G.P. called and conducted a brief over the phone MH assessment. The G.P. stated Jess was not at risk and required no further intervention.<br>Police completed an adult at risk of harm concern report informing the Adult Support and Protection local authority lead and Jess's G.P. of their interactions and concerns |

**HEALTH HISTORY.** Jess has a history of anxiety, depression a Personality Disorder diagnosis, and problematic alcohol use since her early teens. She has sporadic episodes of self-harm and previously engaged with alcohol and third sector services supporting those who self-harm. She is well known to her G.P. Jess is not currently engaged with other health services. She is prescribed anti-depressants. Jess is identified in G.P. files as being a high user of health services by unscheduled and scheduled care.

**POLICE HISTORY** Jess is well known to police services who have attended her home on numerous occasions when she has called requesting support when wishing to self-harm. Jess has one conviction for Breach of the Peace when she became aggressive with police when

called to her home after an incident with a former boyfriend. Both were intoxicated with alcohol and cannabis. She has spent a night in custody when violent to an officer after a call for support when self-harm. Jess is identified in police records as a high user of police services

**SAFEGUARDING JOURNEY TRAJECTORY** - The trajectory of care in this event was determined by intoxication and an absence of physical injuries. Meaning Jess would not be assessed at the E.D or unscheduled care psychiatric services until sober. With no physical injuries, she would not be a priority in the E.D. Police remained with Jess at her home for four hours. A mental health assessment was conducted which concluded Jess was not at risk of harm and police left.

**MENTAL HEALTH ASSESMENT** - This was conducted over the phone by an unscheduled care G.P. At the time of assessment Jess was sober and stated she was no longer at risk. Assessment was brief lasting about three minutes.

**INFORMATION SHARING and REFERRAL** - Police and the unscheduled care G.P. informed Jess's G.P. of their involvement with Jess. Police made a referral to the local authority Adult Support and Protection (ASP) Team. Jess was subsequently deemed not to be an adult at risk of harm under ASP legislation with no further intervention.

## CASE 2 – FIONA.

Fiona is a 26-year-old woman who lives with her parents. She has a long history of self-harm and attempts on her life. She frequently feels suicide is her only option and regularly thinks through how this could be completed. Fiona also has episodes of problematic drinking. On this occasion, she had not consumed alcohol for 6 days and was struggling to control suicidal urges. Fiona has been involved in MH care through outpatient services for many years.

At 11am on Saturday morning, Fiona's mother called NHS 24 requesting assistance. She reported Fiona had cut her wrists and had left the family home stating she was to jump from a city carpark rooftop. NHS 24 contacted police. Multiple police units in the area were dispatched with seven officers attending. Fiona was found close to the edge of the fifth floor of the carpark. A police officer managed to take her to safety. The officer brought Fiona to one of the police vehicles where they attended to superficial wrist lacerations. As there were no serious physical health concerns, two officers transported Fiona to the psychiatric hospital unscheduled care service as a Place of Safety and MH assessment.

On arrival at the hospital three other police vehicles were waiting with other people requiring MH assessment. This resulted in a 4-hour wait. As per policy, officers remained in attendance. Following MH assessment, Fiona returned home in the care of her parents. The examining doctor informed Fiona's G.P. and made a request to prioritise an existing outpatient psychiatric care appointment. Officers completed Place of Safety documentation and an Adult Support and Protection referral to the local authority adult protection team

**HEALTH HISTORY.** Fiona has a history of depression and self-harm with multiple attempts on her life. Her first overdose attempt was at 18 years of age. She is currently engaged with alcohol and eating disorder services. She has a diagnosis of Personality Disorder. Fiona states she thinks about suicide daily. Fiona has previously been refused psychiatric assessment when intoxicated. On this occasion Fiona states this attempt was impulsive and not a planned event. She regrets not having consumed alcohol as this may have given the impetus to complete suicide.

**POLICE HISTORY.** Police have attended when Fiona's parents have called when she has made previous attempts on her life. Fiona has a record of Breach of the Peace following an incident when police were called to her parents' home. Fiona was intoxicated, threatening self-harm and aggressive. She spent the night in custody.

**SAFEGUARDING JOURNEY TRAJECTORY** - Fiona was found in a public place (car park rooftop) meaning the constrictions for police of removing a person from a private dwelling should they not wish to be transported to health care, did not apply. Fiona had minor injuries and no alcohol intoxication. Police transported Fiona to Psychiatric unscheduled care services within the Psychiatric hospital. Two police officers remained in attendance throughout - lasting approximately 7 hours. Following mental health assessment, Fiona returned home to the care of her parents.

**MENTAL HEALTH ASSESMENT** - Conducted face-to-face by a FY2 doctor (year two of general postgraduate medical training programme) taking approximately one hour. Examination found superficial cuts to arms. Mood significantly low but not deemed clinically depressed. Safe to return to parental care.

**INFORMATION SHARING and REFERRAL** - Police and doctor informed the G.P. of their concerns for Fiona. Place of Safety documentation was completed. Police made a referral to the local authority Adult Support and Protection Team. Fiona was deemed not to be an adult at risk under ASP legislation with no further intervention. A request made by the assessing doctor for an out- patient appointment at psychiatric clinic (due in 4 weeks) to be moved forward and for Community Psychiatric Nurse involvement.

## CASE 3- DEB

Deb is a 63-year-old woman who lives alone. Her partner often stays at weekends. They have a history of violence towards each other. Deb states this is exacerbated by alcohol. Deb has a long history of depression, anxiety and fluctuating alcohol abuse problems. This has resulted in her being unable to work. Deb attributes this to a history of childhood and adult trauma.

On a Saturday evening, Deb called 999 numerous times following a domestic abuse incident. She then repeatedly called police services in a bid to call off the police response. However, they attended to check on her safety.

On arrival Deb refused officers entry. She was highly intoxicated, physically violent to herself and stating she wished to kill herself. Officers called for additional support to deal with Deb's partner who was involved in the domestic incident. Officers removed Deb's partner to police custody. Deb's behaviour escalated and she became more aggressive towards herself, hitting herself on her head and arms. Officers called NHS24 requesting a MH assessment and health service support. A G.P. unscheduled care services referral arranged an appointment for Deb at the hospital with police transport. However, Deb refused to leave her home. A request for a home visit was made. Due to their concerns for Deb, officers remained in attendance. When the doctor arrived, an assessment was attempted. However, he advised Deb's intoxicated state a mental health assessment could not be completed. The G.P. advised officers they should take Deb to a Place of Safety. Given Deb was already in a designated Place of Safety (her own home); police were unable to legally remove her to another Place of Safety. Police attempted to secure a family member or friend to support. However, given Deb was isolated and estranged from family, there were no alternative options available. Police officers were forced to consider police custody as the only remaining safeguarding route. To enable this, officers were required to charge Deb with a breach of the peace. This in turn heightened Deb's aggression towards herself and the officers. In order to reduce tensions police decided not to use handcuffs to transport Deb to custody. However, Deb attempted to jump from the moving police vehicle when going at speed, resulting in a need to use restraints.

Deb was held in custody overnight to ensure her safety. In the morning Deb stated she did not wish to self-harm and was transported back home by officers. Deb requested officers drop her a few streets from her home to ensure her neighbours did not see her leaving the police vehicle.

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| Officers submitted a concern report for Adult Support and Protection referral to the local authority adult protection team. |

**HEALTH HISTORY.** Deb has a long history of depression, fluctuating problematic alcohol use and attempts on her life. She is currently being treated for anxiety and depression. Deb is engaged with alcohol services. She is not taking any medication. She has a history of child and adult trauma. Her current relationship can be volatile.

**POLICE HISTORY.** Deb is well known to police services who have attended on multiple occasions to incidents of alcohol-fuelled violence between Deb and her partner. She has previously been violent to officers with incidents of biting and hitting. This has resulted in convictions of breach of the peace and wasting police time.

**SAFEGUARDING JOURNEY TRAJECTORY** - The care pathway was determined by intoxication and place of safety legislation. Deb refused to leave her home meaning police had no legal grounds to remove her for MH assessment (from one place of safety being Deb's home, to another place of safety A&E). The visiting out-of-hours G.P. stated Deb was too intoxicated for MH assessment and should be taken to a Place of safety. The transference to custody was determined by a police officer given no other options and unwillingness to leave Deb whilst intoxicated and threatening suicide. Deb was returned home the next day with no further threats of self-harm or suicide. The incident spanned two police shifts.

**MENTAL HEALTH ASSESMENT** – Attempted by out-of-hours G.P., however, Deb was deemed too intoxicated to make an assessment. No assessment was made when Deb was sober the following day given she had no memory of wishing to self-harm.

**INFORMATION SHARING and REFERRAL** - Police informed Deb's G.P. and local authority Adult Support and Protection Team. Out-of-hours G.P. informed Deb's G.P., Deb was deemed not to be an adult at risk under ASP legislation with no further intervention.

# Appendix 19 – External outputs

## Papers, awards, impact, conferences and invited presentations

| Type | Details | Dates |
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| Book chapter (Submitted) | THOMAS, S., WHITE, C., DOUGALL, N. & **HEYMAN, I**. 2020. Law enforcement and mental health: The missing middle. In: BARTKOWIAK-THÉRON, I., CLOVER, J., MARTIN, D., SOUTHBY, R. & CROFTS, N. (eds.) Law enforcement and public health (LEPH) Springer Collection. New York Springer | 2020 |
| Conference presentation | HEYMAN, I. 2019. The Intersection between Police, People in Mental Health Distress and Unscheduled Health Care: An Exploratory Case Study. The Fifth Scottish Institute for Policing Research (SIPR) and Police Scotland Postgraduate Symposium. Edinburgh: Scottish Institute for Policing Research. | 2019 |
| Presentation National Summit | HEYMAN I, DOUGALL N, THOMAS S, KERR J. Mental Health and Distress in the Emergency Department. National Summit. In collaboration with The Scottish Government Distress Intervention Group and the Global Law Enforcement & Public Health Association (GLEPHA) Mental Health Special Interest Group Presentation by **I. HEYMAN** | 2019 |
| Published paper | ENANG I, MURRAY J, DOUGALL N, WOOFF A, **HEYMAN I,** ASTON E. Defining and Assessing Vulnerability within law enforcement and public health organisations: a scoping review. BMC Health & Justice 7, 2(2019). https://doi.org/10.1186/s40352-019-0083-z | 2019 |
| Poster presentation | I.HEYMAN.2019 The Intersection between People in Mental Health Distress, Police and Out-of-hours Health Services: An Exploratory Case Study School of Nursing and Midwifery Postgraduate Research Symposium, Robert Gordon University, Aberdeen. | 2019 |
| Conference presentation | DOUGALL, N., WHITE, C., MURRAY, J., ENANG, I., WOOFF, A., ASTON, E., & **HEYMAN, I**. The Scottish Centre for Law Enforcement and Public Health: how we got here and where we are going. Major session (M1) presentation given by I Heyman and panel at the 5th Global Law Enforcement and Public Conference, Edinburgh 2019. https://leph2019edinburgh.com/program-monday/ | 2019 |

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| Published paper | MURRAY, J., ENANG, I., DOUGALL, N., WOOFF, A., ASTON, E., & **HEYMAN, I**. (2019, January). Defining and Assessing Vulnerability: Perspectives across Law Enforcement and Public Health (LEPH). Conference presentation, 4th PUBSIC (Innovation in Public Services and Public Policy) Conference, Milan. | 2019 |
| Invited speaker | Police and Emergency Health Practitioner Experiences in the Care of People in Mental Health Distress. Presentations by **I. HEYMAN**. Police Division, Safer Communities Directorate Scottish Government, St Andrews House, Edinburgh | 2018 |
| Invited speaker | Police and Emergency Health Practitioner Experiences in the Care of People in Mental Health Distress Presentations by **I. HEYMAN**, Justice Analytical Services, Scottish Government, Crowne Plaza, Edinburgh | 2018 |
| Poster presentation | I.HEYMAN.2018 Black, white and grey – a case study of the experiences of police, people in mental health distress and emergency health services. School of Nursing and Midwifery Postgraduate Research Symposium, Robert Gordon University, Aberdeen. | 2018 |
| Invited speaker | A study of police and emergency health practitioner experiences in the care of people in mental health distress. Presentations by **I. HEYMAN** Health and Justice Collaboration Board, Scottish Government, St Andrews House, Edinburgh | 2018 |
| Guidelines | KESIC D, THOMAS S, BONOMO A, BRUNO R, CHAMBERS J, **HEYMAN I,** et al. Police Management of Mental Health Crises in the Community. Law Enforcement and Mental Health Special Interest Group Guideline. :31. Available from: https://gleapha.wildapricot.org/resources/Documents/LEMH%20SIG%20Guideline_September%202019.pdf | 2018 |
| Conference presentation | HEYMAN I, DOUGALL N, WILLIAMS B, HEIJMER-MASON O. 2018 Working across sectors to develop an evidence-based approach to policing mental health and distress in Scotland**.** Major session (M14) conference presentation by I HEYMAN and panel at the 4th Global Law Enforcement and Public Conference, Toronto 2018. https://leph2018toronto.com/conference-program/#wednesday24oct | 2018 |
| Published paper (Editorial) | HEYMAN, I. & MCGEOUGH, E. 2018. Cross-disciplinary partnerships between police and health services for mental health care. Journal of Psychiatric and Mental Health Nursing, 25, 283-284. | 2018 |

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| Conference presentation | HEYMAN, I. 2017. Police and emergency health practitioner experiences in the care of people in mental health distress- a 'grey area' of practice. The Fourth Scottish Institute for Policing Research (SIPR) and Police Scotland Postgraduate Symposium. Edinburgh: Scottish Institute for Policing Research. | 2017 |
| Conference presentation | HEYMAN, I. 2017 Black, white and grey – a study of the interface and pathways between police, those in mental health distress and emergency health service.: Robert Gordon University Postgraduate Research Symposium. Aberdeen, Scotland | 2017 |
| Funding award | MURRAY, J., **HEYMAN, I**., WOOFF, A., DOUGALL, N., ASTON, L., & ENANG, I. 2017. Law enforcement and public health: setting the research agenda for Scotland. Scottish Institute for Policing Research SIPR Small Research Grant Competition 2018 http://www.sipr.ac.uk/research-activities/sipr-research (£7986) | 2017 |
| Invited speaker | Black, White and Grey - A study of Police and emergency health practitioner experiences in the care of people in mental health distress. Presentation by **I. HEYMAN**, Justice Analytical Services Scottish Government, St Andrews House, Edinburgh | 2016 |
| Conference presentation | HEYMAN, I. 2016. Supporting an understanding of the pathways and interface between police, those in mental health distress and emergency health services. The Third Scottish Institute for Policing Research (SIPR) and Police Scotland Postgraduate Symposium. Edinburgh: Scottish Institute for Policing Research. | 2016 |
| Conference presentation | HEYMAN, I. 2016. Insider-outsider collaborative health and police research: challenges and facilitators. The Third International Conference in Law Enforcement and Public Health. Amsterdam, The Netherlands. | 2016 |
| Conference presentation | HEYMAN, I. 2016. A study of pathways and interface between police, those in mental health distress and emergency health services. The Third International Conference in Law Enforcement and Public Health. Amsterdam, The Netherlands | 2016 |
| Conference presentation | HEYMAN, I. 2015. Black, white and grey: The pathways and interface between police, those in mental health distress and emergency health services. The Second Scottish Institute for Policing Research (SIPR) and Police Scotland Postgraduate Symposium. Edinburgh Scottish Institute for Policing Research. | 2015 |