An ethnomethodological exploration of police officers' use of a cognitive aid when encountering people with a potential mental disorder.

Volume one

By

Ivan McGlen

A thesis submitted in partial fulfilment for the requirements for the degree of Doctor of Philosophy at the University of Central Lancashire

August 2018

STUDENT DECLARATION FORM

1. Concurrent registration for two or more academic awards

*I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

2. Material submitted for another award

***I** declare that no material contained in the thesis has been used in any other submission or an academic award and is solely my own work

3. Use of a Proof-reader

***The** following third party proof-reading service was used for this thesis, Julie Cook, in accordance with the Policy on Proof-reading for Research Degree Programmes and the Research Element of Professional Doctorate Programmes.

A copy of the confirmatory statement of acceptance from that service has been lodged with the Research Student Registry.

Signature of Candidate _____

Type of award: _____**Doctor of Philosophy**_____

School: _____**School of Nursing** _____

Abstract

Aim

This study investigated a police officer's situation awareness[1], when encountering a potentially mentally disordered person.[2] This underpinned the development of a cognitive aid to support them during such encounters.

Background

Up to 40% of police encounters are associated with someone experiencing a mental disorder. Operational difficulties due to situational complexity, and the police officer's ignorance regarding the features of mental disorder, often translate into flawed situation awareness. This study built upon the work of Wright et al. (2008) with Lancashire Constabulary.[3]

Method

An ethnomethodological design was employed, viewed through the theoretical lenses of symbolic interactionism and Endsley's (1988) situation awareness framework. Completed in two stages, stage one utilised narrative synthesis, and individual semi-structured interviews with eight police officers. Data was thematically analysed to identify emerging themes which underpinned the cognitive aid's development.[4] Stage two employed a pre-post-test design, utilising video vignettes, note-taking exercises, and focus group interviews with seventeen police officers. The cognitive aid was used operationally prior to conducting semi-structured interviews with ten police officers.

[1] Within this study, I drew upon the work of Endsley (1988), who offered a three-level categorisation of situation awareness. Level 1 – one's perception of the elements within a given environment. Level 2 – one's ability to comprehend the significance of, and make sense of such elements. Level 3 – one's ability (on the basis of Levels 1 and 2 situation awareness) to anticipate situational outcomes, and therefore select a course of action.

[2] Reflecting the Mental Health Act (2007 12. (1).), I refer to mental disorder(ed), rather than mental illness. Within this study, mental disorder is considered "…any disorder or disability of the mind." The term mentally disordered" …shall be construed accordingly" (Mental Health Act, 1983a, amended 2007, 12, (1).)

[3] In 2008, Wright, McGlen, Haumueller and Croll (2008) developed the Public Psychiatric Emergency Assessment Tool (PPEAT). The purpose of this tool was twofold. First, to support police officers in making a decision to enact Section 136 of the Mental Health Act (1983, amended 2007). Second, to assist them to relay their observations to healthcare staff in a more structured way.

[4] The redeveloped cognitive aid was termed the PPEAT-R (Public Psychiatric Emergency Assessment Tool-Revised).

Results

Emergent themes identified that pre-encounter factors shaped police officers' situation awareness. This governed their assessment of danger, often resulting in pre-set behaviours to control a situation. Police officers demonstrated improved situation awareness, recognising and responding to a greater range of features of mental disorder when they used the cognitive aid.

Contribution of new knowledge

This was the first study to explore a police officer's situation awareness, when encountering a potentially mentally disordered person. It identifies features police officers associate with mental disorder. The findings highlighted the effect of pre-encounter factors and their influence upon the perception of danger. Significantly, the cognitive aid caused a paradigm shift from one defined by an assumption of criminality, to one defined by the interpersonal in which police officers recognised and responded to a person's mental health and well-being.

Contents

Volume one

Volume two

List of Tables

Table. Page

List of Figures

Acknowledgements

"If I have seen further, it is by standing upon the shoulders of giants"

Sir Isaac Newton (1642-1727).[5]

Whilst I am the author of this study, the giants whose shoulders I have been privileged to stand aloft eclipse my role. I wish to thank the following people. You have enabled me to see further in many ways.

I wish to thank Professor Karen Wright and Professor Joy Duxbury, my Director of Studies. It was Karen who guided me within my first experience of a formal research project. It was also Karen who encouraged me to embark upon this research project. Not only did Karen open up a range of perspectives and experiences I did not realise possible, she supported and inspired me when I was at my lowest ebb. For this, I am forever grateful.

I wish to thank Joy for the guidance and support you have shown me during this programme. As my Director of Studies, you have been with me from the outset of this study. As it twisted, turned and grew, you have always given me the confidence to retain a grip, yet still reach further. You gave me confidence during periods of doubt and uncertainty. Most importantly, you continually inspired me. For this, I am forever grateful.

I wish to thank Dr. Rob Monks and Dr. Beverly French who supported and guided me within this study. I wish to particularly thank Rob for his guidance, support and encouragement. Rob, you helped me to see the world in a different way. I also wish to offer my thanks to Professor Tim Thornton and Clare Wiggans. Tim, you helped me to think of the world in a different way. Clare, I thank you for your advice, support, and especially your kindness throughout this study.

[5]Quotation from Howard (2000, p.624).

I wish to thank the police officers within Durham Constabulary and the Metropolitan Police Service. I am humbled by the professionalism and dedication demonstrated. I wish to offer particular thanks to Inspector Leanne Green (Durham Constabulary) and Inspector Frankie Westoby (Metropolitan Police Service) for supporting me when I undertook this study. I wish to offer particular thanks to Commander Christine Jones (Association of Chief Police Officers lead for mental health) for her support.

I wish to thank the Neuromodulation Team and the Pain Management Programme team, within the Walton Centre, Liverpool. You showed me a new way to live, rather than exist. If it was not for their dedication, kindness and care, I would have not been in a position to continue with this study.

Finally, I wish to offer my most sincere thanks to my family for their tireless support whilst I undertook this study. To my wife Carol, I thank you for your patience and all that you have done, to enable me to undertake this study. It has been a difficult journey for us all, and I thank you for taking my hand and guiding me when I was lost. To my daughters, Eleanor, Catherine and Anna, your enthusiasm and encouragement has been a continual support. In return, I hope my efforts have inspired you to reach further in life, irrespective of the challenges ahead.

Contextualising the Thesis

Prior to embarking upon the journey that is this thesis, I wish to outline the conditions which shape the way it is presented.

Structure

This thesis is presented in two volumes. Volume one presents the thesis and Volume two presents the appendices. The thesis is structured in this way to enable the reader to more easily access and review appended material, referred to in text.

Terminology used

Ozer, Varlik, Ceri, Ince and Delice (2017) note that the way in which mental health conditions are described by professionals can have either positive or negative connotations. It is not my intention to use language which is pejorative, stigmatising or in any way disrespectful. Reflecting the Mental Health Act (MHA) (2007 12. (1).), I refer to mental disorder(ed), rather than mental illness. Within this study, mental disorder is considered as "…any disorder or disability of the mind." The term mentally disordered" …shall be construed accordingly" (MHA, 1983a, amended 2007, 12, (1).). Periodically, I will refer to the police officer's response to a mentally disordered person. As police officers do not have diagnostic powers, the person should be presumed (potentially) mentally disordered.

Rather than use the term participants, I try to use the term police officer(s). Jackson (1999) notes that the term "participant' refers to someone taking part in something (p.1141). It implies an important, but not an equal contribution to the research process (Jackson, 1999). Police officers are experts within their social world; one which I have sought to explore. Viewing them as equal partners and co-creators of knowledge, I try to refer to them in terms of their professional title, rather than as participants.

Presentation

When presenting police officer quotations (from individual semi-structured interview, focus group discussion or notebook data), they are in italics. I also use italics to highlight important areas of text, and themes emerging from the study data. I use

several tables, figures and diagrams within this thesis. Reflecting the work of Larkin and Simon (1987), Gooding (2010), Eddy (2014), and Swedberg (2016) they are used to better represent and explain the concepts and data presented. I also use footnotes throughout this thesis. I do this to clarify points raised, without disrupting the flow of the main body of text (McCaig and Dahlberg, 2015).

Throughout this study, I periodically write in the first person. As suggested by Davies (2012), it is an approach which allows "…an active rather than a passive account" (p.747). One which permits a more reflexive relationship with the subject. This study is however framed within an ethnomethodology design. Purists such as Garfinkel and Sacks (1970), argue that a stance of "…ethnomethodological indifference…" and "…judgemental abstention…" should be adopted, when aligning oneself to this design (p.345).[6] Reformists such as ten Halve (2004) argue however that such rigidity blinds one to the potential for viewing the social group in terms of wider rules and practices. By writing in first person periodically, I sit between Garfinkel and Sacks (1970) and ten Halve (2004). I provide an active account, a narrative, which helps the study (the story) unfold. When exploring the data, I shift to the dispassionate and passive, abstracting the 'I' (Davies, 2012, pp.746-7). Providing stability and coherence is the reflexive bond I hold with the subject.

[6] Ethnomethodological indifference refers to the bracketing of the researcher's own thoughts, feelings and expectations. Judgemental abstention requires the researcher to view the phenomenon without opinion regarding its appropriateness, worthiness or correctness, or its relationship to wider societal rules or practices (Garfinkel and Sacks, 1970, p.345; Pollner and Emerson, 2001; Dowling, 2006, p.11; 2008: ten Have, 2004; 2008, p.298).

CHAPTER 1

INTRODUCTION TO THE STUDY

1 Introduction

This study builds upon the earlier work of Wright, McGlen, Haumueller and Croll (2008), and the Public Psychiatric Emergency Assessment Tool (PPEAT) developed by them. Against this backdrop, the aim of this study was to investigate the processes which shaped the situation awareness police officers used to identify and respond to a potentially mentally disordered person. On the basis of these findings, a more structured, robust and evidence based cognitive aid was to be developed to support police officers when they encountered people with a potential mental disorder. This study then sought to investigate the extent to which a police officer's identification and response to a mentally disordered person was shaped by the re-developed cognitive aid. Further mechanisms to better support a professional group undertaking one of society's most difficult and complex roles, dealing with some of society's most vulnerable members, were explored. Within this chapter, I present my motivation for this study and the prior work providing its foundation. I will then present the thesis structure, summarising the chapters that follow.

1.1 Motivation

My primary motivation for undertaking this study was to redesign and review a tool (the PPEAT) to support police officers in their identification and response to people with a potential mental disorder. In doing so, my hope was that this mechanism would improve police officers' responses, and ultimately, the care outcomes for mentally disordered people with whom they come into contact. I chose to base this study upon British police officers, as I have a professional connection with this public service.

I am a Registered General Nurse (RGN), Registered Midwife (RM) and a specialist practitioner in accident and emergency nursing. Whilst I do not hold a mental health nursing qualification, through my experience as an emergency nurse in Liverpool, I

became concerned by the problems local police officers often experienced when they made a decision to bring a mentally disordered person to the emergency department. On a daily basis, irrespective of the specific emergency department area in which I was working[7], I encountered people experiencing some form of mental disorder, necessitating intervention and care. People with mental disorder attended the emergency department via self-referral, with friends / relatives, by ambulance with paramedics, and often, brought in by police officers, by police vehicle. Police officers commonly brought a mentally disordered person to the emergency department having detained them under Section 136 (S136) of the Mental Health Act (MHA) (1983a, amended 2007, p.104).[8] In doing so, they considered the person (by way of a perceived mental disorder) to pose a risk to themselves, or others.

Individuals encountered by the police in such situations presented in states of significant disturbance and distress, often underpinned, for example, by withdrawal or agitation. To enable safe transport to hospital, police officers attempted to calm the person. This was achieved by police officers using calming measures (communication skills), or through the use of force (handcuffs, physical restraint by multiple police officers, pain compliance[9] or incapacitant [CS gas] spray). When handing the person's care over to emergency department staff, police officers were able to clearly articulate the legal justification for enacting S136 (MHA, 1983a, amended 2007, 10. (136).), and the nature of the risks posed. However, lacking a grounding in health care, they often had difficulty describing the specific clinical features, behaviours and activities of the person which caused police involvement, and consequently, their detention.

[7] To provide a service which is able to respond to any form of accident or emergency, emergency departments are divided into the following specialist clinical areas: triage; resuscitation room, major illness and injury area; minor injury and illness area. Within triage, a senior emergency nurse undertakes an immediate assessment of all people entering the emergency department (via ambulance or self-presenting), and directs them to the clinical area, most appropriate to their needs. People suffering immediate life-threatening conditions, are directed towards the resuscitation room ('resus') for stabilisation and rapid intervention by specialist services (e.g. surgical, cardiothoracic, neurosurgical, intensive care). People whose illnesses or injuries are serious, but do not yet pose an immediate life-threat, are directed towards major illness and injury area ('majors') for assessment and care. Where a person's illness or injury does not pose a life-threat, they are directed towards the minor injury and illness area ('minors'). To enable emergency nurses to maintain their clinical skills, they rotate / move between the resuscitation room, major illness and injury area and minor injury and illness area, on a daily basis. More senior emergency nurses additionally rotate into the triage area.

[8] Section 136 of the Mental Health Act (MHA) (1983a, amended 2007): "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of section 135..." (p.104). Place of safety: described within Section 135 (S135) of the MHA (1983b, amended 2007), "a place of safety means residential accommodation provided by a local social services authority…a hospital…, a police station, a mental nursing home or residential home for mentally disordered persons, or any other suitable place the occupier of which is willing temporarily to receive the patient" (p.104).

[9] Pain compliance may be considered a tactical response, used as part of a police officer's legally mandated right to use force (Martin, 2006; West Yorkshire Police, 2014). It is a technique that "…induces an intense burst of…pain such that the subject can momentarily lose control of body movements…" (Martin, 2006, p.186). It can be applied through 'open hand' techniques such as arm and wrist locks, or through conducted energy devices (TASER) (Martin, 2006; National Police Chiefs Council (NPCC), 2015a, p.13).

On many occasions, the person's clinical presentation had shifted significantly from the time the police officer had initially encountered the person, to their clinical presentation within the emergency department. Where a person was calm, this appeared a consequence of the police officer's de-escalation skills; where the person appeared extremely aggressive and combative, this appeared a reaction to (on-going) physical restraint, and the presence of multiple police officers. In both situations, I observed the police officers' reasons for detaining the person to be challenged. On occasions, I observed emergency department staff question the appropriateness of the police officers' actions and interventions. In some cases, emergency department staff openly stated that they did not think the police officers' actions were in the best interests of the person's mental health or welfare. In my opinion, this resulted in a somewhat antagonistic relationship between the police and emergency department staff. Speaking with police officers within the emergency department, several expressed frustration when encountering a person with a mental disorder. They felt that they were expected to make critical health care decisions, without basic mental health awareness training; decisions that they were often challenged over. They were unable to defend their actions, as they did not have the appropriate technical language to effectively express themselves. Some however felt that it was not their role to bring such people to hospital, and they did so reluctantly, when they felt arrest was not an option.

1.2 The inception of the Public Psychiatric Emergency Assessment Tool (PPEAT)

In 2008, whilst working as a senior lecturer in pre-registration adult nursing, a mental health colleague (Karen Wright), and I were discussing our experiences working within the emergency department; mine as an emergency nurse, my colleague as an emergency department mental health liaison nurse. We had both been involved in situations where police officers were challenged by emergency department staff, having detained a person under S136 (MHA, 1983a, amended 2007). We had also both spoken with police officers, and heard similar accounts regarding their views of responding to, and managing someone with a potential mental disorder. Consequently, we decided to undertake a small-scale research study with police officers from Lancashire Constabulary, using a questionnaire and semi-structured interview method. This study sought to explore what influenced their decision-making, when they applied S136 of the MHA (1983a, amended 2007).

All police officers within Lancashire Constabulary were invited to participate within the study. Three hundred questionnaires were circulated within the constabulary. Sixty three responses were received from police officers across the rank and operational structure. Participants completing the questionnaires were asked to indicate if they wished to participate in a follow-up individual semi-structured interview. Eight participants agreed, and were subsequently interviewed. This small-scale study provided a measure of the participants' mental health knowledge, the depth of mental health training they had received during their career, and their perceptions of how this influenced their decision to apply S136 (MHA, 1983a, amended 2007).

Questionnaire data suggested that police officers considered a number of factors, when applying S136 (MHA, 1983a, amended 2007). These were the appearance of the person, their behaviour, the content and style of their communication, their physical condition, and the risk of danger they posed to themselves. Factors such as the risk posed by the person (with mental disorder) to others, and a fear of escalation of any risk were noted. So too were factors relating to a police officer's prior experience and knowledge of the person, and information provided to the police by others.

Using thematic analysis, six dominant themes (in italics) emerged from the interview data. First, when attending a person with a potential mental disorder, police officers saw their primary role as being to protect both the person (with a potential mental disorder), and the public, from them (*the protective role*). Rather than actively seeking to identify specific signs of mental disorder, it seemed that police officers identified it by a person's demeanour, or the situation was felt to be somewhat incongruous (*this doesn't feel right).* This ability to detect incongruity, and potentially mental disorder, was supported by experience, and local knowledge (*street knowledge*). Despite this, police officers expressed the need to be supported with appropriate specialist mental health education (*the need for training*). It appeared that police officers viewed custody as inappropriate for a person with mental disorder (*inappropriateness of police custody*). It also appeared that a police officer's decision to apply S136 (MHA, 1983a, amended 2007) was underpinned by compassion, and a desire to help, rather than punish the person (*doing the right thing*).

From this small-scale study, Dr Wright and I developed the PPEAT to support police officers in making S136 (MHA, 1983a, amended 2007) decisions and assist them to relay their observations to healthcare staff in a more structured way; information which may have little meaning to the police officer, but may be interpreted as significant by health care staff when presented in a structured way (Wright, McGlen, Croll and Haumueller, 2008). As my clinical background and expertise is within emergency care, we aligned common, key features of mental disorder, to the American College of Surgeons (1997), advanced trauma life support (ATLS) ABCDE framework.[10] Rather than using the ATLS discriminators of airway, breathing, circulation, disability and exposure / environmental control, we retained the ABCDE structure, but (drawing upon themes emerging from the study data), reinterpreted them as appearance, behaviour, communication, danger and environment. A training package was developed to brief police officers on the key features of mental disorder, associated with the PPEAT ABCDE framework. Whilst the American College of Surgeons (1997) advocates a hierarchal approach to the ABCDE assessment approach, police officers were encouraged to prioritise the features of mental disorder (especially 'D' for danger), as they deemed fit. A card (Appendix 1) was given to each police officer to aid their recall, and to frame their handover to healthcare staff. In 2016 (following the data collection for the current study), the PPEAT was adopted by the College of Policing as the "vulnerability assessment framework" (College of Policing (CoP), 2016a, Para. 3).[11]

1.3 The current context

Building upon this initial work, I sought to develop a more structured, robust and evidence based cognitive aid for police officers. I did not seek a mechanism to only support police officers in making S136 (MHA, 1983b, amended 2007) decisions. Rather, I sought to redesign the PPEAT to support police officers within their identification and broader response, when encountering a mentally disordered person. I chose to do this by viewing their actions (when encountering a mentally

[10] Rather than a definitive diagnostic framework, the advanced trauma life support (ATLS) approach is a standardised guide to assessment priorities within the management of major, life-threatening trauma (American College of Surgeons, 1997). This approach recognises that whilst each person will present with differing care priorities, requiring differing levels of intervention, a standardised approach to the identification of life threat and treatment will ultimately result in greater survivability overall. As such, the advanced trauma life support approach offers such a structured, consensual framework that is applicable to all emergency trauma care scenarios. Its approach is hierarchical in nature, following a linear, alphabetical (A, B, C, D, and E) sequence. The most clinically important areas of physiological risk are assessed and appropriate interventions initiated immediately in the following order. **A***: Airway maintenance with cervical spine protection* - assessment and immediate correction of airway compromise; cervical spine stabilisation and prevention of cervical spine injury. **B***: Breathing and ventilation* - provision of high flow oxygen and interventions to enable adequate gas exchange. **C**: *Circulation with haemorrhage control*: assessment of haemodynamic state, and correction of life threatening haemorrhage. **D**: *Disability (neurological evaluation* - assessment of neurological status to establish a base line for subsequent assessments and clinical interventions**. E:** *Exposure / environmental control* - removal of clothing to permit a detailed injury assessment; detailed assessment of injury, control of ambient atmosphere to prevent hypothermia.

[11] The vulnerability assessment framework also forms part of the national police guidance with regard to the following sections: 'response, arrest and detention', 'detention and custody' (CoP (2013a), and 'mental health - detention' (mental health) (CoP, 2016b).

disordered person) through the lens of Endsley's (1988) three-level categorisation of situation awareness. It was therefore necessary for me to re-investigate the ways in which police officers identify and respond to mentally disordered people. To enable this reinvestigation, I adopted a different philosophical position, design and methods to those adopted within the initial work. Furthermore, no data from the initial work was used during this study.

I selected two study sites for this study. One was selected to help me develop the cognitive aid (stage one), and one from which to explore its usefulness (stage two). To avoid contamination of data, the study settings were beyond the influence of the one used within the initial work (Polit and Beck, 2012). I reviewed the structure of the British regional police[12] services, focusing upon their processes relating to the management of mentally disordered people. I also reviewed public health data regarding the prevalence of mental health issues within their areas. I selected two sites: Durham Constabulary for stage one, and the Metropolitan Police Service for stage two. Both study populations served communities with a significant and comparable (relative) prevalence of mental disorder (Association of Public Health Laboratories, 2007). Durham Constabulary was approached for stage one, due to their positive, proactive approach in responding to mentally disordered people. The Metropolitan Police Service was approached for stage two, due to its acknowledged difficulties with police officers identifying and managing such people (Independent Commission on Mental Health and Policing, 2013).[13] The following guide to the thesis structure briefly outlines the process I followed whilst undertaking this study.

[12] These comprise forty-three police services within England and Wales, the Police Scotland, the Police Service Northern Ireland and the four National special police forces (British Transport Police; Civil Nuclear Constabulary; Ministry of Defence Police; National Police Air Service) (Home Office, 2017).

[13] I held formal dialogue with the Association of Chief Police Officers professional ethics portfolio chair to establish the need for this study, and gain permission to approach each proposed study site. Prior to commencing the preparatory work (establishing the basis for the cognitive aid), I undertook meetings with the mental health lead for Durham Constabulary within their police headquarters. Within these meetings, I was provided with an overview of current issues facing Durham Constabulary regarding the management of persons with a mental disorder, and their need for some form of mechanism to support police officers in such situations. Prior to exploring the usefulness of the cognitive aid and testing its usefulness, I met with the mental health lead for the Metropolitan Police Service, and the commander and chief superintendent responsible for territorial policing. Due to the Metropolitan Police Service SCO19 specialist firearm command branch being called to attend a significant number of incidents subsequently found to involve a person with a potential mental disorder, I undertook a SCO19 firearms situation management master class to gain an insight into police officer actions within such encounters. Further meetings were conducted with the mental health lead prior to commencing this phase enabling me to gain a more immersive view of the metropolitan Police Service.

1.4 Thesis structure

1.4.1 Volume one

1.4.1.1 Chapter 2

Within this chapter, I establish the context and rationale for this study. I describe the issues reportedly faced by police officers when they encounter a potentially mentally disordered person. I concentrate on the factors shaping the British policing response. Within this discussion, I explore the role of the police officer as a 'community problem solver', and their gatekeeping response when encountering mentally disordered people.

1.4.1.2 Chapter 3

In chapter three, I present a review of the literature relating to the processes police officers were reported to use to identify and manage a mentally disordered person. I describe the rationale for undertaking a narrative synthesis. I also describe why the narrative synthesis became part of the analytical framework used to support the development of the cognitive aid. I then describe the preliminary and secondary data analysis of the nine papers used within the narrative synthesis. Data from this chapter contributes to the development of the concept framework and cognitive aid, described within chapters six and seven.

1.4.1.3 Chapter 4

Here, I outline the research problem, questions and study aims. I provide justification for this study's constructivist approach, and its epistemological position of social constructionism. I also provide justification for the selection of symbolic interactionism (and its relationship to situation awareness) as the underpinning theoretical framework, and for the selection of an ethnomethodology design.

1.4.1.4 Chapter 5

Within this chapter, I describe the study methods. I describe the defined conditions, boundaries and protocols for data collection, which enabled me to control the study's orientation, and achievement of its aims and outcomes. I also describe the ethical issues governing the conduct of the study.

1.4.1.5 Chapter 6

This chapter describes stage one (the preparatory stage) of this study. I describe the themes emerging from both the individual semi-structured interviews and narrative synthesis (Chapter three). I first describe the overarching themes emerging from the individual-semi structured interviews. Next, I establish the extent and nature of relationships within the data, using narrative synthesis and individual semi-structured interview data.

1.4.1.6 Chapter 7

Within chapter seven, I describe the development of the PPEAT-R. I describe the process of establishing the concepts. Next, I describe the development of the concept framework underpinning the PPEAT-R. I then describe the process of designing the PPEAT-R itself: informed by these findings, and built upon the foundation work of Wright et al. (2008).

1.4.1.7 Chapter 8

This chapter describes stage two (testing the usefulness of the PPEAT-R). I describe the emerging themes, following the testing of the cognitive aid. This chapter is presented in three sections representing each phase of the study. Phase one describes the emerging themes, prior to the introduction of the cognitive aid. Phase two describes the emerging themes, following its introduction. Phase three describes the emerging themes, following the use of the PPEAT-R in operational, real-world practice.

1.4.1.8 Chapter 9

Within chapter nine, I discuss the findings of this study. This chapter is presented in two sections: the preparatory stage, and testing the usefulness of the cognitive aid. Within the section entitled preparatory stage, I discuss how the six concepts[14] encapsulated the newly constructed view of how police officers identified and responded to a person considered to be mentally disordered. Within the section entitled testing the usefulness of the cognitive aid, I discuss the findings prior to, and following the introduction of the PPEAT-R. I also offer my reflection upon the research process.

[14] Pre-encounter, appearance, behaviour, communication, danger, environment.

1.4.1.9 Chapter 10

Within this chapter, I conclude the study. I present the unique contribution that this study has made to the existing body of knowledge, and the new insights it provides. Next, I discuss the strengths and limitations of this study. I then offer my recommendations for practice, further study, and the dissemination plan for the study findings. Finally, I offer my concluding remarks.

1.4.2 Volume two

1.4.2.1 Appendices.

Volume two contains the appended material referred to within this thesis. Forty-one appendices are presented.

1.5 Chapter summary

My motivation for undertaking this study was to redesign and review the PPEAT. In doing so, I wanted to help police officers identify the features of mental disorder and inform their broader response when encountering a person with a potential mental disorder. To do this, I reinvestigated their actions using Endsley's (1988) three-level categorisation of situation awareness. Within the following chapter, I establish the context and rationale for the study. I also establish the relevance of Endsley's (1988) three-level categorisation of situation awareness to this aspect of policing, and therefore, to this study.

CHAPTER 2

STUDY BACKGROUND

2 Introduction

Within this chapter, I seek to establish the context and rationale for this study. My main area of focus relates to the actions and behaviours of British police officers.[15] This chapter is presented in nine sections. I first provide context, exploring the evolution of the British policing response to mentally disordered people. Next, I establish the landscape relating to the issues faced by police officers when they encounter a potentially mentally disordered person, and their subsequent behaviours. I then consider the role of the police officer as a 'community problem solver'. The role of the police officer as a healthcare, criminal, informal and inconsistent gatekeeper are each explored. Finally, I explore Endsley's (1988) three-level categorisation of situation awareness, followed by the chapter summary.

2.1 Evolution of the British policing response, to mentally disordered people

Emsley (1996) describes the British police as "…bureaucratic and hierarchical bodies employed by the state to maintain order and to prevent and detect crime" (p.1). The current, recognisable, organised British policing system stems from the introduction of the Metropolitan Police by Sir Robert Peel in 1829, who stated the overall function of the police to be "The protection of life and property, the preservation of public tranquillity" (Metropolitan Police Service (MPS), 2015, Para. 1). Prior to this, the system of law enforcement and maintenance of social order was fragmented, disorganised and based upon an evolved medieval system of provincial constables, watchmen, militia and, within late eighteenth century London, Bow Street thief takers. Those employed within such roles were poorly educated, poorly trained within their role, and largely ineffectual when compared to current police standards. Throughout the nineteenth century, a national policing system began to evolve. The County Police (Rural Constabulary) Act (1839) permitted

[15] Within this chapter (and those subsequent), I often refer to the experience and practice of police officers from different countries. When doing so, I seek to enrich the discussion with experiences and practices which are common to all police officers, or those which may be contrasted with the British police. Specific legislature and practice guidelines relate directly to the role and function of the British police.

provincial justices of the peace, if they chose, to establish a policing system to replace their excising system of constables and watchmen (Her Majesty's Inspectorate of Constabulary (HMIC), 2006, p.9).

2.1.1 The domestic missionary

The County and Borough Police Act (1856) made the establishment of an organised policing system compulsory within all provincial regions (HMIC, 2006, p.11). This system developed militaristically in relation their uniformed appearance, discipline, and confrontational response to increasingly frequent civil disorder, characteristically amongst striking workers and civil liberty protestors. The police system was often seen as a force to maintain social order and obedience, with the police officer as a "…domestic missionary..." charged to bring "…civilisation and decorum…" to the populous as a whole (Emsley, 1996, p.74). Through the establishment of the Chief Constables Association in 1893, the Association of Chief Police Officers in 1984, the Police Act (1964), and the Local Government Act (1974), the police system shifted from individual provincial systems into a nationally regulated and coordinated system (Emsley, 1996; 2009; Cowley, 2011). It was however one which retained its regional identities (e.g. Durham Constabulary, Lancashire Constabulary, and Metropolitan Police), and its autonomy to dictate significant aspects of policing priorities, practices and training governed by chief constables. To date, whilst the Home Office provides national guidance and imperatives, the chief police officer (chief constable) of each service still retains the authority to direct local priorities and training. The inter-war and, most significantly, the post-second world war period brought great social change, for which the British police were required to adapt and modify their operational role. The changing nature of British society resulted in greater police involvement within communities, notably increasing contact with people suffering mental disorders as a consequence of progressive 'deinstitutionalisation' of British mental health services.

2.1.2 Reformation of the mental health services

Beginning in the 1950s, a reformation of mental health services commenced (Canvin, Bartlett and Pinfold, 2002). This was characterised by the deinstitutionalisation and transfer of provision into the community (termed resettlement), for all but the most acutely or chronically mentally ill (Forrester-Jones et al., 2012, p.5). Deinstitutionalisation was the process of closure of Victorian

asylums, mental hospitals, and nursing homes, and the establishment of community management, support and supervision teams for people suffering from mental disorder, now living within the local communities (Lawton-Smith and McCulloch, 2013). This shift from providing the bulk of mental health care within institutions to local communities, was a result of increasing respect for individual civil rights and welfare coupled with changing views and evolving techniques regarding the management of people with mental disorder; views and techniques which suggested better clinical outcomes for the person if they were managed within their own community, rather than within an institution (Goldberg, 1999; Cummins, 2013; Lawton-Smith and McCulloch, 2013). Within the MHA 1959, the Lunacy and Mental Treatment Acts 1890-1930 and Mental Deficiency Acts 1913-1938, which governed the often legally coercive management and treatment of people with mental disorder were repealed, and replaced with a new framework to govern treatment and where necessary, formal admission for treatment (Cope, 1995, Welcome Library, 2017).

Prior to deinstitutionalisation and resettlement, and the introduction of the MHA (1959), people with a mental disorder (including the "…sane, labelled morally defective due to their unconventional behaviour…") were almost exclusively managed within some form of institution, and as such, cared for beyond conventional society (Gilburt, Peck, Ashton, Edwards and Naylor, 2014, p.3). Police contact was therefore relatively rare. Whilst devolving mental health services failed to anticipate the extent to which the British police would become involved with service users, the MHA (1959) did however articulate police powers when managing a person deemed to be in crisis. Section 135 articulated the powers to remove a person from "…any premises specified in the [a] warrant…" to a place of safety (MHA, 1959 9. (136). (1). (b).). Within Section 136 (mentally disordered persons in public places), it stated "If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care and control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons remove that person to a place of safety…" (MHA, 1959 9. (136). (1).)

Despite articulating the police officer's role within statute (later reaffirmed and updated in the MHA (1983c)), the British police failed to develop coherent strategies outlining the specific manner in which they should identify and respond to a person with a potential mental disorder within this, or any other situation. As

deinstitutionalisation began to accelerate from the late 1970s to the 1990s, the police increasingly became the first point of organisational contact for people with a mental disorder, (Pogrebin, 1986; Cummins, 2013; Lawton-Smith and McCulloch, 2013; Gilburt et al., 2014). In recognition of the changing landscape of mental health care, the MHA (1983) (subsequently revised 2007), was introduced (updating the MHA 1959), and more clearly articulated the circumstances in which a mentally disordered person could be subject to compulsory assessment, treatment or detention, for their safety, or the safety or others (Department of Health, 2012). Whilst the responsibilities of the police were stated, there was still no coherent strategy as to how they should identify and respond to a person with a potential mental disorder.

2.1.3 From a force to a community service

Independent of the acceleration within deinstitutionalisation, during the 1980s, the British police reached an epoch within their evolution; a shift from being regarded as a 'force' (an organisation which commands great influence, power and strength), to a service (an organisation structured to meet public need). This shift, considers Bayley and Shearing (1996), was due to the progressive "…pluralising… of the police officer's role" (p.585). Through this process of 'pluralising' of role, the police officer was now required to keep pace with, and align to, societal needs that extended beyond just the maintenance of social order and obedience (Kappeler and Kraska, 1998). This has the implication that the police have progressively assumed more than one role (roles beyond their original Peelian remit). This shift however, has to date been far from seamless. This was starkly illustrated within the pivotal Scarman report, produced following Lord Scarman's investigation into police culture and organisation, preceding and during the Brixton riots (London) in 1981. At that time, this was the most serious public disturbance to have occurred on the English mainland (Scarman, 1981). Although the report focussed upon the activities of the Metropolitan Police Service, the wide-ranging problems it identified were considered endemic within all British police services at the time, and as such, its findings were considered applicable to British policing as a whole (Loftus, 2009).

2.1.4 The Scarman report

Lord Scarman considered the Brixton riots to be the actions of a disadvantaged, disenfranchised multi-ethnic population, who were responding to sustained

aggressive, abusive, and discriminatory police practices - notably the indiscriminate use of 'stop and search' powers (Towers, 1995; Loftus, 2009). Amongst the report's findings, it was noted that police culture and organisation had failed to understand or to keep pace with the changing needs of the community, responding with often insensitive, rigid and disproportionate police practices, which served to alienate and antagonise (Scarman, 1981; Cowley, 2011; Loftus, 2009). Lord Scarman noted that a major contributory factor to this state, was a police culture (within all ranks) that demonstrated an institutionalised "… preference for crime-fighting, informal working practices…and a willingness to use force," rather than a culture which sought to integrate with, and support, communities (Loftus, 2009, p.125).

Accused of using "…paramilitary policing tactics…" the police appeared a force, rather than a service (Loftus, 2009, p.29). As a consequence, Lord Scarman (1981) recommended greater accountability, structure and transparency within policing practices, so as to more clearly define a police officer's role, responsibilities and powers. Lord Scarman (1981; Hansard, 1982) also recommended that police services should demonstrate greater community engagement, understanding and integration, through the introduction of both police-community liaison committees and community policing approaches. Furthermore, having acknowledged the link between crime, socio-economic deprivation, disenfranchisement and mental disorder, there was a recommendation that all police officers receive training on how to more appropriately (not necessarily punitively) respond to the wider needs of a changing and diverse population.

2.1.5 The aftermath of Scarman

The Scarman report (1981) perhaps represented the most crucial step forward within the pluralisation of the British police officer's role. In doing so, it exposed the true state of policing at that time, laying the foundations for its reform and social integration. Police officers were now formally expected to not only undertake traditional practices (maintain social order, detect and prevent crime and enforce the rule of law) but also develop a role which wholly integrated and aligned them to the community they served. The British police officer was to become a social improvement scheme partner, responsive to all issues relating to community safety; a response which required them to more explicitly acknowledge their responsibilities which, by default, included the identification, and (often shared) local community (multidisciplinary) management of persons with a potential mental disorder (Patch

and Arrigo, 1999; Peaslee, 2009; Department of Health and Concordat Signatories, 2014).

Addressing the need to make police practices accountable and transparent, the introduction of the Police and Criminal Evidence Act (PACE) (1984) established the first (and current) national codes of practice to govern police powers, in relation to the following six domains: stop and search procedures; arrest; detention, treatment and questioning of suspects; investigation of incidents; identification of people in connection with the investigation of offences; interviewing detainees (Home Office, 2014a). Twenty-four years after the recommendations of Lord Scarman (1981), the first national neighbourhood (community) policing strategy was introduced; an approach which sought to increase police presence, community integration and response, allowing the local community a greater degree of participation in decisions relating to local police priorities and issues (Home Office, 2005; Longstaff, Willer, Chapman, Czarnomski and Graham, 2015).

Regarding police training, in 2006, the National Policing Improvement Agency (NPIA) was established (Home Office, 2013). Its wide-reaching remit included the management of the police national computer, fingerprint and DNA databases, the country-wide intelligence sharing police national database as well as supporting the improvement of police practice through input into national learning programmes. Proclaiming that the "…police service must be radically reformed in order to meet growing challenges and deliver the most effective service possible", in 2011, thirty years beyond the Scarman report, the Home Secretary announced the abolition of the NPIA. Its replacement was to be the College of Policing, with its remit to establish and harmonise the standards of training, education and practice across all British police services (Home Office and The Rt Hon Theresa May, 2011). The College of Policing was subsequently introduced in 2012, now thirty-one years beyond the Scarman Report.

The establishment of the PACE Act in (1984) represented a relatively prompt response to Lord Scarman's recommendations for reform within operational, law and enforcement focused policing practices; recommendations acknowledging police powers and responsibilities in relation to the MHA (1983c). However, there appears to have been a marked delay in responding to the call for a more community focused and responsive service, particularly one that addresses the

police management of a person with a potential mental disorder. This is of great significance, given that the percentage of people with diagnosed mental health disorders undergoing treatment within the community has risen. In 1997, this figure was 85% (Peck and Hills, 2000). In 2014, this figure had risen to 93.4% (NHS Confederation, 2014). Of note, such figures do not take into account the police contacts with people with undiagnosed mental disorders.

2.2 The landscape

The Department of Health (DoH) (2015) states that only 'Relevant professionals' should determine if a person "…has a disorder or disability of the mind, in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability" (p.26). Within this context, 'relevant professionals' are those appropriately qualified within mental health care (e.g., Approved Clinicians and approved mental health professionals - psychiatrist, mental health nurse, approved social worker, general practitioner). British police officers are however, often required to provide an immediate, emergency or unplanned response to situations which often involve a mentally disordered person or crisis. In doing so, and despite the requirement that 'relevant professionals' determine the presence of a mental disorder, police officers are required to make rapid, "…street-level…" assessments and decisions (Godfredson, Ogloff, Stuart and Luebbers, 2011, p.181). Such decisions are based upon public safety and what appears to be in the individual's or society's best interest (Abramson, 1972; Patch and Arrigo, 1999; Teplin, 2000; Lamb, Weinberger and Gross, 2004; Lurigio, Smith and Harris, 2008; Department of Health and Concordat Signatories, 2014; Lurigio and Watson, 2010). The bulk of research relating to the response of (publicly mandated) police officers to mentally disorder people originates within Australia and North America. Whilst there is some comment upon this subject within UK literature (predominantly within the last six years), there is however, no significant range of research specifically relating to the manner in which UK police officers identify and manage such situations. This study seeks to add to the current body of knowledge within the UK.

Within the literature the frequency of contact between the police and people suffering from a potential mental disorder is an overarching theme; one illustrating the difficulties in identifying and managing people with mental health problems (Independent Commission on Mental Health and Policing, 2013; Stanyon,

Whitehouse and Goodman, 2014). For Australian police, 10%-20% of encounters are associated with the management of a person with a mental disorder (Fry, O'Riordan and Geanellos, 2002; Godfredson et al., 2011). Amongst North American (Canada and USA) police, such incidents range from 2.7% to 10% (Borum, Williams Deane, Steadman and Morrissey, 1998; Shepard Engel and Silver, 2001; Watson and Engel, 2007) Within England, between 20% and 40% of all police encounters are associated with a person experiencing some form of mental disorder or crisis (Panzarella and Alicea, 1997; Sainsbury Centre for Mental Health, 2009; Reuland, 2010; Maharaj, Gillies, Andrew and O'Brien, 2011; MIND and Victim Support, 2013; House of Commons Home Affairs Committee, 2015; Krameddine and Silverstone, 2015; NHS Confederation and Association of Chief Police Officers, 2015). The police are often the first point, and indeed "…last resort…" of 24 hour-a-day organisational contact, for a person with a significant, and often, as yet undiagnosed mental health need (Short et al., 2014, p.336).

Representing a more concentrated population, London's Metropolitan Police Service report that 48% of all encounters include a person suffering some form of mental disorder (Independent Commission on Mental Health and Policing, 2013, p.11). Within such encounters, difficulties occur as people with mental health problems may present to the police officer in different guises, depending upon the situation. For example, the person may present as a victim, suspect or instigator of a crime, a person either seeking or appearing to need some form of assistance, or where there appears to be safeguarding or vulnerability issue (Godfredson et al., 2011). It must be stated from the outset that the presence of a potential mental disorder may, in itself, be irrelevant, but police officers should be aware of the "contexts" in which a person's mental disorder must be taken into consideration, and how it "…should influence the police behaviour or outcome" (Independent Commission on Mental Health and Policing, 2013, p.11).

Echoing the reported experiences of police within North America and Australia, amongst British police officers, there is significant variation in how they are trained to identify and manage a person with a potential mental disorder. Consequently, there appears to be a corresponding variability in their ability to appropriately identify key signs of mental disorder, respond to the person's perhaps underlying health need, or record information which may be of use to wider health or judicial agencies (Panzarella and Alicea, 1997; Patch and Arrigo, 1999; Teplin, 2000; Fry et

al., 2002; Pinfold et al., 2003; Lamb et al., 2004; Wells and Schafer, 2006; Independent Commission on Mental Health and Policing, 2013; Department of Health and Concordat Signatories, 2014; Krameddine and Silverstone, 2015). From a British perspective, across the police services, there is a lack of concordance regarding the length, depth and content of such programmes, and no national standard training programme exists (College of Policing, 2014). Currently, police officer training ranges from two hours, to one single day (House of Commons Home Affairs Committee, 2015, p.28).

Whilst there are nationally agreed tools and procedures within British police custody suites to enable custody officers to identify and respond to a person suffering a potential mental disorder, there are no current nationally adopted tools to help police officers do likewise, when they are engaged in operational practice (Godfredson et al., 2011; May and the Home Office, 2014a, 2014b; Department of Health and the Home Office, 2014a; Noga, Walsh, Shaw and Senior, 2014; House of Commons Home Affairs Committee, 2015). This has resulted in a situation whereby an inordinate number of people suffering a mental disorder are subject to inappropriate police attention, intervention, inattention (regarding their clinical need) and detention, when their actual requirement is "…urgent mental healthcare instead" (NHS Confederation and Association of Chief Police Officers, 2015, p.1).

2.2.1 Responding to the problems

Within the literature, there is commentary on system-wide initiatives to address the problems experienced by police officers. To date, perhaps the most significant initiative to address the difficulties police (world-wide) experience in such situations, is the crisis intervention team (CIT) model, developed within the United States of America in 1988, and now implemented widely across the USA (Bonfine, Ritter and Munetz, 2014; Dempsey, 2017). This model was developed by the Memphis Police Department, following the fatal shooting by police of Joseph Robinson, a 27-year old male with a history of mental disorder. A relative called the police requesting help to pacify him, as he was acting aggressively, attempting to cut his own throat with a knife. When confronted by the police, he was commanded to drop the knife, but he thrust it in their direction and was immediately shot dead. Following local community condemnation of the policing response, Memphis Police Department undertook a review of the manner in which police officers responded to people with

a potential mental disorder and developed the CIT model (Police Policy Studies Council, 2004).

Undertaken in partnership with police and local health services, the CIT model seeks to improve mental disorder training and response amongst police officers. Furthermore, it seeks to redirect people who had "…become involved with police as a function of their illness rather than through any criminal intent", away from the criminal justice services to services or situations more appropriate to their needs (Bonfine et al., 2014, p.342). Within police services which use the CIT model, police officers volunteer to undertake the programme, and receive forty hours of training in the recognition and management of mental disorder. Local police call handlers, trained in the recognition of mental disorder from call content, dispatch CIT-trained police officers to them. If the person with a potential mental disorder requires health care intervention, a "…no refusal policy…" should exist within local emergency department or mental health services, enabling the police officer to hand the person over, and return to operational duties as soon as possible (Watson and Fulambarker, 2012, p.73).

The Memphis CIT model has undoubtedly provided a positive step in the police management of people with a potential mental disorder (Hanafi, Bahora, Demir and Compton, 2008; Watson et al., 2010; Godfredson, et al., 2011; Watson, Ottati, Draine and Morabito, 2011; Watson and Fulambarker, 2012; Bonfine et al., 2014; Krameddine and Silverstone, 2015). Its success is however dependent upon four factors: first, the accuracy of call dispatchers identifying situations in which a person with a potential mental disorder may be present, and second, the operational availability of a CIT trained police officer to respond. Third, CIT success requires the cooperation and availability of suitable local health services to receive people suffering a potential mental disorder (even if they are brought in error, or their condition does not specifically meet their admission policy), avoiding the need for the police officer to seek alternate, time consuming dispositions (Watson and Fulambarker, 2013). Fourth, and perhaps most significantly, the effectiveness of the CIT model relies on the motivation for police officers to volunteer for the programme (Bower and Pettit, 2001; Bonfine et al., 2014). In some areas where CIT was implemented, less than 25% of available police officers volunteered (Watson and Fulambarker, 2012, p.75). In these areas, the majority will still

encounter people with a potential mental disorder, but their contact may result in potentially different outcomes, compared to CIT trained officers.

From the perspective of British policing, thirty years on from the inception of the Memphis CIT model, the Independent Police Complaints Commission (IPCC) (2008) raised concerns that many vulnerable individuals with mental health problems were being taken to police cells, when custody was not always the most appropriate environment to meet their needs. Behaviours and actions which attracted police attention and subsequent punitive responses were, in many cases, a result of mental health problems, rather than criminal intent or recidivistic behaviour (IPCC, 2008). To address this issue, the IPCC (2008) advocated the need for British police services to more closely engage with relevant health services, and also provide sufficient training for their officers to enable early identification and intervention for individuals with a mental health need. The views of the IPCC (2008) were echoed by Lord Bradley (Ministry of Justice, 2009), who reiterated the need for police officers to identify and manage a person suffering a mental disorder within the correct environment (be it custodial or non-custodial), and provide appropriate and prompt access to health services, irrespective of any associated criminal offence (Sainsbury Centre for Mental Health, 2009; DoH, 2008, 2009; Department of Health and the Home Office, 2014a). Four years on from the IPCC (2008) recommendations, in 2012, Cleveland Police, Leicestershire Police and the British Transport Police undertook the first trials of the street triage initiative (Dean, 2013a, 2013b; Department of Health and Concordat Signatories, 2014; Westminster Briefing, 2015).

2.2.2 Street triage

Street triage has subsequently been trialled within a further nine British police services. A dedicated police officer and registered nurse (mental health) work together, between eight and twelve hours a day, seven days a week (Dean, 2013a; 2013b; DoH, 2013; Parliament.UK, 2015). Street triage differs somewhat from the CIT model. Although there are slight variations in structure within the trial sites, when in operation, a police officer and registered nurse are dispatched to situations involving people thought by police to be in "…need of immediate psychiatric support" (9). In such situations, the registered nurse assesses the person's need and advises the police officer regarding the clinical management of the person (Dean, 2013a; Parliament.UK, 2015). As well as assisting with the emergency

response to situations involving people suffering a potential mental disorder, the registered nurse is available to provide advice and guidance to other officers out on patrol; officers who may suspect the potential for mental disorder, and seek guidance regarding the appropriate course of action. The registered nurse can also advise police communication staff regarding the significance of calls received, and their response. Furthermore, when required, the mental health nurse can more effectively communicate the person's health need to local health services (DoH, 2013; Department of Health and Concordat Signatories, 2014).

Whilst robust evidence does not yet exist detailing the effectiveness of this initiative, initial data hails it a success in terms of relationship building between police and mental health services, (Department of Health and Concordat Signatories, 2014; Westminster Briefing, 2015). Offering the potential to deliver an immediate and appropriate response (based upon shared decision-making), initial data also suggests that significantly more people are diverted away from detention and the judicial system, and towards more appropriate dispositions (health services, advice, no action), when they are managed by the street triage team, or when the registered nurse is consulted by other police officers who consider a person to have a potential mental health disorder (Dean, 2013b; Department of Health and Concordat Signatories, 2014; Westminster Briefing, 2015).

2.2.3 A step in the right direction, but still a way to go

As with the CIT model, the British street triage initiative demonstrates a positive step within the management of people with a potential mental disorder. This is primarily due to the inclusion of a dedicated mental health professional to support and advise police officers at 'street-level.' There are however, four areas of concern: first, reflecting the experience of the CIT model, the street triage emergency response will only occur if police communications staff are able to identify the significance of a mental disorder from the often vague and incomplete information imparted to them by a caller, and activate the police officer- registered nurse partnership appropriately. Second, street triage is not a twenty-four hour service. Outside of operational hours, there is no mental health advice for communications staff or operational police officers beyond pre-existing channels.

Van den Brink et al. (2012) suggest that up to "…39%..." of people with a potential mental disorder are encountered between "…1700hrs and 0900hrs…." (p.173).

During this time, operational police officers are required to default to their usual practices, with the potential for variation in their ability to identify and respond to the person's need, due to a lack of pre-existing mental disorder training (Pinfold et al., 2003; House of Commons Home Affairs Committee, 2015: Sweeney, 2015; Westminster Briefing, 2015). Third, during the period in which street triage operates, there is a reliance upon police officers to seek advice if they suspect a person is suffering from a mental disorder. In such situations, it again cannot be guaranteed that all police officers will be able to consistently differentiate the significance of a mental disorder from other situational factors and distractions, and seek advice and / or assistance (Sweeney, 2015). The success of street triage is not only dependent on the presence and availability of a qualified mental health nurse, but for it to be built upon a foundation where police officers have some training as how to identify and respond to a person with a mental disorder.

The fourth, and perhaps the greatest concern, is the absence of a specific / agreed training model to equip operational police officers with the skills necessary to identify and appropriately respond to the person with a potential mental disorder (Equality and Human Rights Commission, 2015). Strategies to address inadequacies with police training have only recently been developed. In 2014 the College of Policing commenced a cross-service review to identify the appropriateness and sufficiency of the training received by police officers (CoP, 2014). In 2016, the CoP (2016a) published guidance, entitled *Mental health: mental vulnerability and illness.*[16] To date, there have been no national guidelines regarding the implementation of street triage, or the approach to be used. Furthermore, it must be noted that whilst street triage has been trialled with the support of the Home Office, in conjunction with a number of police services, it is a Department of Health initiative, not one borne of the police (Parliament.UK, 2015). Within the literature, beyond the framework by Wright et al. (2008), there is also no mechanism to help police officers identify and respond to a mentally disordered person at 'street-level.'

A lack of formal service-wide training or support mechanisms will undoubtedly predispose to inconsistencies in the way police officers identify and respond to the signs of mental disorder, both during, and outside street triage operation. Hence, it

[16] This includes guidance in relation to the following: introduction and strategic considerations; mental vulnerability and illness; mental health – detention; mental capacity; AWOL patients; safe and well checks; crime and criminal justice; suicide and bereavement response; sources of support (CoP, 2016a).

is too simplistic to consider this the only cause for concern. Indeed, an operational officer's priorities and policing style also appears to have some bearing on the manner in which they make sense of, and manage situations involving a mentally disordered person (Cotton and Coleman, 2010; Kesic, Thomas and Ogloff, 2013; Hansson and Markstrom 2014; Krameddine and Silverstone, 2015). Within the literature, it appears that the identification and management of a person with a potential mental disorder is shaped by a police officer's view that first and foremost, they are agents of the state, who must maintain social order, detect and prevent crime and enforce the rule of law.

Work by the Independent Commission on Mental Health and Policing, (2013) notes that police officers who subscribe to this approach, consider that the identification and management of mental disorder "…is not a legitimate part of their work" (p.34). The identification, and therefore management of mental disorder, is less of a priority than what may be considered more compelling priorities. The identification and management of a potentially mentally disordered person also appears to be shaped by a police officer's view that they are primarily servants of the community who, whilst maintaining the rule of law, must sensitively respond to the wider issues and problems that occur within a local community. For police officers who share this view, "…their civic purpose is focused on improving safety and wellbeing within communities and promoting measures to prevent crime, harm and disorder" (IPCC, 2013, p.2). As such, their response to a person with a mental disorder is viewed as part of their harm prevention role, in partnership with mental health and other aligned services (IPCC, 2013).

2.2.4 The current context

A complex landscape emerges. It is one in which police officers, required to provide an immediate, emergency or unplanned response to situations which often involve a mentally disordered person or crisis, demonstrate somewhat inconsistent, polarised approaches to their identification of, and response to the person. It is also one in which the police have attempted to address such problems through the introduction of street triage, yet this approach fails to build upon an appropriate, pre-existing knowledge base due to the absence of a national standard training programme regarding the identification and management of a person with a potential mental disorder. Consequently, an inordinate number of people suffering a mental disorder are subject to inappropriate police inattention, intervention and detention. To better

understand how this landscape has emerged, and the wider difficulties it presents, one must therefore seek to understand how the changing organisational structure of the police, (in response to a shifting societal landscape), has shaped their priorities and approach (methods and rules) to the management of situations (actions and behaviours) involving a mentally disordered person.

2.3 The police officer as 'community problem solver'

Police officers appear to have a somewhat ambiguous "...broader social mission…" (IPCC, 2013, p.2). Against this backdrop, their operational role has nonetheless evolved to that of an immediate or emergency responder for all issues relating to community safety, and, as noted, increasingly to people with a potential mental disorder (Abramson, 1972; Patch and Arrigo, 1999; Teplin, 2000; Lamb et al., 2004; Lurigio et al., 2008). On many occasions, this response is to complex situations and environments, often with limited (if any) information to guide their actions. The community mental health care services have sought to provide a safety net for those requiring care and intervention. With finite, overstretched and often inadequate resources, the police have now become an unintended mechanism for first-line response, support, and in many cases, control for people with a potential mental disorder (Goldberg, 1999; Schneider, Woolf, Carpenter, Brandon and McNiven, 2002; Cummins, 2012; Independent Commission on Mental Health and Policing, 2013; Department of Health and Concordat Signatories, 2014).

Despite Bayley and Shearing's (1996) assertion of a progressive "…pluralising…of the police officer's role", there appears to have been rather an uneasy meld of the two, reflecting the police officer as an agent of the state, and the police officer as a servant of the community (p.585). This has resulted in the police officer becoming what Sellars, Sullivan and Veysey (2005) term, the "…community problem solver…" (p.648). As a 'community problem solver', the police officer is tasked with providing a response not only to issues of public safety and the rule of law, but also taking into consideration an individual's wellbeing within society as a whole (Sellars et al., 2005; Department of Health and Concordat Signatories, 2014). This role presents an inherent difficulty for the police officer, due to the expectation that they are able to determine what constitutes a criminal or anti-social act, or a mental disorder, and respond accordingly.

2.3.1 The conflicted role

Laws serve to define the rules of conduct and behaviour of a society. For a police officer, a criminal act is therefore the action, omission or commission of an action that violates a clearly defined law, and as such is liable to a punishment, as defined within law (Home Office, 2011; Merriam-Webster, 2015). Subject to a greater degree of police officer interpretation, an anti-social act, as defined by the Crime and Disorder Act (1998) 1., and guided by the Anti-social Behaviour, Crime and Policing Act (2014) 1. (2)., is applied to someone "Acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as (the defendant)" (Police Foundation, 2010, p.2). Despite country-wide variations in training, there is both a public and professional expectation that a police officer has sufficient knowledge to identify particular behavioural signals and patterns, indicative of mental disorder or 'vulnerability' (Moore 2010; Godfreson et al., 2011; MIND and Victim Support, 2013; May and the Home Office, 2014a; CoP, 2014; House of Commons Home Affairs Committee, 2015), and knowledge which is sufficient to 'alert' them to the need to consider "…special support and care…" for a person with a potential mental disorder (National Police Improvement Agency (NPIA), 2010, p.10). There is however, no explicit requirement for officers to employ any form of clinical judgement to guide their actions as they are neither mental health nor social workers (May and the Home Office, 2014a; House of Commons Home Affairs Committee, 2015).

Although the MHA (1983, amended 2007) outlines the legal definition of mental disorder, Bain and Thomas (2008) consider its interpretation far more difficult, as a mental disorder is more "…a social concept…used to explain (rather than rigidly define) many differing forms of behaviour that have fallen outside the norms of society." As such, its definition (and therefore interpretation) is shaped by social morals, values, tolerance and biases, rather than rigid criteria (Bain and Thomas, 2008, p.282). Whilst the PACE Act (1984) clearly outlines the police officers' operational framework for the maintenance of social order, detection and prevention of crime and enforcement of the rule of law, the interpretation of behaviours characteristic of mental disorder lends itself to a great degree of subjectivity. Although a breach of the law may be easier to define, the often diffuse behaviours characteristic of mental disorder may be difficult to interpret, and therefore overlooked or misinterpreted, particularly within complex situations which demand

immediacy of decision and action (Trad, 1991; Angermeyer and Schulze, 2001; Phelan and Link, 2004; Markowitz, 2011; Nee and Witt, 2013).

2.3.2 A deviation from the norm

Jones and Mason (2002) note that it is often 'bizarre', 'abnormal' behaviour, or behaviour that deviates from the social norm, that attracts the attention of the police, either directly, or via members of the public. These behaviours, which, for example, may be viewed as "…erratic…preoccupied…loud and bothersome…", and failing "…to exercise judgement" are characteristic of a mental disorder (Patch and Arrigo, 1999, pp.31-32). Whilst such behaviours may fall short of a criminal act, a police officer may interpret them in accordance with the "…subjective phenomenon…" that constitutes the legal definition of anti-social behaviour (Police Foundation, 2010, p.3). This situation is compounded by the Home Office (and therefore policing) imperative to actively tackle anti-social behaviour for the purpose of "improving quality of life" through the 'protection' of local communities, neighbourhoods and public places (Home Office, 2012, pp.26-28). Behaviours potentially deserved of care interventions, now equally become behaviours that are a characteristic of a need to control and maintain social order.

For the 'community problem solver' however, they often encounter situations involving a person with a potential mental disorder, for "…which they are often unprepared…without needed tools and resources…" (Reuland, 2010, p.315). In such circumstances, the operational reality is that the police officer defaults to the policing approach they feel is most appropriate, and / or which they feel the situation dictates. In doing so, they wield the discretionary power of gatekeeper to three management pathways: the healthcare, criminal and informal action pathways (Patch and Arrigo, 1999; Lamb et al., 2004; Novak and Engel, 2005; Wells and Schafer, 2006; Gallacher 2007; Huckabay 2009; NPIA, 2010; Martinez, 2010; Godfredson, et al., 2011; Charette, Crocker and Billette, 2011; Department of Health and Concordat Signatories, 2014; Department of Health and the Home Office, 2014; Watson, Swartz, Bohrman, Kriegel and Draine, 2014). The gate through which the person with a mental disorder is passed – healthcare, criminal or informal action - has potentially far-reaching implications for the person if selected unadvisedly (Teplin, 2000; Godfreson et al., 2011; Tucker, Van Hasselt, Vecchi and Browning, 2011).

2.4 The police officer as a healthcare gatekeeper

Irrespective of their geographical location, a police officer provides a vital service during the course of their duties, identifying and responding to mentally disordered people, and referring them to appropriate healthcare services (Redondo and Currier, 2003). In such circumstances, the person's mental disorder is afforded primacy over any other situational considerations. This serves to reinforce the role of 'community problem solver' who both responds, and is also responsive to the wider issues and problems affecting a person within a local community. Redondo and Currier (2003) note that when police officers encounter a person with a potential mental disorder, a decision has to be made if they should pass through the healthcare gateway via informal or formal entry (Figure 1). Such a decision is based on the assessed need of the person, their mental capacity (in accordance with the Mental Capacity Act, 2005), their perceived threat to self or others as a consequence of a potential mental disorder, and the police officer's perception of the significance and magnitude of any concomitant / suspected criminal offence (Redondo and Currier, 2003).

Having determined the need for intervention, informal entry to healthcare implies that it is with the consent and cooperation of the person. Godfredson et al. (2011) term this the "…help-centred outcome…", which occurs when a police officer is / feels able to identify the presence of a mental disorder and understand its significance as a health need, within a specific situation (p.187). Informal entry may take the form of calling an ambulance, contacting the community psychiatric nursing team for advice, to attend or accept a referral, or taking the person directly to a mental health or emergency department (Green, 1997; Hartford, Heslop, Stitt and Hoch, 2005; National Policing Improvement Agency, 2010; Department of Health and Concordat Signatories, 2014; CoP, 2015a and b). It is an approach which is most likely to occur where there is greater collaboration and joint working between police and healthcare services, and where the police officer has undertaken some form of education / preparation regarding the identification of signs and symptoms of mental disorder and the needs of the person in crisis (Borum et al., 1998; Wells and Schafer 2006 ; Watson et al., 2010; Ritter, Teller, Marcussen, Munetz and Teasdale, 2010; Tucker et al., 2011; Watson et al., 2011; Erdner and Piskator, 2013). Formal access however implies the use of a state mandated mechanism to facilitate a person's access to healthcare, without the person's explicit consent.

Godfredson et al. (2011) term this a "…mental-health apprehension" (p.187). For British police officers, such state mandated 'mental health apprehension' mechanisms, (guided by the PACE Act, 1984, Code C), are Section 135 and Section 136 of the MHA (1983a and b, amended 2007).

2.4.1 Section 135 (S135) of the Mental Health Act 1983 (amended 2007)

Section 135 (S135) of the MHA (1983b, amended 2007, 10. (135).) is enacted when a person is considered at significant risk or in crisis by nature of their mental disorder and located within a private property or residence. Without the person's consent, the police have powers of entry only with a warrant issued by a court (NPIA, 2014). S135 of the MHA (1983b, amended 2007) has two subsections, determining how it may be enacted. Where an approved mental health professional has significant concerns regarding a person's well-being, S135, subsection (1) allows them to apply to a court for a warrant to enter the premises to assess and, if necessary, have the person removed to a place of safety. Its application however deprives a person of their liberty to enable their mental health assessment, for a period not exceeding 72 hours (DoH, 2015, p.139). For the purposes of S135 (and 136) of the MHA (1983a and b, amended 2007), a place of safety is defined as any specified "residential accommodation provided by a local social services authority; a hospital; an independent hospital or care home for mentally disordered persons; a police station; or any other suitable place where the occupier is willing to temporarily receive the patient" (Department of Health and the Home Office, 2014, p.16). In practice however, a person detained under S135 (and S136), is only transported to a dedicated health service assessment suite, emergency department or a police station (Her Majesty's Inspectorate of Constabularies and the Care Quality Commission, 2013; Durcan, 2014; Department of Health and the Home Office, 2014).

When S135, subsection (1) is enacted, only the police officer can execute the warrant to enter the premises (by force if necessary); their role in such a circumstance is not to assess the person, but to ensure safety of all those present, search the property for the person, to restrain them and remove them to a place of safety for assessment if required (NPIA, 2014, p.12). Where a police officer deems a person (within a private property) to be at significant risk or in crisis due to a potential mental disorder, they can invoke S135, subsection (2), and apply to a court

for a warrant to enter the premises and remove them to a place of safety (Care Quality Commission (CQC), 2014; NPIA, 2014; Rethink, 2015). Such situations can occur when police are alerted by members of the public (or other, non-approved mental health care professionals) to the potential for a person being at risk by way of a mental disorder.

The person with a potential mental disorder is again deprived of their liberty to enable their mental health assessment, for a period not exceeding 72 hours (DoH, 2015, p.139). Should the person be considered at such risk that it is inappropriate to seek a warrant, Section 17(1) (e) of the PACE Act (1984) permits entry to private premises "…to save life and limb" whilst Sections 5 and 6 of the Mental Capacity Act (2005) respectively, permit the police officer to act "… in connection with care or treatment…" of the person, using 'proportionate' restraint (NPIA, 2014). Without the warranted powers of S135, the police officer must seek to access the most appropriate, emergency care for the person (NPIA, 2014).

2.4.2 Section 136 (S136) of the Mental Health Act 1983 (amended 2007)

Section 136 (S136) of the MHA (1983a, amended 2007) is a mechanism through which "The police may, in the interests of the person or for the protection of others, remove to a place of safety a person found who appears to be suffering from a mental disorder and to be in immediate need of care and control." Whilst S135 is enacted for people within private properties, under direction of a court-issued warrant, S136 is a power of arrest. It is enacted for people within a public place[17], who may be unwilling or unable to consent to informal access to healthcare. The power of arrest is governed by Section 26 and Schedule 2 of the PACE Act (1984), but does not result in criminal charges (Department of Health and the Home Office, 2014). Despite this, (as with S135), S136 deprives a person of their liberty to enable their mental health assessment, for a period not exceeding 72 hours (DoH, 2015, p.143).

2.4.3 Care and control

People who require such immediate care and control are likely to be in crisis. They may be demonstrating significantly disinhibited, violent, or aggressive behaviours

[17] A public place is considered "…a place to which the public have lawful access whether on payment or otherwise; this includes an emergency department of a hospital, and does not include private premises such as a front garden" (Metropolitan Police Service, 2014, p.5-6).

which may threaten the well-being of themselves, others or property. These behaviours may be associated with a criminal act, but they may be attributable to an underlying mental disorder. When S135 or S136 is applied, it may involve the use of proportionate force and / or restraint. This may include the use of one or more of the following tactical options: baton; Taser; incapacitant (CS) spray; handcuffs; open hand (pain compliance) techniques; prone restraint. Such tactical options are used to subdue and control the person, prior to transport to a place of safety. This is usually a police station if on-going violence is demonstrated / anticipated (Jones and Mason, 2002; Her Majesty's Inspectorate of Constabularies and the Care Quality Commission, 2013; 2015a). Such tactical options may cause the person being subdued and controlled to feel criminalised and de-humanised (Department of Health and Home Office, 2014; CQC, 2014; Durcan, 2014). These tactical options also however raise the potential for injury and, in some circumstances, death of the person whilst being apprehended or detained (IPCC, 2010).

When considering the application of S136 (or S135, 2), the role of the police officer is to determine if the person "…*appears* to be suffering from a mental disorder" deserved of care (Jones and Mason, 2002, p.74). In doing so, they must further determine if it is one of sufficient magnitude to require the removal of their liberty (Sainsbury Centre for Mental Health, 2009; DoH; 2008, 2009; IPCC, 2008; Department of Health and the Home Office, 2014). In doing so, the police officer must attempt to separate this out from other confounding, perhaps criminal or anti-social behaviours, without the guidance of 'relevant professionals' (Department of Health and the Home Office, 2014). The Department of Health and the Home Office, 2014) however consider that "…too often…" S136 apprehensions are inappropriately applied (p.69). This is particularly so where a police officer is required to differentiate what appears to be the often disinhibited, violent, or aggressive effects of intoxication, from a mental disorder. Furthermore, even if a S136 (or S135) apprehension is conducted appropriately, a far-reaching effect may be its subsequent disclosure by a chief police officer, during an enhanced Disclosure and Barring Service check (Department of Health and the Home Office, 2014).

A disclosure would only be made in exceptional circumstances. This could be where a chief police officer considered a person (at the time of S135 or S136 apprehension), to present a significant high risk of harm to themselves or others. It

could be where the person was considered to present a particular risk to a vulnerable individual or population (e.g. children). It could also be if the person demonstrated a repeated pattern of high risk behaviour. Even if the mental disorder precipitating S135 or S136 apprehension is no longer of relevance, disclosure may have unexpected, deleterious effects upon a person's current personal and professional life (Department of Health and the Home Office, 2014; Home Office, 2015; Rethink, 2015).

2.4.4 The healthcare gateway

A decision to access the healthcare gateway (Figure 1), either formally or informally, therefore accepts that the police officer, within their 'community problem solver' role, is able to recognise the person as having a mental disorder requiring some form of specialist help. Such actions are however dependent upon the judgement of the police officer, and their ability to disentangle the signs of mental disorder from the array of competing information within a situation (Lurigio and Watson, 2010; Krisnan et al., 2014; Usher and Trueman, 2015). However, when a police officer either fails to recognise the appearance of underlying mental disorder within people in crisis, intentionally aligns their situational approach to that of an agent of the state, or they feel that they have no situational options available, a mentally disordered person may enter the criminal gateway.

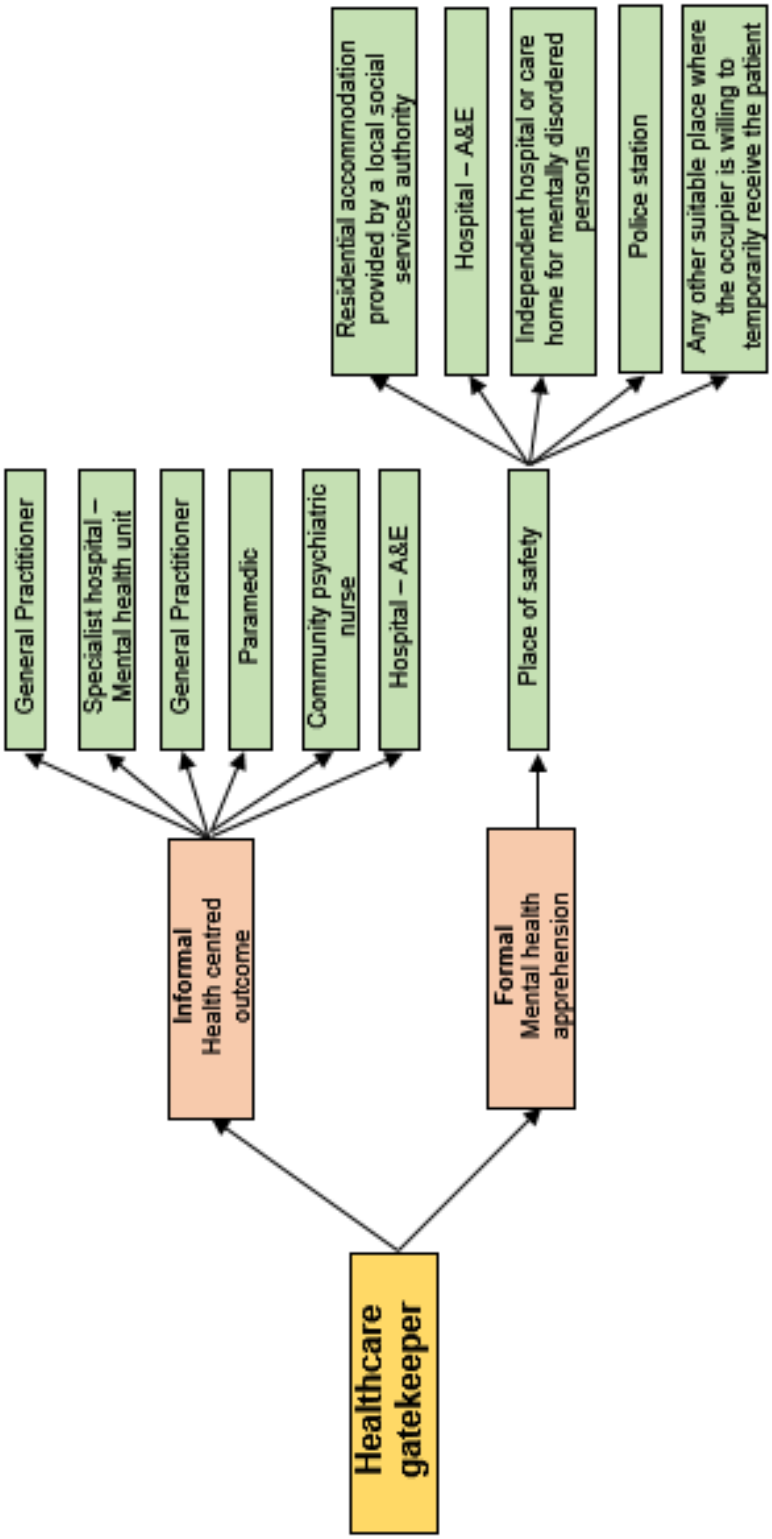


Figure 1: The Healthcare Gateway.

2.5 The police officer as a gatekeeper to criminality

People suffering from mental disorder are subject to disproportionately higher police attention than people not suffering from mental disorder (Crocker, Hartford and Heslop, 2009; Coleman and Cotton, 2010). They are also more likely to be arrested for relatively minor offences than the general population, thus facilitating their entry into the criminal pathway (Bittner, 1967; Teplin, 1984; Fry et al., 2002; Hartford et al., 2005; Novak and Engel, 2005; Crocker, et al., 2009; Franz and Borum, 2011). This situation gives rise to what Abramson (1972) calls the "…criminalisation of the mentally disordered…" (p.16). This is the often unnecessary entry into, and overrepresentation of, people suffering a mental disorder within the criminal justice system (Schnapp, Nguyen and Nguyen, 1998; Cotton, 2004; Lamb et al., 2004; Markowitz, 2006; Ringhoff, Rapp, and Robst, 2012). Arrest, and therefore entry of the person suffering a mental disorder into the criminal pathway, may occur in three ways: firstly, through a police officer's failure to identify the signs of mental disorder; secondly, through a police officer's rejection of the 'community problem solver' role; thirdly, through the inadmissibility of the person with an identified mental disorder to a healthcare facility (Figure 2).

2.5.1 The agent of the state

The 'community problem solver' role requires an "…appropriate response…" to people suffering from a potential mental disorder or crisis (MIND and Victim Support, 2013, p.5). However, this response is dependent upon the police officers' underpinning knowledge, coupled with their ability to disentangle and decipher the often complex behaviours occurring within complex street-level situations (MIND and Victim Support, 2013; House of Commons Home Affairs Committee, 2015). In situations where an offence is suspected, a failure to identify and interpret the cues, signs and behaviours indicative of a potential, contributory mental disorder (particularly in aggressive, violent or time-critical situations), may result in the police officer defaulting to their role as agent of the state, and acting punitively by arresting the person (Teplin, 1984; Lamb et al., 2004; Skeem and Bibeau, 2008; Gur, 2010; Douglas and Cuskelly 2012; Hollander, Lee, Tahtalian, Young and Kulkarni, 2012). Following arrest, a person is taken to a police custody suite, where, within this controlled environment, a detailed mental health risk assessment is undertaken by a custody officer (CoP, 2015b; 2016b). If a person is identified as suffering some form of mental disorder, they may receive specialist care concomitant with judicial

process. Ideally, they would be redirected toward healthcare services, rather than onward through the criminal justice system (Home Office, 2003; National Police Improvement Agency, 2010; College of Policing, 2015b; 2016b). Although the potential exists for mental disorder to be subsequently identified and managed following arrest, a failure to recognise the presence of, or potential for an underlying mental disorder during initial 'street-level' contact, represents an opportunity missed for early healthcare intervention; one which avoids the potentially negative psychological and social consequences of unnecessary criminalisation (Franz and Borum, 2011).

2.5.2 The carceral continuum

Waters (2007) offers the view that the police are fundamentally and ultimately opposed to social integration. Their role within the community is to stand apart from it for the purpose of "…monitoring, regulation and enforcement of a defined social order or situation." (Waters (2007, p.268). Instead of being a mechanism of social support, their primary purpose is to facilitate the entry of an offender into what Foucault (1977) terms the "…carceral continuum…" (p.303). This is the pathway that extends from the "…smallest coercions to the longest penal detention…" by virtue of the police officers' and judicial system's "…right to punish" (Foucault, 1977, p.303). Where a police officer rejects the 'community problem solver' role, they choose to overtly act as an agent of the state. In doing so, they enforce and apply the rule of law in accordance with the PACE Act (1984), placing its violators at some point within the carceral continuum; a role seen as the primary function of policing, even when a person encountered is suspected of having a mental disorder (Bittner, 1967; Waters, 2007; Independent Commission on Mental Health and Policing, 2013).

Irrespective of the wider issues within a situation, police officers may arrest a person having made value judgements regarding the severity of an offence committed / suspected, or having estimated the potential success of a conviction, or they simply apply a zero tolerance approach to all deviations / breaches of social order (Finn and Stalans, 2002; Mulvey and White 2014). Arrest, or, as Godfredson et al. (2011) terms it, "…criminal apprehension", may occur due to "…on-the-job…" experience of similar situations, or police intelligence relating to the person's prior behaviour (p.187). Where mental disorder is recognised, arrest may occur as the behaviours are seen as a precursor to a criminal act, due to the police officers' perceived fear of

dangerousness, unpredictability and the volatility associated with it (Teplin, 1984; Ruiz and Miller, 2004; Novak and Engel, 2005; Morabito, 2007; Nee and Witt, 2013).

Arrest may also occur due to a police officer's belief that the behaviours associated with mental disorder are "…de facto criminal offences…" which, irrespective of circumstances, warrant arrest (Junginger, Claypole, Laygo and Crisanti, 2006, p.879). De facto criminal offences that warrant arrest appear somewhat divergent: the person suffering a potential mental disorder is commonly involved in low-level antisocial, nuisance or criminal behaviour (often influenced by substance abuse and / or alcohol), or conversely, involved in violent, aggressive behaviour; all of which are behaviours characteristic of forms of mental disorder (Bittner, 1967; Teplin, 1984; Menzies, 1987; Fry et al., 2002; Hartford et al., 2005; Novak and Engel, 2005; Clifford, 2010; Cotton and Coleman, 2010; Franz and Borum, 2011; Hollander et al., 2012; Kesic et al., 2012; Independent Commission on Mental Health and Policing, 2013; Ogloff et al., 2013; Mulvey and White, 2014; Watson et al., 2014; Engel, 2015; Krameddine and Silverstone, 2015; Morabito and Socia, 2015). Furthermore, when a police officer encounters a situation involving a person with a suspected or identified mental disorder, their potential for arrest is nonetheless increased if a victim is present, they have associated injuries and / or if the victim demands police action in the form of arrest (Novak and Engel, 2005). The potential for arrest also increases if the person with a suspected or identified mental disorder demonstrates resistance to police command, verbal abuse, and / or disrespect toward the police officer (Van Maanen, 1978; Finn and Stalans, 2002; Pizo, 2014).

2.5.3 The 'help-centred outcome'

Arrest does occur, even when the police officer deems the person deserved of care, and seeks a 'help-centred outcome.' Watson and Angell (2007) and Cooper, McLearen and Zapf (2004), suggest police officers routinely decide if the mentally disordered person they are managing would be admissible or not to hospital or other care facility. This is a situation which frequently occurs when the person is also considered to be intoxicated through alcohol or drugs (Department of Health and the Home Office, 2014). Where a person is judged inadmissible, it is based upon prior experience of rejection from the facility. For example, when a person with a potential mental disorder was previously taken to a healthcare facility but was deemed too disruptive or violent to be admitted. As such, they remained the

responsibility of the police. Where the person's condition had resolved to such a degree during police transit that the healthcare staff disputed the presence of mental disorder, this brought into disrepute the veracity and accuracy of their assessment (McLean and Marshall, 2010; Reuland, 2010; Canales, 2012; Wilcox, 2015).

In such circumstances, arrest, for often minor, inconsequential offences occurs for two reasons: firstly, it may be considered the only way to remove the person from a situation so societal norms can be restored at that time; secondly, it may be the only viable method in which the police officer can protect the person or others from harm or facilitate some form of protective supervision (Bittner, 1967; Finn and Stalans 2002; Lamb, Weinberger and DeCuir Jnr, 2002; Sellars et al., 2005; Wells and Schaefer, 2006; McLean and Marshall, 2010; Reuland, 2010). Whilst the motivation of the police is one of benevolence, the experience of arresting and detaining a person with a mental disorder, particularly in crisis, can result in a severe worsening or deterioration in their condition, and therefore, a counterproductive outcome for both police and the person arrested (Blaauw, 2001; Ogloff, Warren, Tye, Blaher and Thomas, 2011). Significantly, amongst police officers forced to make such decisions, there is recognition that despite arrest being used as a mechanism to protect, the outcome again is counterproductive as the impact of criminalisation serves only to punish the person with a mental disorder (McLean and Marshall, 2010).

Given that the police are often the first point of contact, the fallibility of how they make sense of, and manage situations involving a potentially mentally disordered person clearly emerges. Despite the negative connotations associated with the 'criminalisation of the mentally disordered', within the criminal justice system, the opportunity for identifying and helping a person with a mental disorder does exist, even if it is beyond the initial contact with the police officer. However, such a situation does not always exist if the police officer seeks the informal pathway.

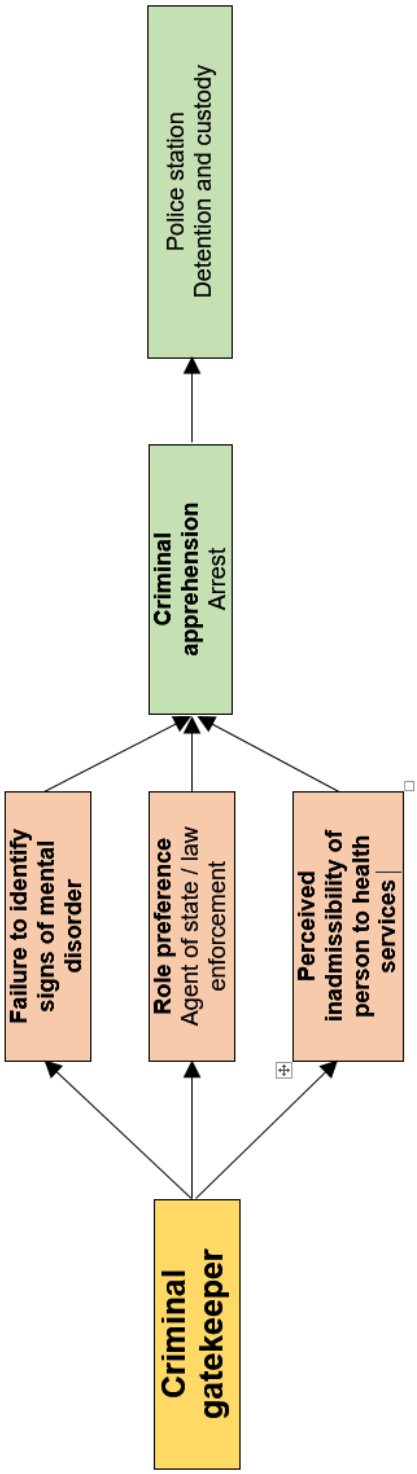


Figure 2: The Criminal Gateway.

2.6 The police officer as an informal action gatekeeper

'Informal action' is where police officers manage the person locally. In doing so, they do not access criminal justice pathways or healthcare services (Teplin and Pruett, 1992; Wells and Schafer, 2006). This is the most common approach to the management of a potentially mentally disordered person, occurring within 52-70% of interactions (Bittner, 1967; Teplin and Pruett, 1992; Borum et al., 1998; Green, 1997; King and Dunn, 2004; Godfredson, Ogloff, Stuart and Luebbers, 2010). A police officer's approach to 'informal action' appears to fall within a wide continuum, ranging from the somewhat dismissive to the supportive (Figure 3).

2.6.1 The continuum of response

2.6.1.1 The 'dismissive pole'

At the 'dismissive pole' there is a belief that a police officer's role is to protect life or property, preserve order, or prevent / respond to the commissioning of a crime (Teplin and Pruett, 1992; CoP 2015c). As such, a belief exists that there is little value in responding to the needs of a potentially mentally disordered person unless there is an associated policing purpose (Bittner, 1967). Often undertaken without any formal record of contact, 'informal action' may be considered an expedient way of dealing with time-consuming 'neighbourhood characters', 'mentals', 'troublemakers', 'quiet crazies' and mentally disordered 'deviants'[18] (Klinger, 1997, pp.288-89;). It is an approach which requires "…neither paperwork nor unwanted "downtime" (time off the street)…" (Teplin and Pruett, 1997, p.152). Such pejorative descriptions imply an ability to recognise a potential mental disorder, yet a reluctance to intervene unless it is deemed absolutely necessary. As such, the policing response commonly takes the form of avoiding the person, a brief interaction with them (particularly where there has been prior contact) with no subsequent intervention, and in some cases, moving them on to another location to either avoid or limit further contact (King and Dunn, 2004; Godfredson et al., 2010). Such views are reported to feature amongst 11% of police officers, and are both encouraged and perpetuated by local departmental cultures, which support negative views about the mentally disordered (Cotton, 2004). Furthermore, this approach to

[18]
- Neighbourhood characters' are 'mentals': people, known to demonstrate familiar and tolerated behaviours.
- 'Troublemakers': people who demonstrate behaviours that are so disruptive to the police service (during arrest or transport to healthcare), that the police simply avoid any depth of engagement where possible.
- 'Quiet crazies': people whose behaviours are noted to be obviously idiosyncratic, but not causing distress or inconvenience to others (Teplin and Pruett, 1997, p.152; Corrigan, Markowitz, Watson, Rowan and Kubiak 2003; Sellars et al., 2005).

the person with a potential mental disorder is characterised by an overreliance upon prior personal experience (at the expense of formal training). There may also be a rejection of the significance of the person's account (which may have clues to the person's mental health need). There may be an overreliance on the significance of police intelligence (which may have limited relevance to the current situation), and the disavowal of competence regarding the assessment of the potentially mentally disordered person (Bittner, 1967; King and Dunn, 2004; Clayfield, Fletcher and Grudzinskas 2011). Where police officer actions fall toward the 'dismissive pole' this may significantly reduce the possibility of some form of "…appropriate response…" (MIND and Victim Support, 2013, p.5). Certainly, a disavowal of competence within mental health assessment fundamentally precludes the initiation of any form of coherent intervention.

Cotton (2004) however, seeks to offer a more optimistic tone, noting police officers, in general, are "…benevolent…" and "…well-intentioned…" towards people suffering from a potential mental disorder (p.143). As such, informal action, by default, occurs simply because the police officer is unable to interpret the cues, signs and behaviours indicative of a potential, contributory mental disorder (Morabito, 2007; Douglas and Cuskelly, 2013). Police officers however, frequently face the dilemma of being placed in situations where there is "…a social expectation to do something…", but where the perceived management options are limited (Cotton, 2004, p.143). In such situations, the police officer may be suspicious as to the presence of a mental disorder, but lack sufficient knowledge or confidence to engage in action that acknowledges this need. Similarly, where there is no clear indication to arrest, or where police officers feel that health services will not accept the person from them on the basis of their perceived level of need, informal action becomes the most expedient way to deal with the situation (Cotton, 2004; McClean and Marshall, 2010).

2.6.1.2 The 'supportive pole'

Where there is a shift from 'informal action' towards the 'supportive pole', police officers appear to more fully embrace their "social welfare role" (Godfredson et al., 2011, p.193). When doing so, they demonstrate actions and behaviours that reflect a greater degree of engagement and empathy with people suffering a potential mental disorder (McLean and Marshall, 2010). Rejecting pejorativeness and disengagement, which characterises the dismissive action pole, police officers who

acknowledge the significance of the person's situation and account occupy the furthermost point on the continuum, demonstrating what may be termed a "…subjective-client centred approach…" (Godfredson et al., 2011, p.187). The 'subjective-client centred approach' acknowledges that a police officer draws upon their prior experience when seeking out an informal resolution; a resolution, which best fits the situation and the person (Godfredson et al., 2011). It is an approach that is chosen when the person with a potential mental disorder is compliant and considered to demonstrate only ambiguous or 'mild' signs of mental disorder (Novak and Engel, 2005; Godfredson et al., 2010; Markowitz and Watson 2015). Resolution may, for example, be in the following forms: de-escalating a situation, resolving an issue via an on-the-street Level 1 restorative justice approach[19]; advising the person to seek medical help (rather than directly arranging it); seeking out a relative or carer to support the person or simply making time to comfort the person (Ogloff et al., 2013; Ministry of Justice, 2013; CoP, 2017a). Within such situations, there is however an assumption that the police officer is able to accurately identify and gauge the degree of mental disorder present, and that the form of resolution is appropriately applied. However, given their lack of formal preparedness, this cannot be guaranteed.

Whilst informal action may avoid any potential criminalisation of a mentally disordered person, if undertaken unadvisedly it may also be considered a missed opportunity for referral to some form of health or support service. Furthermore, it presents the opportunity for repeat police contact, with subsequent police officers being forced to again "…juggle with numerous types of potential outcomes for interventions with people with mental illness", particularly if there is no record of prior contact, observations or management (Charette et al., 2011, p.683).

[19] Non-criminal resolution to a situation if the person has committed a low-level offence (Ministry of Justice, 2013; CoP, 2017a).

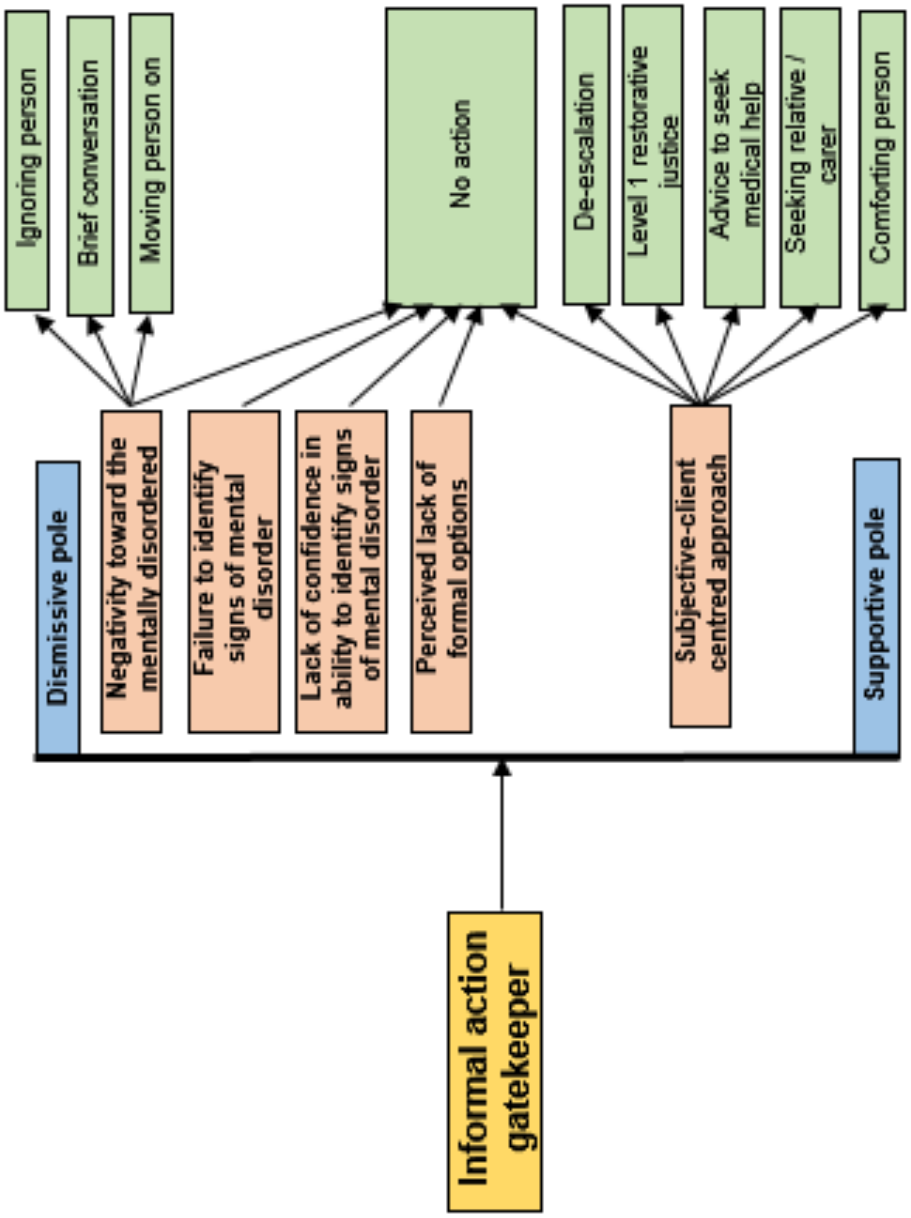


Figure 3: The Informal Action Gateway.

2.7 The police officer as an inconsistent gatekeeper

Although the gatekeeper concept appears to capture the broad pathways available when a police officer manages a person with a potential mental disorder, it is more of an umbrella term. It is one which belies a very complex landscape, fraught with inconsistency due to the potential for a wide range of police officer responses (Reuland, 2010; Chappell and O'Brien, 2014; Watson et al., 2014; Perlin and Lynch, 2016). These responses appear dependent upon three things. First, the police officers' knowledge / understanding of the signs and significance of a potential mental disorder. Second, the manner in which they perceive their policing role. For example, perceiving their role as an agent of the state, a servant of the community, or indeed, somewhere between. Third, the determinants of the situation. Based upon how police officers appear to make sense of, and manage situations involving a mentally disordered person, their responses can be categorised as (Figure 4) the informed approach, non-informed approach, and role aligned approach (which reflects both an informed and non-informed approach).

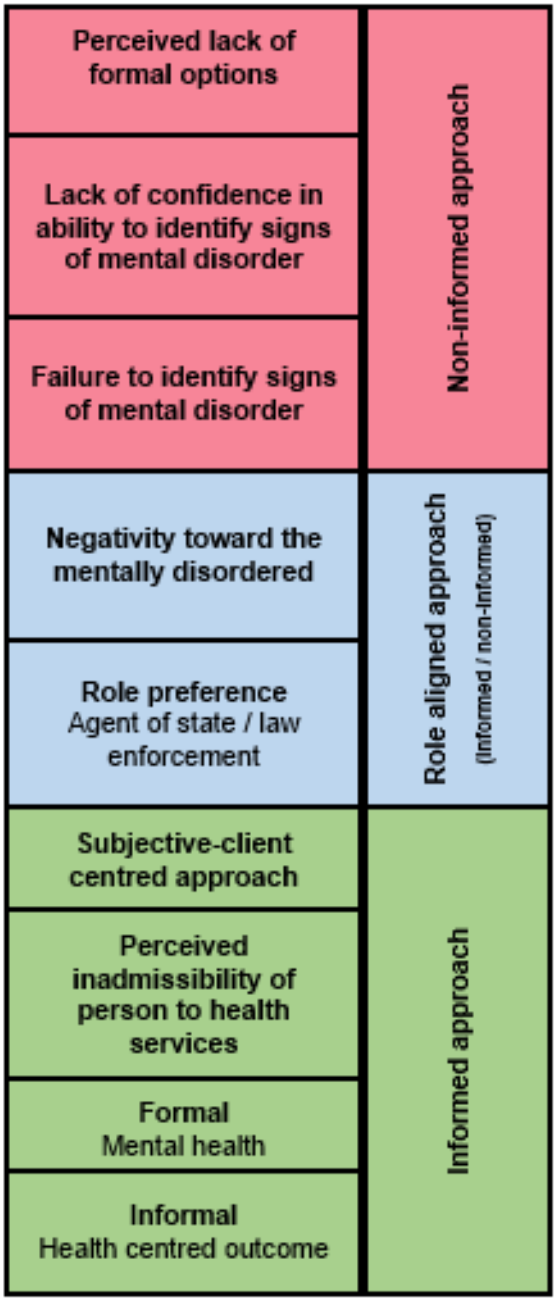


Figure 4: Spectrum of Response.

2.7.1 The shifting landscape

For police officers acting as the healthcare gatekeeper, their response consistently reflects an informed approach when undertaking informal (help-centred outcome), or formal (mental health apprehension) entry. All three approaches are possible for the police officer acting as the criminal gatekeeper. A failure to identify the signs of mental disorder reflects a non-informed approach, resulting in arrest. Where there is a perceived inadmissibility of a person to health services, the police officer demonstrates an informed approach in order to safeguard the person, despite the resultant criminalisation of the person. Where a role aligned approach is demonstrated, police officers either intentionally disregard the signs of mental disorder (informed), or act punitively as they view their primary role to enforce and apply the rule of law (non-informed). All three approaches again are possible for the police officer acting as the informal action gatekeeper.

Negativity towards mentally disordered people implies some understanding (informed approach), yet a reluctance to act unless it is deemed absolutely necessary as such contact is not commensurate with the law enforcement role. Where actions do occur, they appear dismissive or cursory. Where a police officer fails to identify the signs of mental disorder, lack confidence in their ability to identify such signs or they feel there are limited formal options available, a non-informed approach is demonstrated. For police officers whose approach falls within the dismissive pole, such failure to act may be potentially detrimental to the person with a potential mental disorder, aside from it being a missed opportunity to redirect them to appropriate healthcare. The subjective-client centred approach implies one that is informed; the police officer seeks to select the most appropriate management approach appropriate to the person and situational features. Further, it assumes that the police officer holds sufficient knowledge to judge that a person with a potential mental disorder requires intervention, but not enough to pass them through the healthcare gate. Despite good intentions, again, a failure to act may be potentially detrimental to the person with a potential mental disorder. This is aside from it again being a missed opportunity to redirect them to appropriate healthcare. The literature suggests that each situation encountered by a police officer presents ten potential responses (methods and rules), which ultimately shape the gatekeeper response (actions and behaviours), and an even wider array of corresponding management options (Figure 5). This inconsistency suggested a position illustrative of flawed situation awareness (McAnally, Morris and Best, 2017).

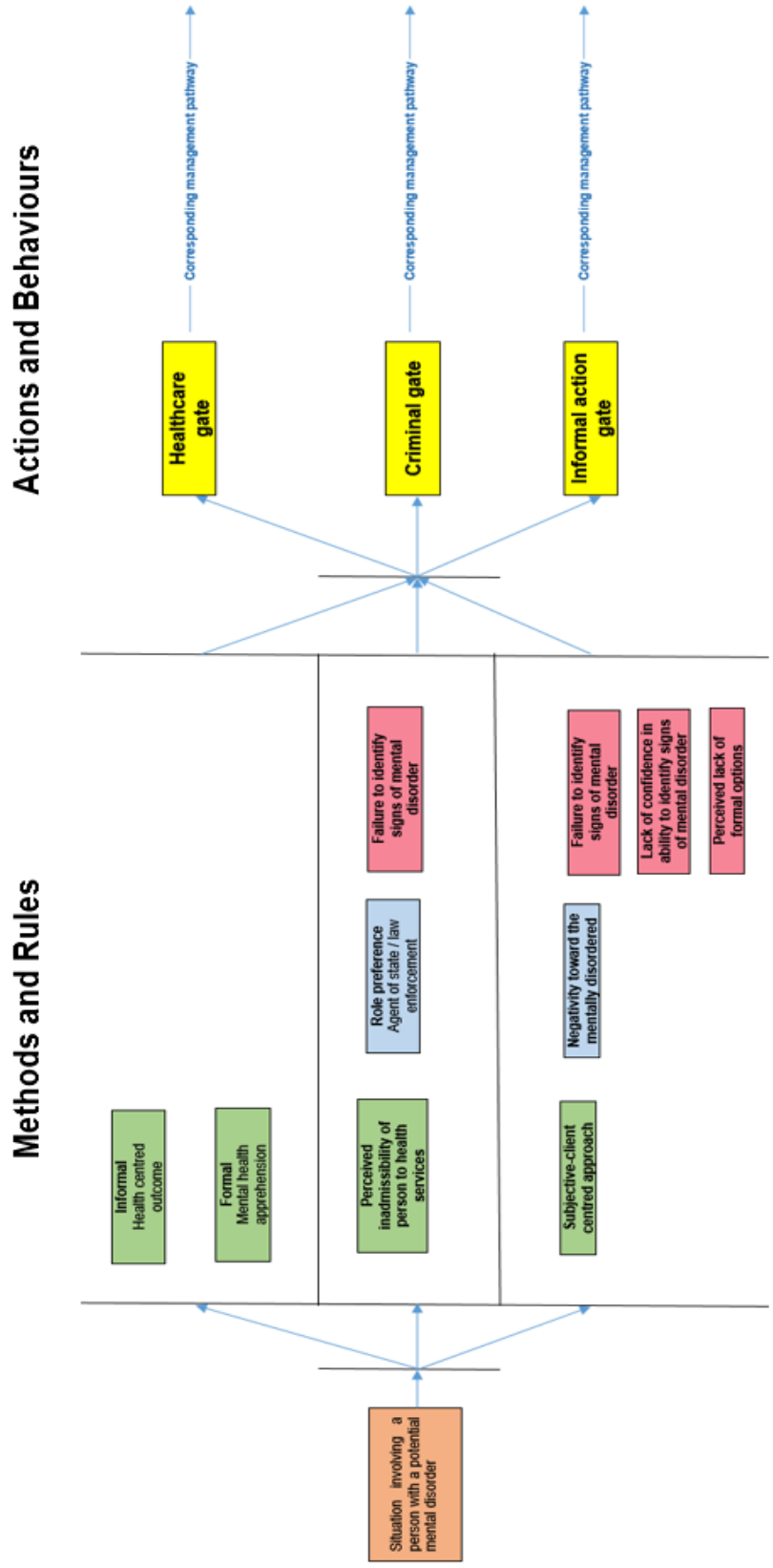


Figure 5: Potential Responses.

2.8 Situation awareness

Situation awareness (SA) may be considered a cognitive process in which a person interprets meaning (relative to a particular time frame and task) and, as a consequence, anticipates potential outcomes. Such anticipation informs a person's subsequent decision-making, actions or behaviours (Endsley, 1988; 1995; Fracker, 1988; Sarter and Woods, 1991; Stanton, Chambers and Piggott, 2001; Saus et al., 2006; Fedack and Fedack, 2008; Durso and Sethumahavan, 2008; Munduteguy, 2011). Situation awareness draws its origins from the combat pilot training programme developed by the First World War German aerial fighter ace, Captain Oswald Boelcke (1891-1916). This training programme was developed in response to a new form of warfare involving aircraft, which was emerging over the battlefields of northern France and Belgium in 1914 (Endsley, 1988; Spick, 1988; Werner, 2009; Wright and Fallacaro, 2011).

At the onset of the First World War, notes Werner (2009), the opposing forces primarily used aircraft for tactical reconnaissance duties relating to the identification of troop positions / movement and the identification of artillery positions not visible to ground-based observers and cavalry patrols. Although pilots carried small arms on board for defensive purposes, such aircraft were not considered offensively useful tools (Spick, 1988; Werner, 2009). Whilst the conflict evolved during the latter months of 1914, the opposing forces rapidly appreciated not only the tactical reconnaissance value of aircraft, but also their offensive potential. As well as undertaking reconnaissance duties, if aircraft were equipped with a payload of high explosives, they could locate and immediately strike enemy installations through aerial bombardment. If fitted with forward-facing, fixed, large calibre machine guns, fired along the direction of flight, enemy aircraft and ground targets could be more aggressively, precisely and successfully attacked (Spick, 1988). To maximize the value of such an evolving offensive aircraft, a new form of warfare began to emerge in the form of air combat (Spick, 1988).

By 1915, the performance and offensive capabilities of Allied and German military aircraft were developing at broadly similar rates, with the crude and unrefined combative skills of their fighter pilots similarly evolving "…almost entirely by trial and error, in the unforgiving arena of air combat." (Spick, 1988, p.42). As his role as a combat aviator evolved, Captain Oswald Boelcke considered offensive air

superiority to be the ultimate goal of air combat. Offensive air superiority is the process of actively seeking out enemy aircraft, aggressively engaging them and driving them back over their own lines into a defensive (rather than offensive) position; enemy aircraft therefore assume a position of weakness, rendering them significantly more susceptible to suppression and destruction. Once enemy aircraft are destroyed, or their threat controlled, enemy airspace becomes clear for unopposed reconnaissance and targeted air-to-ground strikes (McCaffery, 1990; O'Dorico, 2005; Coniglio, 2010). Boelcke understood that the strategic objective of offensive air superiority was only achievable if combat pilots consistently overcame the enemy during each engagement.

Appreciating the parity amongst pilots and aircraft of both forces, Boelcke recognised that any necessary advantage, and thus combat victory would only be through the pilot's understanding of the specific operational goal, their knowledge of the combat environment, (key advantageous / disadvantageous features) and their ability to rapidly identify, understand, monitor and anticipate the actions of an enemy in flight. The ability to rapidly assimilate such information and act upon it, alongside the pilot's knowledge of the performance limits of both theirs and their opponent's aircraft and weaponry would provide the necessary tactical advantage for combat victory and thus eventual offensive air superiority (Spick, 1988; Werner, 2009). How a pilot understands their combat environment, and how this informed their actions, was now as important as the functionality of their aircraft.

2.8.1 The Dicta Boelcke

Whilst striving towards his eventual victory tally of forty allied aircraft (destroyed or downed), Boelcke developed a structured air combat training programme for the fledgling Jagdstaffel[20] fighter squadrons (Werner, 2009). To assure victory over the enemy (the fundamental objective of any sortie) the theoretical Dicta Boelcke (Boelcke's pronouncement) underpinned practical training. The Dicta Boelcke articulated key principles, which sought to inform and direct a pilot's attention and awareness to features and expected actions within a combat environment (situation). This enabled them to rapidly identify, assimilate and anticipate the actions of the enemy, and destroy them (Spick, 1988; Werner, 2009). Despite superior allied aircraft numbers, by 1917, Boelcke's approach led to German

[20] Jagdstaffel is German for hunting season.

offensive air superiority and dominance over French and Belgian battlefields, reducing the life expectancy of the less-skilled Allied pilots to an average of 11 to 21 flying days. This was significantly less than that of Dicta Boelcke trained German pilots (McCaffery, 1990; Royal Air Force, 2013). With its overarching principles requiring a person to be aware and act upon significant features and behaviours of others within a defined, often complex time-pressured context, the Dicta Boelcke evolved to not only form the basis for future combat pilot training and practice worldwide, it also served to influence pilot training and practice within the emerging civil aviation industry. Recognised as a valuable method to guide pilot actions within both military and civilian aviation, such principles were collectively termed 'situation awareness' by the United States Air force during the 1960s (Sarter and Woods, 1991; Gaba and Howard, 1995; Bedney and Meister, 1999).

Situation awareness (as a set of guiding principles) evolved pragmatically, without any coherent scientific basis or structure (Sarter and Woods, 2001; Stanton, et al., 2001). During the 1970s however, situation awareness increasingly became a topic of interest amongst psychologists. Consequently, they sought not only to investigate the value of the principles guiding a pilot's behaviour, but more fundamentally, a pilot's cognition (Jensen, 1997; Adams, Tenney and Pew, 1995). This is the cognitive state of "…knowing…" in which a person acquires, processes, understands and utilises information, particularly within complex situations (Neisser, 1976, p.1). The action "…of knowing [through] the organisation, and use of knowledge" requires information to be first perceived, before it can be meaningfully processed and utilised within a person's working and long-term memory (Neisser, 1976 p.1). Working memory, states Johannsdottir and Herdman (2010) is of "…limited capacity... [and] …used to temporarily store, update, prioritise, integrate and mentally manipulate information" (p.663). Long-term memory however comprises the schema: embedded mental models, frameworks and cognitive maps built up from prior knowledge and experience from which disparate cues may be identified and framed as significant in relation to a given goal or task (Sanford and Garrod, 1981; Endsley, 1995; Adams et al., 1995; Durso and Sethurmahaven, 2008).

2.8.2 The perceptual cycle

Utilising both working and long-term memory, perception becomes a constructive process whereby a person perceives information (cues) within an environment,

eventually building up a mental picture of events relative to a particular goal or task (Adams et al., 1995). Reflecting Neisser's (1976) perceptual cycle (Figure 6), when information is perceived, it is then absorbed into the sub-conscious long-term memory. The schema within the long-term memory interprets this information, allowing a person to begin to generate conscious understanding within the working memory. As this conscious understanding begins to develop, attention is directed to seek (sample) more contextually significant and relevant information. Following an on-going cyclic process occurring within a particular situation, contextually relevant information is perceived, interpreted and modified within the schema and working memory. This enables the person to seek sufficient contextually relevant information to help them to understand what is currently going on, and, by continually sampling (potentially changing information), anticipate how a particular event will alter or evolve. The perceptual cycle therefore permits both a real time and predictive picture of events, relative to a particular situation, task and time frame (Neisser, 1976; Adams et al., 1995; Smith and Hancock, 1995). This mental picture, established within a person's working memory, is considered their state of awareness. Such a mental picture established within a dynamic, fluid environment is considered the state of situation awareness. It is a cognitive state, rather than a set of guiding principles (Sarter and Woods, 1991).

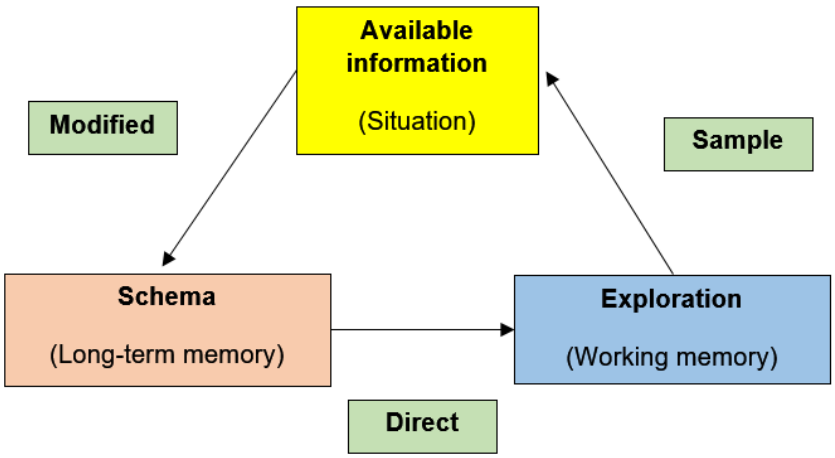


Figure 6: The Perceptual Cycle.

Within the field of aviation psychology, there was an increasing acknowledgement of situation awareness as a specific cognitive state, rather than simply a series of operational principles echoing the Dicta Boelcke. This enabled a better

understanding of a pilot's response to the challenging and confusing situations that occurred because of increasingly complex aircraft design and operation (Wiener and Curry, 1980; Jensen, 1997). Flight control systems, operational and training protocols began to be designed around how a pilot interpreted and made sense of their world, rather than how they were instructed to do so; thus improving performance and safety (Jensen, 1997; Bolstad, Endsley, Costello and Howell, 2010). The emerging 'human factors' movement of the 1980s considered it to have significant potential benefits within other complex, non-aviation disciplines. However, this was only if a unifying definition and conceptual framework was present to enable their practices to be examined and developed (Gaba and Howard, 1995; Jensen, 1997; Caserta and Singer, 2007; Durso and Sethumahaven, 2008). Whilst the scientific basis for understanding situation awareness was emerging within the aviation industry, a consistent definition and conceptual framework from which to articulate it both within the aviation industry and beyond, was not yet established.

Seeking to address such inconsistency within the aviation community, Endsley (1988) sought to proffer a definition and conceptual framework (Caserta and Singer, 2007; Wright and Fallacaro, 2011). Whilst echoing the principles laid down with the Dicta Boelche, but now recognising the cognitive dimension, Endsley (1988) considered situation awareness (SA), to be a "…complex process of perception and pattern matching…" governed by a person's training, experience, preconceptions and the nature of the operational objective. Using this as a basis to establish its key domains, Endsley (1988) defined situation awareness as "…the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future" (p.97). To enable the aviation industry to better investigate and understand how a person achieves situation awareness, Endsley (1988, p.97) stratified this definition into three hierarchal levels, representing the three key points in which situational information is acquired, processed and utilised (Figure 7).

Situation awareness (SA)	
Level 1	Perception of elements in the environment.
Level 2	Comprehension of the current situation.
Level 3	Projection of future states.

Figure 7: Three levels of situation awareness.

Appearing to closely align to Neisser's (1976) perceptual cycle, Endsley's (1988) three-stage framework assumes that when pursuing an operational objective, a person firstly perceives the elements (information) within an environment (Level 1 SA) relevant to achieving that objective. Within the schema of the long term memory and within the working memory, they process and make sense of the elements perceived (Level 2 SA). Having made sense of the elements perceived, the person is able to predict potential outcomes, thus enabling them to decide upon the most appropriate response to achieve the required operational objective (Level 3 SA) (Endsley and Bolstad, 1994; Durso et al., 1998; Bedney and Meister, 1999; Stanton, et al., 2001; Durso and Sethurmahaven, 2008; Endsley, Bolte and Jones, 2003; Johannsdottir and Herdman, 2010; Munduteguy, 2011).

Subject to debate regarding its place as the aviation industry-wide definition and conceptual framework, Endsley (1995) responded, expanding the scope of the 1988 definition (Fracker, 1988; Sarter and Woods, 1991; Bedney and Meister, 1991). Situation awareness was now considered a cognitive process in which "…a state of knowledge…" is achieved by a person, within a specific, dynamic, situation, at a specific point in time and in relation to a specific task or goal (Endsley, 1995, p.36). The 'state of knowledge' achieved (the product of situation awareness), is the understanding of the relevance of such information in relation to a given goal / task, which in turn governs current / future decision-making or actions (Adams et al., 1995; Endsley, 1995; Federico, 1995; Derefeldt et al., 1999; Saus et al., 2006; Wickens, 2008; Sulistyawati, Wickens and Chui, 2011). Recognising the applicability of Endsley's (1995) definition and three-level categorisation of situation awareness, not only to the airline industry, but to any discipline or industry featuring complex, dynamic, time-critical situations managed by a person (such as policing), a

unifying definition and conceptual (three-stage) framework was now formally established (Endsley, 1995; Caserta and Singer, 2007).

2.8.3 Situation awareness: the policing perspective

Situation awareness is a continually fluctuating state, dependent upon the effectiveness of the perceptual process through which a person identifies relevant symbols, gathers information, constructs, revises, and reconstructs it (Sarter and Woods, 1991; Sneddon, Mearns and Flin, 2006; Sulistyawati et al., 2011). Whilst there is a professional expectation that British police officers identify behavioural patterns indicative of mental disorder, the literature highlights a dissonance between this expectation, and the real-world manner in which police officers make sense of and manage situations involving a person with a potential mental disorder. When a police officer's contact with a person suffering a potential mental disorder is viewed through the lens of Endsley's (1988) three-level categorisation of situation awareness, a failure to effectively identify or seek contextually relevant cues or information (Level 1 SA), establishes a flawed perception of the elements in the environment. In this case, the 'elements' are the features suggestive of mental disorder. When the police officer seeks to 'make sense' of the 'flawed' information received (Level 2 SA), the potential for an inaccurate, absent or distorted view of the behavioural patterns indicative of mental disorder exists. This creates a flawed comprehension of the current situation. This flawed comprehension translates into an inappropriate and inconsistent (Level 3 SA) response to a mentally disordered person. It is a response which fails to alert the police officer to consider "…special support and care…" for a person with a potential mental disorder (NPIA, 2010, p.10).

2.9 Chapter summary

Discussed earlier, the complex landscape in which police officers operate presents the real possibility of an inconsistent response when they encounter a person with a potential mental disorder. The literature infers that the prevailing influences are the police officer's priorities and policing style, and the superficial approach to training and tools to support their identification and management. However, the operational, real-world ability (and indeed willingness) of the police officer to direct the person through the most appropriate gateway, is ultimately shaped by several other interlocking factors. These certainly include the degree to which the police officer

has an understanding of the signs and significance of a potential mental disorder and their situational / contextual relevance, and their willingness to engage with, or respond to them. Furthermore, the police officer's street-level, real-world ability to direct the person through the most appropriate gateway seems to be shaped by situational features and distractions; rapidly changing events; available information at the contact scene. It also seems to be shaped by their personal and professional assessment of the situation - at that time, under those specific conditions (Lamb et al., 2002; IPCC, 2005; Department of Health and the Home Office, 2014). Central to this is the manner in which a police officer integrates processes and makes sense of the information available to them (attention, memory and perceptual capabilities), and their spatial abilities. These spatial abilities include the manner in which they form, maintain and reform a mental map of the situation encountered as it shifts, and the police officer's priorities alter (Endsley and Bolstad, 1994; Stubbings, Chaboyer and McMurray, 2012).

Against this backdrop, where a person suffering a potential mental disorder is directed through an inappropriate gateway, this suggests a state of affairs illustrative of a police officer's flawed situation awareness. This is an area which to date has not been formally investigated (Endsley and Bolstad, 1994; Jones and Endsley, 1996; Fry et al., 2002; Saus et al., 2006; Kleider, Parrott and King, 2009; Martinez, 2010; Independent Commission on Mental Health and Policing, 2013 Department of Health and Concordat Signatories, 2014). Within the following chapter, I therefore explore the literature specifically relating to the manner in which police officers reportedly identify and respond to a mentally disordered person. I do not solely explore the literature for the purpose of illustrating the unique viewpoint of the study. Rather, I describe the manner in which I used the literature review to expose the reported methods, rules, actions and behaviours of police officers, for the purpose of contributing to the development of a cognitive aid to support them when encountering a mentally disordered person.

CHAPTER 3

LITERATURE REVIEW: THE NARRATIVE SYNTHESIS

3 Introduction

This chapter is presented in seven sections. I first articulate the gap in the literature that this study sought to address. I then outline the purpose of the narrative synthesis, which underpins the literature review. Next, I describe the search strategy, followed by the screening of studies for inclusion. I then describe the data analysis process. This is followed by a description of the preliminary and secondary synthesis of the data. Finally, a summary is presented.

3.1 The knowledge gap

When reviewing the literature, three significant gaps emerged. First, whilst there was a considerable body of literature describing the frequency in which police officers encountered a potentially mentally disordered person, it failed to explore how they identified the features, suggestive of its presence. Second, although the literature described extensively the fallibility of police officers when they attempted to make sense of, and manage situations involving a potentially mentally disordered person, to date, there had been no exploration of police officer situation awareness, during such encounters. Third, against this backdrop, the literature failed to identify any consensual approaches to support individual police officers within their identification and response to a potentially mentally disordered person.

Having identified these gaps, I sought to explore the methods, rules, actions and behaviours shaping a police officer's situation awareness, when they encountered a potentially mentally disordered person. This underpinned the development of a cognitive aid to support them during such encounters. I did this by undertaking individual semi-structured interviews with police officers following the systematic exploration of the literature.

3.2 Taking an alternate path

Traditionally, a literature review is presented within its own chapter, and is essential for the researcher to expose and explore the range of literature relevant to an area of focus; in doing so the researcher is able to identify gaps, which the study will address (Gibson and Brown, 2011; Wellington, Bathmaker, Hunt, McCulloch and Sikes, 2011; Race, 2008). When reviewing and analysing the literature, I began to see very useful patterns emerging regarding the reported process police officers used to identify and respond to mentally disordered people. Rather than use the literature review solely as a mechanism to expose gaps, I wished to utilise the emerging patterns of reported processes in a more structured manner, identifying emergent themes. Reflecting the views of Wolcott (2002) and Atkins and Wallace (2017), there is a precedent for such use of a literature review, if it offers a more meaningful and active role within a study. I therefore chose to undertake a narrative synthesis, exploring the specific processes police officers reportedly used to identify and manage a mentally disordered person. The emerging processes (themes) were viewed through the lens of Endsley's (1988) three-level categorisation of situation awareness. This approach was used to support the development of the cognitive aid.

3.3 Narrative synthesis

A narrative synthesis is a systematic review of multiple studies, with the findings presented textually as an account, rather than statistically (Popay et al., 2006; Rodgers et al., 2009). It is used to investigate a range of heterogeneous literature (reflecting differing philosophical or methodological paradigms), establishing a greater degree of homogeneity between them (Barnett-Page and Thomas, 2009; Popay and Mallinson, 2010; Ring, Ritchie, Mandava and Jepson, 2011). It is a transformative method, that seeks to produce a "…whole, which is more than the sum of its parts" (Barnett-Page and Thomas, 2009, p.15). Using this approach, this study investigated the order and structure of police officers' common sense behaviours in three domains: the ability to recognise signs of mental disorder (Level 1 SA); situational understanding (Level 2 SA); common responses (Level 3 SA).

3.4 Search strategy

3.4.1 Databases searched

A search of the following databases and electronic journals was made between January and July 2011:

- Journals@Ovid Full Text.
- British Nursing Index and Archive.
- Embase.
- ISI Web of Knowledge.
- Scopus.
- PsycINFO.
- ProQuest.
- Psychiatric Services.
- National Institute of Justice.
- The Campbell Collaboration Crime and Justice Group.
- Journal of Research in Crime and Delinquency.
- International Journal of Police Science and Management.
- Police Journal.
- Police Practice and Research: An International Journal.
- Policing: An International Journal of Police Strategies and Management.

The literature obtained within this search directly contributed to the development of the cognitive aid within the preparatory stage of this study. Data collection using the cognitive aid was subsequently undertaken in January 2014. Whilst this database and electronic journal search was completed in July 2011, ongoing searches continued up until the point of submission of this thesis. Where further, relevant information was obtained, it informed the discussion chapter.

3.4.2 Parameters

The included population group were police officers within publicly mandated civilian services. Only work that was independently sourced and verified was included. If abstracts were considered appropriate, the full paper was reviewed / requested. The reference lists of all retrieved documents were searched for works appropriate

to the narrative synthesis. To permit a broad review, the following limits were applied:

- Studies published in English (due to an absence of translation services).
- Studies from 1960 to 2011. This time frame represented the period during which major organisational upheaval occurred within the management of people with a mental disorder within health care, and chronicled police involvement.
- Data from quantitative or qualitative studies.
- Systematic reviews of randomised controlled trials.
- Single randomised controlled trials.
- Systematic reviews of cohort studies.
- Before and after studies.
- Case control studies.
- Individual cohort studies.
- Evidence from descriptive, non-experimental studies.
- Non-analytic studies / literature reviews.
- Theoretical / scholarly reviews.
- Documented evidence based upon expert opinion.

3.5 Screening of studies for inclusion or exclusion from narrative synthesis

3.5.1 Inclusion criteria

Studies were included according to their relevance to the processes police officers were reported to use to identify and manage a mentally disordered person. This included the characteristics, predictors, and tools which a police officer was reported to use to identify a person as having a mental disorder. Studies were included if they satisfied the following criteria:

- Abstracts and full-text documents.
- The management of people with a mental disorder by a police officer.
- The management of people with a mental disorder at initial police contact, street-level contact.

- The mechanisms, tools or processes used to support police officers within their management of a person suffering a mental disorder.
- The recognition of mental disorder / specific signs of a mental disorder by police officers.
- The effect of police officers' perceptions of people suffering a mental disorder.
- The impact of prior information regarding the presence of mental disorder within a person encountered during operational duty.
- How police officers formulate their decisions within acute / time-critical situations involving people with a mental disorder.
- The impact of relevant prior experience when managing a person with a mental disorder.
- The nature of decisions made by police officers when managing a person with a mental disorder.
- How the presence of a mental disorder shaped the decisions and actions of police officers.

3.5.2 Exclusion criteria

Studies were excluded if they failed to reflect the inclusion criteria or reflected any of the following exclusion criteria:

- Material published prior to 1960.
- Studies not published in English.
- Studies not directly relating to the police management of a person with mental disorder.
- The management of people with a mental disorder, by health services.
- The management of people with a mental disorder within a police station, custody suite or designated place of safety (beyond initial, street-level contact).
- Studies relating to the management of people with a mental disorder, within the criminal justice system – judicial, probationary, penal system.

Having identified the papers to be included, a primary screening tool was devised to support the screening of studies (Appendix 2).

3.5.3 Search process

A Boolean search was undertaken, using the terms 'police,' 'mental disorder,' 'assessment' and 'cognition' (Table 1) These were entered within the 'all text' and 'title' fields of OvidSp, and its sub-divisions. These terms were considered to encompass the processes police officers use to identify and manage a mentally disordered person.

Table 1: Search Process.

Search	Search terms				Retrieved
1	Police				10289
2	Mental disorder				253796
3	Assessment				817661
4	Cognition				49430
5	Police	+ Mental disorder			2511
6	Police	+ Assessment			26864
7	Police	+ Cognition			4273
8	Police	+ Mental disorder	+ Assessment		1838
9	Police	+ Mental disorder	+ Cognition		4912
10	Police	+ Mental disorder	+ Assessment	+ Cognition	231

A focussed search was adopted, using MeSH terms aligned to the Boolean search terms, 'mental disorder,' 'assessment,' and 'cognition.' These terms were systematically combined to identify articles relevant to this study (Table 2):

Table 2: MeSH Terms.

Primary search term	MeSH terms
Mental disorder +	Violence; mental health assessment; psychological tests; personality assessment; substance related disorders; delirium; dementia; cognitive disorders; impulse control disorders; mood disorders; personality disorders; neurotic disorders; schizophrenic with psychotic disorders; sexual / gender disorders; substance related disorders; learning disorders.
Assessment +	Risk factors; assessment outcome, outcome assessment; process assessment; guideline adherence; evaluation; appraisal; estimation; measurement.
Cognition +	Reasoning; recognition; perception; thought,; rationality; cognitive aid; perception; cues; decision making; judgement; algorithm / framework; guideline adherence.

Two hundred and thirty-one articles deemed initially relevant to this study were retrieved. The abstracts of these works were reviewed for their relevance to this study. Fifty-two were deemed appropriate to meet the inclusion criteria. Full-text copies of each study were obtained. Forward and reverse citation searching from within these studies identified nine hundred and eighty articles for further review (Figure 8).

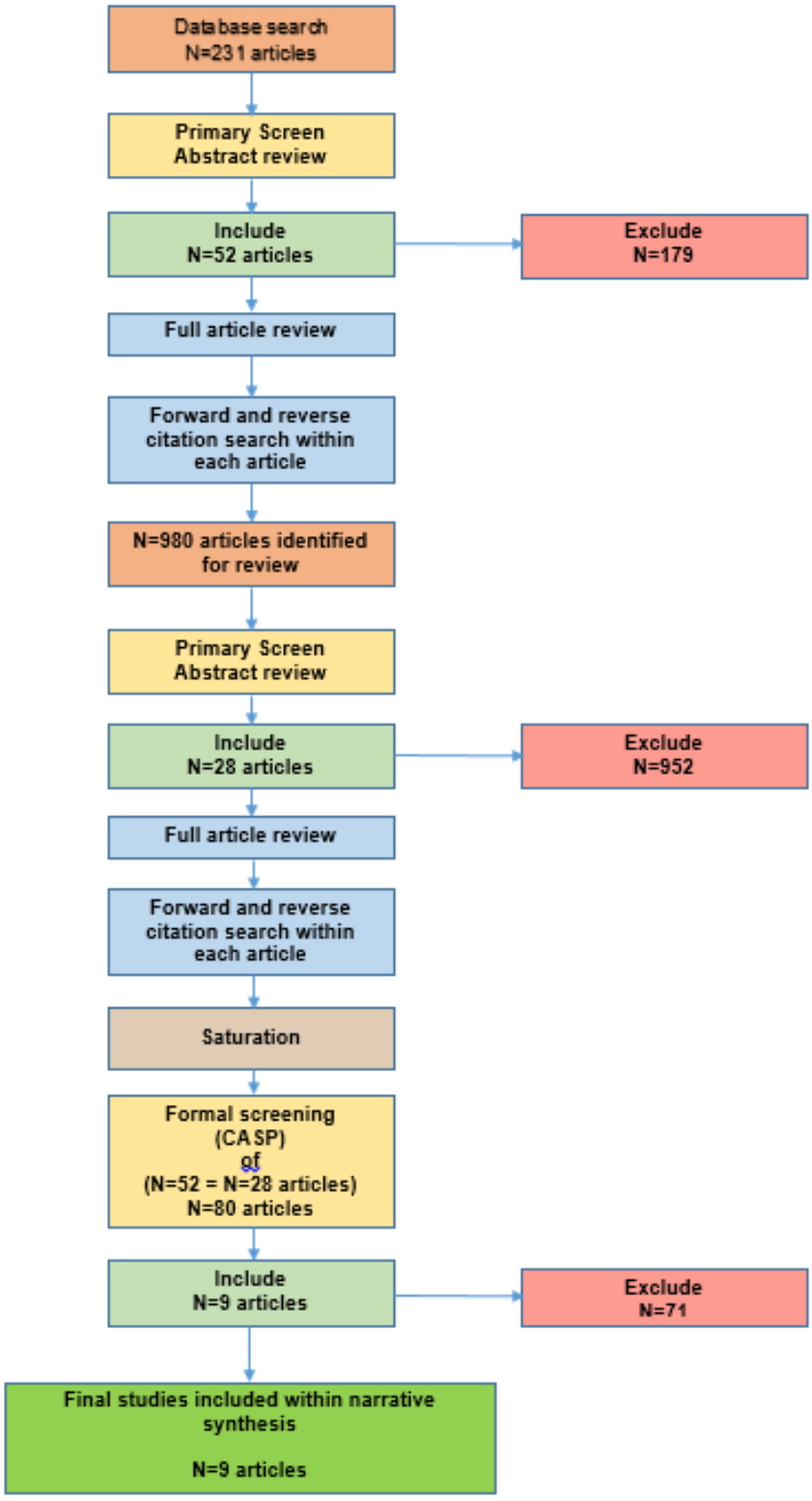


Figure 8: Search Strategy.

Replicating the primary screening process, a search was undertaken to locate the abstracts, for review. A further twenty-eight articles were deemed appropriate to meet the inclusion criteria. Forward and reverse citation searching from within these studies was again undertaken, and saturation was reached within the literature search. Eighty (fifty-two plus twenty-eight) were available for further review and screening, using the Critical Skills Appraisal Programme (CASP) qualitative checklist (CASP, 2011).[21] Nine articles were selected for review within the narrative synthesis (Table 3). Seventy-one studies were rejected because of issues relating to their design, data collection, analytical frameworks and, clarity of their findings. The main reason for rejecting these studies was that upon formal inspection, they failed to offer any meaningful or coherent insight into the reported methods, rules, actions and behaviours police officers used to make sense of, and respond to, situations involving a potentially mentally disordered person (Birks, 2014; Pace et al., 2017).

Table 3: Selected Articles.

Study	Participants / data source	Method	Focus
Bittner, (1967). USA	Police officers N=Unknown	Quantitative / qualitative Observation and retrospective case review	Police decision-making
Finn & Stalans, (2002). USA	Police officers N=257	Quantitative Simulation and questionnaire	Police decision-making.
Flin et al, (2007). Scotland	Police officers Part 1: N=23 Part 2: N=122	Quantitative Two-part study Part 1: simulation Part 2: questionnaire	Situation awareness.
Godfreson et al, (2010). Australia	Police officers N= 304	Quantitative Questionnaire and simulation	Police attitudes and decision-making
Hartford et al, (2005). Canada	Police administrative database records. N=100	Quantitative Retrospective case review	Predictors which identify a person as suffering a mental illness.
Novak & Engel, (2005). USA	Police officers: N=442 Subject contacts N=617	Quantitative Observational	Police decision-making
Teplin, (1984). USA	Police officers: N=283 Subject contacts: N=506	Quantitative and qualitative Observational	Police decision-making
Watson et al, (2004). USA	Police officers N=382	Quantitative Questionnaire and simulation	Police decision-making
Watson et al, (2010). USA	Police officers N=216	Quantitative and qualitative Interviews and self-rating scale.	Police decision-making and tools to support decision-making.

[21] The eighty studies were reviewed in relation to the following ten questions contained within the CASP (2011, pp.2-6), qualitative checklist:

1. "Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between the researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?"

3.6 Data analysis

Within the nine selected articles, there was variability in their explicit area of focus, their design, method, recruitment, sampling, data analysis, and clarity. Consequently there was variability within their conceptual framing, transparency, validity, reliability and cogency. Reflecting the work of Pawson (2006), rather than consider the methodological structure, rigour or limitations of the articles selected for inclusion, the researcher should consider the relevance and theoretical contribution of a study to the question underpinning a review. As noted by Pawson (2006), "'Bad' research may yield 'good' evidence, but only if the reviewer follows an approach that involves analysis and appraisal" (p.127).

Data from the nine selected studies was systematically extracted and analysed in the following stages: preliminary synthesis; exploration of the relationships between the studies; secondary synthesis (Popay et al., 2006; Arai et al., 2007; Rodgers et al., 2009) (Figure 9). Through the lens of situation awareness, the summarised, textually described data then underwent theoretical thematic analysis. Reflecting Braun and Clarke's (2006) approach, data was manually transcribed, then closely examined, line by line. Each line of text was numbered, to clearly identify text which may be subsequently coded. As recurrent, similarly occurring features emerged across the range of data, they were highlighted within the text and assigned a code for subsequent review and collation (Lapadat, 2010; Staller 2010). Codes (including extracted data excerpts) were grouped into emergent, core themes. This process was visually represented within thematic maps to support the identification of associations / overlap, and the refinement of emergent themes. The refined themes were reviewed in relation to their coherence of fit within the data set, and the methodological and theoretical frameworks, prior to the establishment of final themes.

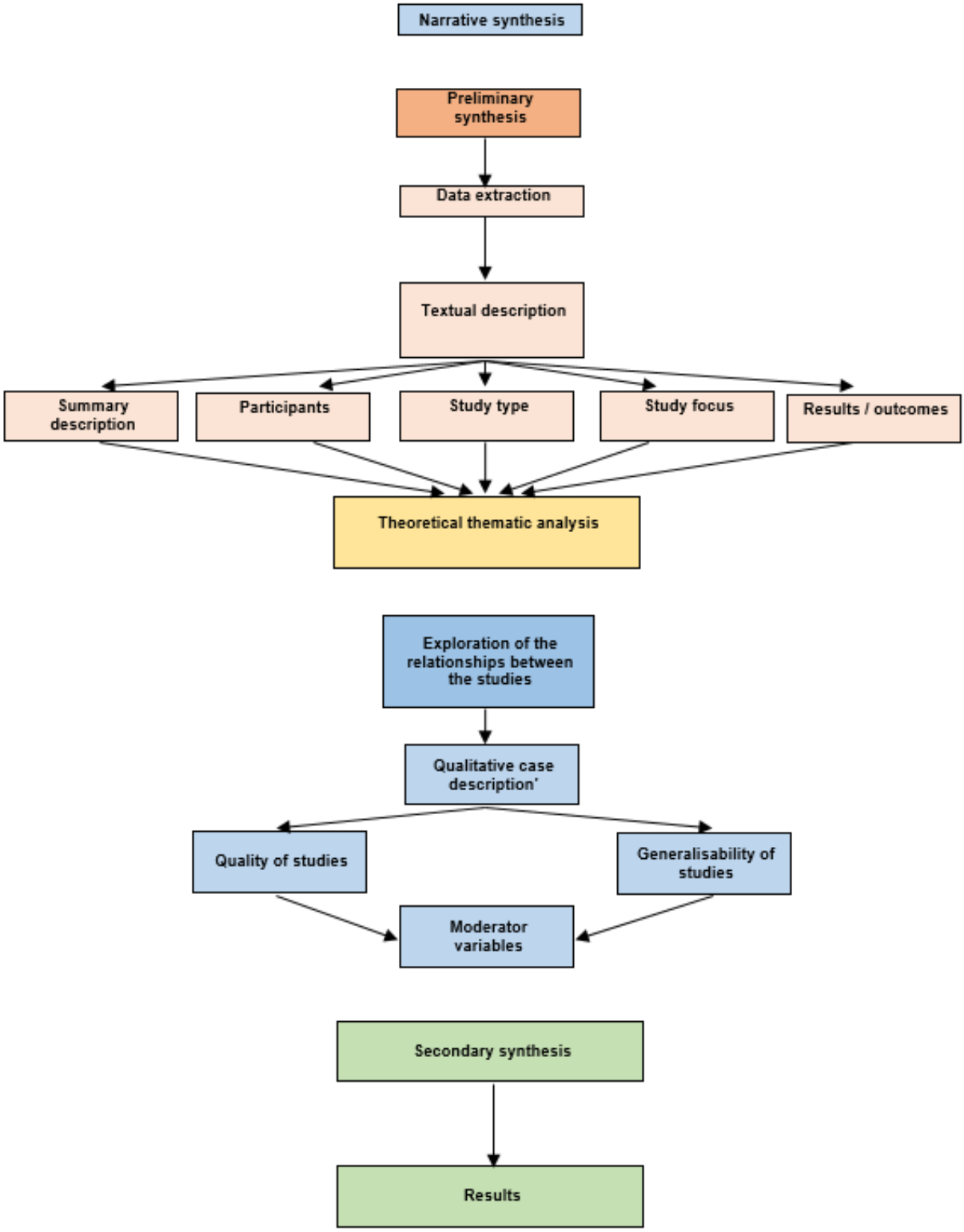


Figure 9: Stages of Analysis.

3.7 Preliminary synthesis

The purpose of the preliminary synthesis was to extract data, systematically summarise papers, and identify patterns across groups (Aria et al., 2007). First, data was presented in the form of a textual (qualitative case) description.

3.7.1 Textual description

Six studies were conducted in the United States of America, one in Canada, one in Australia and one in Scotland. The oldest study was completed in 1967. Within eight studies, the participants were serving police officers within their country of study. One study related to police activity data held within a computer system.

3.7.2 Study type

There were seven quantitative studies and two mixed-method studies. Five studies collected data directly from police officers (Finn and Stalans, 2002; Flin et al., 2007; Godfreson et al., 2010; Watson et al., 2004; Watson et al., 2010). Within the studies by Bittner, (1967), Novak and Engel, (2005), and Teplin, (1984), police officer behaviours / actions were observed. Simulation was used within the study by Finn and Stalans, (2002) whilst simulation in conjunction with a questionnaire was used within the studies by Flin et al. (2007), Godfreson et al. (2010) and Watson et al. (2004). Within the study by Hartford et al. (2005), data was collected from a police administrative database.

3.7.3 Participants

The participants within three studies (Finn and Stalans, 2002; Godfreson et al., 2010; Watson et al., 2004) were drawn from police in-service training events. Field observation of participants was undertaken within the studies by Novak and Engel, (2005), Teplin, (1984) and Bittner (1967). Within the study by Watson et al. (2010), police officers were selected from personnel lists contained within four operational districts of a large North American city. Flin et al. (2007) undertook a two-part study. For part one of their study, participants were drawn from one Scottish police service reflecting both an urban and rural area of coverage. Within part two of their study, participants were drawn from two Scottish police services, each reflecting an urban and rural area of coverage. The study by Hartford et al. (2005) did not involve police officers directly. This study referred to data relating to any call for

police assistance or police action / intervention, held within a police administrative database, in a single Canadian city, over a two-year period.

3.7.4 Interventions

Three studies explored police officer decision-making relating to decisions to arrest a person demonstrating signs of mental disorder (Novak and Engel, 2005; Teplin, 1984; Watson et al., 2004). Two studies explored police officer decision-making relating to decisions to arrest or apprehend (using state mandated processes) a person demonstrating signs of mental disorder or facilitate such a person's access to health care services (Finn and Stalans, 2002; Bittner, 1967). One study (Watson et al., 2010) explored the impact of training police officers in the specific management of people with mental disorder, and its impact upon arrest / access to health services. Another (Godfreson et al., 2010) sought to explore factors and police officer attitudes influencing police discretion when managing a situation involving a person with mental disorder. Two further studies did not directly relate to police officer decision-making when they encounter a person suffering a mental disorder, but they included material relevant to police actions within such situations. One study considered the factors influencing police officers' responses within an acute, time-critical situation (Flin et al., 2007), whilst one study (Hartford et al., 2005) sought to highlight to police officers, people with a mental disorder in a police administrative database via an algorithm composed of caution / dependency flags, addresses and text indicative of mental disorder.

3.7.5 Results / outcomes

The management of people suffering from mental disorder by police officers appeared to be subject to some degree of variability. The studies appeared to explore the factors which influence or shape police officer decision-making, or how they are supported within their decision-making. One study (Hartford et al., 2005) considered people with mental disorder more likely to have contact with police than people not suffering a mental disorder, regardless of the nature of the interaction. The behaviour of such a person appears to influence the actions of police officers (Novak and Engel, 2005; Teplin, 1984). The ability of the police officer to recognise the signs of mental disorder also appears to influence their actions (Godfreson et al., 2010; Bittner, 1967; Watson et al., 2010). One study considered the degree of professional experience of police officers to be a factor when managing a domestic

violence situation involving a person with mental disorder (Finn and Stalans, 2002). A further study (Watson et al., 2004) considered the impact of more subjective variables, such as the police officers' perception of a person's (suffering mental disorder) degree of responsibility within and for a particular situation, the perceived level of danger they posed, the perceived credibility / veracity of their account and the degree of pity or anger they afforded them within a situation. The remaining study (Flin et al., 2007) was more wide ranging, considering the broader situational and personal factors influencing police officers' responses to time-critical or unfamiliar events, which included reference to people with mental disorder.

Data was then tabulated (Appendix 3), according to the following criteria:

- Author details, and country of publication.
- Aim of paper.
- Design and method.
- Sample / client group.
- Comment upon paper, and question paper appears to ask.
- Comment in relation to the specific processes police officers use to identify and manage a mentally disordered person.
- How police identify a person as suffering from mental disorder, and terms used.
- Factors relating to police decision-making.
- Factors suggestive of situation awareness.

This data was then summarised, highlighting the specific processes each article reported police officers to use, when identifying a person with a mental disorder (Appendix 4). Data was extracted, and a final, in-depth textual description of these reported processes was then undertaken (Appendix 5).

The final, in-depth textual descriptions underwent 'narrative juxtaposition' - the side-by-side comparison of potentially dissimilar literature sources, for the purpose of identifying homogeneous themes (Dixon-Woods, Agarwal, Jones, Young and Sutton, 2005). The 'narrative juxtaposition' took the form of a five-stage theoretical thematic analysis which sought distinct, recurring, unifying and meaningful patterns

(themes) within the data (Marks and Yardley, 2004; Braun and Clarke, 2006; Vaismoradi, Turunen and Bondas, 2013) (Figure 10).

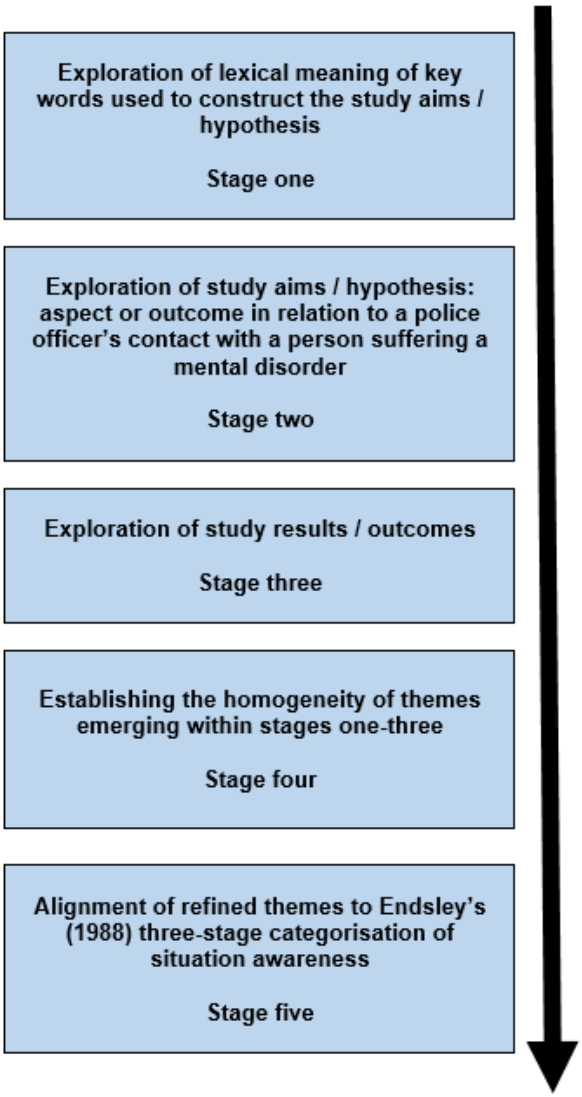


Figure 10: Stages of Analysis.

In line with the narrative synthesis, the five-stage theoretical thematic analysis sought to explore the interconnectedness of words. It also sought to explore their linguistic forms, and their context of use, illustrative of the specific processes police officers used to identify and manage a mentally disordered person (ten Have, 2004; Braun and Clarke, 2006; Popay et al., 2006; Schwandt, 2007a; Ayres, 2008; O'Leary 2004; Lapadat, 2010; Roulston, 2010; Vaismoradi, Turunen and Bondas,

2013; Polit and Beck, 2012). Within stage one, the lexical meaning of the words used to construct the study aims / hypotheses was examined (Appendix 6). This method was employed to identify, through examination of the lexical meaning of the words contained with the study aims / hypotheses, any emergent themes relating to the questions posed by the researchers within their work, and the relevance of such to the research question posed within this study.

Within stage two, the focus of each study was investigated from the perspective of its aim / hypothesis, to identify the phenomenon being examined, and expose themes relevant to this study (Appendix 7). Within stage three, each study was textually described in-depth, and their results / outcomes reviewed to identify initial emergent themes (Appendix 8). To provide a more refined stratification, within stage four, the themes emerging within stages one, two and three, were further reviewed as to their relative homogeneity (Appendix 8). Within stage five, the refined themes were aligned to Endsley's (1988) three-level categorisation of situation awareness (Appendix 9). This step was also textually described in-depth so as to illustrate the alignment of the refined 'juxtaposed' themes to the narrative synthesis literature. A confirmation exercise was then undertaken (Appendix 10).

3.7.6 Exploration of the relationships between the studies

A detailed, in-depth exploration of the relationships between the studies was undertaken. This approach sought potentially hidden issues of significance, particularly moderator variables, and their effect (Popay et al., 2006). Using a 'qualitative case description' approach, an exploration of the relationships that existed between the structure of each study, and their findings, and the relationships that existed between the findings of each study, was undertaken (Popay et al., 2006; Arai et al., 2007; Rodgers et al., 2009). This was achieved by undertaking a detailed textual examination of the quality of the studies, study location, population, method, outcome and the nature and effect of emerging moderator variables (Cramer and Howitt, 2004; Stone-Romero, 2007). The nine selected articles were textually described (Appendix 11), and analysed according to the study type; sampling method; data collection method; data analysis method; transparency of the study; generalisability; relevance and theoretical contribution of the article to the question underpinning narrative synthesis..

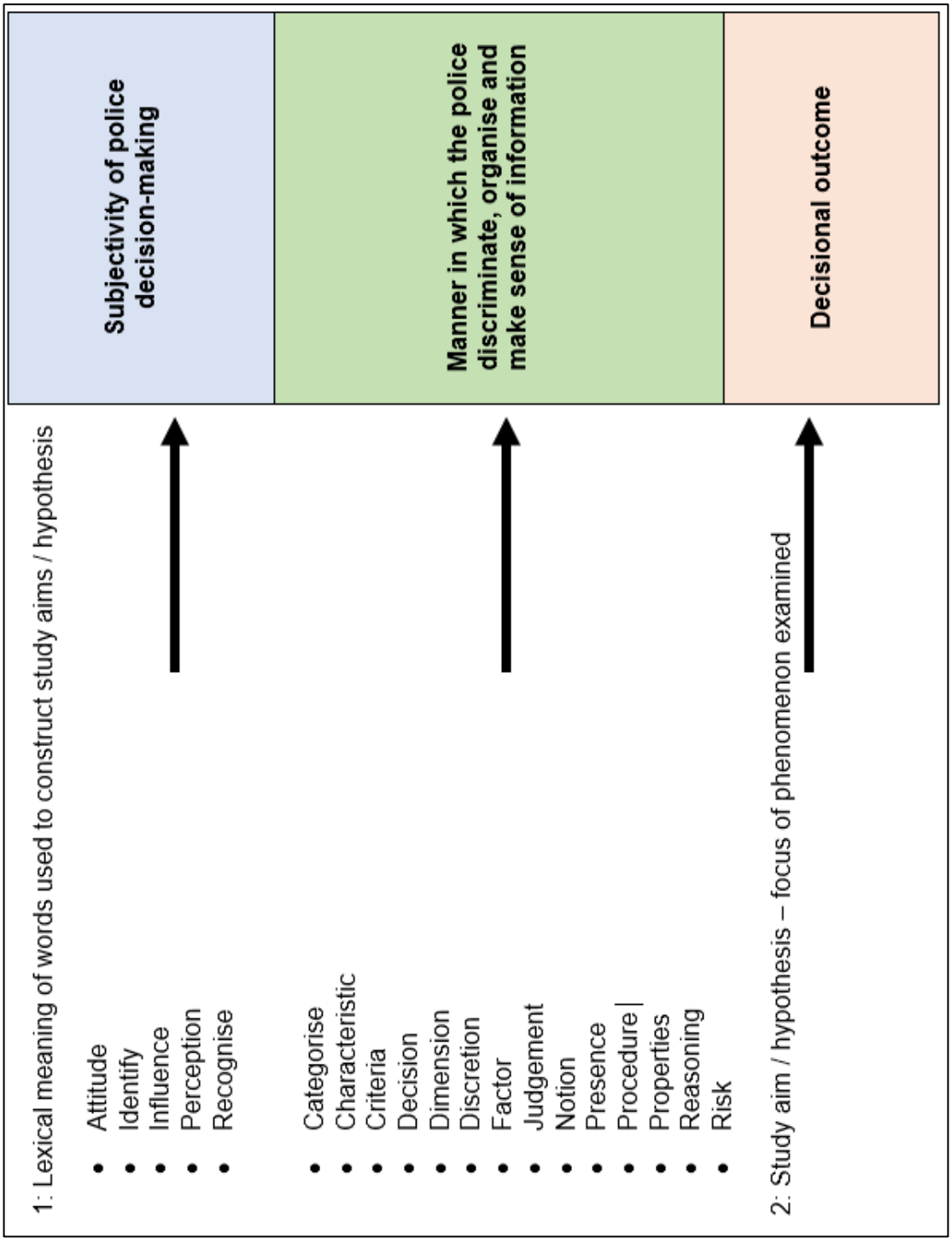
3.8 Secondary synthesis

A secondary synthesis sought to establish the final extent and nature of relationships within the data regarding the specific reported processes police officers use to identify and manage a mentally disordered person. This data was viewed through the lens of Endsley's (1988) three-level categorisation of situation awareness (Klein, 2000; Crandall, Klein and Hoffman 2006; Segall, Kaber, Taekman and Wright, 2013).

3.8.1 Emerging themes

Within stage one of the theoretical thematic analysis, words such as 'identify,' 'influence,' 'recognise,' 'perception,' were noted, suggesting the authors' recognised and sought to explore the subjectivity of police officer decision-making, their ability to identify key issues when managing a person with a mental disorder and its impact upon the phenomena in focus. This was categorised as *subjectivity of police decision-making* (Table 4). Words such as 'categorise,' 'characteristic,' 'criteria,' dimension,' 'discretion,' 'factor,' 'notion,' 'judgement,' 'presence,' 'procedure,' 'properties,' 'reasoning' and 'risk,' suggested that the authors sought to explore the manner in which the police officers discriminated, organised, ordered and made sense of information relative to their decision-making when managing a person with a mental disorder. This was categorised as the *manner in which the police discriminate, organise, and make sense of information*. Within stage two, the focus of the works seemed to suggest the need to explore the outcome / nature of the decisions made by police officers when managing a person with a mental disorder – informal management, arrest, and consideration of medical treatment. This was categorised as *decisional outcome* (Table 4).

Table 4: Stage one and two Analysis.



Within stage three, when exploring the results / outcomes of each study, twenty emergent themes were identified. There appeared to be alignment of these themes to the categories established following stage one and two data analysis. Three emergent themes appeared to align to the category *subjectivity of police decision-making*: police officer characteristics as a predictor of decisional outcome; perception of mental health services as a predictor of decisional outcome; characteristics of the police officer as a factor influencing decision-making. Ten emergent themes appeared to align to the category *manner in which the police discriminate, organise and make sense of information*: mental health training as a predictor of 'contact only' actions; mental health training as a predictor of arrest; mental health training as a predictor of referral to mental health services; operational familiarity with the characteristics of mental disorder; operational familiarity with mental disorder; operational familiarity with a situation as factor which influences decision-making; operational familiarity with a situation; predictors of interactions with police; situational characteristics influencing police response; situational characteristics of mentally disordered suspects. In relation to the third category, *decisional outcome*, there appeared to be alignment amongst seven emergent themes: awareness of schizophrenia as a predictor of decisional outcome; degree to which mental disorder is demonstrated as a predictor of likely and ideal decisional outcome; predictors of interactions with police, and outcomes; signs of mental disorder as a predictor of decisional outcome; situational awareness as a predictor of decisional outcome; situation characteristics influencing decisional outcome; situational factors as a predictor of decisional outcome.

Within stage four, when combining the themes emerging within stages one to three, there appeared to be some degree of homogeneity. This resulted in nine refined themes (Appendix 8). The refined themes appeared to fall within three broad, overarching categories. Firstly, themes reflecting the personal characteristics / experience of police officers, their ability to identify / discriminate / respond to behaviour suggestive of mental disorder and the situational variables within such encounters. This was categorised as *individual and contextual factors influencing police decision-making*. Secondly, themes reflecting the factors which influence a police officer's ability to synthesise and make sense of a particular situation seemed to emerge. These seemed to include the rules and processes used to support the formation of judgments and decisions. This was termed *criteria and process within decision-making*. Thirdly, themes seemed to reflect decision-making within

situations, and the individual (police officer) and contextual factors, which appeared to influence and shape often inconsistent decisions. This appeared to include the value afforded by police officers to available health services and their perception of how situations involving mentally disordered people should be managed. This was termed *outcome of police decision-making*.

Within stage five, the nine refined themes were considered in relation to their fit within Endsley's (1988) three-level categorisation of situation awareness, and their explicit alignment to the supporting data (Appendix 9 and10). Illustrative of the category *individual and contextual factors influencing police decision-making*, five refined themes aligned to Level 1 situation awareness (perception of the elements in the environment):

- *Signs of mental disorder as a predictor of decisional outcome.*
- *Operational familiarity with a situation as factor, which influences decision-making.*
- *Mental health training as a predictor as a factor influencing decision-making.*
- *Characteristics of the police officer as a factor influencing decision-making.*
- *Situational characteristics of mentally disordered suspects.*

Illustrative of the category criteria and process within decision-making, one refined theme aligned to Level 2 situation awareness (comprehension of the current situation):

- *Operational familiarity with the characteristics of mental disorder*.

Illustrative of the category outcome of police decision-making, three refined themes aligned to Level 3 situation awareness (projection of future state):

- *Degree to which mental disorder is demonstrated, as a predictor of likely and ideal decisional outcome.*
- *Situation characteristics influencing decisional outcome.*
- *Perception of mental health services as a predictor of decisional outcome.*

3.8.2 Identification of moderator variables

The exploration of the relationships between the studies, their quality and generalisability, identified twelve moderator variables (Appendix 12). Viewed across the range of studies, their nature and distribution highlighted a broad range of factors influencing the processes police officers used to identify and manage a mentally disordered person. A three-level moderator hierarchy emerged (stage one having the greatest effect, and stage three, the least), based on their apparent effect upon the specific processes police officers use to identify and manage a mentally disordered person (Table 5):

Table 5: Moderator Hierarchy.

	Moderators	
Stage one	Recognition of the significance / type / effect of mental disorder	Level 1 Situation awareness
	Situational response	Level 1 Situation awareness

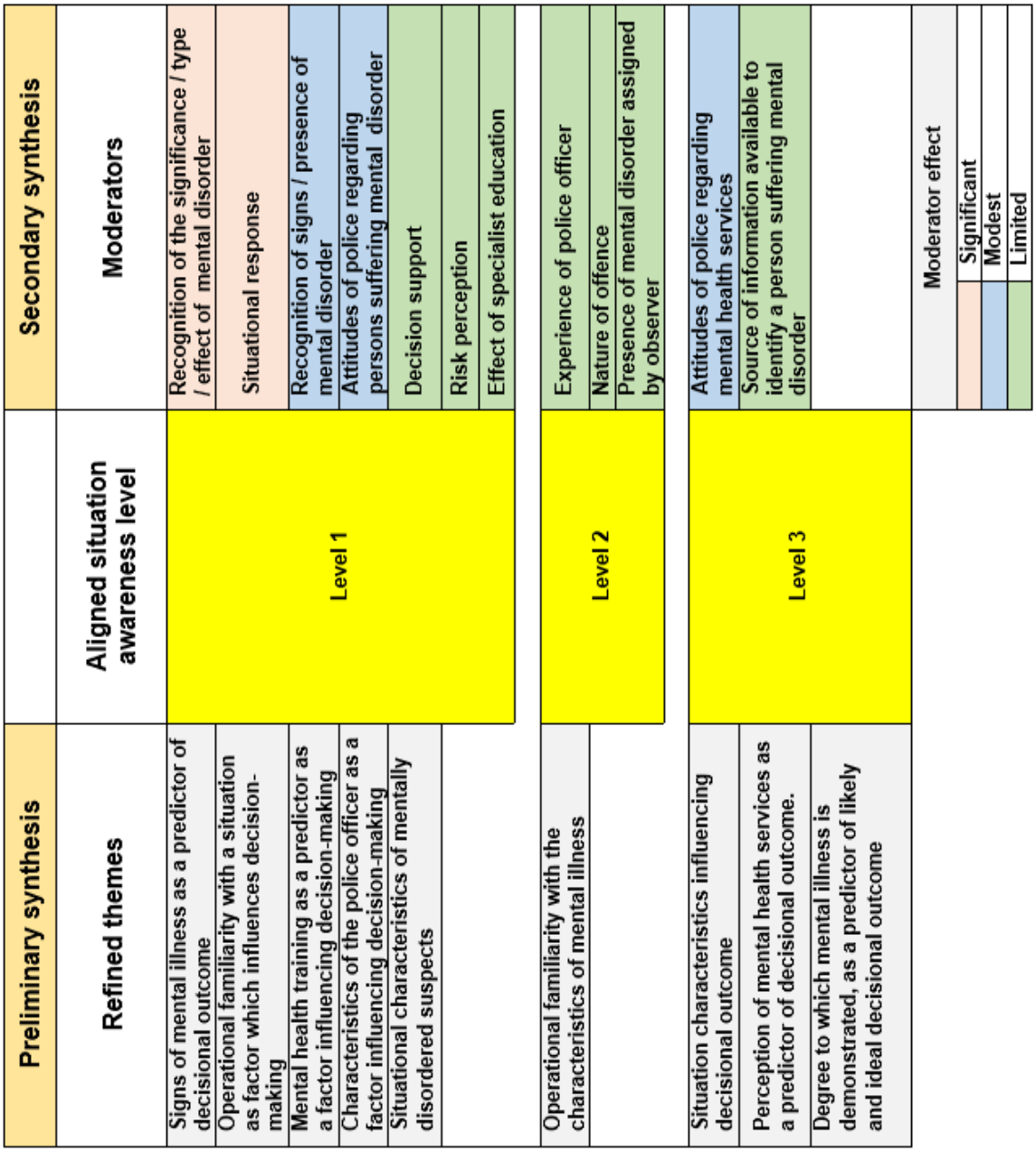
	Moderators	
Stage two	Recognition of signs / presence of mental disorder	Level 1 Situation awareness
	Attitudes of police regarding persons suffering mental disorder	Level 1 Situation awareness
	Attitudes of police regarding mental health services	Level 3 Situation awareness

	Moderators	
Stage three	Decision support	Level 1 Situation awareness
	Risk perception	Level 1 Situation awareness
	Effect of specialist education	Level 1 Situation awareness
	Experience of police officer	Level 2 Situation awareness
	Nature of offence	Level 2 Situation awareness
	Presence of mental disorder assigned by observer	Level 2 Situation awareness
	Source of information available to identify a person suffering mental disorder	Level 3 Situation awareness

The moderators appeared to align with Endsley's (1988) three-level categorisation of situation awareness. Within the first stage, a police officer's ability to recognise the significance and effect of a mental disorder, and their response to situation-determined factors, provided the most significant moderator effect upon Level 1 situation awareness. Within the second stage, moderators relating to both a police officer's attitude, and their ability to recognise the presence of a mental disorder had a modest effect on both Level 1 and 3 situation awareness. Within the third stage, the availability of decisional support and the presence of specialist (mental disorder) education had a limited moderator effect upon Level 1 situation awareness. A police officer's perception of risk also had a limited moderator effect upon Level 1 situation awareness. The experience of a police officer, the nature of an offence (actual / suspected) and the presence of mental disorder within a person, stated by a third party, had a limited moderator effect upon Level 2 situation awareness. Information sources available to support a police officer in identifying a mental disorder had a limited moderator effect upon Level 3 situation awareness

Within the preliminary and secondary synthesis, there was homogeneity of the emergent themes and moderators to the categories of situation awareness (Table 6). Significantly, the emergent themes did not appear equally distributed within the three stages; the bulk of the emergent themes and moderators related to Level 1 situation awareness.

Table 6: Homogeneity of Themes.



3.9 Chapter summary

The processes police officers use to identify and manage a mentally disordered person appeared to be individually and situationally determined, rather than governed by guidelines or protocols. The narrative synthesis suggested that police officers demonstrated Level 1 situation awareness to a greater degree, compared to Levels 2 and 3. According to the literature reviewed, the bulk of the emerging themes suggested police officers had difficulty in identifying or seeking contextually relevant cues / information necessary to both identify and respond to a person's mental health needs. Situational factors appeared to have a significant influence upon a police officer's processes. These included the nature of the environment in which a mentally disordered person was encountered, and the manner in which that person acted within, and responded to, that environment. They also included distractions, rapidly changing events, and available information at the contact scene, inextricably interwoven with the police officers' personal and professional assessment of the situation. When the findings of the narrative synthesis are viewed through the lens of Endsley's (1988) three-level categorisation of situation awareness, it seemed that a police officer's failure to effectively identify or seek contextually relevant cues or information (Level 1 SA), could establish a flawed perception of the person, and any signs of mental disorder displayed. The real potential for an inaccurate, absent or distorted view of the features indicative of mental disorder seemed to exist (Level 2 SA). This potentially flawed comprehension of the current situation could therefore be translated into an inappropriate and inconsistent response (Level 3 SA).

Within the previous chapters, I have described the issues police officers appeared to experience when encountering a mentally disordered person. I have also stated that the purpose of this study is to develop a structured, robust and evidence based cognitive aid for British police officers. In Chapter 5, I will describe in more detail the contribution of the narrative synthesis to this study. Within the following chapter however, I describe the philosophical positioning of this study, necessary to enable the development and testing of the cognitive aid.

CHAPTER 4

PHILOSOPHICAL POSITIONING

4 Introduction

This chapter is presented in eight sections. I first outline the research problem, questions, aims and objectives. I then establish the study framework. Reflective of Crotty's' (2012) ''…scaffold…" approach, I justify this study's epistemological position (p.4). It is one which is positioned within the constructivist paradigm, supported by relativist ontology. I next justify this study's theoretical perspective of symbolic interactionism, and its relationship to situation awareness. Addressing the study's methodology (design), I justify the selection of an ethnomethodology design. Finally, I present a summary of the chapter.

4.1 The research problem

Having explored the landscape relating to the issues faced by police officers, three main areas of evidence appeared deficient. First, there was limited evidence regarding the way police officers identify a person with a potential mental disorder. Second, there had been no exploration of police officer situation awareness when encountering a potentially mentally disordered person. Third, there were no consensual approaches to support individual police officers within their identification and response to a potentially mentally disordered person.

4.2 The research questions

Two underpinning research questions emerged:

- First, what are the methods, rules, actions and behaviours police officers use to make sense of, and respond to situations involving a potentially mentally disordered person?
- Second, what is the usefulness of a cognitive aid to assist police officer situation awareness, when encountering a potentially mentally disordered person?

4.3 Research aims and objectives

The aim of this study was to investigate the methods, rules, actions and behaviours shaping the situation awareness police officers used to identify and respond to a potentially mentally disordered person. This underpinned the re-development[22] of a cognitive aid to support police officers during such encounters. The objective of this study was first, to develop a structured, robust and evidence based cognitive aid for police officers encountering a potentially mentally disordered person. Secondly, to investigate the extent to which a police officer's identification and response to a potentially mentally disordered person, was shaped by the re-developed cognitive aid.

4.4 Establishing the study framework

When embarking upon the research process, Crotty (2012) advocates 'scaffolding.' This is the establishment of a skeletal framework to support the development of more robust epistemological, theoretical and methodological structures. This enables the study to be directed and articulated. Prior to establishing the 'scaffolding', one establishes a firm foundation upon which to mount it. Having already determined the research problem and questions, this foundation was in the form of the research aim and objectives. The 'scaffolding' comprised four interdependent domains (Table 7) (Crotty, 2012, pp.2-3). Each domain was essential to the success of the study. They were arranged sequentially, as each stage informed the next. To disregard this sequence jeopardised the integrity and coherence of the study, and thus the outcome (Crotty, 2012).

[22] This study builds upon the work of Wright, McGlen, Haumueller and Croll (2008), which resulted in the development of the Public Psychiatric Emergency Assessment Tool.

Table 7: Crotty's (2-12) 'Scaffold.'

Crotty's 'Scaffold'	Study position
Epistemology The theory of knowledge underpinning the theoretical and methodological approaches selected	• Constructivist paradigm, • Relativist ontology, • Social constructionism.
Theoretical perspective The theoretical positioning informing the selection of the methodology to address the study aims and objectives	• Symbolic interactionism, • Situation awareness
Methodology The structured mechanism through which the desired study aims and outcomes are achieved	• Ethnomethodology
Methods The specific processes, instruments and protocols selected to gather and analyse the data	• Methodological triangulation overarching approach ***Stage one*** • Narrative synthesis • Individual semi-structured interviews • Concept mapping of combined data ***Stage two*** • Pre-post testing of cognitive aid using video vignette and note-taking exercise, followed by focus group interviews • Data analysis using concept and observable indicator framework • Concept mapping of combined data • Use of the cognitive aid in real-world conditions followed by semi-structured interviews

4.5 Epistemological stance

Epistemology is concerned with the sources and methods of knowing, and the theories of knowledge a person uses to interpret, understand and make sense of the world (Goldman, 2001; Ritchie and Lewis, 2004; Green and Thorogood, 2004). Importantly, epistemology acknowledges the ontological stance, which concerns the nature and theory of existence – the philosophical view of how the social world exists. The ontological stance allows the person to not only "…understand what it means to know…" (epistemology), but to position themselves so as to understand "…what is…" (ontology) (Crotty, 2012, p.10). Epistemology therefore establishes the specific conditions "…definitive of knowing" and of existence (Monist, 2001, p.368). It is these conditions which determine the accuracy of a person's description, interpretation, understanding, and sense making of the world (Monist, 2001; Nicholson, 2013). The first two specific conditions related to the paradigm within which the study was placed, and its ontological stance.

4.5.1 The positivist / post-positivist paradigms

Historically, the research process fell within the positivist paradigm; belief that the world is fixed and its mysteries are knowable and predictable (O'Leary, 2009). Such assumption is reflective of realist ontology – belief that an objective real world exists, ordered by natural (naturalist) laws, beyond that created within the human mind (Polit and Beck, 2012). Positivists assume there to be a specific objective truth, unaffected by the researcher (Ritchie and Lewis, 2004). When exploring aspects of human behaviour, objective truth is determined using large, representative sampling methods and controlled, structured, systematic methods of quantitative enquiry, which are deductive, correspondent, reductionist, numerable, generalisble, predictable. Such methods seek to exclude researcher subjectivity, and thus seek to assure objectivity (Crabtree and Miller, 1999; Polit and Beck, 2012). In contrast, the emergent post-positivists of the late twentieth-century believed the world is not fully knowable, is complex, consisting of multiple realties - truth is not fixed, but idiographic (O'Leary, 2009).

Post-positivism is reflective of a critical realist ontology – the assumption that whilst there may be a real world, ordered by natural laws, it is imperfect, therefore not fully knowable. Acknowledging such imperfection, a critical realist ontology acknowledges the value of "…context-specific conditions…" which may provide

insight into a unique human reality (DeForge and Shaw, 2011, p.85). Whilst objectivity within the conduct of the study is the ideal, for post-positivists this is not always assured due to the variable nature of the phenomena being studied, coupled with the inherent human fallibility of both subject and researcher (Mittwede, 2012). Outcomes are therefore "…conjectural…" with absolute truth always being unobtainable (Creswell (2009, p.7). Cognisant of such complexities, beginning with a theory, rather than seeking objective truth, post-positivists seek probabilistic evidence and evidence that supports / refutes the theory (Creswell, 2009; Polit and Beck, 2012). Seeking to describe the methods, rules, actions and behaviours shaping situation awareness, which police officers use to identify and manage a person with a potential mental disorder, this study did not lend itself to the search for an objective truth, a predicted quantifiable outcome or probability. Rather, it lent itself to the investigation and description of how individuals (police officers) construct their own knowledge within their social world (Burr, 2004, p.186).

4.5.2 The constructivist paradigm

Taking its origins from the work of Jean Piaget (1896-1980), Hershberg (2014a) defines constructivism as "…a theory of learning… [and] a theory of knowing …" (p.183). The constructivist paradigm assumes that individuals construct multiple contextual realities within their minds; as such, there can be no fixed objective truth (Polit and Beck, 2012). Such contextual realities, note Gergen and Gergen (2011, p.461), are created (constructed) through "…processes inherent in the individual mind – as opposed to human relationships." Such an assumption is reflective of relativist ontology, which asserts that truths and non-truths are relative only to a given context (Denzin and Lincoln, 2003; Cheu-Jey, 2010; Quayle, 2010). Constructivists therefore assume meaning (rather than truth), is inherent within the individual human mind, resulting from engagement with the real world, and making sense of it (Mathison, 2005; Maréchal, 2012a; Crotty, 2013; Hershberg, 2014a). Meaning is grounded in the experience of the subjects (Polit and Beck, 2012). As such, there are no ultimate truths, only "…context-bound constructions that are part of a larger universe" (Crabtree and Miller 1999, p.10). By engaging with the subject and their social world, using inductive, small sampling methods and flexible theory-generating approaches (which produce richly descriptive, intersubjective, qualitative data), an understanding of such meaning is possible (Ritchie and Lewis 2004; Hall, Griffiths and McKenna, 2011; Polit and Beck, 2012). This study sought an in-depth investigation of human meaning, which acknowledged the existence of multiple

cultural and contextual derived realties. It was therefore positioned within the constructivist paradigm, supported by relativist ontology.

Having established the paradigm within which this study was positioned, and the ontological stance, the next 'specific condition' related to the epistemological lens through which this study interpreted, understood and made sense of the social world, commensurate with the study aims and objectives. Crotty (2012) offers three overarching lenses: objectivism, subjectivism and constructionism.

Objectivism holds that reality is positioned beyond human consciousness (Cronjé, 2006). As such, the real world is explicitly structured with an object in focus "…a well-defined, detected and independent entity which we can observe whenever we wish, since it does not change." (Dorfman, 2013, p.121). Meaning is therefore a product of human interpretation of something that already exists (Crotty, 2012). Subjectivism however asserts that reality is positioned within individual human consciousness, as the mind is a representational system, transforming real-world objects from abstract, to concrete (Glock, 2009). Meaning comes not from the interplay between the phenomenon and the person, but is ascribed solely by the person (Domsky, 2004; Crotty, 2012). Whilst this study sought to understand human interpretation of phenomena, the phenomenon under investigation was not considered well-defined, unchanging, or an independent entity. Furthermore, the investigation of the wholly subjective human interpretation of phenomena was not the purpose of this study; this study sought the social context in which police officers encountered and interacted with a person suffering a potential mental disorder. To more coherently address the study aims and objectives, a middle ground was sought in constructionism.

Constructionism assumes that knowledge is constructed by humans, via social interaction (Vogt, 2005). Constructionism recognises both the presence of an objective reality beyond human consciousness, and, through individual interpretation, constructed meanings "…which are at once objective and subjective… [and] …insolubly bound up." (Crotty, 2012, p.48). To the individual, meaning, and therefore reality, is usually contextually driven, dependent and bound. This paradigm differs from constructivism, where meaning and reality are considered solely a product of human consciousness and interpretation (Maréchal, 2012; Hershberg, 2014). Rather than focus upon how individual meaning was

derived, this study investigated the social origins, influences and contexts in which individuals (police officers) recognised and acted in response to the behaviours of other individuals (people suffering from a potential mental disorder). To enable me to begin to interpret, understand and make sense of the social world related to the study aims and objectives, the overarching epistemological lens of constructionism was refocused to that of *social* constructionism.

Reflecting a relativist ontology, social constructionism rejects a single, objective truth, favouring a constructed understanding of what individuals hold to be their reality within their specific social group (White, 2004; Cruikshank, 2011; Crotty, 2012). Denzin and Lincoln (2003) observe that as humans, we interact with and interpret the social world around us. We do this, notes White (2004) through collective"…frameworks of meaning…" (p.9). Collective meaning is influenced by, and set within, the milieu of a social group's shared knowledge, language, processes, procedures, history, culture, and socio-political values (Denzin and Lincoln, 2003; Hosking and Morley, 2004). Given the diversity and range of human social groups and contexts, the possibility exists for such frameworks to be "…constructed in limitless, different ways" (White, 2004, p.9). This is because "…worlds are artificial, and constructed by people" (Hosking and Morley, 2004, p.14). Rejecting generalisble, predictable, probabilistic and therefore quantifiable data outcomes, social constructionism allows the creation and grouping of new, unspecified meanings, drawn from, and relevant to, a particular social world (Petterson, 2012; Chung-Jey, 2012). It is a transformative process through which the researcher "…can refashion the prevailing intersubjective norms…" gaining a unique insight into a particular social group, within a particular social context (Cruikshank, 2011, p.76). Through the lens of social constructionism, this study investigated the shared knowledge, collective frameworks of meaning, history, culture, socio-political values and social norms, related to the methods, rules, actions and behaviours shaping situation awareness, which police officers use to identify and manage a person with a potential mental disorder. The subsequent transformative and refashioning process was the development of a structured, robust and evidence based cognitive aid for police officers encountering such a person.

Addressing the first domain of Crotty's (2012) 'scaffold', the epistemological stance was positioned within the constructivist paradigm, supported by relativist ontology, and one which reflected social constructionism.

4.5.3 Theoretical perspective

Forming Crotty's (2012) second domain, the theoretical perspective provided the "...philosophical stance lying behind the methodology" (Crotty, 2012, p.66). It represented the particular (theoretical) criteria used to identify, describe and define the key areas of a phenomena to be explored. Within this study, it determined the manner of investigation into the methods, rules, actions and behaviours shaping situation awareness, which police officers use to identify and manage a person with a potential mental disorder, and the extent to which this was shaped by a cognitive aid. The theoretical perspective determined what Cresswell (2009) terms the "…orientating lens", guiding the unique viewpoint posed by this study (p.62). Of key importance to this study was how police officers derive and ascribe meaning, when encountering a person with a potential mental disorder. The theoretical perspective ('orientating lens') used within this study was therefore the concept of symbolic interactionism, in light of Endsley's (1988) three-level categorisation of situation awareness.

4.5.3.1 Symbolic interactionism

Symbolic interactionism traces its origins to the work of George Herbert Mead (1863–1931) (Mead, 1934). It is the "…peculiar and distinctive character of interaction as it takes place between human[s]…" (Blumer, 1969, pp.78-79). This peculiarity is the human ability to interpret and define the actions of one another, rather than simply reacting to them (Blumer, 1969). Symbolic interactionism assumes people to be inextricably rooted within their society, and that a person gives meaning to actions, verbal and non-verbal communication by assigning "…social symbols…" (Polit and Beck, 2012, p.491). These social symbols, are "…the natural units of interaction…" (Goffman, 1972, p.1). One's meaning and as such, active adjustment to differing situations, is therefore determined through social interaction (Dingwall, 2001; Burbank and Martins, 2009; Charon, 2010; Crotty, 2012; Oliver, 2012; Hall et al., 2012). This study investigated how police officers interpreted and defined social symbols suggestive of potential mental disorder. A range of police officer views, methods, rules, actions and behaviours, were utilised

to develop a cognitive aid. The purpose of this was to enable them to apply a more consistent and informed approach to the identification and management of people with a potential mental disorder. Mead, and therefore symbolic interactionism, had three main influences: Darwinism, behaviourism and pragmatism (Charon, 2010; Hall et al., 2013); influences which also shaped this study.

4.5.3.2 Darwinism

Darwinism considers that species best able to adapt to their environment proliferate, whilst those unable to do so, die out - the basic premise of natural selection, explicable in terms of natural laws and events (Darwin, 1859, p.20). Humans however, do not necessarily follow the process of natural selection; rather they adapt through the systematic, conscious modification of their environment, utilising abilities held by less physically able members of their social group (Darwin, 1859). Proliferation appeared because of the interaction occurring between humans, with and within their natural world. Rather than being subject to passive, incremental evolutionary process, Mead considered a person's adaptive behaviour resulted from highly evolved cognitive functions (Mead, 1934). This enabled them to construct knowledge of an external reality through the active "…engagement between subject and object…." (Oliver, 2012, p.411). Coupled with the ability to communicate verbally and non-verbally within a shared medium, people were able to establish symbols of recognisable meaning, allowing them to express thoughts, feelings, or desires, and have another understand them. Through this medium, people collectively adjust, engineer and define their social existence (Mead, 1934; Charon, 2010; Milliken and Screiber, 2012). Through Mead's interpretation of Darwinism, the manner in which police officers construct and express knowledge was explored. This contributed to the development of a cognitive aid, which sought a shared and consistently applied medium, structuring how such knowledge was constructed and expressed, relative to the identification and management of a person with a potential mental disorder.

4.5.3.3 Behaviourism

Based upon the early 20th century ideas of Watson (1878 –1958), behaviourism sought to understand humans through detailed observation and measurement of what was considered their organised responses (an amalgam of instinctive, learned, and Pavlovian conditioned responses), enabling them to adapt to an environment

(Watson, 1913; Skinner, 1985; Lecas, 2006; Charon, 2010). Mead rejected the view that behaviour was simply instinctive, learned, or conditioned, but rather something more sophisticated and fluid, constructed within a person's mind in response to a specific social situation. Mead postulated that key to understanding human behaviour was to understand the person's situational comprehension, the nature of their 'peculiar and distinctive' interpersonal interactions and the symbols of meaning that governed their behaviour within a complex world (Mead, 1934; Blumer, 1969; Burbank and Martins, 2009; Charon, 2010). Viewing situational comprehension in terms of situation awareness, this study was directed to investigate how contact scene features, distractions, and rapidly changing events, shaped their symbols of meaning – necessary to support the investigation into the usefulness of a cognitive aid within differing situations and presentations of mental disorder.

4.5.3.4 Pragmatism

Pragmatism assumes a reality both within, and external to, the mind (Creswell, 2009; Crotty, 2012; Oliver, 2012). Pragmatism, notes Charon (2010), provided three ideas that established the foundation for symbolic interactionism. Firstly, a person does not simply respond to their specific environment, rather they interpret it. For Mead, this was through 'self-conscious intelligence'; the cognitive process whereby a person consciously seeks to make sense of a social environment through shared and individual interpretation of symbols, rather than exclusively responding with an instinctive, learned, or conditioned action (Mead, 1934, p.328). Secondly, a person assigns belief to something, depending upon its perceived usefulness within specific situations. For Mead, this represented socially acquired memory. Through repeated engagement with differing social situations, a person is exposed to a plethora of differing symbols. A 'memory image' is then established, which a person uses to assign value, meaning and significance (belief) to something, based on prior exposure to particular symbols (Mead, 1934, p.332). Thirdly, within a social situation, a person's attention / focus is selective. Mead (1934) termed this "…rational intelligence…", whereby a person achieves a shared understanding of socially generated symbols, but assigns their own significance to them (p.334). A person's behaviour is therefore dependent upon individual interpretation, and ascribed significance, of the symbols present.

This study investigated the degree to which 'self-conscious intelligence' shaped a police officer's situation awareness, when encountering a person with a potential mental disorder, and how this related to their professional role perception / requirements. Also, the degree to which prior mental disorder education ('memory image') contributed to a police officer's situation awareness, and identification and management of a person with a potential mental disorder. Investigating what police officers considered to be key indicators of mental disorder, enabled an exploration of their 'rational intelligence', and as such, further contributed to the development of the PPEAT-R cognitive aid.

Influenced by the troika of Darwinism, behaviourism and pragmatism, Mead considered a person complex, sentient and rational; their behaviour, a representation of their interpretation and response to the socially generated symbols around them (Mead, 1934; Milliken and Screiber, 2012). Through the generation of interrelated words, used to identify and order physical reality, a person is able to "…make assumptions and value judgments about what we are seeing…" (Charon, 2010, p.4). Whilst a person may be subject to a plethora of differing verbal and non-verbal symbols, it is with internalised words that symbolic meaning within a social situation is derived (Charon, 2010). Having internalised and interpreted symbols, a person defines the nature of the current social situation and determines the expressed response (behaviour) (Burbank and Martins (2009; Hall et al., 2013). This may be a verbal response, a physical act or gesture intended to elicit a response within or from others (Mead, 1934; Burbank and Martins, 2009; Oliver, 2013). In doing so however, the person becomes an actor, whose performance is ever shifting within society (Charon, 2010). This study viewed police officers as specific actors with their own relationships, practices and group-specific words (professional and colloquial). To establish the boundaries, and therefore the usefulness of the PPEAT R, it was necessary for this study to investigate the often differing methods, rules, actions and behaviours which actors (police officers) used to identify and respond to a person with a potential mental disorder. It was therefore necessary to investigate the manner in which their performance shifted within their societal group.

4.5.4 Societal meaning

Milliken and Screiber (2012) consider society a medium for consensus and common understanding, defined in terms of its structure, intersubjective relationships, customs, and stratifications (Heritage, 1984; Dean, 2010; Johnson, 2013). Within a society, a person does not directly sense social situations, rather they selectively perceive, interpret and define them through interaction with the symbols present (Burbank and Martins, 2009; Hall et al., 2013). An actor's assigned symbolic meaning for something is therefore a product of how they and others act towards it, within their social group (Blumer, 1969; Jeon, 2004; Burbank and Martins, 2009; Milliken and Screiber, 2012). A society is therefore a middle-ground; a point of shared, common symbolic understanding, enabling "…co-operative conduct…" amongst the group (Mead, 1934, p.55). The key to 'co-operative conduct' is the establishment of a reference group.

A reference group is "…the group within which the individual communicates and whose [collective] perspective is [created and] applied to situations" Charon (2010, p.36). Within reference groups, actors seek to engage with a shared communication medium, and a similarly shared view of the current social reality. Reference groups are contextually and temporally determined (Shibutani, 1955). Often diverse in nature (e.g. family, religious or employment groups), they provide societal norms, patterns of conduct and frames of reference (Shibutani, 1955; Blumer, 1967; Burbank and Martins, 2009; Charon, 2010). Through this, the actor interprets, responds to, and generates collectively symbolic acts, demonstrating the plasticity required to continually adjust to their individual and collective changing social landscape. This plasticity enables actors to understand the meaning of the symbolic acts of others, and guide the attainment of their own needs, and / or the collective needs of others within the social (reference) group (Mead 1934; Milliken and Screiber, 2012). Such interdependence appears somewhat reflexive, as an actor is shaped by society and, through expressed symbolic acts, also shapes the collective understanding amongst the inhabitants of their social world (Mead, 1934; Blumer, 1967; Jeon, 2004; Charon, 2010; Milliken and Screiber, 2012).

Investigating 'co-operative conduct' (as individual and grouped police officers), this study explored collectively and individually recognised features of mental disorder, and areas where individual / shared knowledge was deficient. Of importance was the description of how police officers internalised, interpreted and responded to

signs of mental disorder. This contributed to the establishment of the cognitive aid boundaries. Viewing symbolic interactionism as inextricably rooted within a society, this study investigated how the reference group of police officers selectively perceived, interpreted, and defined the presence of a potential mental disorder. More specifically, given that operational policing is subject to complex, dynamic, time-critical constraints, this study investigated how the symbolic meaning of a police officer's training, experience, preconceptions, operational situational variables, dynamics and imperatives shaped a police officer's situation awareness, within such complex social interactions.

4.5.5 Situation awareness

Building upon the foundation established by Mead, Blumer established three tenets of symbolic interactionism:

1. "Humans act towards things on the basis of the meanings that the things have for them."
2. "…the meaning of… things is derived from, or arises out of, the social interaction that one has with one's fellows."
3. "…these meanings are handled in, and modified through an interpretive process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2).

Echoing the work of Blumer (1969), in its broadest sense Endsley's (1988) definition three-level categorisation of situation awareness (described with chapter 2)[23] provides a way to explore the constructed understanding of what individuals hold to be their reality and meaning, within their specific social group and situation (White, 2004; Cruikshank, 2011; Crotty, 2012). Through the exploration of how a person perceives (Level 1 SA), comprehends (Level 2 SA) and responds to something (Level 3 SA), they are better positioned to identify what shapes their interpretive process. Viewed through the lens of Endsley's (1988) three-level categorisation, this study investigated how meaning was derived (Level 1 SA - perception of the elements in the environment) and symbols assigned, from or out of the social interaction with a person with a potential mental disorder. This study investigated how such meanings were handled and modified, and the processes to make sense

[23] Within this study, I drew upon the work of Mica Endsley (1988), who offered a three-level categorisation of situation awareness. Level 1 – one's perception of the elements within a given environment. Level 2 – one's ability to comprehend the significance of, and make sense of such elements. Level 3 – one's ability (on the basis of Levels 1 and 2 situation awareness) to anticipate situational outcomes, and therefore select a course of action.

of the symbols perceived (Level 2 SA - comprehension of the current situation). This study then investigated the range of outcomes selected by actors, based on the meanings things have for them (Level 3 SA - protection of future state). Through an investigation of police officer situation awareness, this study sought to develop a mechanism to support police officers with their identification and therefore management of a potentially mentally disordered person.

Addressing Crotty's (2012) second domain, the theoretical criteria of symbolic interactionism was selected, in light of Endsley's (1988) three-level categorisation. This contributed to the development of the structure and domains comprising the cognitive aid and the mechanisms to explore its usefulness. This approach therefore determined and guided the unique viewpoint posed by this study. This was viewing the phenomena through the lens of Endsley's (1988) definition and three-level categorisation of situation awareness. Furthermore, it provided clear direction for study design, data collection, and analysis, necessary to address the study aims and objectives (Arminio and Hultgren, 2002). Next, I reviewed some of the options available to me.

4.6 Methodology (design)

Forming Crotty's (2012) third domain, the methodology (or design) represents the social research tradition, (historically rooted in the disciplines of medicine, anthropology, sociology, sociolinguistics, philosophy or psychology), enabling the researcher to address the study aims and objectives (Jacob, 1987; Creswell, 2009; Polit and Beck, 2012; Crotty, 2012). Research traditions provide a means to calibrate the social world, providing distinct credible mechanisms (or lenses) through which to investigate, interpret and analyse specific phenomena (Jacob, 1987; Ritchie and Lewis, 2003; Crotty, 2012; Polit and Beck, 2012). Having evolved somewhat disparately, or as a distinct discipline borne out of an existing convention, research traditions vary in their "…conceptualisation of what questions are important to ask and in the methods they consider appropriate for answering them" (Polit and Beck, 2012, p.489). When seeking to address this study's aims and outcomes, I considered if this study sought a deep exploration of human experience (phenomenology). One considered if, through the process of systematic data analysis, it sought to identify the significant social processes and actions emerging from the data (grounded theory), or investigate the cultural behaviour within a

particular societal group (ethnography). One also considered if the study was best served by investigating the methods, rules, actions and behaviours actors use to make sense of their world (ethnomethodology) (Garfinkel, 1967; Heritage, 1984; Button, 1991; Fawcett and Downs, 1992; Coulon, 1995; Green and Thorogood, 2004; ten Have, 2004; Frances and Hester, 2004; Ritchie and Lewis, 2003; Creswell, 2009; Polit and Beck, 2012).

4.6.1 Phenomenology

Phenomenology, the description of a phenomenon as the person perceives it, enables the researcher to identify social meanings and activities, through an exploration of an actor's everyday lived experience (Fawcett and Downs, 1992; Earle, 2010; Polit and Beck, 2012). Phenomenology allows the researcher to explore the essence of an actor's understanding of an aspect of their conscious lived experience, through their personal description (Creswell, 2009; Dowling and Cooney, 2012). This 'essence', note Polit and Beck (2012), represents an unchanging ('invariant') structure within a particular experience, that is the product of intentionality; the relationship between an actor's consciousness, and their external world within which they interact, reason and communicate with (symbolic) objects (Earle, 2010; Crotty, 2012). By understanding such structure, "…critical truths about reality…grounded in people's lived experiences" can be identified (Polit and Beck, 2012, p.494). Drawing its contemporary approaches from the work of Husserl (1859-1938), Schultz (1899 –1959), Heidegger (1889-1976) Merleau-Ponty (1908-61) Gadamer (1900-1902) and van Manen (1942-), phenomenology is aligned to three overarching schools: descriptive (eidetic), interpretive (Hermeneutic) and the Utrecht (descriptive and interpretive) schools (Dowling, 2005; Earle, 2010; Dowling and Cooney, 2012; Polit and Beck, 2012; Tuohy, Cooney, Dowling, Murphy and Sixsmith, 2012).

The underpinning question for descriptive phenomenologists is, what do people know? A description of the actor's experience of life is therefore sought, as they experience it (Polit and Beck, 2012). Descriptive phenomenology requires the researcher's own thoughts, feelings, prejudices and preconceptions to be 'bracketed' when seeking the 'essence' of a phenomenon (as perceived by the actor), enabling it to be explored in its purest form, without distortion or imposed meaning by the investigator (Earle, 2010; Polit and Beck, 2012; Dowding and Cooney, 2013). Through the process of 'intuiting,' the researcher is required to be

receptive to the actor's ascribed meaning of the phenomenon. Following analysis, the phenomenon is described, enabling an understanding of the social meanings and activities relevant to that phenomenon (Polit and Beck, 2012).

Interpretive phenomenology assumes an actor's lived experience is a product of their interpretation of their world and seeks to identify (interpret) what represents their existence or being: their Dasein (Earle, 2010; Crotty, 2012; Polit and Beck, 2012; Tuohy et al., 2012). Their Dasein can be interpreted via the philosophical approach of hermeneutics - the structured interpretation and explication of the character and meaning of human behaviour (Denzin and Lincoln, 2003; Earle, 2010; Crotty, 2012; Polit and Beck, 2012). Through the 'hermeneutic cycle', the researcher firstly acknowledges the fore-structure: what is currently understood or perceived about the phenomenon. Interpretive phenomenology avoids the explicit 'bracketing' of the researcher's own thoughts, feelings, prejudices and preconceptions, arguing one's own being cannot be separated from their interpretation of an actor's experience. One therefore adopts a reflexive position, "…simultaneously living in the moment, actively constructing interpretations of the experience and questioning how those interpretations came about" (Laverty, 2003, p.22).

Noted by Polit and Beck (2012) and Dowding and Cooney (2013), the researcher is required to be mindful of the effect of prior held understanding / views (fore-structure), and their potential effects, prior to being "…open to other people's meanings" (Tuohy et al., 2012, p.19). One then acknowledges the existential themes that enable the interpretation of an actor's interpretation of their world: the influence of an actor's physical environment ('lived space'); the temporality of an experience ('lived time'); the effect of, or upon their physical body ('lived body'); the mechanisms through which an actor engages with others with whom they share the world ('lived human relation'). One then seeks to (interpret) what represents the actor's existence or being. Allowing the circle to revolve, the researcher is able to penetrate deeper into the actor's existence, until understanding is achieved (Earle, 2010; Crotty, 2012; Tuohy et al., 2012).

The Utrecht school reflects elements of both the interpretive and descriptive approaches, viewing phenomenology as a practical and reflective mechanism from which to produce a rich and uncorrupted description of an actor's lived experience

(Dowling, 2005; Earle, 2010; Dowding and Cooney, 2013). It attempts to do this by seeking a phenomenon of personal interest. The researcher then explores the actor's lived experience, as they live it (by immersing themselves within the phenomenon), reflecting upon the themes that encapsulate that experience, so as to identify the 'essence' of the phenomenon. The researcher then describes the phenomenon through writing and rewriting, thus facilitating the emergence of meaning. Throughout the study, the researcher must maintain a close relationship with the phenomenon to enable the deepest, purest and richest description (Dowling, 2005; Earle, 2010; Dowding and Cooney, 2013).

This study investigated the relationships existing between an actor's consciousness, and their external world (be it interpreted, described or an amalgam of both). This study also investigated the significance of existential themes within their interactions, communication and reasoning that occurs within their worlds with the purpose of producing a deep, pure and rich description. This study however did not seek to exclusively explore the 'essence' of the actors lived experience, rather their mechanisms of understanding and response (behaviours, processes and meanings) to a phenomenon. Phenomenology was therefore rejected.

4.6.2 Grounded theory

Through rigorous, detailed and iterative exploration of data, grounded theory enables the researcher to develop conceptual, explanatory theories (representations) relating to an actor's behaviours, processes (actions) and meanings within their social world (Denzin and Lincoln, 2003; Hall et al., 2011; Milliken and Schreiber, 2012; Polit and Beck, 2012; Burstrom, Starrin, Engstrom and Thulesis, 2013). 'Classic' grounded theory emerged from the work of Glaser and Strauss. Seeking to elevate the scientific credibility of qualitative methodologies amongst the positivist movement, they offered a rigid, systematic qualitative methodology, which, rather than simply presenting a description, enabled strict codification of qualitative data, and the generation of theories relating to social behaviour drawn only from within it (Ritchie and Lewis, 2004; Denzin and Lincoln, 2003; Creswell, 2009; Polit and Beck, 2012; Hall et al., 2013). Tracing its philosophical origins to Mead and Blumer's symbolic interactionist approaches, it acknowledges the presence of symbols which serve to illustrate an actor's behaviours, processes and meanings when they engage within their social world

(Dingwall, 2001; Burbank and Martins, 2009; Charon, 2010; Crotty, 2012; Milliken and Schreiber, 2012; Oliver, 2012; Hall et al., 2013).

Language is central to the understanding and description of an actor's world. One therefore accepts and explores an actor's linguistic descriptions and meanings, without superimposing the researcher's own meaning (Milliken and Schreiber, 2012). Reaffirming this stance, when seeking explication of an actor's activities and meanings within 'classic' grounded theory, prior to the study, the researcher neither offers a hypothesis nor reviews literature related to the phenomenon. This maintains objectivity, avoiding contamination or distortion of the findings. One becomes objectively 'grounded' in the emerging data, with understanding coming only from what is within the data (Hall et al., 2013). Becoming 'grounded', implies a deep immersion within the data. Whilst so deeply immersed, the researcher begins to draw conceptual, explanatory theories through a recursive, reductionist process, whereby data is collected, analysed and categorized. Through the process of 'constant comparison', emerging categories are continually compared to data emerging within the study. This recursive, reductionist approach enables similarities / dissimilarities between theories and data to be identified. Eventually a narrow range of rich conceptual, explanatory theories are drawn only from the study data (Denzin and Lincoln, 2003; Polit and Beck, 2012; Milliken and Schreiber, 2012; Puolakka, Haapasalo-Pesu, Kiikkala, Astedt-Kukuri and Paavilainen, 2013).

In 1990, Strauss and Corbin, sought to challenge the original work of Glaser and Strauss by moving towards a constructivist approach (Straus and Corbin, 1990; Goldkuhl and Cronholm, 2010; Polit and Beck, 2012; Hall et al., 2013). Within their interpretation of grounded theory, they purported that a person constructs and interprets reality. The researcher becomes an active participant within the generation (construction) of explanatory theories, and engages with appropriate literature, enriching the overall analysis and theory generation. In 2006, Charmaz sought to make this transition complete, viewing grounded theory as being a wholly interpretive process, which identifies multiple realities; one in which theories are constructed, rather than discovered (Hall et al., 2013). Advocating the need for reflexive immersion with both the data, and actor, the researcher creates data that is jointly constructed; the resultant theories are therefore viewed as being socially constructed (Gardner, Fedoruk and McCutcheon, 2007; Goldkuhl and Cronholm, 2010; Hall et al., 2013).

Irrespective of their epistemological stance, grounded theory enables the researcher to systematically explore, in-depth, the symbols which serve to illustrate an actor's behaviours, processes (actions) and meanings when they engage within their social world. Within this study, this related to the range, significance and meaning of symbols suggestive of mental disorder. This study however did not seek to offer theory generation, rather an understanding of the meaning / significance of human behaviour within a particular society or culture - within this study, the society / culture occupied by police officers when they encounter a person suffering a potential mental disorder. Rejecting this, an ethnographic approach was considered.

4.6.3 Ethnography

Ethnography is the "…description and interpretation of social / cultural behaviour" (Polit and Beck, 2012, p.492). It is a method to describe and interpret such behaviour within either a large group (macroethnography) or a more precisely defined, smaller group (focused, or microethnography) (Fawcett and Downs, 1992; Brewer, 2000; Polit and Beck, 2012; Cruz and Higginbottom, 2013). It enables the study of actors within their natural settings, identifying "…their social meaning and ordinary activities…" (Brewer 2000, p.6). The researcher, far from being remote to those studied, becomes an active participant within their society / culture, enabling meaning to be generated from within, rather than beyond the established societal / cultural boundaries (Brewer, 2000; Cruz and Higginbottom, 2013; Fienup-Riordan, Brown and Braem, 2013). Through multiple, in-depth data collection techniques, which include, detailed (often lengthy) participant observation, in-depth interviews, field notes, and the review of culturally relevant documents or symbols, the researcher is able to develop an understanding of the meaning of human behaviour within a particular society or culture (Brewer, 2000; Creswell, 2009; Cruz and Higginbottom, 2013; Fienup-Riordan, Brown and Braem, 2013; Gagon, Carnevale, Mehta, Rousseau, and Stewart, 2013). Whilst this study investigated the behaviour of a specific social group (police officers), due to operational / study constraints, it did not do this from deep within their natural setting. As such, this methodology was rejected.

This study sought to take account of the relationships that exist between an actor and their communication, reasoning and actions when encountering a person with a potential mental disorder. Acknowledging the potentially useful methodological

features of phenomenology, grounded theory and ethnography, each one failed to calibrate the social world sufficiently to address the study aims and objectives. To investigate the methods, rules, actions and behaviours British police officers use to make sense of, and manage situations involving a mentally disordered person, the most appropriate calibration (and as such, lens to view the phenomenon) was via an ethnomethodological approach.

4.6.4 Ethnomethodology

Ethnomethodology is the methodology of choice in this study. Ethnomethodology assumes that within a social group, its everyday, commonplace, often subconscious activities represent significant phenomena, deserved of investigation (Garfinkel, 1967; Heritage, 1984). Ethnomethodology assumes the social world to be occupied by members (actors), whose common contribution to, and experience of a particular phenomenon, grants membership to the social group within which it is manifest (Zimmerman, 1978; Francis and Hester, 2004; Charon (2010). Within this study, the members were police officers who, by nature of their specific societal role, encounter people with a potential mental disorder. Ethnomethodology is a mechanism through which the researcher can explore, and make known, a member's mundane, common sense understanding, methods, behaviours, and socially held rules, which collectively govern their interaction and conduct within their social world (Heritage, 1984; Coulon, 1995; Francis and Hester, 2004; ten Have, 2004). Whilst acknowledging the contribution of the individual, this study sought the collectively held common sense understanding, methods and socially held rules (Warfield Rawls, 2002).

Ethnomethodology was established by Harold Garfinkel (1917–2011) (Garfinkel, 1967; Heritage, 1984; Coulon, 1995; Francis and Hester, 2004; ten Have, 2004; Warfield Rawls, 2011; Crotty, 2012). Whilst an undergraduate, Garfinkel became interested in the everyday processes people used to function and achieve order within their groups. Seeking to explore this, he drew inspiration from the works of Parsons, Mead, Husserl, Schultz, Znaniecki and the Chicago sociology tradition (Zimmerman, 1978; Coulon, 1995; Warfield Rawls, 2011). Garfinkel drew significant (initial) inspiration from the work of Parsons. Parsons considered social interaction to be governed by actions an actor has personal control over, and those for which they have no control (Parsons, 1937). By understanding the nature of the relationship existing between the two, Parsons asserted that the researcher can

theorise as to the nature of human activity and interaction (Heritage, 1984; Maynard and Clayman, 1991; Coulon, 1995). For Parsons, when engaging within the social world, any action requires the actor to achieve an objective (motivation). Motivation becomes assimilated within a socially acknowledged normative construct (rule), governing the actor's action, and how others within the group respond.

The nature and motivation of the act, the normative construct, and the acceptability of the act (beyond the actor's control), determine its meaning, and the degree to which social interaction and order is maintained or disrupted (Heritage, 1984; Button, 1991; Coulon, 1995; ten Have, 2004). The work of Parsons enabled Garfinkel to consider how actors interact within their social group, and preserve its order (Heritage, 1984). Through the work of the Chicago sociology tradition, Garfinkel considered the significance actors afford to symbols as mechanisms to imbue sense-making within social situations (Coulon, 1995; Dennis, 2011). In Husserl and Schultz, Garfinkel drew inspiration from the perspective of phenomenology, enabling the researcher to explore an actor's conscious lived experience through their personal description (Heritage, 1984; Coulon, 1995; Warfield Rawls, 2011; Eberle, 2012). With Schultz, Garfinkel embraced the premise that actors navigate their social world through common sense actions, based upon their interpretation of socially generated symbols (Heritage, 1984; Coulon, 1991).

Common sense is a state of often imprecise situational understanding, sufficient to enable members to undertake their everyday actions and interactions (Heritage, 1984, p.49). Rather than being the product of detailed individual understanding / experience, it is a state of "…practical rationality…" (Kalberg, 1980, p.1151). This is a state reflecting a social group's interpretation and common, accepted response to available situational information (Kalberg, 1980; Heritage, 1984; ten Have, 2004). For Shultz, common sense behaviours were intersubjective, socialised, and necessary for social order and function (Heritage, 1984; Coulon, 1991; ten Have, 2004). Central to this study was the investigation of what constituted 'practical rationality' amongst police officers, and how this shaped their situation awareness, when encountering a person with a potential mental disorder. Furthermore, this study investigated the intersubjective influences upon practical rationality within such situations, enabling the development of a cognitive aid which was of use to a broad range of police officers, holding a broad range of experiences and views.

With Znaniecki, Garfinkel was able to recognise that common sense behaviours were characteristic of an axionormative order (the structure governing socially regulated rules) and axionormative structure (methods producing similar patterns of behaviour amongst differing members) (Sztompka, 1986). With Znaniecki, Garfinkel recognised that the meaning / significance of social actions and behaviours must always be understood from the perspective of both the individual, and the collective, otherwise confusion / misinterpretation occurs (Sztompka, 1986). To Garfinkel, a state of interdependence existed between collective members (rather than actors), governing their everyday, mundane social order, behaviours, and socially determined rules. Such rules were thought to be established and maintained through a process of common (sense) understanding of social symbols, discoverable from the perspective of individual members and the collective membership.

Despite Garfinkel's methodological influences, no single approach enabled him to expose the specific everyday processes members use to function and achieve order within their social groups. In 1952, having observed the manner in which jurors within a court of law reached decisions based upon their common sense interpretation of fact and supposition, Garfinkel considered their deliberations to be specific to the way in which this membership group (ethno) established sets of principles and methods of organisation (methodology) to enable them to reach a decision (Warfield Rawls, 2002; ten Have, 2004). Ethnomethodology was therefore proposed as the study of common sense methods within a social group (Lynch, 2002). In particular, it sought to explore the methods which constituted "…socially organised conduct." (Coulon, 1994, p.15).

Common sense actions may be so common, that they become ingrained within everyday social interaction, and their meaning may not be immediately acknowledged by the members of a social group (Garfinkel, 1967). To expose and understand such actions, ethnomethodology requires the researcher to investigate the members' practice accomplishments, accountability, reflexivity, and the indexicality of their account (of the action) (Garfinkel, 1967; Heritage, 1984; Coulon, 1995; Francis and Hester, 2004; ten Have, 2004; Liu, 2012). Rather than investigate the nature of a particular action *per se*, an investigation of members' practice accomplishments requires the researcher to seek out the contextually determined processes they use within the action itself, and how they assiduously

establish, adjust, and maintain their social structures, rules, and social norms (Coulon, 1994). Practice accomplishment represents the "…operational structure of common understanding as a process of production or accomplishment rather than as a product" (Fox, 2006, p.434). Ethnomethodology therefore seeks to expose the common rubric which shapes such contextually determined accountable acts.

Accountability refers to the specific methods members use to make their actions immediately (or upon demand) intelligible, meaningful, understandable and explicable to others (Coulon, 1994; ten Have, 2004; Liu, 2012; Pollner, 2012). This makes visible how they continually construct and reconstruct their "…fragile and precarious social order…" (Coulon, 1994, p.26). To be reflexive, a member must consider the nature of the action to be undertaken, its personal and intended meaning, the context of use, and the anticipated meaning to other members (Heap, 1980). It is the process whereby an individual "…presupposes the conditions of the action…" (Coulon, 1994, p.23). Here, the researcher interprets and responds to their current social situation and attempts an action, recognisable to other members (Heap, 1980; Dowling, 2007). Aggestam (2010) suggests that this occurs because the action has some form of local, historical basis, made recognisable in the "…local history of the moment and instantiates human interaction" (p.352).

Produced actions (processes) therefore become discoverable, if they are aggregated and made explicable through interpretation of the language used by the member(s) describing them (Garfinkel, 1967; Heritage, 1984). Indexicality therefore, refers to language used by members to describe their understanding and methods, within a specific context. Linguistic description, and therefore meaning, is specific to, and dependent upon the context in which the act occurs (Garfinkel, 1967; Heap, 1980; Francis and Hester, 2004; ten Have, 2004; Dowling, 2006). Consequently, language / words may assume differing, "…transsituational…" meaning within differing contexts (Coulon, 1994, p.17). For ethnomethodology, indexicality refers to the relationship existing between language / words describing a member's action, and the contextually determined meaning that is potentially discoverable (ten Have, 2004). Grounded within a specific social situation, ethnomethodology therefore permits the description of *how* sense making activities and actions are undertaken, rather than *why* (Francis and Hester, 2004).

This study therefore investigated *how* the axionormative order and structure of members' (police officers') common sense behaviours activities and actions were undertaken, when encountering a person with a potential mental disorder (Level 1 SA). Furthermore, it investigated their inherent, embedded local (individual / collective) knowledge and situational understanding (Level 2 SA), and the common, accepted responses of the social group (Level 3 SA). This study also investigated the contextually determined processes (common rubric) used to identify and manage a person with a potential mental disorder (practice accomplishment), the methods used to make their actions intelligible and contextually explicable (accountable and reflexive), and the language used by members to describe their methods within such situations (indexicality).

4.6.5 Ethnomethodological enquiry

When investigating how a phenomenon is produced, made recognisable and understandable, ethnomethodology utilises a variety of approaches. These include, close, non-participatory observation; self-experience of a phenomenon; provoking conditions to make visible the phenomenon; close examination of linguistic structures; methods which utilise interviews, audio / video recordings, field notes; and the examination of documents illustrating how social practices are accomplished (Schegloff and Sacks, 1973; Jefferson, 1992; ten Have, 2004; Ball and Smith, 2011). Robertson, Kerridge and Walter (2009) note that ethnomethodology does not advocate a specific approach to data collection and analysis, and as such, there is latitude to utilise techniques utilised within wider qualitative approaches. The unique viewpoint of this study was considered best served through the use of narrative synthesis, individual and focus group interviews, simulation, note-taking activities and a concept and observable indicator tool (developed from study data). This approach was considered to offer the best insight into the phenomenon, enabling the researcher to investigate the orders, structures, and common sense-making activities, drawn from a range of literature, and members (individual and group) constructed accounts.

Embarking upon ethnomethodological enquiry, Garfinkel and Sacks (1970) advocate the adoption of two positions. First, "…ethnomethodological indifference…" (p.245). Here, the researcher must "…resist any personal judgements of the correctness of the members' activities" (Dowling, 2006, p.11). This is achieved through the "…bracketing…" of the researcher's own thoughts,

feelings, views, preconceptions, expectations and standards (Dowling, 2006, p.10). This enables the social situation / phenomena to be explored and described on its own terms, without the undue influence of the researcher (Garfinkel and Sacks, 1970, p.345; Pollner and Emerson, 2001; ten Have, 2004; 2008). Adopting the second position, the researcher must "…abstain from all judgments…" (Garfinkel and Sacks, 1970, p.345). Here, the researcher views the phenomenon solely within the context of its own distinct structures, actions and interactions. It is undertaken without opinion regarding its appropriateness, worthiness or correctness, or its relationship to wider culturally established rules, practices or, 'schema' (Garfinkel and Sacks, 1970; ten Have, 2004).

Indifference and abstention may however, blind the investigator to the potentially useful opportunity of viewing the social group in terms of the influence of wider rules and practices. One may therefore fail to grasp their significance as resources for making members' actions meaningful and intelligible (ten Have, 2004). Should the researcher deviate from this position of complete indifference and abstention, exploring the social group's behaviour in terms of specific, ethnomethodologically significant actions, they should specify the actions of interest as "…members' practices…', highlighting them for inspection (ten Have, 2004, p.177). From this, areas deserved of 'practical supplements' (mechanisms to support and improve an aspect of the social world) can be identified (ten Have, 2004, p.179). Within this study, the 'members practices' for inspection were the methods, rules, actions and behaviours shaping situation awareness, which police officers used to identify and manage a person with a potential mental disorder, underpinning the development of a 'practical supplement' in the form of a revision to the PPEAT-R cognitive aid.

4.7 Chapter summary

Crotty's (2012) framework provided a useful vehicle to help me structure and articulate this study's epistemological, theoretical and methodological (design) approaches. From an epistemological perspective, I positioned this study within the constructivist paradigm, supported by a relativist ontology. I did so, as I sought to undertake an in-depth investigation of an aspect of human meaning; one illustrative of the social, cultural and contextually derived realties associated with police officers. I sought to make sense of these realities through the epistemological lens of social constructionism. Through this lens, I was able to construct understanding

of how police officers, within their social world, identified and responded to a mentally disordered person. Through the 'orientating lens', I established this study's unique theoretical viewpoint. Through the lenses of symbolic interactionism and Endsley's (1988) three-level categorisation of situation awareness, I was able to expose how police officers derived and ascribed meaning, when encountering a potentially mentally disordered person. Using an ethnomethodology design, I explored the nature of this meaning, for the purpose of constructing a cognitive aid to support police officers, when encountering such people. Having addressed three of the domains forming Crotty's (2012) 'scaffold', in the following chapter, I address the final one – the method. This fourth domain of the 'scaffold' encompasses the distinct, carefully designed, unifying and coherent techniques, procedures and activities employed to address this study's aims and objectives (Fawcett and Downs, 1992; Bowling, 1999; Crotty, 2012; Polit and Beck, 2012).

Chapter 5

Methods

5 Introduction

Within this chapter, I describe the methods related to stage one (the preparatory stage) and stage two (testing the usefulness of the cognitive aid) of this study. I describe the defined conditions, boundaries and protocols for data collection, necessary to control the study's orientation. This chapter is presented in seven sections. I first describe the overall research design and data collection techniques for both stages of the study. Next, I describe the specific methods used within stage one. Here, I outline the role and function of a cognitive aid. Next, I describe the specific methods used within stage two. Here, I describe the three phases comprising this stage. Next, I describe the data analysis processes for stage one and stage two of this study. This is followed by a description of the ethical issues governing the conduct of the study. I then address issues related to academic rigour, followed by a summary of the chapter.

5.1 Research design and data collection techniques

This study was undertaken in two stages (Figure 11). Triangulation provided the overarching condition for the conduct of data collection, within both stages. Triangulation utilises multiple collection methods for the purpose of establishing data completeness - the provision of differing views of a phenomena, resulting in a deeper, more contextually accurate and credible reconstruction (Krefting, 1991 Shih, 1998; Fossey, Harvey, McDermott and Davidson, 2002; Tobin and Begley, 2004; Tucket, 2005; Casey and Murphy, 2009; McBrien, 2008; Houghton, Casey, Shaw and Murphy, 2013). Stage one, termed the preparatory stage, utilised a 'within method' triangulation approach. When utilising a 'within method', two (or more) data collection methods are used to investigate the same phenomenon, enabling the researcher to better evaluate the consistency and completeness of the emergent themes (Foss and Ellefsen, 2002; Ritchie and Lewis, 2004; Halcomb and Andrew, 2005; Casey and Murphy, 2009; Roulston, 2010; Polit and Beck, 2012; Netanda, 2012). Reflecting a qualitative approach, stage one utilised narrative

synthesis (described within chapter three), and individual semi-structured interviews. This stage informed the review and revision of the PPEAT cognitive aid and its guiding concept and observable indicator framework. It also informed the development of the Concept and Observable Indicator Tool, which was used to support data collection, when exploring the PPEAT-R's usefulness (Klein, 2000, p.2).

The second stage, termed testing the usefulness of the cognitive aid, comprised a pre-post-test design. It used multiple methods, comprising video vignette, note-taking activities, focus group and individual semi-structured interviews. This part of the study investigated participant responses, prior to, and following, the introduction of an intervention – the introduction of the revised PPEAT cognitive aid, and training in its use (Grimshaw, Campbell, Eccles and Steen, 2000; Robson, Shannon, Goldenhar and Hale, 2001). It comprised three phases. Phase one (undertaken during a study day), investigated participant responses, prior to the introduction of the PPEAT-R. Phase two (undertaken during the same study day), investigated participant responses following the introduction of the PPEAT-R. Phase three investigated the usefulness of the PPEAT-R, following its use in operational, real-world practice.

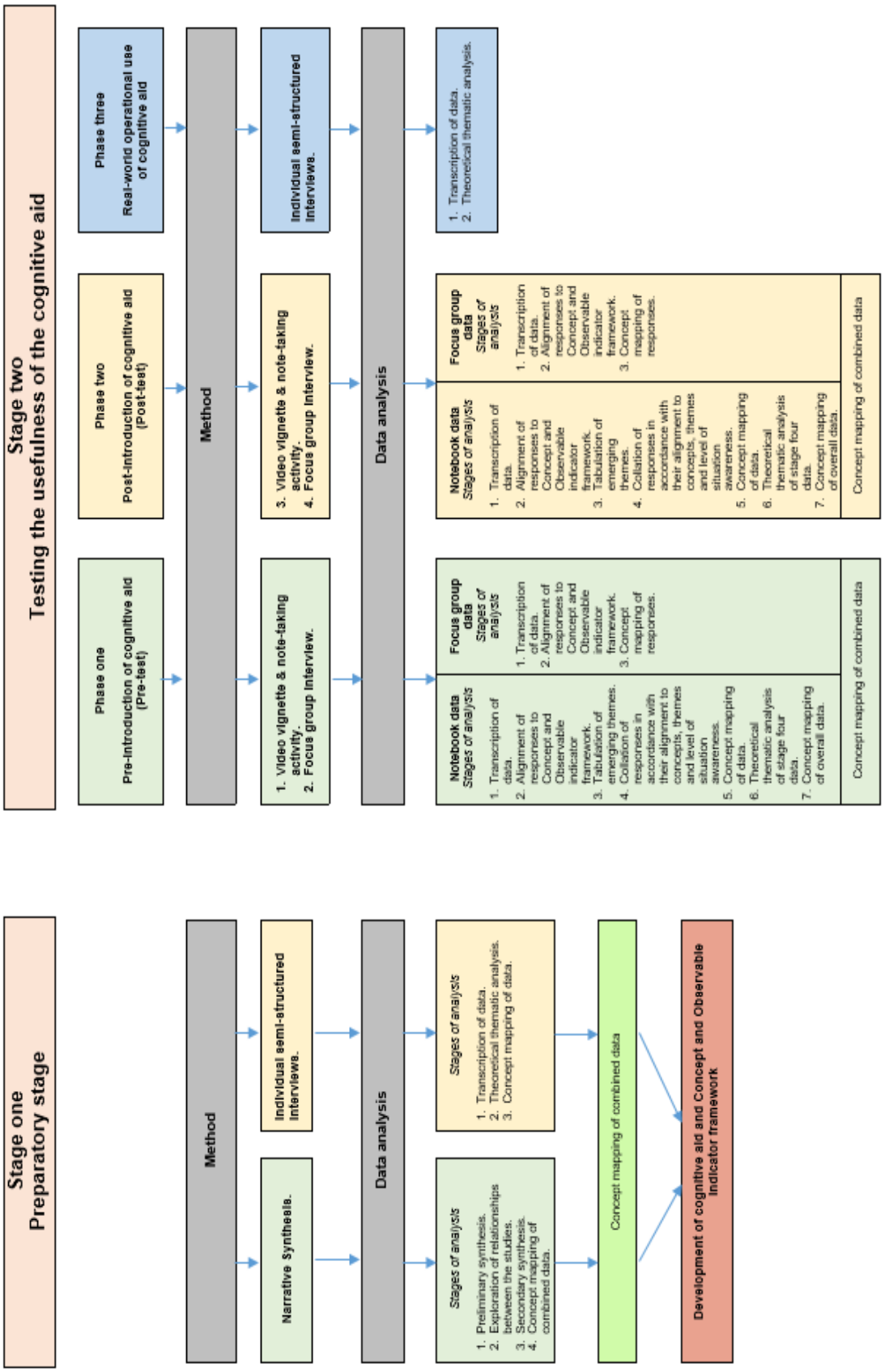


Figure 11: Research Design and Data Collection Techniques.

5.1.1 Theoretical Thematic analysis

Based upon the work of Emile Durkheim (Lukes, 1982), research within the social sciences traditionally follows an inductive approach; the process through which a theory / hypothesis "…emerges through patterns of relationships among constructs…found [only] during data analysis…" (McLaren, 2010, p. 458). Rather than seeking to draw themes solely from the data via an exclusively inductive approach, I deviated from this, undertaking a process of "…theoretical thematic analysis…" throughout this study (Braun & Clarke, 2006, p.84). Theoretical thematic analysis is an approach which allows the researcher to not only explore the data inductively, but also establish a coding system through which the data can then be explored deductively; an approach more akin to positivist enquiry (Blaikie, 2004a; Blaikie, 2004b; Braun & Clarke, 2006; O'Reilly, 2009). In contrast to induction, when following a deductive approach, the researcher starts with a theory / hypothesis, and uses the data to support or refute it (Brewer, 2003a; Shank, 2008; Kennedy, 2018).

For Clark et al. (2015), a rigid adherence to a particular paradigm may deny the researcher the opportunity to better explore something. Rather, they should be prepared to adopt a position of "…analytical pluralism…" (Clark et al., 2015, p.183). Through 'analytical pluralism', the researcher intentionally engages "…with multiple ontological [and] epistemological…positions to produce coherent theoretical understanding and explanation of phenomena" (Clark et al., 2015, p.183). Whilst remaining fundamentally grounded within a particular paradigm, the researcher is however willing to adopt "…more diverse ways of looking…" (Coyle, 2010, p. 81). By taking a more diverse view of the data, it is possible to construct "…rich, multi-layered, multiperspective readings of any qualitative data set…" (Coyle, 2010, p. 81). Despite the adoption of somewhat unconventional approaches, within qualitative enquiry, the objective is to "…maximise holistic understanding, rather than to achieve consensus or [objective] truth" (Coyle, 2010, p. 81).

Adopting a position of 'analytical pluralism' I used theoretical thematic analysis to inductively expose data relating to the processes, reasoning, and criteria police officers used to identify and respond to a person with a potential mental disorder. From this, I established a defined frame of reference in the form of the concepts and observable indicators, illustrative of reported processes, reasoning, and criteria used. Using this frame of reference, and through the lens of situation awareness, I

then undertook a systematic (deductive) examination, analysis and interpretation of a range of data, to identify a police officer's situation awareness, when encountering a potentially mentally disordered person (Marks & Yardley, 2004; Braun and Clarke, 2006; Vaismoradi, Turunen & Bondas, 2013). Through analytic pluralism, I was able to investigate the processes used by police officers, sufficient to develop a cognitive aid and explore its usefulness.

5.2 Stage one: preparatory stage

5.2.1 Objective

The objective of this part of the study was to investigate methods, rules, actions and behaviours, which police officers reportedly used to identify and respond to a potentially mentally disordered person, sufficient to enable the revision of the PPEAT cognitive aid to assist them within such encounters.

5.2.2 The cognitive aid

Used in various forms within aviation and healthcare (similarly complex environments), a cognitive aid seeks to provide a brief prompt, during times of cognitive stress (Hales and Pronovost, 2006; Gurses, Ozok and Pronovost, 2011; Clay-Williams and Colligan, 2015; Merry and Mitchell, 2016; Eberl, Koers, Van Haperen and Preckel, 2017). Dick (2000), Chopko (2010), Grawitch, Barber and Kruger (2010) and Barath (2017) suggest that police officers frequently encounter stressful and unexpected situations as part of their routine, operational role. From a physiological perspective, Schwabe, Joels, Roozendaal, Wolf and Oizl, (2011), Boals and Banks (2012) and Plieger et al. (2017), note that exposure to such stress, negatively impacts upon what Cohen and Bacdayan (1994) describe as "…procedural memory…" (p.554). This is the subconscious cognitive function associated with skill and routine. It also negatively impacts upon the encoding, processing and retrieval of current situational information.

Dickerson and Kemeny (2004) note that a person sometimes faces "…novel…unpredictable… [or] …threatening…" situations with the "…potential for harm…" (p.355). When faced with such situations, the potential exists for a person to "…cognitively misfire…." (Cohen and Bacdayan, 1994, p.554). Such a cognitive 'misfire', is considered characteristic of cognitive failure. This is a "…"…lapse in

perception, attention, memory and action", and as such, incomplete or incorrect situation awareness (Kahn, 2015, p.140). Fundamentally therefore, a cognitive aid is a mechanism to improve a person's performance, within a given (often stressful) context. It enables the user to manipulate current events, for the purpose of achieving a desired outcome, mitigating against the effects of cognitive overload (Simon, 1996, p.111).

A cognitive aid cannot be viewed as an isolated intervention; rather it must be part of a more structured approach to addressing a problem. Chrimes (2016) advises a cognitive aid comprises two distinct parts: a '"…foundation tool…" and an "…implementation tool" (p.20). A 'foundation tool' represents an intervention (e.g. a teaching session) which explains something, providing a theoretical / or practical understanding, *prior* to undertaking a particular task. Within this study, this was the preparation session, guiding police officers in the use of the PPEAT-R. The 'implementation tool' is the cognitive aid; something designed to stimulate recall of 'foundation' information, *during* the task (Chrimes, 2016, p.20).

5.2.3 Method

5.2.4 Individual semi-structured interviews

Whilst the narrative synthesis provided a useful insight into the specific processes, police officers reportedly used to identify and manage a mentally disordered person, participant contact enabled a more detailed understanding, and constructed description. An ethnomethodology design was employed, using individual semi-structured interviews (Cutcliffe and McKenna, 1999; Seale, 2002; Tobin and Begley, 2004; McGinn, 2010; Thomas and Magilvy, 2011; Houghton et al., 2013). Eight participants undertook individual semi-structured interviews. Each participant was issued with a participant number, corresponding to a series of unique identifiers used to align all data created by, or relating to the participant during this study. Individual semi-structured interviews sought to penetrate and uncover representations of the participants (member's) social world, from their authentic, constructed and contextually expert perspective; descriptions which may be difficult to obtain from literature alone (Crabtree and Miller, 1999; Alvesson, 2003; Denzin and Lincoln, 2003; Baker (2004); Gill, Stewart, Treasure and Chadwick, 2008; Burbank and Martins, 2009; Kvale and Brinkmann, 2009; Roulston, 2010; Elmir,

Schmied, Jackson and Wilkes, 2011; Schultze and Avital, 2011; Hall et al., 2013; Roulston, 2017). Each semi-structured interview lasted up to 60 minutes - a period considered sufficient to establish a trusting, egalitarian relationship, and elicit constructed accounts (Beale, Cole, Hillage, McMaster and Nagy, 2004; DiCicco-Bloom and Crabtree, 2006; Knox and Burkard, 2009; Ryan, Coughlan and Cronin, 2009; Doody and Noonan, 2012).

An interview protocol was designed to provide structure to the semi-structured interviews. The interview protocol contained pre-determined open, descriptive questions and probes, which shaped and guided the interview flow, and provided structural consistency across all interviews. Questions and probes encouraged the interviewee to expand their narrative. This enabled themes to be uncovered, and addressed, yet permitting the interviewer latitude to investigate the intricacy of the interviewee's responses, altering the sequence of questions in response to emerging themes (Crabtree and Miller, 1999; Ritchie and Lewis, 2004; Gill et al., 2008; Knox and Burkard, 2009; Kvale and Brinkmann, 2009; O'Leary, 2009; Ryan et al., 2009; Roulston, 2010; Schultze and Avital, 2011; Doody and Noonan, 2012; Polit and Beck, 2012). The questions and probes populating the interview protocol were drawn from issues emerging within the study context, and narrative synthesis (Appendix 13). They were considered to have sufficient contextual grounding to expose (in the interviewee's own words) the "…order producing practices", situational understanding, common sense behaviours, and axionormative orders and structures related to the methods, rules, actions and behaviours shaping situation awareness, which police officers use to identify and manage a mentally disordered person (ten Have, 2004, p.75).

5.2.5 Digital audio recording and field notes

Digital audio recording and field notes supported data collection, sufficient to ensure as clear a representation of the constructed reality as possible, (Fernandez and Griffiths, 2007; Al-Yateem, 2012). Digital audio recording provided an authentic, permanent, and digitally re-playable record of both semi-structured and focus group interviews (DiCicco-Bloom and Crabtree, 2006; Gill et al., 2008; Whiting, 2008). Used for subsequent transcription and analysis, it allowed me to capture verbatim, the interview mechanics. These are the paralinguistic properties, dialectal, phonological, morphological, syntactical, semantic and grammatical components, and the indexical and trans-situational descriptions, occurring within the discourse

(Garfinkel, 1967; Heap, 1980; Heritage, 1984; Coulon, 1994; Francis and Hester, 2004; ten Have, 2004; Dowling, 2006; Kvale and Brinkmann, 2009, Polit and Beck, 2012; Tessier, 2012). It provided context to the interview, capturing what was said, and by whom, how it was said and the circumstances in which such discourse was captured (Crichton and Childs, 2005).

Within each individual semi-structured interview, detailed, 'descriptive' notes were made to contemporaneously and chronologically record the interviewee's non-verbal gestures / behaviours, the social and temporal context of such actions, and the interviewee's interaction with the local environment (Polit and Beck, 2012). Reflective 'methodologic', 'theoretical', 'personal' and 'reflexive' notes were made (Polit and Beck, 2012). 'Methodologic' notes recorded features relating to the structure and flow of the interview. 'Theoretical' notes recorded the interviewer's (unstructured) thoughts or suppositions regarding emergent themes, whilst 'personal' notes, recorded the interviewer's thoughts, feelings, reflections and emotions regarding issues emerging within the interview (Polit and Beck, 2012). This study's deviation from 'ethnomethodological indifference' and 'judgemental abstention' permitted this only from the relationship of the interviewer's theoretical and personal thoughts, to the methods, rules, actions and behaviours shaping situation awareness, which police officers use to identify and manage a mentally disordered person. 'Reflexive' notes, however enabled the critical reflection of the interviewer's part in the construction of the dialogue, and emergent issues (Beale et al., 2004; Vogt, 2005; Bloor and Wood, 2006; Jupp, 2006; Whitting, 2008; Schwandt, 2007; Al-Yateem, 2012; Doody and Noonan, 2012).

5.2.6 Study setting

Durham Constabulary was chosen to explore the specific processes their police officers used to identify and manage a potentially mentally disordered person, in the course of their work.

5.2.7 Access to participants

This part of the study required access to police officers and locations governed by the Official Secrets Act (1989), Prevention of Terrorism Act (2005), Police Act (1996), and Counter-Terrorism Act (2008). Following local

(University of Central Lancashire[24]) ethics committee agreement, permission to approach Durham Constabulary was formally sought from, and granted by the Association of Chief Police Officers professional ethics portfolio chair (Appendix 14).[25] Following agreement, the mental health lead for Durham Constabulary[26] was contacted to discuss local access arrangements, and the distribution of the participant information packs (Figure 12). For reasons of operational security, all interviews involving police officers were undertaken within police premises.

[24] There are currently three ethics committees within the University of Central Lancashire: Business, Arts, Humanities, and Social Sciences (BAHSS); Psychology and Social Work (PSYSOC); Science, Technology, Engineering, Medicine and Health (STEMH). As this study was based within the School of Nursing, ethical permission was granted via the BuSH sub-committee (Built Environment, Sport and Health), later replaced by STEMH.

[25] The research proposal and material to be used within / to support the study, was provided to assist their deliberation, at each application.

[26] Durham Constabulary: when interviewing participants, I was required to notify the Durham Constabulary mental health lead of the dates I intended to be present within Durham Constabulary boundaries. Six police buildings were used as interview venues during the study. I was not however required to notify the Durham Constabulary mental health lead of the specific study location (district police station or police headquarters). Upon completion of the study, the mental health lead for Durham Constabulary was informed of study completion, so as to rescind my access authorisation.

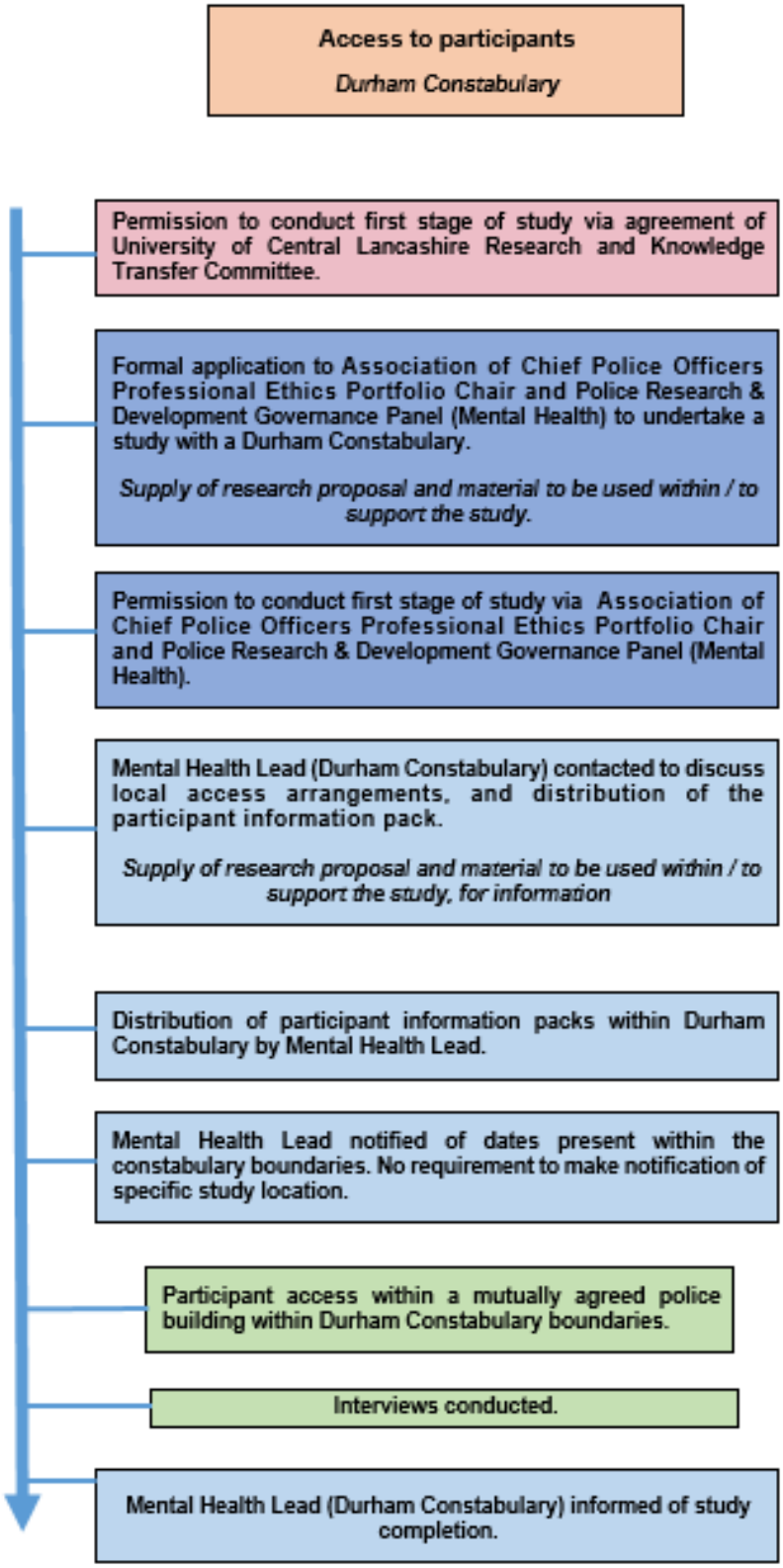


Figure 12: Access to Participants.

5.2.8 Participant sampling strategy

This study sought participants who could enable the study aims and outcomes to be addressed. A purposive (nonrandom), homogenous sampling strategy identified a population demonstrating characteristics of significance to the study - police officers who may encounter a person with a mental disorder (Arminio and Hultgren, 2002; Green and Thorogood, 2004; Morse, 2004; Ritchie and Lewis, 2004; Bloor and Wood, 2006a; Battaglia 2008; Eide, 2008; Palys, 2008; Daniel, 2012; Polit and Beck, 2012). Homogenous sampling sought to reduce / limit variability amongst the participants by selecting those demonstrating a narrow / specific range of characteristics of particular significance to this study, in accordance with a defined inclusion and exclusion criteria (Fink, 2003; Ritchie and Lewis, 2004; Eide, 2008; Daniel, 2012; Polit and Beck, 2012) (Figure 13).

5.2.9 Inclusion Criteria

Participants were required to be serving front-line[27] police officers within Durham Constabulary.

5.2.10 Exclusion Criteria

- Non front-line police officers.
- Police community support officers.
- Police officers undertaking restricted duties preventing front line duties.
- Police officers undertaking managerial duties preventing front-line duties.
- Police officers undertaking training and educational roles preventing front-line duties.
- Police officers from other constabularies.
- Former police officers (Figure 13)

The sample frame was considered narrow enough to focus upon an appropriate population, yet permit sufficient breadth to access appropriate participants, (Ritchie and Lewis, 2004; Morgan, 2008a). Had a high level of interest to participate been demonstrated, stratified (purposive) sampling would have occurred, selecting

[27] *Police officers forming part of: the neighbourhood police team; criminal investigation department; organised crime units; major crime teams; economic crime units; vulnerability units; public protection units; operations support department; accident unit; casualty reduction; dog section; traffic section, air support unit; firearms team (Durham Constabulary, 2013). Front-line policing encompasses activities such as: dealing with incidents; enquiries; observations / surveillance; searches; arrest and detention powers; issuing advice and warnings; interviewing; detaining and dealing with suspects and detainees; paperwork and case file preparation; dealing with incidents; visible patrol; investigating complaints; special operations; dealing with informants and community involvement (Suffolk Police, 2006 p.27).

participants demonstrating further, somewhat homogenous characteristics (Lynn 2004; Ritchie and Lewis, 2004; Morgan 2008a; Lemm, 2010).

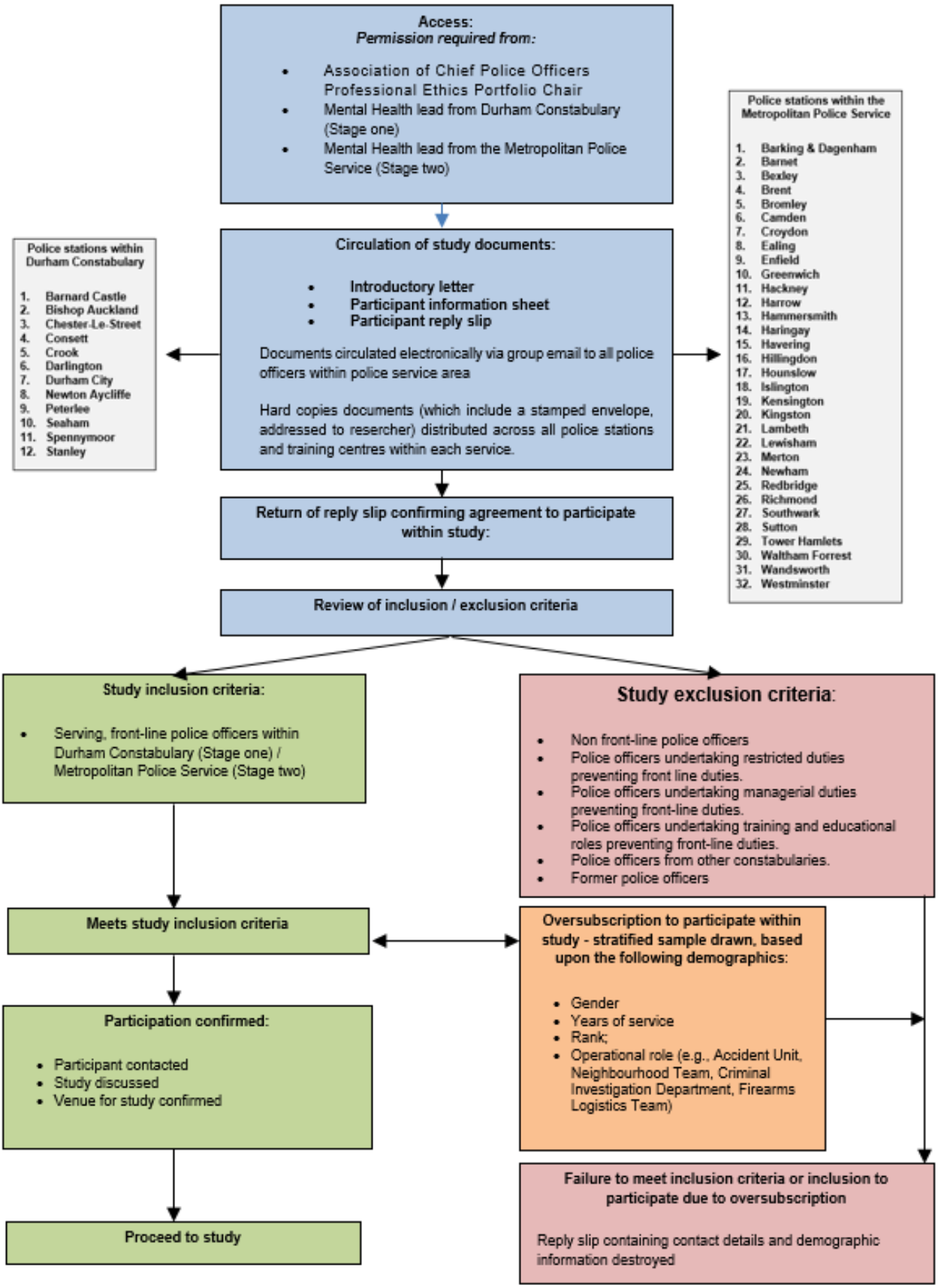


Figure 13: Inclusion and Exclusion Criteria.

5.2.11 Participant sample size

Eight police officers from Durham Constabulary were recruited to undertake individual semi-structured interviews. Reflecting the social constructionist underpinnings of this study, it is not necessarily the number of participants that provide unique insights, but "…the rich understanding that may come from the few, rather than the many" (O'Leary, 2004, p.105).

5.2.12 Participant recruitment

Participant information packs were created; each one containing an introductory letter (Appendix 15), participant information sheet (Appendix 16), and a reply slip with a return envelope, addressed to researcher (Appendix 17). The written material within this pack was clearly and unambiguously articulated, and of sufficent length and detail to enable participants to understand the nature of the study, their role, and make an informed choice regarding participation (Ballinger 2008; Brophy, Snooks and Griffiths, 2008; Antoniou et al., 2011; Kirkby, Calvert, McManus and Draper, 2013; Huggins, 2014). Two-hundred hard copies of the information packs were distributed across all police stations and training centres within Durham Constabulary, by the mental health lead.

Police officers were asked to express their interest in participating, by completing a reply slip and returning it to me. This enabled police officers to respond directly to me, without the involvement of their service. On receipt of the reply slip, I contacted participants to further discuss the study, and arrange to meet to undertake the study.

5.2.13 Data analysis

Following the process of theoretical thematic analysis, data obtained from the individual semi-structured interviews were manually transcribed, then closely analysed line by line, using the qualitative data package MAXQDA plus[28] (Braun and Clarke, 2006; Cleverbridge, 2012). Field note data were transcribed to support data analysis. Having determined the broad, overarching emerging themes, this study sought to establish the extent and nature of relationships within the data, using a concept mapping approach. Concept mapping enables the researcher to identify, and chart the constructed processes and influences associated with an

[28] MAXQDA plus is an advanced data analysis software package. Through visual text exploration, it allows coding and concept mapping of qualitative data. It enables visualization of word combinations (ranks, distributions, frequencies), and content and vocabulary analysis. It also enables one to define search categories to support this.

activity, highlighting the conceptual and semantic relationships, connections, interconnections and juxtapositions within the data (Klein, 2000; Boje 2001; Thiétart and Wauchope, 2001; Crandall et al., 2006; Ackermann 2008; Leech and Onwuegbuzie, 2008; Chauvin, Genest and Loiseau, 2009; Kane and Trochim, 2009; Powell, 2010; Willment, 2010). Using a concept mapping approach, data were analysed for patterns, sequences and configurations relating to a police officer's perception, identification, and management of a person with a potential mental disorder (Appendix 18).

A secondary analysis of data, obtained within both the narrative synthesis and individual semi-structured interviews, was undertaken. This approach also followed a concept mapping approach (Appendix 19) which sought to identify the key features and themes police officers associated with mental disorder. Reflecting the work of Crandall et al. (2006), the secondary analysis sought to establish a newly constructed view of the specific processes police officers use to identify and manage a mentally disordered person, culminating in an 'output', illustrating how such actions and behaviours could be better supported (Klein, 2000, p.2). Within this study, the 'output' was the development of the concepts, definitional propositions (theoretical and operational definitions) themes and observable indicators, structuring the cognitive aid, its underpinning concept framework, and the data analysis framework (concept and observable indicator framework), used in stage two of this study.

5.3 Stage two: testing the usefulness of the cognitive aid

5.3.1 Objective

The objective of stage two of the study, was to explore the specific processes police officers used to identify and manage a mentally disordered person, prior to and following the introduction of the PPEAT-R, and the relationship of such, to Endsley's (1988) three-level categorisation of situation awareness.

5.3.2 Method

This part of the study comprised three phases. Phase one (pre-test) investigated participant responses prior to the introduction of the cognitive aid, whilst phase two (post-test) investigated their responses following its introduction. Phases one and

two were undertaken during a single study day. Two separate participant groups undertook phases one and two. Each group attended on a different day, and neither group met. The study days lasted 6 hours, and used multiple methods, comprising video vignette, note-taking activities, and focus group interviews (Figure 14). For phase three, participants from each group were asked to use the cognitive aid in real-world, operational practice, for one month.

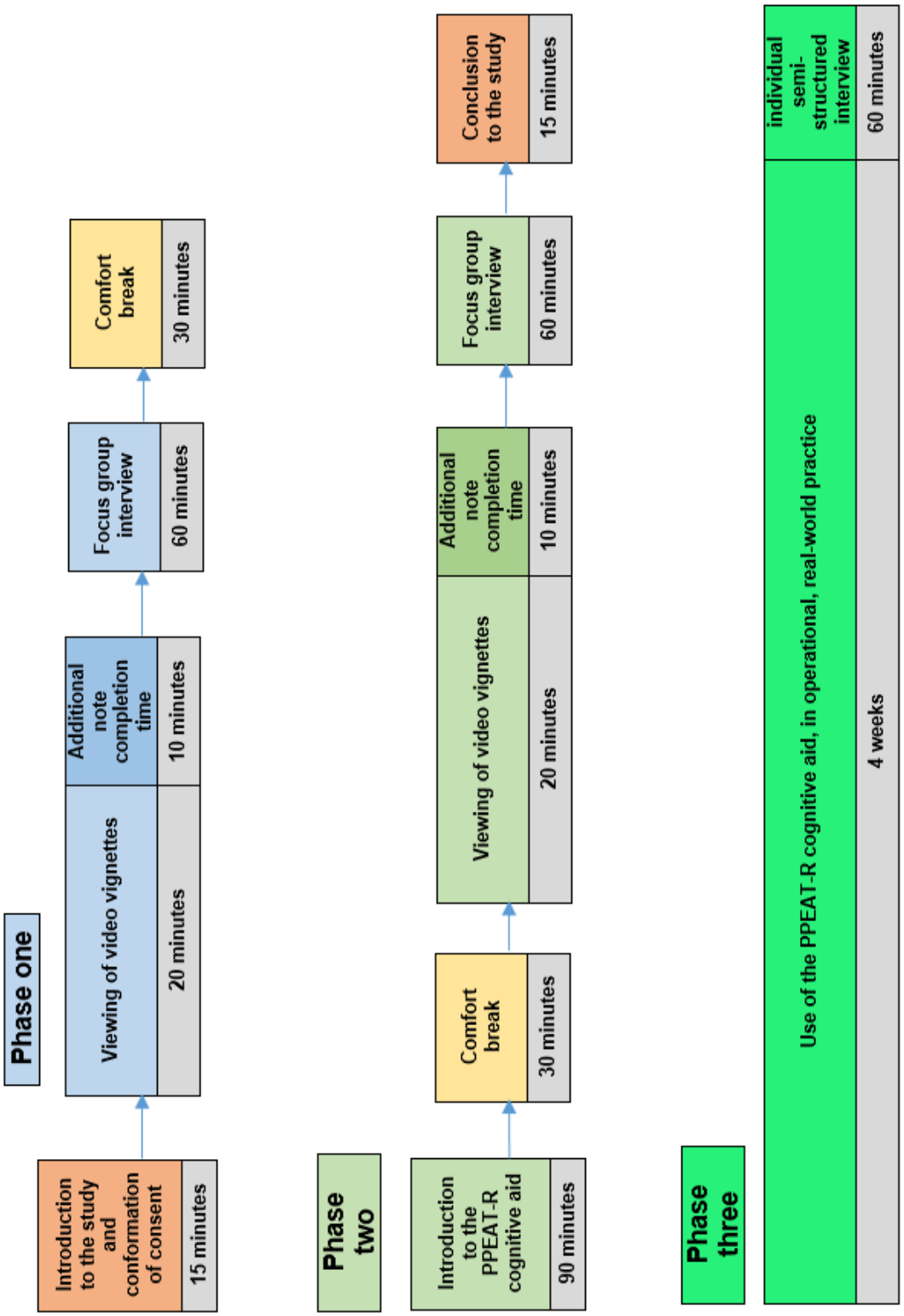


Figure 14: Outline of Study Phases One and Two.

5.3.3 Phase one (pre-test)

The study day was conducted in a single room, with all participants from their respective study group present. Following confirmation of consent to participate within the study, each participant was issued with a sequential number, and referred to only by this number during the study. This number corresponded to a series of unique identifiers used to align all data created by, or relating to the participant during this study (Appendix 20). A 15-minute introduction to the study was undertaken, prior to the commencement of phase one. Each participant was then issued with a police pocketbook sized notebook and pen, which contained a unique identifier, corresponding to them (Appendix 21). Participants were asked to view a series of eight video vignettes (Appendix 22), recording their observations for each one, within their notebook, without any conferring.

5.3.4 Video vignette and note-taking exercises

The eight video vignettes were designed to be concise, 'snap-shot' simulations of real-life situations they may encounter within operational practice; situations, difficult to observe with each participant in the real world. They represented a constructed and controlled environment, with iconographic properties (Appendix 23). They were designed to engage and immerse the participant, and elicit the responses they would commonly use to respond to, and navigate such situations (Hughes, 1998; Barter and Renold, 1999; Brewer, 2000; Richman and Mercer, 2002; ten Have, 2004; Wilks, 2004; Brauer, et al., 2009; Polit and Beck, 2012; Hillen, van Vliet, de Haes and Smets, 2013). Each vignette sought to produce a video-based, simulated environment, which provided sufficient visual and auditory information, cues and context. The aim was to generate an immersive, realistic experience (Sleed, Durrheim, Kriel, Solomon and Baxter, 2002; Bloor and Wood, 2006b). One which sought to "…evoke or replicate substantial aspects of the real world…" (Gaba, 2004, p.2). To ensure that the vignettes were sufficiently non-directive (allowing the police officers to make their own sense of the situations depicted), this study sought the best possible fidelity (Finch, 1987; Lanza, Carifio, Pattison and Hicks, 1997; Gaba, 2004; Lawton, Gardner and Plachcinski, 2010).

Fidelity represents the degree to which a simulation replicates reality: the higher the fidelity, the more realistic the vignette (Beaubien and Baker, 2004). Fidelity has four domains; environment fidelity (the extent to which the simulation replicated the

sights and sounds of a specific environment); psychological fidelity (the extent to which the participant believed the authenticity of the simulation); equipment fidelity (the extent to which the equipment present replicated that within a real situation); functional fidelity (the extent to which real life skills were able to be undertaken within the simulation) (Maran and Glavin, 2003; Beaubien and Baker, 2004).

5.3.4.1 Environment fidelity

The video vignettes depicted situations police officers may commonly respond to (Table 1). They were created, scripted, filmed and edited, in consultation with an expert panel, comprising senior mental health nursing, paramedic practice and adult nursing lecturers, and the Metropolitan Police Service lead for mental health[29] (Gould, 1996; Paddam, Barnes and Langdon, 2010; Hillen et al., 2013). Each vignette portrayed a person demonstrating behaviours associated with the presence of a particular mental disorder, portrayed and acted out by an expert panel member, within real-life locations[30] (Hillen et al., 2013; van Vliet, Hillen, van der Wall, Plum and Bensing 2013) (Appendix 22 and 23). Each person's mental disorder was expressed along a continuum, ranging from subtle, non-time critical situations, to time-critical situations (Table 8). The expert panel considered the range, and nature of the mental disorders depicted, sufficient to generate a range of responses, yet not so complex as to prevent the identification of key features of mental disorder. Hi-definition filming occurred, and video editing was undertaken using Adobe Creative Suite 6 Production Premium.[31]

[29] The expert panel from the University of Central Lancashire comprised: Ivan McGlen (Principal Lecturer in Adult Nursing and study researcher); Professor Joy Duxbury (Professor of Mental Health Nursing); Professor Karen Wight (Head of School of Nursing – former academic lead for mental health nursing); Inspector Frankie Westoby (Metropolitan Police Mental health lead); Sarah Trail (Principal Lecturer – Mental Health Nursing); Nic Bohannon (Senior Lecturer in Mental Health Nursing); Emma Jones (Senior Lecturer in Mental Health Nursing); Matt Potts (Senior Lecturer in Mental Health Nursing); Sharron Sykes (Senior Lecturer in Mental Health Nursing); Georgina Ritchie (Senior Lecturer in Adult Nursing); Simon Dykes (Senior Lecturer – Paramedic Practice); Lizi Hickson (Senior Lecturer – Paramedic Practice); Colin Atherton (Senior Lecturer – Paramedic Practice).

[30] Vignette one - Lizi Hickson (Senior Lecturer – Paramedic Practice) and Colin Atherton (Senior Lecturer – Paramedic Practice); vignette two - Simon Dykes (Senior Lecturer – Paramedic Practice); vignette three - Nic Bohannon (Senior Lecturer in Mental Health Nursing); vignette four - Sarah Trail (Principal Lecturer – Academic Lead for Mental Health Nursing); vignette five - Georgina Ritchie (Senior Lecturer in Adult Nursing); vignette six - Matt Potts (Senior Lecturer in Mental Health Nursing); vignette seven - Sharron Sykes (Senior Lecturer in Mental Health Nursing); vignette eight - Emma Jones (Senior Lecturer in Mental Health Nursing).

[31] Adobe Creative Suite 6 Production Premium is a professional video / sound editing application. With this application, I was able to film the vignettes using a Hi-definition digital video camera then edit and sequence the video vignettes.

Table 8: Nature of Video Vignette.

No.	Nature of vignette	
		Non time-critical presentation of mental disorder
7	A woman demonstrating an anxiety attack	
4	A woman demonstrating a post-traumatic stress response	
6	A male demonstrating obsessive compulsive disorder	
3	A male demonstrating significant suicide risk	
1	A woman who has self-harmed herself (cut wrists and forearms).	
2	A male demonstrating acute behavioural disturbance.	
8	A woman demonstrating anti-social personality disorder	
5	A woman demonstrating puerperal psychosis	
		Time-critical presentation of mental disorder

5.3.4.2 Psychological fidelity

Participants were asked to assume each vignette was a situation they were either called to, or encountered during operational duty. Prior to viewing each vignette, a brief introduction was given to provide context, and any prior information available to them (e.g. information from the public or police control room) (Appendix 23). Participants were not informed of the presence of a mental disorder, or guided to how they should respond. Participants were asked to assume the camera view was their view, and any camera movement, their head / body movement (Hillen et al., 2013). All key features of mental disorder were visible within the vignettes. The vignettes were ordered randomly, and the same order was followed by each participant group, prior to, and following the introduction of the cognitive aid (Table 9).

Table 9: Video Vignette Order of Presentation.

No.	Nature of vignette	Duration	
		Minutes	Seconds
1	A woman who has self-harmed herself (cut wrists and forearms).		22
2	A male demonstrating acute behavioural disturbance.		18
3	A male demonstrating significant suicide risk	1	5
4	A woman demonstrating a post-traumatic stress response	1	
5	A woman demonstrating puerperal psychosis	1	42
6	A male demonstrating obsessive compulsive disorder	3	22
7	A woman demonstrating an anxiety attack	1	22
8	A woman demonstrating anti-social personality disorder		50

5.3.4.3 Equipment and functional fidelity

The notebooks used within this study corresponded to the size and shape of police pocketbooks[32] (Appendix 21). Participants were asked to use them as they would whilst on duty, noting their observations, findings and actions, in their usual manner, in their usual language and style (e.g. abbreviations, colloquialisms, and professional terms). Where a participant felt a vignette required support for an intervention (e.g. further assistance, handcuffs, baton, Taser), they were asked to indicate this within their notebook.

5.3.5 Pilot testing of the video vignettes

Prior to phase one of this study, the video vignettes were pilot tested with the Metropolitan Police mental health lead, and a police sergeant, also from the Metropolitan Police Service. Pilot testing serves to establish the "…appropriateness …" of a method (O'Sullivan, 2011, p.100). Pilot testing also highlights issues which may negatively affect data collection and ultimately, data analysis and results (Litwin, 2003; O'Sullivan, 2011; Rothgeb, 2008; Maxwell, 2018). In doing so, it

[32] Police pocketbooks are official police documents, each one containing a unique serial number. They are only permitted to be used for policing purposes. The notebooks used within this study were commercially obtained, and were a similar shape, size and design to police pocketbooks. These were assessed for fidelity and suitability by the mental health lead for the Metropolitan Police Service. Participants were assured that the note books would not be reviewed by any police officer, as the purpose of this study was not to operationally investigate or judge their practice.

enables them to be either corrected or redesigned (Litwin, 2003; Rothgeb, 2008). Pilot test also reaffirm the suitability and "…workability…" of a method (Sussman and Ashby Wills, 2001, p.11). Within this study, both police officers considered that the vignettes captured the time-pressured and, sometimes confusing situations, frequently encountered within operational practice. Both police officers considered each vignette to be of sufficient detail and fidelity, to enable the police officers to detect the features associated with the presence of a particular mental disorder.

5.3.6 Undertaking Video vignette and note-taking exercises

The video vignettes lasted 9 minutes, 26 seconds. They spanned a twenty minute period, to enable time between each one for participants to complete their notes. Upon vignette completion, a further ten minutes was available for participants to make any additions / corrections to their notes. Upon completion of the video vignette and note-taking exercise, participants then undertook a focus group interview. During the focus group, the participants were permitted to use their notebooks for reference.

5.3.7 Focus group interviews

The focus group interviews were facilitated group discussions, with the participants collectively focussed upon specific, predetermined, topic areas (Kitzinger, 1994; Kitzinger, 1995; Reed and Payton, 1997; Sim, 1998; Robinson, 1999; Kruger and Casey, 2000; Webb and Kevern, 2000; Puchta and Potter, 2002; Duggleby, 2005; Barbour, 2007; Kvale and Brinkmann, 2009; Roulston, 2010). The focus group interviews reflected a 'single-category design', whereby multiple groups (two) followed the same interview approach prior to, and following the introduction of the cognitive aid (Kruger and Casey, 2000). This approach enabled a deeper exploration, generating data comparable across the two groups (Kruger and Casey, 2000). They were socially constructed events. Through listening, observation and note-taking, I was able to take advantage of the diversity of verbal and non-verbal interaction and behaviours occurring amongst the participant group. This diversity of response was unobtainable through individual interviews (Morgan, 1995; Kitzinger, 1994; Asbury, 1995; Kitzinger, 1995; Reed and Roskellstewart, 1997; Dreachslin, 1998; Wilkinson, 1998; Duggleby, 2005; Stewart, Shamdasani and Rook, 2007). Questions and probes populating the interview protocol were drawn

from the emerging themes. Digital audio recording and field notes supported data collection (Fernandez and Griffiths, 2007; Al-Yateem, 2012).

Rather than posing questions to each participant in turn, I (as moderator) posed questions that stimulated a focused '*inter*-change of *views',* driven by, and amongst, the group; still retaining focus upon the predetermined topic areas outlined within the interview protocol (Appendix 24 and 25) (Morgan, 1995; Crabtree and Miller 1999; Kruger and Casey, 2000; Stewart et al., 2007; Morgan, 2012). Through interactive discourse, I was able to expose not only what the group said (e.g. vocabulary, metaphor), but also how it was collectively constructed and perceived (e.g. thought-processes, norms), and the symbolic meanings the group afforded to the words and actions that occurred (Morgan, 1995; Wilkinson, 1998; Robinson, 1999; Bloor, Frankland, Thomas and Robson, 2001; Denzin and Lincoln, 2003; Barber, 2007; Stewart et al., 2007). The focus groups were therefore useful vehicles to identify the axionormative orders and structures, common rubrics, practice accomplishments, methods, and indexical expressions collectively constructed by the group prior to, and following, the introduction of the cognitive aid (ten Have, 2004). At the end of the pre-test (phase one) focus group interview, all notebooks were collected in, and securely stored.

5.3.8 Phase two (post-test)

Following a thirty-minute break, the post-test phase commenced. Participants undertook a ninety-minute preparation session[33], instructing them in the use of the PPEAT-R [34] (Appendix 26). This represented the 'foundation tool' (Chrimes, 2016, p.20). Participants were given a pocket-book sized copy of the PPEAT-R cognitive aid. This represented the 'implementation tool' (Chrimes, 2016, p.20).

Participants were asked to re-watch the vignettes, but this time, using the PPEAT-R to support their response. Participants were each given a new notebook (containing a unique identifier, corresponding to them), and again asked to record their

[33] The first third of this session addressed the emerging themes, seemingly shaping a police officer's identification and response to mentally disordered people. The remaining sixty-minutes instructed police officers in the use of the cognitive aid, highlighting and exploring the features, illustrative of mental disorder, derived from the preparatory stage data. This session was supported with a handbook, designed in conjunction with a mental health specialist.

[34] From a teaching and learning perspective, these preparatory sessions generated what Biggs (2003) terms "…unintended outcomes…"' (p.160). This is "…learning that is productive and relevant, but unanticipated" (Biggs, 2003, p.160). Within the context of these preparation sessions, learning was from the generation of potentially rich sources of data, further exposing common rubrics, shaping situation awareness, when encountering a mentally disordered person. Hanson and Jones (2017) suggest that when undertaking research, one should draw upon the best information available, at the time. Indeed, the participatory nature of this session resembled in parts, focus group interviews, yielding a wealth of data. However, the research design and ethical frameworks governing the conduct of this study, prevented me from formally recording and / or utilising, potentially useful data (Wasserman, 2013; Al-Adawi, Ali and Al-Zakwani, 2016).

observations of each video vignette. Following completion of the vignettes, the participants undertook a further focus group interview, retaining their notebooks for reference. These were again collected in at the end of the focus group and securely stored.

5.3.9 Phase three

At the conclusion of the study day, participants were provided with broad non-individualised feedback regarding their before and after responses. This feedback did not form part of the data analysis. All study day participants were asked to use the PPEAT-R in operational practice for four weeks, and then undertake an individual semi-structured interview (lasting up to 60 minutes), exploring its usefulness.[35] Operational practice reflected the London policing boroughs where the participant worked. A protocol which acknowledged both the use and non-use of the PPEAT-R, was designed to provide structure to the semi-structured interviews (Appendix 27). Digital audio recording and field notes supported data collection (Fernandez and Griffiths, 2007; Al-Yateem, 2012).

5.3.10 Study setting

The Metropolitan Police Service in London was chosen to explore the specific processes police officers use to identify and manage a mentally disordered person, prior to, and following the introduction of the PPEAT-R.

5.3.11 Access to participants

As with the preparatory work, this part of the study required access to police officers and locations, governed by the Official Secrets Act (1989), Prevention of Terrorism Act (2005), Police Act (1996), and Counter-Terrorism Act (2008). I initially met with the mental health lead for the Metropolitan Police Service, and the Metropolitan Police Service and Association of Chief Police Officers mental health lead, to discuss this project. Formal permission was granted to undertake this study with the Metropolitan Police Service (Appendix 28). Following local ethics committee agreement, permission to undertake this study within the Metropolitan Police Service was formally sought from, and granted by the Association of Chief Police Officers professional ethics portfolio chair (Appendix 29). Due to issues of local and national and international

[35] Due to a serious illness, it was necessary for me to suspend this programme of studies shortly after completing part one of this study, from January – September 2013. Participants were contacted and made aware of both my interruption and resumption of study. The mental health lead for the Metropolitan Police Service and the university ethics committee were made aware of both my interruption and resumption of study.

security, limitations of movement within the Metropolitan Police Service were imposed.[36] Following permission to conduct this study, I met with the mental health lead for the Metropolitan Police Service, to discuss local access arrangements, and the distribution of the participant information packs (Figure 15). For reasons of operational security, all interviews involving police officers were undertaken within the confines of New Scotland Yard, London.

[36] *Metropolitan Police Service*. For reasons of local, national and international operational security related to the functions of the Metropolitan Police Service, all participant interviews were undertaken within New Scotland Yard (Metropolitan Police Headquarters), London. As this is a secured building, I was required to notify the mental health lead for the Metropolitan Police Service of the study dates, and how long I intended to remain within the building. The mental health lead then issued me with rooms within a quiet part of the building, away from sensitive areas. I then contacted the selected participants individually and arranged an interview time / date / venue. Due to the significance of New Scotland Yard to national security, I was required to undertake a detailed security scan, search, and validation of identity by a senior police officer prior to each entry and departure.

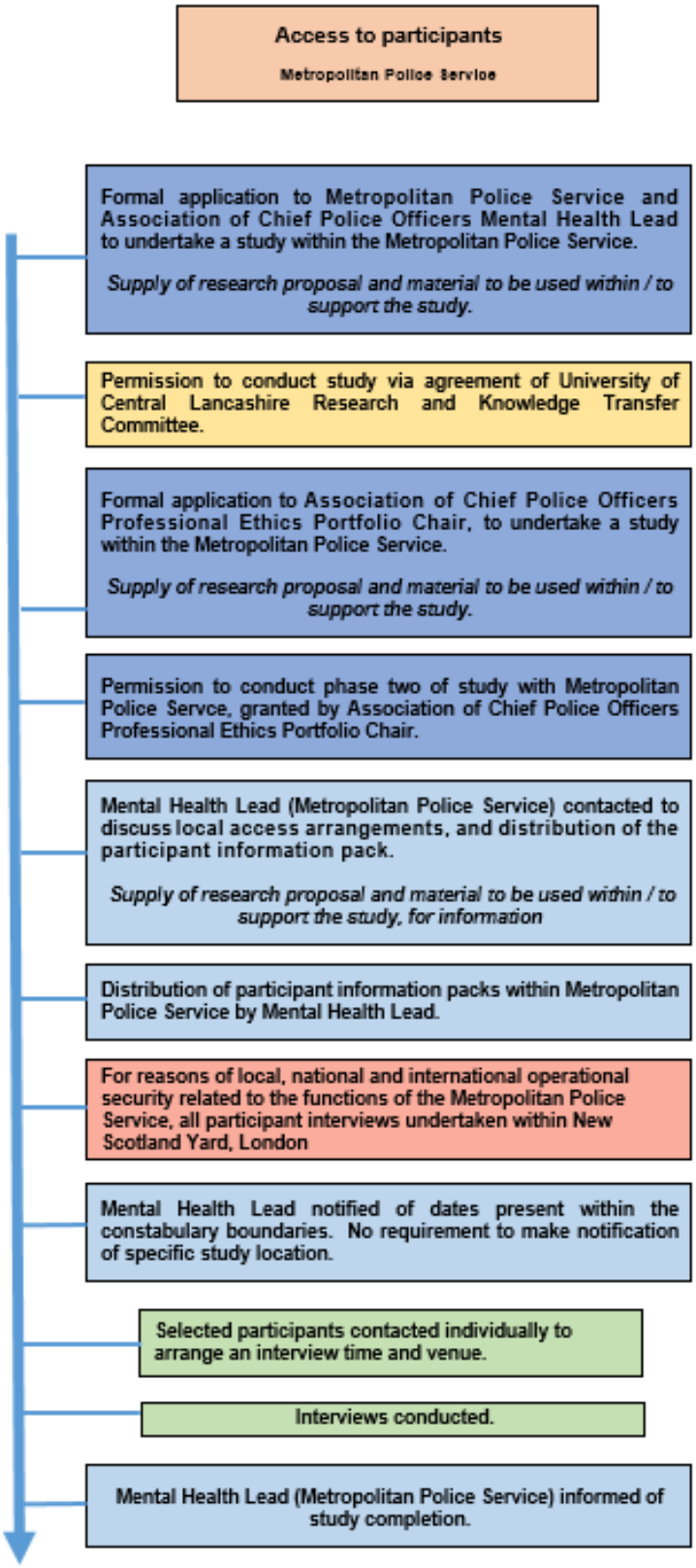


Figure 15: Access to Participants.

5.3.12 Participant sampling strategy, inclusion criteria, exclusion criteria and recruitment

The participant sampling strategy, inclusion and exclusion criteria and recruitment, reflected the approach undertaken within the preparatory phase (Figure 13). Participants were however required to be serving, front-line police officers within the Metropolitan Police Service. Participant information packs were created; each one, containing an introductory letter (Appendix 30), participant information sheet (Appendix 31) and a reply slip with a return envelope, addressed to researcher (Appendix 32). The mental health lead circulated these to all police officers within the Metropolitan Police Service, via internal email. Return envelopes were circulated within Metropolitan Police Service districts.

Only participants who undertook the study day (phases one and two), were contacted by their point of contact email, and invited to attend the individual semi-structured interview to explore the usefulness of the PPEAT-R in operational practice. On receipt of the reply, I contacted participants to further discuss the study, and the arrangements to undertake it.

5.3.13 Participant sample size

Seventeen police officers from the Metropolitan Police Service were recruited to undertake this part of the study. Two participant groups were formed. Group one comprised ten participants, and group two, seven participants.[37] Participant groups were considered large enough to enable a sufficiently diverse range of viewpoints, yet not too large to exclude participation, or create facilitation difficulties (Crabtree and Miller 1999; Kruger and Casey, 2000; Stewart et al., 2007). Following completion of the study day, ten[38] participants from across both groups were recruited to undertake the individual semi-structured interviews, exploring the usefulness of the PPEAT-R in operational practice.

[37] Twenty participants were scheduled to undertake this study, with ten participants in each group. One the first day that the study was conducted, ten participants presented (group one). On the second day the study was conducted, seven participants presented (Group two).

[38] All of the participants who undertook the first part of the study consented to use the PPEAT-R cognitive aid in operational practice. The participants were numbered, according to the order in which they were originally recruited. A range of interview slots were scheduled across the three days. The interview slots were purposely designed to avoid overlap (if the interview went over time), and accidental participant contact. Ten participants presented to undertake this part of the study – No 1, 2, 3, 4, 12, 14, 15, 16, 17, and 18. Seven participants did not attend.

5.4 Data analysis: Phases one and two

5.4.1 Concept and observable indicator framework

Data analysis followed two strands: analysis of phase one data, and analysis of phase two data (Figure 16). The conceptual framework underpinning data analysis was the concept and observable indicator framework developed from the concept framework. Two concept and observable indicator frameworks were developed for each of the eight video vignettes; one for use prior to the introduction of the cognitive aid, and one for use following its introduction. An example of this is provided within Appendix 33 and 34. The concept and observable indicator frameworks were specifically tailored to each video vignette. This was through the inclusion of features directly or indirectly suggestive of the presence of mental disorder, for the specific scene depicted.[39] These features were then aligned to the appropriate concept, its respective overarching themes, and observable indicators. Each participant's response was aligned to the framework, prior to, and following, the introduction of the PPEAT-R. This approach sought to explore the apparent relationship of their responses to the six concepts, the overarching themes, and observable indicators, prior to, and following, the introduction of the PPEAT-R.

[39] When aligning the concept and observable indicator framework to each video vignette, the expert panel, who advised on their development, were consulted as to which features, directly or indirectly suggestive of mental disorder, sat best within the concepts pre-encounter, appearance, behaviour, communication, danger and environment.

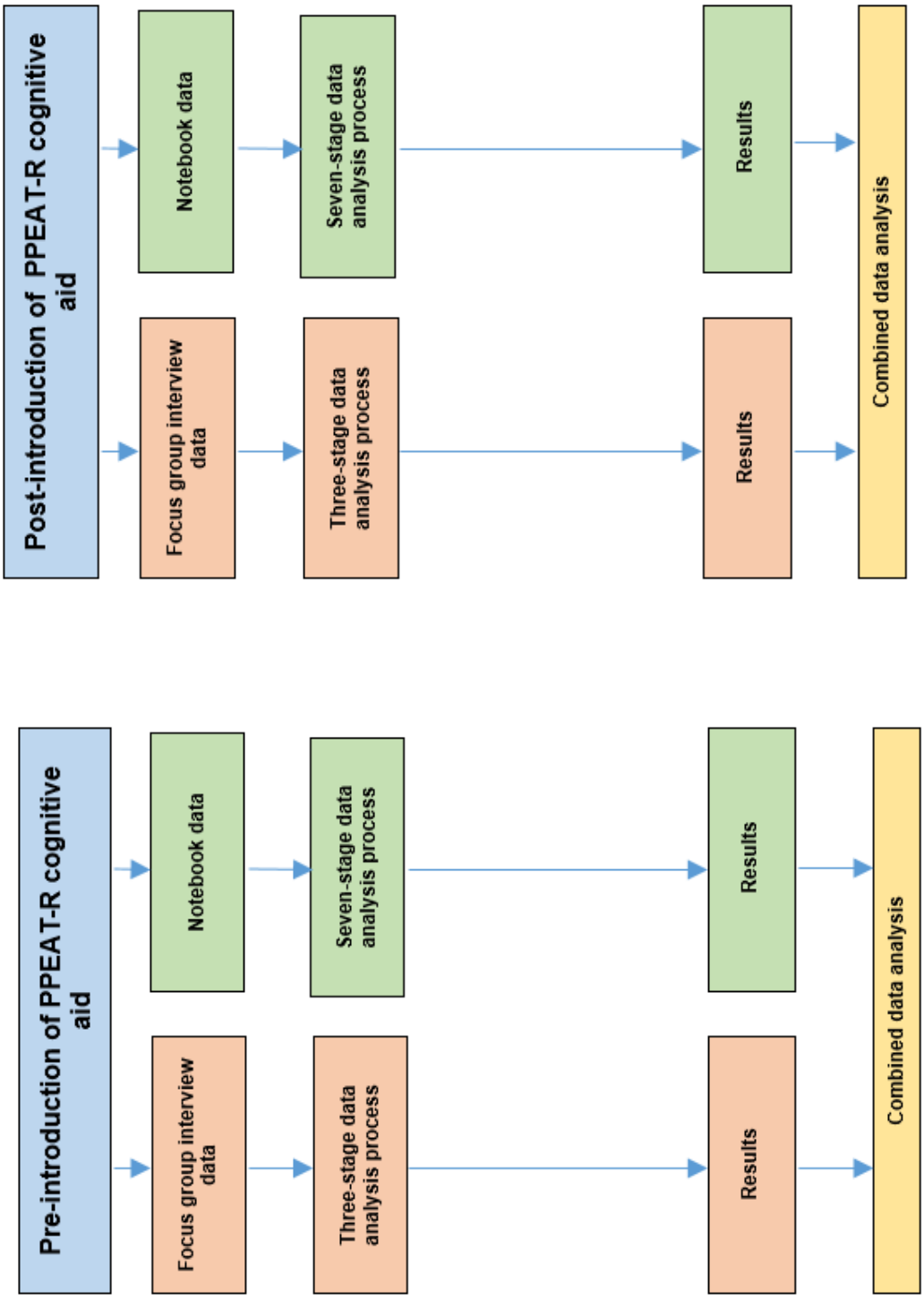


Figure 16: Data Analysis Process.

5.4.2 Notebook data analysis

Notebook data, obtained during the study day, underwent a seven-stage data analysis process prior to, and following, the introduction of the cognitive aid. This was informed by a theoretical thematic analysis and concept mapping approach. The concept and observable indicator framework supported data analysis.

First, data from each participant's notebook was transcribed verbatim. Second, this data was used to populate a concept and observable indicator framework, for the respective video vignette (described earlier). Within each framework, the participant's notebook responses were aligned to what appeared to be the most appropriate concept. These responses were then aligned to what appeared to be the concept's most appropriate overarching theme, and corresponding level of situation awareness (observable indicator). Third, a table was designed to capture the emerging themes within each vignette (pre- and post-introduction of the cognitive aid); themes indicative of the features police officers identified as being significant within the video vignettes, and the corresponding level of situation awareness. Examples are presented within Appendix 35 and 36. This tabulation enabled overview of individual and overall group responses, to each video vignette.

Fourth, each participant's qualitative responses (drawn from their individual concept and observable indicator frameworks) were collated, in accordance with their identified concept, overarching theme, and corresponding level of situation awareness. Fifth, this data was presented within a concept map for each vignette, to more clearly illustrate the relationship of the data to the concepts, pre-encounter, appearance, behaviour, communication, danger and environment, and the level of situation awareness demonstrated. Sixth, stage four data underwent a further theoretical thematic analysis, using MAXQDA plus. Refined codes were then assigned. Within step seven, this data was added to the stage five concept map. A final overarching concept map was established, to more clearly illustrate their relationship to each vignette.

5.4.3 Focus group interview data analysis

Framed by the interview protocol questions, focus group data analysis investigated how, within the group context, participants' (reconstructed) sense-making processes were shaped during the video vignettes, prior to, and following the introduction of

the cognitive aid. A three-stage data analysis process was informed by a theoretical thematic analysis and concept mapping approach. The concept and observable indicator framework supported data analysis. First, data was manually transcribed, then closely analysed line by line, using MAXQDA plus (Braun and Clarke, 2006; Cleverbridge, 2012). Field note data was also transcribed to support data analysis. Second, participants' responses were aligned to what appeared to be the most appropriate concept, overarching theme, and corresponding level of situation awareness (observable indicator). Third, emerging themes were presented within a concept map, to more clearly illustrate their relationship, and their relationship across the groups.

5.4.4 Combined data analysis

Using a further concept mapping approach, the themes, in the form of qualitative comments, emerging from the focus group interviews and notebook entries, were combined.[40] Examples are presented within Appendix 37 and 38. This approach sought to illustrate the overall relationship of the group's responses to the concepts, pre-encounter, appearance, behaviour, communication, danger and environment, and the level of situation awareness demonstrated prior to, and following, the introduction of the PPEAT-R. The emerging themes were considered in relation to their fit within the concepts and sub-themes comprising the cognitive aid, and Endsley's (1988) three-level categorisation of situation awareness.

5.4.5 Phase three

Data analysis comprised a theoretical thematic analysis of individual semi-structured interview data. Data was manually transcribed, then closely analysed line by line, using MAXQDA plus. Field note data was transcribed to support data analysis. Data analysis investigated how the police officers reconstructed sense-making processes were shaped by the real-world, operational use of the PPEAT-R.

[40] The following key refers to the type of data, and participant group:

Letters A-J:	notebook data.	group one
Letters S-Y:	notebook data.	group two
No's 1-10: *G1*	focus group data	group one
No's 1-7: *G2*	focus group data	group two

5.5 Ethical issues governing the conduct of the study

This study was guided by the World Medical Association (2013) *Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. Permission to undertake it was through agreement of both the University of Central Lancashire (UCLan) Research and Knowledge Transfer Committee, and the Association of Chief Police Officers professional ethics portfolio chair (Appendix 14, 28, 29, 39 and 40). Study conduct was governed by the UCLan (2014) *University Code of Conduct for Research,* and the *Ethical Principles for Teaching, Researching, Consultancy, Knowledge Transfer and Related Activities* (UCLan, 2015). Researcher conduct demonstrated "…integrity, objectivity, accountability, openness, [and] honesty…" required by the Committee on Standards in Public Life (1995; 2013, p.14). Accordingly, this study afforded 'unconditional' ethical consideration to: participant consent, anonymity, data protection, protection from harm and the dissemination of results (Gillon, 1985; Andersson et al., 2010; Ealy, 2011; Sutrop, 2011; Polit and Beck, 2012; Sim, 2010). This was underpinned by the ethical principles of beneficence, autonomy, justice and non-maleficence (O' Leary, 2004, p.50).

5.5.1 Participant consent

Informed consent was the process of providing police officers with sufficient information to enable them, without duress or coercion, to freely reach a decision to participate, or decline inclusion within this study, (O'Neill, 2003; Green and Thorgood, 2004; Whitcher, 2008; Ploug and Holm, 2013; Polit and Beck, 2012; Eyal, 2012). At recruitment, police officers were provided with a pack containing an introductory letter inviting them to participate in this study (Appendix 15 and 30), a participant information sheet (Appendix 16 and 31), illustrating the aims and conduct of the study, and a reply slip (Appendix 17 and 32), for them to return to me in an enclosed stamped addressed envelope Within the participant information sheet and introductory letter, police officers were invited to contact me if they had any questions relating to this study. Upon receipt of the reply slip, I spoke with each police officer and explained the study and its conduct, to ensure that consent was informed. This was reaffirmed at the beginning of each study stage involving police officers, prior to securing their written, informed consent. Two copies of the consent form were obtained, signed by both the police officer and researcher. One was retained by me and one by the police officer (Appendix 41 and 42).

The principle of justice implies the fair and equitable treatment of others. Recognising that a person's consent to participate within a study does not constitute a binding agreement, police officers were informed that they could abstain from study activities, and withdraw at any time, without sanction or follow up communication (Andersson et al., 2010; Ealy, 2011). This was communicated within the introductory letter and participant information sheet.

5.5.2 Anonymity

For police officers undertaking phase one individual semi-structured interviews, full anonymity was not possible as they would not be anonymous to me. Their participation was kept confidential, as were their identifiable responses. Each police officer was assigned a unique code, specified within the digital audio recording of the interview, and assigned to the audio recording transcription. The same code was applied to manual records made during the interview. Further reference was made only to this code. Police officers undertaking individual interviews were informed that the digital audio recording could be replayed, edited or sections deleted upon request.

Within phase two, whilst the study design prevented contact between groups, participation was not anonymous to the researcher, or those within an allocated focus group interview. To reinforce anonymity, when consent was taken, each police officer was given a laminated A4 sheet containing a sequential number, ranging from one to twenty. This was placed for all participants to see. The group were asked to refer to others present only by their number. Police officers were identified only by this number, during study days one and two. This number corresponded to a series of unique identifiers used to align all data created by, or relating to the police officers during the study (Appendix 20). To enable police officer identification during focus group data analysis, each police officer was audio-recorded, stating their number, and a few words of their choice.

Prior to each focus group interview, police officers were asked to agree to maintain confidentiality regarding the presence of others, and any identifiable responses / quotes occurring within the discussion (UCLan, 2014). For the focus groups, the police officers' digital audio recording could be replayed, edited or sections deleted, only with group consensus. Without group consensus, individual contributions, or specified elements of their contributions could be deleted at a later point by me and

verified with them, by me. Police officers were informed that any written notes made by me during the study, could be reviewed, edited or sections deleted upon request.

5.5.3 Data protection

This study adhered to the principles of the Data Protection Act (1998). Manual records such as consent forms, contact details (reply slip), interview notes and venues where the interviews take place were stored within a locked metal filing cabinet within a locked room, within the University of Central Lancashire. Electronic material (word-processed / verbal) was stored within password-protected files within a password protected computer and, if in transit, within an encrypted data stick. This was transferred to a secured computer upon reaching the destination and the data deleted from the encrypted data stick. All records made are kept and stored for a maximum of 5 years (UCLan, 2014; 2015). During transit, electronic devices used during interviews, manual records, including completed consent forms, field notes and documentation pertinent to the study, were transported in a locked metal security box.[41]

Participant identities, and their individualised, identifiable responses were not disclosed to any police service or authority. Should details be released, this would be with the police officer's written consent, and they would be informed to whom they are being released, and why. Should any significant concerns relating to criminal activity be raised / disclosed during the course of an interview, the research would be terminated, the BuSH ethics committee[42], the Association of Chief Police Officers Professional Ethics Portfolio Chair, and research supervisory team would be immediately informed. This response was stated within the participant information sheet, and highlighted to the police officers prior to study commencement. Police officers were also asked to avoid explicitly naming members of the public or staff. If named, then such references were appropriately anonymised.

[41] The metal transit box was an armoured, flame retardant, former Post Office cash transit box. It was locked with a key, which was kept separate to the box at all times.

[42] There are currently three ethics committees within the University of Central Lancashire: Business, Arts, Humanities, and Social Sciences (BAHSS); Psychology and Social Work (PSYSOC); Science, Technology, Engineering, Medicine and Health (STEMH). As this study was based within the School of Nursing, ethical permission was granted via the BuSH sub-committee (Built Environment, Sport and Health), later replaced by STEMH.

5.5.4 Protection from harm

Within the participant information sheet, police officers were advised of the potential to explore sensitive / emotive issues. Police officers were advised that if they needed support during or following the study, this could be offered within the police services, or via external, independent counselling services. This was reiterated at each stage of the study. At the end of each interview, there was a period for conclusion (debrief). Police officers were informed that I would discuss individual issues, if required. Police officers were also informed that they could contact me following their departure by email or telephone.

When using the PPEAT-R within a real-world, operational context, its use was supplemental to the police officers' usual operational procedure and practice. Whilst no untoward issues were anticipated, should any difficulties occur, police officers were to default to their usual practice, cease use of the cognitive aid, and notify me of their concern as soon as practicable. Mindful of potential reputational harm, should any complaint emerge because of my actions within this study, its nature would be identified and immediately relayed to the University of Central Lancashire Ethics Committee for Science, Technology, Engineering, Medicine and Health (STEMH), the Association of Chief Police Officers Professional Ethics Portfolio Chair, and the researcher's supervisory team. If police officers remained unhappy and wished to complain formally, they could contact my Director of Studies.

5.6 Academic rigour

Academic rigour represented the strict, accurate, and precise methods used to demonstrate the legitimacy, integrity, competence, utility, and therefore quality, of this research process (Sandelowski, 1986; Morse, Barrett, Mayan, Olson and Spiers, 2002; Seale, 2002; Tobin and Begley, 2004; Saumure and Given, 2008; Ryan-Nicholls and Will, 2009; Thomas and Magilvy, 2011). This study sat within the constructivist paradigm and as such, the "…trustworthiness criteria…" represented the benchmark of rigour (Guba and Lincoln, 1994, p.114). Trustworthiness is the degree to which the researcher reliably and accurately represents the police officer's contribution to the study, the accuracy and precision within the research process, and the utility of the study outcomes (Lincoln, 2004; Koch, 1994; Shenton, 2004; Høye and Severinsson, 2007; Schwandt, 2007b; Given and Saumure, 2008;

Chung-Jey, 2012). The somewhat intertwined criteria of credibility, transferability, dependability and confirmabilty (Figure 17) provided the apparatus from which trustworthiness, and therefore academic rigour, was determined (Krefting, 1991; Guba and Lincoln, 1994; Koch, 1994; Lincoln, 2004; Høye and Severinsson, 2007; Schwandt, 2007b; Given and Saumure, 2008; Haggerty, 2008; Polit and Beck, 2012).

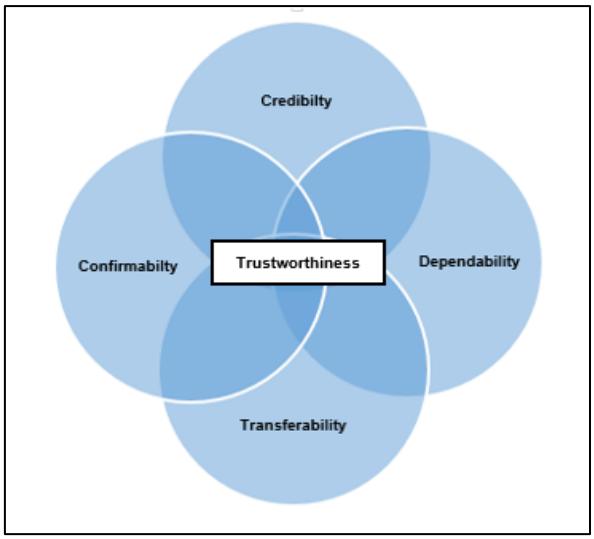


Figure 17: The Establishment of Trustworthiness.

5.6.1 Credibility

Comparable with the positivist standard for rigour, *internal validity*, credibility refers to the degree to which the study convincingly and accurately addressed its aims and outcomes, reconstructing and describing data in a believable and truthful manner (Sandelowski, 1986; Shenton, 2004; Tobin and Begley, 2004; Tuckett, 2005; Given and Saumure, 2008; Polit and Beck, 2012). This was achieved by the use of robust and transparent practices and methods, to obtain a depth of contextually appropriate data, which was faithfully (truthfully) interpreted and reconstructed (Sandelowski, 1986; Seale, 2002; Shenton, 2004; Tobin and Begley, 2004; Mathison, 2005; Jensen, 2008a; McGinn, 2010; Polit and Beck, 2012). Based on the guidance offered by Lincoln and Guba, 1985; Arminio and Hultgren, (2002) and Shenton (2004), credibility sought to make explicit the following domains:

- Data analysis.
- Representation of self within the research process.

5.6.2 Data analysis

Recognising the potential for distortion within the researcher constructed descriptions, this study sought to offer assurance that systematic and transparent processes were employed within data reduction, transformation and interpretation (Sandelowski, 1986; Shenton, 2004). Methodological triangulation sought to ensure data confirmation, comparing data drawn from differing data collection methods (Høye and Severinsson, 2007; Houghton et al., 2013). This approach sought to identify the degree and nature of "…convergence…" (or incongruence) of themes (Casey and Murphy, 2009, p.41). By providing thick descriptions, this study sought to truthfully and faithfully construct and describe the data, in such depth that the readers could establish a clear context and understanding of the phenomena (Geertz, 1973, p.6; Shenton, 2004; Maxwell and Mittapalli, 2008; Bakker, 2010; Dawson, 2010). Verifying the degree to which such descriptions were believable, truthful and faithful, was sought via member checking. This seeks to assure data interpretation and description, and clearly reflects the participant's contribution, experience, meaning and context (Lincoln and Guba, 1985; Krefting, 1991; Shenton, 2004; Tuckett, 2005). This was achieved by offering participants the opportunity to verify the accuracy, adequacy and intentionality of their account and to clarify, redact or offer additional information (Lincoln and Guba, 1985).

5.6.3 Representation of self within the research process

Whilst undertaking constructivist enquiry, I acknowledged the inseparability of the "…researcher and researched", and offered a reflexive account (Brewer, 2003, p.260; Hammersley, 2004; McBrien, 2008). Reflexivity is considered the continual, contextually and temporarily determined relationship, existing between the researcher and researched (Gilbert and Sliep, 2009). It is the process of "…critically examining one's own characteristics, biases and insights…" (Williams, 2005, p.37). Through this critical examination, the researcher reflects upon the influence these have upon each aspect of the research process, the social context in which it is undertaken, the participants, and the effect upon, and of, oneself (Mauthner and Doucet, 2003; Hammersley, 2004; Vogt, 2005; O'Leary, 2007; Anderson, 2008). As this study progressed, I used a research diary to capture my reflexive accounts,

illustrating my shifting thoughts, preconceptions, expectations and biases, (Dowling, 2008, p.748). It served to illustrate the degree to which I influenced (and was influenced by) the research process, and the controls (epistemological, theoretical, methodological and method) required to assure sustained objectivity[43] (Krefting, 1991; Koch, 1994; Shenton, 2004; Dowling, 2008; Houghton et al., 2013). The research diary was a useful adjunct to my regular research student supervisory sessions, undertaken throughout this study.

5.6.4 Student supervision

I undertook supervision with my Director of Studies and supervisory team, at specified intervals throughout this study. This provided opportunity for comment and guidance regarding the epistemological, theoretical and methodological positions and methods used, and the manner in which data was obtained, analysed and described (Lincoln and Guba, 1985; Cutcliffe and McKenna, 1999; Tuckett, 2005; Houghton et al., 2013).[44] I also sought the views of colleagues holding a specialist understanding, relevant to this study's distinct epistemological, theoretical, and methodological positions and methods.[45] Acknowledging the significant professional practice orientation of this study, peer debriefing was also sought from the mental health leads within Durham Constabulary, the Metropolitan Police Service and the Association of Chief Police Officers.

5.6.5 Transferability

Comparable with the positivist standard for rigour, *external validity*, transferability referred to the applicability of this study's findings to wider, similar populations and contexts (Lincoln, 2004; Tobin and Begley, 2004; Jensen, 2008b; Polit and Beck, 2012). For constructivist enquiry, the "…situational uniqueness…" of the phenomena being studied presents an inherent difficulty in transferring study findings to wider populations / contexts (Krefting, 1991, p.220). The researcher (the "…sending context…"), is therefore only able to make claims regarding the local meaning of the findings; decisions regarding transferability of study findings is made by "…receiving contexts…" (Lincoln and Guba, 1985, p.316). That is, the readers of

[43] Establishing a foundation for my indexical account, it was necessary for me to acknowledge my participation within earlier research. It was also important for me to acknowledge my professional contact with police officers, whilst an emergency nurse, whereby I gained often first--hand awareness of the difficulties they experienced when identifying and managing a person suffering a potential mental disorder.

[44] I sought advice and guidance from academic staff specialists in narrative synthesis and ethnomethodology. I also sought advice and guidance from academic staff with focus group expertise.

[45] Prior to registering this study, I discussed my study rationale, aims and objectives with the Association of Chief Police Officers professional ethics portfolio. I continued to liaise with the Association of Chief Police Officers professional ethics portfolio both directly, and through their staff officers, for the duration of this study. I also held meetings with the mental health leads for Durham Constabulary and the Metropolitan Police Service. Where I had queries regarding aspects of police procedure, I contacted the mental health lead of the police service I was currently engaged with.

the research base their opinion on sufficiently thick descriptions to enable them to translate the study findings for their use (Lincoln and Guba; Shenton, 2004).

The founding tenets of ethnomethodology purposely sought to eschew "…modifying, elaborating, contributing…explicating, [and] foundation-building…" (Garfinkel and Sacks, 1972, p.346). Its subsequent methodological flexibility permitted its respecification, for the purpose of describing the "…rules, statements, practices or procedures…" occurring within a specific social situation (ten Have, 2004, p.22). This position enabled the development of the cognitive aid to support practice. As a product of methodological 'respecification', the aims and objectives of this study (the 'sending context') reflected the development of a practical supplement in the form of the cognitive aid, and subsequent investigation into its usefulness, both within a focus group setting and real-world practice. Within this study, thick descriptions provided sufficient information to assure 'receiving contexts' of the 'fittingness' of this study within British operational policing contexts. In terms of their own experiences and judgment, it is meaningful and applicable (fits) to operational policing, and study findings could be used ('fittingness') within contexts beyond those incorporated within the boundaries of the study (Sandelowski, 1986, p.32).

5.6.6 Dependability

Analogous with the positivist standard for rigour, *reliability*, dependability was the assurance that the research process followed a logical, expected progression, commensurate with specific epistemological, theoretical and methodological positions and methods. Furthermore, methodological positions, methods and associated decisions were documented and externally verifiable for quality assurance purposes, enabling reproduction by others (Lincoln and Guba, 1985; Koch, 1994; O'Leary, 2004; Tuckett, 2005; Given and Saumure, 2008; Jensen, 2008c; Saumure and Given, 2008).

Within this study, the precise replication of the results was not possible. This was due to the contextually and temporally determined circumstances determining the reality explored at the time of the study (Heritage, 1984; Sacks, 1992; Hammersley, 2003; Francis and Hester, 2004). This study therefore provided an audit trail of research practices, of sufficient depth and detail to create the climate for another to repeat (verify) its steps. Doing so, it allowed the possibility for another to achieve

"…comparable but not contradictory conclusions…" (Koch, 1994, p.92). It also permitted the research design to be a "…prototype model…" for a replication of the study (Shenton, 2004, p.71).

The audit trail (which included the research diary) articulated the motivation for the study; its aims and objectives; participant selection; data collection and analysis methods; the process of reconstruction and description of findings; notes / records conveying relevant contextual details, challenges, dilemmas, decisions and their rationales occurring within, and influencing the research process - information considered sufficient for reproduction of the study (Lincoln and Guba, 1984; Sandelowski, 1986; Koch, 1994; Lincoln, 2004; Shenton, 2004; Jensen, 2008; Thomas and Magivily, 2011; Polit and Beck, 2012; Houghton et al., 2013).

5.6.7 Confirmability

Akin to the positivist standard for rigour, *objectivity,* confirmability was the assurance that my interpretation, reconstruction and description of a phenomena was indisputably grounded within a specific social context. The participants' (police officers) observed behaviours, narratives and constructed accounts, were therefore not, "…figments of the inquirer's [my] imagination" (Schwandt, 2007b, p.299).[46] It was the assurance that the study findings could be traced through their reconstruction and interpretation (acknowledging the effect of researcher bias), to where they were described, and to the underpinning epistemological, theoretical and methodological positions and methods, governing why and how they were obtained and transformed (Seale, 2002; Shenton, 2004; Tuckett, 2005; Schwandt, 2007b; Saumure and Given, 2008; Thomas and Magilvy, 2011; Polit and Beck, 2012: Houghton et al., 2013).

[46] This study therefore maintained records in accordance with Lincoln and Guba's (1985, pp.319-320), six-stage "…confirmabilty audit…" of the following materials and processes:

1. "Raw data: physical materials from which study data was obtained, and from which the pathway of interpretation, reconstruction and description could be clearly traced.
2. Data reduction and analysis products: records demonstrating the manner in which themes and categories were generated, and their linkage to supporting raw data.
3. Data reconstruction and synthesis products: records demonstrating concept generation and explanation, descriptions of the phenomena, and their linkage to their points of origin / significance within the data.
4. Process notes: records demonstrating methodological decision-making, explanations, rationales, strategies and procedures, data peer / supervisory review and member check feedback, and its relationship to data analysis.
5. Materials relating to intentions and dispositions: records demonstrating the relationship of the study to its aims and objectives, its epistemological, theoretical and methodological positions, and the researchers' reflexive stance.
6. Instrument development: records illustrating the development of the concept and observable indicator tool, and its relevance to the social reality being explored."

5.7 Chapter summary

Guided by an ethnomethodological design, and situation awareness framework, within this chapter, I defined the processes and ethical considerations governing the conduct of this study. Using distinct approaches to data collection and analysis, within stage one I established the conditions and boundaries necessary for the revision of the PPEAT cognitive aid (establishing the PPEAT-R), its underpinning concept framework, and the data analysis framework (concept and observable indicator framework), used in stage two (phases one and two). Similarly, within stage two, I established the conditions and boundaries necessary for the investigation of police officer responses, prior to, and following, the introduction of the PPEAT-R (phases one and two), and an investigation of the usefulness of the PPEAT-R, in operational, real-world practice (phase three).

Within the following chapter, I describe the findings of stage one of this study. I first describe the themes emerging, as a consequence of thematic analysis and concept mapping of individual semi-structured interview data. I then describe the themes emerging as a consequence of a secondary analysis of the overall data obtained from both the narrative synthesis and individual semi-structured interviews.

CHAPTER 6

FINDINGS

STAGE ONE: PREPARATORY STAGE

6 Introduction

Within this chapter, I describe the themes which emerged from both the individual semi-structured interviews and narrative synthesis (Chapter three). This chapter is presented in three sections. I first describe the overarching themes emerging from the individual semi-structured interviews. Next, I establish the extent and nature of relationships within the data, using the results of the narrative synthesis and individual semi-structured interview data. Finally, I provide a summary of the chapter.

6.1 Individual semi-structured interviews: overarching themes

Within the individual semi-structured interview data, four overarching themes emerged, illustrative of the specific processes police officers used to identify and manage a mentally disordered person (Appendix 18):

1. *Pre-encounter.*
2. *Encounter.*
3. *Processes used to make sense of the situation.*
4. *Synthesis and decision.*

6.1.1 Pre-encounter

The study data suggested that the specific processes, reasoning, and criteria police officers used to identify a mentally disordered person, do not necessarily come into play at the point of encounter, but prior to it, during, the pre-encounter phase. The pre-encounter phase reflected the factors which were seen to govern a police officer's ability to perceive, comprehend and respond to mentally disordered person, prior to encountering them in the course of their work. Several factors shaped police officers' responses to a person with a mental disorder, prior to their

encounter. These were the level of knowledge and understanding regarding the identification and management of mental disorder (prior specialist knowledge, fear of mental disorder). The level of operational experience of such people (experiential response) was a factor. So too was the manner in which they perceived mental disorder (views), and the manner in which they perceived and applied their professional role (role expectations). These interconnected factors shaped a police officer's Level 1, 2 and 3 SA.

6.1.2 Encounter

The encounter phase reflected the factors which governed a police officer's ability to perceive the presence of mental disorders, during their operational exposure to them. The encounter phase was influenced by situational factors and the processes they used to acquire information within a situation. A police officer's response was however shaped by pre-encounter factors. This was (noted above) in the form of their operational experience, their ability to identify and assign significance to signs of mental disorder, their views regarding mental disorder, and how they viewed their operational role. These factors shaped a police officer's Level 1 SA.

6.1.3 Processes used to make sense of the situation

Having encountered a person and begun the process of information acquisition, police officers sought to make sense of it. Three interconnected factors influenced the manner in which police officers comprehended the presence of mental disorder. First, were factors which influenced the manner in which police officers were able to piece together information necessary to comprehend the presence of mental disorder (pattern recognition). Second, their level of knowledge and understanding regarding the identification and management of mental disorder (prior specialist knowledge) appeared to influence their comprehension. Third, was the ability of the police officer to disentangle the signs of mental disorder, from apparent criminal behaviour. Underpinning this response were again Pre encounter factors. These factors shaped a police officer's Level 2 SA.

6.1.4 Decision

Synthesis and decision represented factors which shaped a police officer's operational decisions and response to a person with a mental disorder. Echoing the pre-encounter phase, the response to and within a situation was largely dependent

upon the individual police officer's experience, personal characteristics, and their perception of their role (individual mechanisms). Factors relating to the police officer's perceived value of and response to health services had some bearing upon their decisions and response (relationship with healthcare agencies). Police officers also considered their decisions and responses to be mostly appropriate to the situation encountered (doing the right thing). These factors shaped a police officer's Level 3 SA.

6.2 Establishing the extent and nature of relationships within the data

Following concept mapping of narrative synthesis and individual semi-structured interview data, six overarching themes emerged. These themes were illustrative of the factors underpinning the specific processes police officers used to identify and manage a potentially mentally disordered person:

1. *Pre-encounter.*
2. *Appearance.*
3. *Behaviour.*
4. *Communication.*
5. *Danger.*
6. *Environment.*

6.2.1 Pre-encounter

Reflecting the themes emerging within the concept mapping exercise, pre-encounter factors had a significant influence upon a police officer's ability to perceive, comprehend and respond to a potentially mentally disordered person, prior to their operational exposure to them. *Pre-encounter* was characterised by five dominant, interconnected sub-themes:

1. *Viewpoints.*
2. *Role-specific response.*
3. *Prior specialist education.*
4. *Experiential response.*
5. *Multi-agency relationships.*[47]

[47] The themes are italicised in-text to aid reference.

Fundamentally, the personal *viewpoints* held by police officers shaped their perception of mental disorder, and as such, their professional response to it. For some, mental disorder was something which was not understood, and as such, something to be feared:

> *"…if er, if you put it in, in a context… I did history at university …and the one of the big problems to lead up to the first world war is the battleships, it's not, it's not the building of battleships it's what's the perceived threat from say battleships, or the perceived building programs, it's got nothing to do with what's actually there… And, and, and it, and it's that in mental health to my mind is ex, it's almost exactly the same thing in a different context…" (No. 2)*

Others were derisive, seemingly viewing mental disorder as a justification for their actions:

> *"I mean a, a lot of people use mental illness as an excuse…" (No. 7)*

Such views were however not illustrative of all police officers. This was particularly noted where police officers had personal experience of mental disorder, experienced by a family member. In such cases, their experience of mental disorder had a positive influence upon their response:

> *"Me mam suffers from quite severe mental health problems, so… And it's something that I see people like people saying I have a quite positive in regards to try helping people…" (No. 8)*

In addition to the influence of personal viewpoints, the manner in which police officers perceived their operational role and duties (*role-specific response*), shaped their perception, and therefore their response, to a potentially mentally disordered person. Amongst all of the police officers, there was a clear view of what their professional role entailed:

"I'm here to prefect, protect the public …Maintain safety, and prevent crime." (No. 6)

Some police officers had fixed views of their role, potentially affecting how they dealt with a mentally disordered person. Several police officers expressed the view that their role was simply the management of people who violated clearly defined laws; a role which did not include the recognition and management of social or mental health problems:

"You know, we are not social workers, we are not mental health workers, we are police officers and our role is to deal with the criminals." (No. 1)

Others however, saw their role as being more person-centered. In doing so, they seemed to view a criminal offence, as a consequence of a person's mental disorder. Such views appeared illustrative of police officers with greater experience of working within local communities, alongside health and social care services:

"Some people aspire to be, they think that everything got to be dealt with through a criminal justice route because we are police officers, so we use criminal justice, and there are those, perhaps neighbourhood officers who maybe have a much more multi agency approach, so it's an individual thing." (No. 1)

Despite the apparent inconsistent manner in which some police officers viewed situations involving a potentially mentally disordered person, each one felt they were acting appropriately according to how they perceived the role. When exercising this role, they felt that they were doing:

"…*the right thing." (No.1)*

However, the ability to do the right thing when attending a person with a mental disorder implied some degree of prior education, to equip the police officer with the requisite skills. The degree and nature of *prior specialist education* therefore had some influence upon police officers' understanding of the features and management

of a person with a mental disorder. Amongst most police officers, there was an acknowledged difficulty in recognising and responding to the features characteristic of mental disorder; most police officers acknowledging a distinct gap in their knowledge, rendering their response somewhat inconsistent:

> *"The majority of cases, you can't make that decision because mental illness is so, I would say, complicated and deep, and certainly not in my expertise." (No. 4)*

> *"You know there's certain areas where we're probably might interpret wrongly rather than correctly…" (No. 6)*

This difficulty was reported to be due to a lack of education in the identification and management of a mentally disordered person. Whilst police officers who viewed their role in terms of simply preventing crime, seemed somewhat ambivalent, police officers who were more person–centred, considered specialist education to be vital:

> *"…but I think we can actually, I think we can widen people's awareness, and widen people's focus on mental health by introducing just, I mean it's not, to just introduce some basic, basic concepts…" (No. 3)*

Rather than simply being a product of specialist education, police officers who had practical understanding and operational know-how within situations containing a mentally disordered person, also appeared to be influenced by their *experiential response*. For a few police officers, the *experiential response* appeared to be shaped by a personal resource, which they could draw upon during encounters:

> *"…you sort of have in your brain a toolkit bag, and what can I pull out of that toolkit bag to help me right now, whether it be other departments, other people, or whether it be my skills and abilities." (No. 4)*

The 'tools' utilised were dependent upon how a particular situation presented itself:

> *"…it depends on what's what you are dealing with, as to what sort of tools, and and, the other impact factors, where you are, what time of night it is, who else is available, as, as to what tools you pick out." (No. 4)*

This personal resource ('toolkit') was equipped by some form of prior education, but largely by the individual experience of the police officer:

> *"As you progress through the police force, your level of understanding and experience of what you've got available to you, within the police force or your own skills, or externally, different departments, different agencies." (No. 4)*

However, this personal resource did not appear to ensure a consistent response by the police officer, rather one evolving individually:

> *"It may be I've dealt with a person and a specific incident… five years on, I am dealing with a similar incident, but I may well now deal with it very differently, because of this toolkit in my head." (No. 4)*

Despite additional training, when faced with such complex, often unpredictable situations, and where there are inexact operational protocols, police officers referred to prior experiences to assist them:

> *"… but no policy or guideline can tell you cos it depends on that person you are dealing with, em, the policy or guideline might say in this particular instance, you do this, actually I can't because my victim, isn't, I'm not able to do that right now. So you adapt." (No. 4)*

In such situations, most police officers reported that they utilised the experiential response of 'gut instinct' to guide their response to people, and situations. 'Gut instinct' was considered a product of years of experience, during which time they encountered differing (often mentally disordered) people, in differing situations. This 'gut instinct' seemed to draw a police officer's attention to a particular person's

features, actions or activities; features, actions or activities which may themselves appear innocuous, yet are subconsciously significant:

> *"…when you come into daily regular contact with people…you can again think, well that was like x or y on this occasion … you rely on your probably it's, it's almost like er like a an instinct or a, or a gut feeling…" (No. 3)*

However, police officers developed gut instincts from some, but not all situations they encountered. 'Gut instinct' was therefore a somewhat inconsistent mechanism to identify a potentially mentally disordered person:

> *"It's either something that you, I think you have or you haven't." (No. 3)*

A police officer's ability to identify and respond to a mentally disordered person was influenced by their personal and professional viewpoints, prior education and experience. This was shaped by the depth and significance of their *multi-agency relationships.* Irrespective of how police officers perceived their role, once they had identified a person as being potentially mentally disordered, they had an expectation that the person would receive some form of help:

> *"…where we label everybody as, as you know having some mental health problems, we assume that the support services the network of the mental health caring system would be there to… To, to undertake some sort of response to them." (No. 3)*

It was reported that paramedic services could be called upon, for people considered to be in immediate crisis. In all other circumstances however, all police officers reported difficulty in accessing health services such as general practitioners, and mental health crisis teams. This seemed particularly problematic outside 'normal' working hours:

> *"I don't know of any, other than the crisis team, hospitals, where any expertise, that you can draw upon, when the bulk*

of the problems occur, which are on a night time and predominantly on a weekend." (No. 1)

When trying to access these services, most police officers reported that they had to approach a range of different services, as their requests for help were often rebuffed or redirected. When their requests for help either with, or for a mentally disordered person, were rejected or deflected, they had to spend a great deal of time seeking a service that would help. In such circumstances, police officers often found this process to be frustrating, time consuming and unproductive:

"…because you can't say, you can't get into the what I call the people table tennis… And that, what like ping ponging them on to, to different agencies, and that's what you feel like sometimes, and I don't want to say well then your gonna have to phone such and such." (No.7)

Police officers reported that particularly during the night, their numbers were reduced, compared to day-time shifts. As such, there was significant operational pressure for them to conclude 'jobs' as quickly as possible. Dealing with a mentally disordered person was broadly considered a time-consuming, and often frustrating task. In the absence of accessible mental healthcare support, decision-making regarding the management of the person defaulted to individual officers:

"And so, we are being asked to make decisions, and at times, where, where, ordinarily, three, four o'clock in the morning, you know, where you haven't got the support." (No. 1)

Most police officers however, recognised a distinct gap in their knowledge, rendering their response somewhat inconsistent:

"You know there's certain areas where we're probably might interpret wrongly rather than correctly…" (No. 6)

6.2.2 Pre-encounter-danger linkage

A significant link between the themes *pre-encounter* and *danger* was identified. This link was their *role-specific response*. The findings revealed that police officers' pre-existing knowledge, skills, experiences and attitudes (*pre-encounter* factors), governed their assessment and response to danger, within every situation encountered. The assessment of danger was undertaken before any other assessment and this determined their role-specific response. Whilst a police officer's response was to some degree governed by situational dynamics, the findings suggested that they defaulted to a series of pre-set behaviours to control and contain a situation before undertaking further enquiries. These behaviours were either pre-learned as part of their training, or learned experientially.

Pre-encounter factors also underpinned and governed a police officer's identification and response to a potentially mentally disordered person. Their operational, street-level response was shaped by a constellation of other factors, falling within five distinct, yet somewhat interlinked domains: appearance; behaviour; communication; danger; environment (Figure 18).

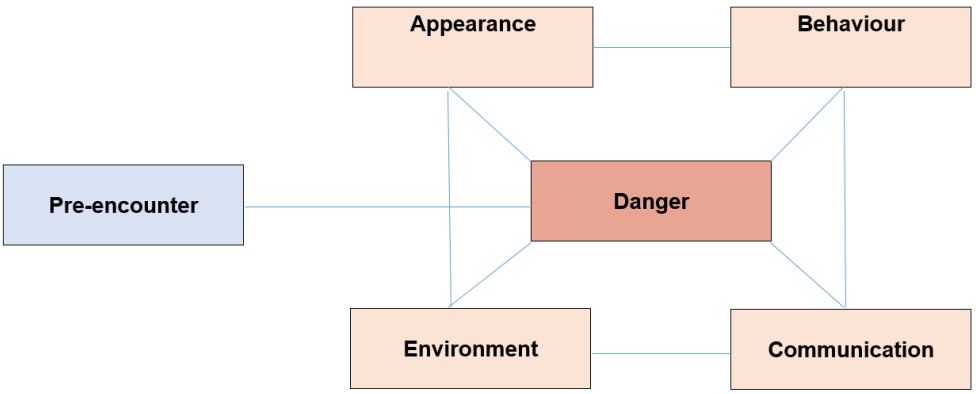


Figure 18: Interconnectedness of Concepts.

6.2.3 Appearance

Within the study data, police officers associated certain features of a person's appearance with the presence of a mental disorder. However, not all police officers noted the same features associated with *appearance*. A police officer's recognition

of a person known to have a mental disorder (prior contact) provided a clear association. Police officers also considered certain patterns of dress, physical characteristics and patterns of injury or illness as being associated with the presence of a significant mental disorder. This theme therefore reflected the factors which governed a police officer's ability to perceive, comprehend and respond to a mentally disordered person, based on their appearance. *Appearance* was characterised by seven interconnected sub-themes:

1. *Incongruence with own norms.*
2. *Prior contact.*
3. *Features of mental disorder.*
4. *Clothing.*
5. *Signs of physical injury.*
6. *Signs of self-harm.*
7. *Physical characteristics.*

Incongruence with own norms was characterised by the features of a person's appearance, which due to mental disorder, did not align to a police officer's accepted conventions; conventions shaped by their views or experience. Some police officers did not always immediately associate specific features of a person's appearance with the presence of a mental disorder, yet they were able to perceive something as being of potential significance: something that did not explicitly align to their expectations. Police officers considered themselves particularly skilled in this:

> "*Erm I tend to think police officers are, when they're out there day in day out they know when people, they're probably very good at picking up the little things." (No. 6)*

The sub-theme *prior contact* represented a police officer's recognition that a person had a mental disorder, based upon their previous dealings with them. When encountering a person, the first question most police officers asked themselves was:

> "…do we know them before?" *(No. 6)*

If a person had previous, formally recorded dealings with the police, any significant mental health issues would be recorded within the police national computer system (PNC).[48] In seeking to determine the presence of mental disorder, some police officers would provide a detailed description of the person to the police control room. Descriptions would include any particular physical markers, which could be cross-checked with any information held within the PNC:

> *"You then, em, look for identifications, whether it be that person actually hasn't got any identification on them, they've got nothing, you then start to look at tattoos, marks, scars." (No. 4)*

When determining the presence of mental disorder, all police officers expressed personally held viewpoints as to the *features of mental disorder*. All police officers however, provided descriptions in broad, non-specific terms, often using diagnostic terms, without qualification:

> *"…became you know he became verging on the psychotic I think erm I don't know maybe that's not the right word." (No. 2)*

Within their initial assessment, most police officers assessed for illness or injury. *Signs of physical injury* represented wounds / physical, which was suggestive of mental disorder. Some police officers recognised that it could be difficult to differentiate mental disorder from other conditions, as the *signs of visually apparent physical injury or illness* may be very similar:

> *"…there's a lot of similarities between somebody who is under the influence of alcohol or drugs, em, and there's, somebody who is under the influence of alcohol or drugs, somebody who is ill through diabetes or some other factor, or somebody who is actually mentally ill. And those three*

[48] The Police national computer is a national database containing information about a person, following their arrest or caution. It includes: "personal descriptions; bail conditions; convictions; custodial history; wanted or missing reports; warning markers; pending prosecutions; disqualified driver records; cautions; drink drive related offences; reprimands; formal warnings." (Home Office, 2014b, p.5). It contains information relevant to the circumstances of the person's arrest, and any additional comments from the police officer, and warning markers considered of use during subsequent police contact (National Police Improvement Agency, 2012; Her Majesties Inspectorate of Constabulary, 2017).

results could all have the same, em, displays in that person." (No. 4)

To all police officers, some injury patterns were indicative of mental disorder. *Signs of self-harm* represented the signs / patterns of injury of illness police officers considered to have resulted from intentionality, rather than misfortune. Cutting oneself was the most common self-harm act identified. As such, where mental disorder was suspected, police officers sought to identify signs:

"…but while I'm listening to what they're saying I'm looking at them, I'm looking for signs of self-harm…" (No. 7)

Police officers often associated certain *physical characteristics* with the presence of mental disorder. Uncleanliness, poor physical hygiene and a lack of attention to personal grooming were associated with mental disorder:

"…you know is that somebody who's unkempt because you know they, they don't know how to look after themselves or they're deliberately choosing not, not to look after themselves." (No. 3)

Some police officers associated a particular gait with mental disorder. Reflecting 'gut instinct', when pressed they were unable to specifically describe particular gait patterns. Yet, they were assured that some mentally disordered people walked in a particular way:

"…other things, like the way they're walking…" (No. 4)

The manner in which a person dressed, or the state of their *clothing,* could be suggestive of mental disorder. Police officers reported that mentally disordered people often dressed incongruously, when compared to others within a locale. Mentally disordered people were also reported to be often, somewhat unkempt:

"There was food down her clothes, and her clothes were a little odd that presented as quite a smart appearance, which wasn't, which wasn't in keeping with anything else." (No. 2)

Within the interviews, police officers associated several aspects of a person's appearance with mental disorder. A person's appearance did not however explicate the wider processes police officers used to make this association. Within the interviews, police officers also aligned certain features of a person's behaviour with mental disorder.

6.2.4 Behaviour

All police officers associated certain features of a person's behaviour with mental disorder. However, not all police officers noted the same features. Police officers associated certain unpredictable or aggressive actions with the presence of a mental disorder. Conversely, unexpectedly quiet / introverted behaviours were also associated with a mental disorder. Some police officers associated intoxication with the presence of mental disorder; often impeding their ability to clearly identify it. Some police officers also associated certain criminal acts with mental disorder; some did not. This overarching theme therefore reflected the factors which governed a police officer's ability to identify mental disorder, based on a person's behaviour. *Behaviour* was characterised by nine interconnected sub-themes:

1. *Incongruence with own norms.*
2. *Features of mental disorder.*
3. *Self-harming behaviour.*
4. *Disrespect towards police officer.*
5. *Effects of intoxication.*
6. *Role-determined response.*
7. *Aggressive or violent behaviour as a consequence of a mental disorder.*
8. *Criminality.*
9. *Deviation from expected criminal behaviour.*

Incongruence with own norms was characterised by the features of a person's behaviour, which due to mental disorder, did not align to a police officer's accepted conventions. Whilst all police officers were unable to articulate all behaviours associated with mental disorder, there was a tacit recognition that a deviation from their norm, could be indicative of mental disorder:

"…there is something, not quite right, that we need to help." (No. 4)

There was degree of variability amongst police officers regarding their ability to identify and describe, in their own terms, particular *Features of mental disorder*. Reported features included inconsolable distress, withdrawal, preoccupation, delusion, and a belief that an inappropriate act is appropriate. Inconsolable distress (distress that appeared disproportionate to the situational context) seemed to be something which made some police officers consider the presence of mental disorder:

"…somebody could be crying, very, very upset." (No. 4)

The presence of mental disorder was associated with a person gesticulating (with their hands or fingers), either towards others, or in some cases, without a specific focus:

"…we saw a bit of the usual finger pointing…" (No. 2)

A definitive sign of mental disorder was withdrawal, and a corresponding lack of responsiveness towards police officers, or others:

"I had a male in, showing clear signs again of mental health problems, really down…" (No. 5)

Preoccupation was also considered a definitive sign. Police officers reported that people who were preoccupied were unduly focussed upon things, to the exclusion of all else going on:

"…and they fixate on things…" (No. 7)

Some police officers were able to differentiate this from people who appeared to be somewhat detached from reality (e.g. suffering a delusion). In some cases, a delusion was manifest as *criminality*; the person seemingly believing that an inappropriate act is appropriate:

> *"…or they've stolen something, in their head they believe they are well entitled to that because of, and they give a, such a , it's obviously not good a reason, but they give such a sort of compelling sort of a story behind it and you think, well, if you believe that, I can see why you've done that." (No. 5)*

All police officers had individual ideas of what constituted mental disorder. This was translated into the way they described it. All police officers described behaviours associated with mental disorder in broad, non-specific terms, often using diagnostic terms in a 'pick-and-mix' fashion, without qualification:

> *"…whether someone with a personality disorder, that is just their personality, or whether they might be suffering from schizophrenia, they might be em you know, suffering from like bi-polar, and, em…" (No. 1)*

Whilst there was some degree of variability amongst police officers regarding their ability to identify and describe, in their own terms, particular *Features of mental disorder*, *self-harming behaviour* was something police officers were particularly vigilant for. This sub-theme represented the range of actions considered suggestive of intentional self-injury (actual or potential). It was most commonly associated with suicide attempts:

> "*The majority of mental health wise, em, mental health, I would suggest a lot, the majority of mental health come in for suicide attempts." (No. 5)*

For some police officers, a person who demonstrated any evidence of *self-harming behaviour* was considered a suicide risk. For one police officer, historic injuries were still considered a strong indicator of risk:

> *"Well old scarring doesn't mean to say that they've stopped self-harming… Erm cos they could be self-harming in other areas where you can't see." (No. 7)*

Other behaviours were associated with mental disorder. When a person demonstrated *disrespect and resistance towards police officer,* it was not always associated with a person's lack of respect and / or refusal to comply with police command, but the manifestation of a potential mental disorder:

> *"…you can you're talking to people in like you're talking to them, and they're just not listening… Or not that they're not listening…And like you just like distancing it just like you're talking to somebody that's not listening." (No. 8)*

A lack of response, even active resistance toward a police officer, was considered a possible indicator of mental disorder:

> *"I think some, sometimes people who, people associate mental health with people who are shouting and raving and bawling that you know they, you know they're strong, and resisting, and, and it's the quiet ones that sometimes worry me, the people who are reserved and withdrawn who aren't saying very much." (No. 3)*

The *effects of intoxication* represented the behavioural features of mental disorder associated with drug and / or alcohol intoxication. Most police officers appeared to consider intoxicant use a significant factor in altering a person's behaviour:

> *"…and different people react differently to alcohol. Some people are very placid, some people can become extremely violent." (No. 1)*

For some police officers, intoxicants severely impeded the process of identifying the presence of mental disorder:

> *"And the usual thing is, we can't make an assessment, until they're sober, which is quite right, but what they are doing is, they're asking us, who are least placed, to make that decision. We're being asked to make a decision, 136 or drunk and disorderly, on the behaviour…" (No. 1)*

Within the interviews, aggression was commonly associated with intoxicant use, further compounding this process:

> *"We take that as err, as an indicator erm because people show they can be more aggressive when they've got, when they're err under the influence of drugs and alcohol." (No. 7)*

For one police officer, the aggressive effects of intoxicant use were considered significant, particularly as they may result in a heightened (tactical) police response:

> *"And they're harder to control when they are more aggressive, because with the pain thresholds a lot higher erm and the, sometimes in, in, in particular they, they're on drugs and alcohol erm they get this super human strength… And that influences well, like how many officers would, deal with it, it would all depend on the situation." (No. 7)*

Reflecting a *role-specific response*, where there was escalating resistance from the person (particularly where violence was anticipated), rather than seek to diffuse the situation, most police officers defaulted to their role of managing those who violate clearly defined laws:

> *[The person appears] "…rude, so you become confrontational…and that's not really the answer because often that just means they'll become more confrontational. And you'll get in an escalating situation, but it's recognising that and I, I think we're not the best at those, dealing with those things." (No. 6)*

Within confrontational / combative situations, rather than act punitively, some police officers however sought to differentiate *aggressive or violent behaviour as a consequence of a mental disorder,* from other, non-mental disorder-related causes:

> *"…sometimes just extreme, extreme violence, just that a, a, a, a real lack of, a lack of engagement." (No. 3)*

Irrespective of aggressive or violent behaviour being a consequence of mental disorder, police officers often had limited scope within which to manage the situation:

> *"…if somebody's physically violent, the fact that they are mentally ill doesn't really make much of a difference because you have to just get control of the situation." (No. 4)*

Getting "…*control of the situation…"* was getting control of the person. Often, this was through the through the use of restraint. With some caveats, the presence of mental disorder did not preclude restraint, if such control was required:

> *"Physical disability, weapons, or pregnancy will, because it has an impact on what force you can use etc. dealing with somebody who's violent, unless there' something glaringly obvious that says, hang on, they've got a knife, don't do that, don't use that kind of restraint, or they're pregnant, don't use that kind of restraint, then we wouldn't deal with them any different." (No. 4)*

To most police officers however, *criminality* associated with mental disorder was a common occurrence. This theme represented the criminal acts police officers considered most frequently committed by a person with a mental disorder.

> *"… shoplifting at Tesco's, which for me, is the more common type of crime committed by somebody who later down the line, happens to be suffering from a mental illness, that I've been involved with." (No. 4)*

> *"… you might get shoplifting because they are nicking their alcohol…-But not a burglar in the house." (No. 6)*

Deviation from expected criminal behaviour represented the methods police officers used to determine the underlying reason for a criminal act. Within the interviews, police officers demonstrated a spectrum of views regarding the culpability of a person suffering a mental disorder. At one end of the spectrum, three police officers

considered their primary role to respond to people who violate clearly defined laws. They felt that a criminal act should be punished, regardless of mitigating factors:

> *"We are there to deal with the crime, the crime has taken place, regardless whether someone has done it because they have suffered some mental breakdown or whatever but that crime has taken place and their role is to deal with that crime." (No. 1)*

Moving across the spectrum, for some, culpability was considered dependent upon information or evidence immediately available, during initial contact with the person:

> "*And unless something's glaringly obvious, that says, I didn't do this because I'm a criminal, I did this because I am ill, then you just have to deal with what you have got. Everything is on suspicion." (No. 4)*

Within these encounters, the perpetrator may disclose that they have a mental disorder, by way of mitigation. One police officer appeared to express their suspicion as to the veracity of such disclosures:

> *"So, so like as in that instance it would be like, well I've got somebody who's done a bit of a petty crime, but now I've got someone who saying let's kill their self… And I'm thinking, I'll be thinking to myself are they genuine firstly… It does cloud your judgement cos you think you know how many times has somebody said I've got this or this that's the reason why I've done that… You know what I mean, it it is hard." (No. 8)*

Moving towards the more person-centered end of the spectrum, a person's health need appeared to assume greater significance, than their culpability:

> *"…if you look at everything on the whole, if you look at the incident he's a criminal, if you look at everything in the whole this guy, perhaps this guy needs help more than he needs a criminal record." (No. 2)*

At the person-centred end of the spectrum, it was the person, and their mental health need, that seemed to take precedence over any associated criminal act:

> *"But then are you criminalizing somebody who is genuine, is a genuine suffering from mental health problems… Doing things a bit out of character, and a little bit lost, doesn't know what they're doing, and then say I don't know for example you know I've not took the tablets for a couple of days… all over the place, because they haven't." (No. 8)*

6.2.5 Communication

Police officers drew upon a range of information sources when determining the presence of mental disorder. Within the study data, what people said, and how they said it, could suggest the presence of mental disorder. Information from wider sources, such a police intelligence systems, or others present, could provide information about a person. This often suggested that a person may have a mental disorder. This overarching theme therefore reflected the factors which governed a police officer's ability to perceive, comprehend and respond to a mentally disordered person, based on their communication, or communication between other sources. It was characterised by ten interconnected sub-themes:

1. *Information obtained prior to arrival at scene.*
2. *Incongruence with own norms.*
3. *Communication style.*
4. *Vocalised intention to deliberately self-harm.*
5. *Presence of mens rea.*
6. *Demonstration of capacity.*
7. *Information obtained from the person.*
8. *Information obtained from police intelligence sources.*
9. *Information obtained from persons within scene.*
10. *Information obtained from the multi-disciplinary team.*

Information potentially useful to a police officer was often relayed to them by the police computer-aided dispatch (CAD)[49] operator, prior to their arrival at an incident

[49]The CAD operator is based within the control room of a police service. They are the central point of communication for all police officers. They dispatch police officers to incidents, and relay information to them. They also have access to the PNC and are therefore the point of contact when police officers,

scene. Most police officers reported that they were often given some degree of contextual information if called to attend an incident. Such *information, obtained prior to arrival at scene* represented the range of prompts, suggestive of mental disorder, provided by concerned members of the public, or family members:

> *"We massively rely on intelligence and information from members of the public." (No. 5)*

Such calls provided a useful indication of the situation to be encountered:

> "*I think a lot of it's pub, probably where we get it er obviously calls, I wouldn't call it criminal activity it was calls from members of the public who are concerned about them because they're sitting on a bridge or they've said… Something to somebody…" (No. 6)*

For one police officer, such information often caused them to respond in a somewhat pre-determined manner:

> *"Then erm there are clearly issues in your mind…" (No. 3)*

For one officer, however, where there were multiple information updates whilst en-route, rather than being helpful, it could be confusing:

> *"The more information is coming from the public, it's constant decision change in process." (No. 4)*

Upon arrival, most police officers were very skilful in detecting the often subtle and ambiguous cues suggestive of mental disorder. Often there was an *incongruence with own norms.* This was characterised by the features of a person's communication, which, due to mental disorder, did not align to the police officer's accepted conventions. For one police officer, an absence of communication, where conversation was expected, rendered the potential for mental disorder:

---

attending an incident, seek information. For example, checking a car registration, or information (if available within the PNC database) about a person they are speaking to. This could be information regarding any previous mental health problems, resulting in police involvement.

"…but it's the people who you don't hear, the people that erm you think there might be something going on in their life, you think that something is, that they've got that erm is just not right, you know it." (No. 3)

The *communication style of the person encountered* represented the varying verbal and non-verbal symbols police officers commonly used to identify mental disorder. For some police officers, speech directed to an unknown / unseen person was associated with mental disorder:

"…if they are talking to people, that's generally a sign that they'd be answering people, or suggesting there's somebody there with them that's to blame." (No. 5)

As too was incoherence:

"It is mainly what's said. It really sounds bizarre, but they're all people talking to themselves or rambling on…That's obviously a clear indication." (No. 5)

Eye contact was also considered significant:

"…one party who just doesn't give us eye contact…" (No. 4)

For most officers, shouting and screaming was viewed as a feature of mental disorder:

"…people who are shouting and bawling…" (No. 2)

Often, this was in conjunction with behavioural features such as invasion of personal space:

"…shouting maybe getting a bit close in the face, but no physic…." (No. 2)

Conversely, for some police officers, quietness was significant. For one police officer, rather than appearing incongruent, it was seen as a precursor to acts of self-harm:

> *"It is, but the sort of corollary to that is my concern about the quiet ones is the quiet ones are likely to harm themselves or have a, a, a, an attempt at er, er, at er killing themselves." (No. 3)*

Through their interpretation of the person's verbal communication, *vocalised intention to deliberately self-harm* represented the features police officers considered suggestive of intentional injury (actual or potential). Most police officers felt able to recognise words which indicated a person's intention to deliberately self-harm:

> *"Certain I know there's words to like you can kinda think that word like I'm going to commit suicide, I'm going to kill myself." (No. 8)*

For one police officer, a vocalised intention to deliberately self-harm was sometimes shrouded within a metaphor, requiring them to disentangle the significance:

> *Erm and then they would tell him themselves you know yourself what, sometimes they'll tell you that, oh I'm feeling a bit crap." (No. 6)*

A vocalised intention to self-harm (to the police officer or others) or a 'suicide note' was a clear indicator of mental disorder, and as such a need to intervene to safeguard the person:

> *"Cos that's what we're here for to try and make sure people, to save people's lives if they're in danger, and obviously even saying I'm gonna go and kill meself, left a suicide note, as previous for self-harm, and stuff like that you're thinking, I was like the sergeant that night I think to myself bloody hell we need to find this person like." (No. 8)*

Some police officers were sensitive to *information obtained from the person,* in the form of triggers, suggestive of the presence of mental disorder:

> *"…one of things that, that I look at as a police officer is if I can, the first things I notice isn't just I hear what they're saying, and I listen to what they're saying." (No. 7)*

Where time constraints permitted, some police officers probed for more information to identify mental disorder:

> *"That's, to me that's the important thing, listening and talking to him… And saying what's the problem you know, how can I help yer, listening to what he's saying." (No. 7)*

For one police officer however (despite the unfortunate analogy), this was also an opportunity to establish the authenticity of a person's mental disorder, and as such, possible culpability:

> *"…equally if they're not telling the truth, the more time you spend with them the more information they give you, the more chance they have of beginning to conflict just with that you know, give them the rope to hang themselves with." (No. 2)*

Although most officers did not seek to establish the authenticity of a person's mental disorder, they all sought to establish the *presence of mens rea.* This represented the factors police officers considered, when seeking to establish if a person intended to commit a crime, or this intention was obscured by mental disorder. The establishment of *mens rea* however, came after they had controlled the situation:

> *You've got to do further investigations then to see, do they actually have the mens rea to do that. And the mens rea comes down to whether it is criminal intent, black and white, yeah, you've committed a crime, or whether actually, they didn't have the relevant mens rea, because they have no*

idea what they are doing, they're ill. That has to come after you've made your initial intervention." (No. 4)

Most police officers reported that they would also attempt to establish a person's *capacity*. This represented the factors police officers considered when seeking to establish if a person was able to understand and process information necessary for decision-making. It also included their ability to communicate decisions, either verbally or non-verbally.

"…we're guided by people's capacity to, and fitness to be detained, for them to be interviewed." (No. 3)

A few police officers considered a person's lack of awareness indicative of a lack of capacity, and therefore a possible feature of mental disorder:

"…they appear very confused and they don't know who they are." (No. 4)

For one police officer, the manner in which the person answered their questions could signify a lack of capacity, and as such potential mental disorder:

"…how they're answering the questions are they being a bit evasive, do they seem a bit vague or… Or distracted err are they making sense, do they know… Are they oriented kind of thing." (No. 6)

When probing for information, all police officers however noted a voiced, prior medical history of mental disorder, as significant:

"So I think it's, I think a lot of people do take into account previous history and try and get checks done and things…" (No. 5)

These 'checks' reflected *Information obtained from police intelligence sources*, primarily the PNC. All police officers routinely sought information about a person,

which could be cross-checked with data held in the PNC. This data was updated during police encounters. Where there was prior contact, it was termed a 'marker':

> *"…something on PNC, the police national computer – they might marker it." (No. 6)*

Even fragments of information could be used to try and identify mental disorder:

> *"…a name, a phone number…" (No. 4)*

Where a person's identity could be verified, the PNC could potentially yield information regarding relevant, available medical history, and risk factors:

> *"…if I've got previous history on the PNC of they are a self-harmer, they are violent, they assault police." (No. 5)*

Where there were recorded concerns, it was seen as a mechanism to support police officer decision-making:

> *"So yes, if we found out, it would then be on our intelligence system, and the next time we meet that person, actually they suffer from mental health and that's where we get the, yes, I can actually make that decision more immediately, than, before. And that will affect my decision." (No. 4)*

This included validating decisions to enact S136:

> "*So again, if we are on the street, and you're having to make a decision there and then, an entry on the PNC to say, what they are doing, or if they have any updates or any concerns, then we can directly section them." (No. 5)*

Where available, police officers also sought information from victims, bystanders, witnesses or passers-by. Such *information obtained from persons within scene* reflected the range of information / prompts elicited from victims, witnesses or passers-by:

> *"…are the family members around. Are they a local person, is there other people who would be able to give you that information. And all of that would be going on in the background." (No 4)*

Where mental disorder was suspected, some police officers would try to contact health services for information. In such circumstances, *information obtained from the multi-disciplinary team* would potentially enable them to make more informed decisions,

> *"…something very basic, something that was, so that we could say on there, if they're on the street, they could say, oh, it's drugs, or it's not, he actually had got mental health problems." (No. 5)*

For some police officers, information regarding a person's mental disorder was only forthcoming when they were asked to search for someone deemed at risk:

> *"…but we are routine, I would say once every other shift we've, we've got somebody that's either wandered out of the hospital unless the, the acute hospital, and they've said look they were waiting for treatment, they've been gone an hour we're concerned about them could you look for them, so we've got somebody who's potentially at harm." (No. 6)*

Most police officers considered this relationship to be somewhat one-way. A common source of frustration was a lack of response when police officers sought information from multi-disciplinary teams for a person they were concerned about. For one police officer, where mental disorder was suspected, it was left to individual police officers to make a decision regarding the degree of risk posed, and the powers they should enact:

> *"…we're being asked to make that decision." (No. 1)*

6.2.6 Danger

Noted earlier, a police officer's ability to identify and respond to danger was shaped by *pre-encounter* factors. It was also central to their assessment of a person's *appearance, behaviour, communication* and *environment.* Within the study data, police officers assessed and responded to the threat potential to, and by a person with a mental disorder, including the threat potential to members of the public and themselves. The anticipation of *danger* underpinned each encounter with the public:

> *"…everybody wants to fight you and even the decent people hate the police." (No. 1)*

The overarching theme *danger*, therefore reflected the factors governing a police officer's ability to perceive, comprehend and respond to a potentially mentally disordered person. It was based on the perceived dangers posed to, or by, a potentially mentally disordered person. It was characterised by eight interconnected sub-themes:

1. *Incongruence with own norms.*
2. *Experiential assessment of danger.*
3. *Person with potential mental health need.*
4. *Role-specific response.*
5. *Threats.*
6. *Weapons.*
7. *Public.*
8. *Police officer.*

Most police officers felt they could rapidly sense, and respond to danger. Some reported that whilst they could not always qualify the specific nature of the danger posed, they were able to sense something of concern (*incongruence with own norms*):

> *"…signs, that to me, might say, actually I don't think you're quite safe in this situation." (No. 4)*

In such situations, some police officers responded rapidly:

> *"I could meet that person and within 10 seconds, I've made a decision that I'm going to have to stay here and deal with this…" (No. 4)*

Where police officers reported that they could sense, and respond rapidly to danger, this was as a consequence of their *experiential assessment of danger.* Most police officers reported that they had amassed their experience through repeated exposure to dangerous situations, involving people with mental disorder:

> *"…it's very difficult to put into words, as a police officer, and the more and more experience you get, the more you deal with certain individuals, your gut instinct does tend to be on the same parallel." (No. 4)*

Common to all police officers, was an attempt to identify danger within each person encountered. When encountering a *person with potential mental health need,* police officers actively sought features (actual / potential) they associated with danger to the person, self or others. It seemed that there was no risk assessment protocol to assist them within every situation they encountered. The assessment of danger was therefore based on individual judgements, and shifted depending on the context:

> *"I couldn't give you a hard and fast, this is my matrix risk assessment motives because our work is fluid and what you might think is the same type of incident as yesterday isn't because of various you know peoples personalities, peoples abilities, staff availability you know there's all sorts of things, so it's very much a, a dynamic risk assessment on each and every time." (No. 3)*

In the absence of a formal risk assessment protocol / matrix, all police officers considered the presence of obvious, potentially life-threatening injury associated with a self-harm act, a clear indicator of danger:

> *"I could see the guy, he had t-shirt on, there was blood everywhere, he was bleeding profusely, but I could see he had old self harm marks on his wrists, on both of his wrists, and this one fresh injury." (No. 7)*

So to was the suspicion that someone had attempted to deliberately self-harm, or had done so previously:

> *"…taken something, harmed them self, done it before." (No. 3)*

For one police officer, even flippant comments were considered significant indicators of danger:

> *"I've got somebody who says they're going to kill their self, so if I let them people, if I let them…and I'm sitting in bed thinking, as that person done something, or have, have they killed their self, cos I said like not as a joke, you know when I say as a joke, but an offhand comment…" (No. 8)*

For some however, the significance of the danger posed by a self-harm act was sometimes dismissed:

> *"experience for me, is, eh, and I hope I am never proved wrong, is that when people are making these threats, when people are generally being very vocal about wanting to commit suicide, it's more the attention." (No. 1)*

Somewhat intertwined with the *pre-encounter* sub-theme, within this context, *role-specific response* reflected the actions of police when danger was anticipated or present, during their contact with a person with a mental disorder. Where there was the potential for violence, even where mental disorder was considered a factor, some police officers chose to arrest the person. In such instances, they dismissed the significance and effect of a person's mental disorder upon the situation encountered:

> *"…and the violent offences then the priority is, and the attitude, the priority is the crime, and detect the crime and protect you know the victim, and the attitude is no sympathy for that person." (No. 6)*

For others, arrest was viewed as an expedient way of gaining access to healthcare:

> *"…so it's a case of arrest for the offence, bring them in here, we'll get them assessed, and we'll get them dealt with." (No. 5)*

Whilst S136 was a power of arrest (governed by Section 26 and Schedule 2 of the PACE Act 1984) used to facilitate healthcare for people (within a public place) unable or unwilling to consent it, its application could appear punitive, rather than carative:

> *"She wanted help, and something about her in the instant you get with people say if I tell you you're under arrest for 136 which I should do probably that will be it you'll lose it, you will, you will stop com, you will stop helping me to help you if that makes sense… So you made that judgment call…" (No. 2)*

When a person was within a private dwelling, S136 could not be enacted. In such situations, arrest for a breach of the peace was enacted as mechanism to facilitate the access to care:

> *"But she was in her own house, so they erm arrested her and she actually kicked off then which, well you mightn't, you might say well you would if you're getting arrested for… A breach of the peace." (No. 3)*

With some caveats, restraint, in the presence of a potential mental disorder, did not appear to be precluded, if control was required:

> *"Physical disability, weapons, or pregnancy will, because it has an impact on what force you can use etc. dealing with somebody who's violent, unless there' something glaringly obvious that says, hang on, they've got a knife, don't do that, don't use that kind of restraint, or they're pregnant, don't use that kind of restraint, then we wouldn't deal with them any different." (No. 4)*

Threats represented the precursors to danger, which all police officers considered significant. Even where mental disorder is suspected, all police officers were required to rapidly determine the nature, focus and potential danger associated with the threat:

> *"…and he was, he was armed with a knife when I went there, and there was two children in the house." (No. 2)*

Where mental disorder was suspected, police officers sought to identify potential *weapons*. Police officers thought that the presence of weapons, particularly cutting instruments, posed a significant danger:

> *"…or you're standing talking to somebody in a kitchen where they've got access to knives, not only is it personal safety, but also erm it's a duty of care to them." (No.* 2)

Where weapons were identified, all police officers were duty-bound to intervene:

> *"…but she's still grabbed a knife and threatened to harm herself I can't exactly walk out of this one." (No. 2)*

All police officers made judgements regarding their personal safety when intervening. For one police officer, it was the mental disorder that was of significance, not the weapon:

> *"…because I felt at that time using me experience, and what he was saying to us, I felt safe enough to go in there that he wasn't going to turn that knife on me." (No. 7)*

However, depending upon the individual police officer's assessment of the situation, an escalated, perhaps unwarranted police response may ensue:

> *"… you're looking at a, a small situation which could have just got blown, cos then what would have happened was we would have had more resources at the scene, firearms units at the scene… And that small situation would have just getting blown so way like it would have just that you know we would have had the house…surrounded, we could have ended up with possibly a hostage situation unnecessarily because that's how, that's how it could have been perceived by somebody else, like the fact that he's got two children in the house, a knife in his hand, and he's bleeding heavily." (No. 7)*

The sub-theme *public* represented the danger posed to members of the public from someone with a mental disorder. Echoing the *pre-encounter* sub-theme, *role-specific response,* for all police officers:

> *"… the first of the priority protect the public." (No. 6)*

To protect the public, police officers had to first, identify those potentially at risk:

> *"…you've then got to take into account other members of the public that's in the area." (No. 7)*

Second, control the risk:

> *"…because obviously the public it's about if there's already harm, minimising the harm er to anybody else and just keeping it as safe as possible…" (No. 6)*

For some police officers, rather than seeking to defuse the situation, or facilitate some form of access to health care, control would be established through the arrest of the mentally disordered person:

> *"But erm cos they, the default thing would be they'd get arrested…" (No. 6)*

All police officers were concerned for their personal wellbeing. The sub-theme *police officer* however, represented the perceived danger posed by a mentally disordered person:

> *"I've got to look at officer safety…" (No. 3)*

Where there was overt hostility, for some police officers, intervention may be delayed until back-up arrived; the police officer adopting a less interventionist approach:

> *"It doesn't mean to say they are going to be treated ultimately any differently, but what it means is that em you've got to perhaps withdraw." (No. 1)*

A less interventionist approach could also occur if a potentially mentally disordered person was encountered in a remote environment:

> *"…where you know your assistance is going to be twenty-thirty minutes away, you will deal with things far differently than someone who knows that they have got assistance two minutes away." (No. 1)*

6.2.7 Environment

Police officers consider both the effect of a potentially mentally disordered person upon their immediate environment, and the effect of the immediate environment itself upon that person. Police officers associated certain environmental features, such as certain times of day, and environment (locations) with mentally disordered people. The time available to respond within an often fluid environment, also influenced a police officer's identification and response to, a person with a mental disorder. This overarching theme therefore reflected the factors which governed a police officer's ability to perceive, comprehend and respond to a mentally disordered person, based on their current environment. It was characterised by seven interconnected sub-themes:

1. *Familiarity / prior experience of a situation.*
2. *Incongruence with own norms.*
3. *Stability of the environment.*
4. *Speed of operational response.*
5. *Person with a potential mental disorder.*
6. *Locations associated with a person suffering a mental disorder.*
7. *Immediate environment (physical).*

For most police officers, *familiarity / prior experience of a situation* enabled them to determine the most appropriate response to a mentally disordered person

> *"…but err experience and that sort of experiential learning cycle of past err past dealings with individuals at situations or scenarios or incidents gives you a bit of, a sort of your own database, your own I – internal IT's system where you can you know recall and reflect, think about what worked what didn't work, and what you'd have done better, so there's a lot of adaptability, erm but when there's no policy you know you're very much in the dark." (No. 3)*

Where police officers were "…very much in the dark", police officers actively sought situational information and cues, to enable them to make better sense of it. As with other themes, police officers were attuned to features which seemed to generate *incongruence with own norms.* When making an initial assessment in situations involving a mentally disordered person, most police officers could frequently sense that the environmental features did not explicitly correspond with their expectations:

> *"When you turn up the person… I'd be, I'd be lying, if you, you turn up and you get, sometimes you get a gut feeling in the first minute is this Kosha is this not… Kosha you know are they making this up… Are they not making this up?" (No. 2)*

In such situations, they sought to gather as much situational information as possible so as to make sense of their encounter:

> *"…so I mean there's, there's a huge amount of information which I would process at any one time, which contracts or expands depending on the, on the seriousness or the unusual nature of the situation." (No. 3)*

Gathering situational information and responding to it, was an active, somewhat fluid process:

> *"I've then made a decision I'm gonna have to find a bit more about this and do something about it. And then making another decision because the situation could have changed, the person could be walking off and not communicating with us, they might be an unwilling party, there's a lot of ongoing decisions*." *(No. 4)*

It was therefore important that a police officer was sensitive to the fluidity of a situation, and be able to shift their priority of focus, depending on the *stability of the environment*:

> *"Erm ar a what's, what else is going on, if there's other, if there's other sort of things that sort of evolving need more of a attention like sort of faster like more immediate sort of incident." (No. 8)*

The need to sift through, and process the plethora of situational information was of particular importance:

> *"…wide range of things that would affect, er, how they are actually acting there and then, what's being said, the information that other people are passing to you." (No. 5)*

All police officers reported that, where possible, they tried to control the situation, enabling them to be better placed to gather information and respond to the mentally disordered person:

> *"As to what you do next, it's the next steps, you deal with what you've got in front of you. You take control, you have a calm situation, then you decide what you're gonna do." (No. 4)*

One police officer described this as the process of establishing a 'new normality':

> *"A new, new normality they often call it in bigger incidents but it's that kind of thing right well how do we try to restore things… and try and make decisions about freeing up and getting back to some sort of normality." (No. 1)*

The *speed of operational response* therefore, was reflective of the situational factors encountered:

> *"…because as a police officer you have to make instant judgement, instant decisions you don't, you can't stand back and go, oh let's think about this for ten minutes… Let, let me write something down, you have to make decisions." (No. 7)*

When gathering information to support decision-making, police officers considered both the impact of the environment (including others present) upon a *person with a potential mental disorder*, and their impact upon it. Some police officers were sensitive to the response and behaviours of others toward a mentally disordered person. Often, the actions of a mentally disordered person had been of an anti-social, or antagonistic manner, resulting in a negative response from others within the environment:

> *"The behaviour of the people at the time. If you arrive at the scene and immediately the people are negative, hostile..." (No. 1)*

Such reactions were observed in *locations associated with a person suffering a mental disorder*. One police officer reported that they commonly encountered mentally disordered people in very public areas, often intoxicated, and causing a public nuisance:

> *"…hanging round the bus station or places like that drinking and drugs… intoxicated that erm… But those kind of, those sort of areas where we tend to come in to contact with them because they're behaving anti socially." (No. 6)*

Railways, bridges, rivers and coastlines were also locations associated with people with a mental disorder, particularly those attempting attempting self-harm:

> *"Situations erm having a train station and two very big viaducts here… And a, and a very big river which I've been in… For a, for someone who's thrown themselves in there a few times and we have actually come across people on bridges and viaducts, erm who are quite determined to kill themselves, erm so there's, there's them occasions." (No. 7)*

Some police officers associated a person's *immediate environment (physical[50])* as being suggestive of mental disorder. Dirty and unkempt living conditions were reported as being particularly significant:

> *"…got through the door, and the first thing I noticed was there was no carpet on the floor, and the house was minging… Absolutely, it was a such a state that she went oh take a seat on the couch, I'll kneel on the floor it's all right…" (No. 2)*

As was the presence of an excessive amount of empty alcohol bottles / cans:

> *"…drinks bottles as in alcohol, so I think well okay, cos normally say if somebody's an alcoholic there's drinks bottles everywhere." (No. 2)*

For some police officers, encounters with mentally disordered people often occurred at particular times of day:

[50] *Physical environment:* the features of an environment associated with the presence of a person with mental disorder. Features such as the, time of day and weather conditions were considered significant. So too were the features of more local environments, such as the type of environment (private / public), the state of décor, the condition of objects in the locale, the degree and nature of damage to objects, and the location and position of objects.

"…most of the things occur in the night time." (No. 1)

At night, however, it was often difficult to visually assess a person:

"…well it was dark er you know two o'clock in the morning it is dark, the street lamps aren't particularly great at seeing if somebody's and the car lights." (No. 2)

During the night, it was reported that potentially useful police and healthcare services were reduced, or absent:

"…erm sometimes a time is a critical factor because there might be err a time of day when I know for instance that you know obviously doing daytime hours err there are departments within my organisation which will be available to assist and similarly departments like the social services which are in theory more readily accessible." (No. 3)

With limited resources, coupled with police officer fatigue, police officers took a less interventionist approach at night, irrespective of its appropriateness:

"You will find towards three o'clock four o'clock in the morning when people are due to finish work…there is awful lot more discretion gets used at that time than probably ten o'clock because em people are tired, they want to go home, they don't want to em ordinarily they might arrest someone for drunken disorderly, at that time they just try and talk to them to get them away. Now that that may or may not work." (No. 1)

6.3 Chapter summary

Despite apparent similarity with the domains shaping the Public Psychiatric Emergency Assessment Tool (PPEAT) (Wright et al., 2008), my study design enabled me to establish a newly constructed view of the specific processes police officers appeared to use to identify and manage a mentally disordered person.

Amongst this, it appeared that a police officer's identification of danger was central to, and underpinned all operational contact, and response. It also appeared that personal views, experience, specialist education, multi-agency relationships and professional identity, influenced police officers' responses to a mentally disordered person, prior to their encounter. Within the following chapter I describe how this newly constructed view informed the concepts governing the development and design of the PPEAT-R, its underpinning concept framework, and the concept and observable indicator framework.

CHAPTER 7

DEVELOPMENT OF THE COGNITIVE AID

7 Introduction

Within this chapter, I describe the development of the PPEAT-R cognitive aid, and its associated supporting frameworks. This chapter is presented in four sections. First, I describe the process of establishing the concepts. Next, I describe the development of the concept framework, underpinning the PPEAT-R. I then describe the process of designing the PPEAT-R itself, informed by these findings, and built upon the foundation work of Wright et al. (2008). Finally, I provide a summary of this chapter.

7.1 Development of the cognitive aid: establishment of the concepts

Key to the development of the PPEAT-R, and its data analysis framework, were the development of the concepts, and the associated definitional propositions (theoretical and operational definitions) themes and observable indicators. A concept is something that symbolises or identifies an abstract idea or mental image (Waltz, Strickland and Lenz, 1991). It is an overarching term used to broadly represent / designate phenomena sharing a combination of similar, related behaviours, characteristics or features and which are separate from other, non-directly related phenomena. Emerging from the narrative synthesis and individual semi-structured interview data, six concepts were established; concepts which appeared to encapsulate the newly constructed view of the domains, and aligned themes, shaping specific processes police officers use to identify and manage a mentally disordered person:

1. Pre-encounter.
2. Appearance.
3. Behaviour.
4. Communication.
5. Danger.

6. Environment.

7.1.1 Theoretical and operational definitions

These six concepts provided the overarching structure for the PPEAT-R, and the development of its supporting concept framework (Appendix 43). The concept framework sought to establish "…a distinct [ordered and organised] frame of reference…" for this study's subsequent exploration into the extent to which a police officer's identification and management of a person with a potential disorder was shaped by the cognitive aid (Fawcett and Downs, 1992, p.101; Green, 2014). First, data from the secondary analysis was used to establish theoretical and operational definitions for each concept. Theoretical definitions provided a clear description and frame of reference for each concept, clearly separating one another, within the concept framework. Operational definitions defined how each concept would be measured during subsequent (phase two) data analysis (Waltz et al., 1991; Fawcett and Downs 1992). Second, the emerging themes, which appeared to illustrate key methods, rules, actions and behaviours shaping police officer situation awareness, were aligned to each concept. Third, observable indicators were identified. Aligned to Endsley's (1988) situation awareness framework, the observable indicators represented the more refined, specific behaviours, characteristics and features emerging from the data, which shaped a police officer's situation awareness, when encountering a mentally potentially disordered person (Waltz, et al., 1991; Fawcett and Downs, 1992) (Appendix 43).

When seeking to explore the level of situation awareness for an activity within a specific discipline, Salmon, Stanton, Walker and Green (2006), and Loft et al. (2015) suggest that there are a wide array of evaluation tools available. Endsley (2000) however notes that "…the objectives of the researcher and the constraints of the testing situation…" may require one to design a specific framework, for a clearly defined purpose (p.28). Within this study, this was illustrated by the development of the concept framework, with the inclusion of the observable indicators. This enabled me to gauge the level of situation awareness demonstrated, when police officer responses were aligned to the emerging themes.

7.2 The concept framework

7.2.1 Pre-encounter

The concept pre-encounter was theoretically defined as the pre-existing personal and professional characteristics, experience, and expertise which underpin a police officer's operational response to a potentially mentally disordered person. This concept was operationally defined as the extent to which a police officer's pre-existing specialist knowledge, experience and expertise relating to the identification of signs of mental disorder, their personal characteristics, viewpoints, role adherence and ascribed value to multi-agency relationships underpins and shapes their situation awareness, and therefore their operational response to a potentially mentally disordered person. Five overarching themes were aligned to this concept:

1. *Viewpoints:* Characteristics which informed their personal views of mental disorder, its significance, and management.

2. *Prior specialist education:* This informed a police officer's understanding of the features and management of a person with a mental disorder.

3. *Experiential response:* This was significantly influenced by knowledge, understanding and know-how, developed during operational contact.

4. *Role-specific* response: This theme embodied both the expected and perceived role of a police officer, including role-specific rules shaping their response to a mentally disordered person.

5. *Multi-agency relationships:* This represented the degree to which a police officer understood and valued the roles and functions of multi-agency services involved within the subsequent management of a mentally disordered person.

7.2.2 Appearance

The concept appearance was theoretically defined as the concrete characteristics of a potentially mentally disordered person observed by a police officer in the context of operational contact. The operational definition was the situation awareness of a

person's appearance within the following domains: the person's physical characteristics; clothing; association of appearance to expected signs of mental disorder; signs of visually apparent injury, deliberate self-injury or illness; prior contact with the person; degree to which appearance is congruent / incongruent with personal / professional norms. Seven overarching themes were aligned to this concept:

1. *Incongruence with expected personal / professional norms*. Characterised by the features of a person's appearance, which due to mental disorder, did not align to a police officer's accepted conventions; conventions shaped by their personal and / or professional experience.

2. *Prior contact*. Representative of a police officer's recognition that a person had a mental disorder, based upon their previous dealings with them.

3. *Signs of visually apparent physical injury.* This referred to the presence of wounds / signs of physical harm, which police officers considered suggestive of mental disorder.

4. *Features of mental disorder.* This referred to the visually apparent features police officers associated with a mental disorder (linked to the concepts of *behaviour, communication, danger and environment)*.

5. *Clothing.* The features of a person's clothing / dress often associated with the presence of mental disorder.

6. *Signs of self-harm.* This represented the signs / patterns of injury or illness resulting from intentionality, rather than misfortune (linked to the concepts of *behaviour, communication and danger*).

7. *Physical characteristics.* The physical characteristics reported to be associated with the presence of mental disorder.

7.2.3 Behaviour

The concept behaviour was theoretically defined as the actions, activities and responses by a potentially mentally disordered person, observed by a police officer in the context of operational contact. The operational definition was the situation awareness of a person's behaviour within the following domains: behavioural signs associated with mental disorder; degree of respect / disrespect, compliance / resistance to police command; agitation and aggression; self-harming acts; nature of any criminal act and its association with mental disorder; effects of intoxicants; degree to which behaviour is congruent / incongruent with personal and professional norms. Eight overarching themes were aligned to this concept:

1. *Incongruence with expected personal / professional norms*. Characterised by the features of a person's behaviour which, due to mental disorder, did not align to a police officer's accepted personal / professional conventions.

2. *Criminality*. Criminal acts which were considered to be most frequently committed by a mentally disordered person

3. *Deviation from expected criminal behaviour.* The methods police officers used to determine the underlying reason for the act.

4. *Features of mental disorder.* The key behavioural features police officers commonly associated with mental disorders.

5. *Effects of intoxication.* The behavioural features of mental disorder some police officers associated with drug and / or alcohol intoxication.

6. *Self-harming behaviour.* The range of actions police officers used to identify intentional self-injury (actual or potential) (linked to the concepts of *appearance, communication and danger)*.

7. *Disrespect towards police officer.* The features of mental disorder commonly associated with a person's lack of respect and / or refusal to comply with police command (Linked to the concept *communication*).

8. *Aggressive or violent behaviour.* The features police officers used to differentiate violence / aggression, as a consequence of a mental disorder, from other, non-mental disorder-related causes (linked to the concept *danger).*

7.2.4 Communication

The concept communication was theoretically defined as the relevance of information obtained by a police officer from a potentially mentally disordered person, or other contextually relevant sources during operational contact. The operational definition was the situation awareness of information obtained from the person and others within the following domains: the communication style of the person encountered - method, style, content, meaning of information obtained; presence of mens rea; information obtained from the person, other people relevant to the police contact or from police intelligence sources; information available prior to arrival; information from multi-disciplinary sources; vocalised intention to self-harm; degree to which communication is congruent / incongruent with personal / professional norms; degree to which a person demonstrates capacity. Ten overarching themes were aligned to this concept:

1. *Incongruence with expected personal / professional norms*. The features of a person's communication which, due to a potential mental disorder, did not align to a police officer's accepted personal / professional conventions.

2. *Communication style of person encountered**.*** The varying verbal and non-verbal symbols police officers commonly used to identify a potential mental disorder.

3. *Vocalised intention to deliberately self-harm***.** Through their interpretation of the person's verbal communication, the features police officers considered suggestive of intentional injury (actual or potential).

4. *Information obtained from person.* The range of verbal / non-verbal prompts police officers associated with potential mental disorder.

5. *Information obtained from persons within scene.* The range of verbal / non-verbal prompts, suggestive of mental disorder, elicited from victims, witnesses or passers-by.

6. *Information obtained from multi-disciplinary team.* This commonly related to requests for police assistance with a person with a potential mental disorder, deemed at risk.

7. *Information obtained prior to arrival at scene*. The range of information / prompts, suggestive of mental disorder, provided prior to arrival on-scene.

8. *Information obtained from police intelligence sources.* The range of information / prompts suggestive of mental disorder held within the PNC. This information was available prior to, and during contact with a person.

9. *Presence of mens rea.* The factors police officers considered when seeking to establish if a person intended to commit a crime, or an intention was obscured by a potential mental disorder.

10. *Capacity.* The degree to which a person can communicate, process and retain information relevant to the present situation. The relationship of this to a potential mental disorder.[51]

7.2.5 Danger

The concept danger was theoretically defined as the potential for harm or injury to a potentially mentally disordered person, a police officer, relevant other individuals or the potential for damage to property identified during operational police contact. The operational definition was the situation awareness of actual and potential danger within the following domains: the person suffering a potential mental disorder; associated significance of a concomitant criminal offence committed by a person suffering a potential mental disorder; perceived danger to the police officer; perceived danger to the public; threat assessment; presence of weapons; role-

[51] In operational practice, where a person's capacity is in question, police officers are advised to undertake a best interests assessment based upon the following criteria:
1. Is the person suffering an impairment or disturbance of mind / brain? *And*
2. Are they are unable to communicate, understand, retain or evaluate information?

To determine a lack of capacity, the police officer must identify one of the criteria in point one, and one of the criteria in point two (CoP, 2016c, Para. 4.2).

specific response; congruence / incongruence with personal / professional norms**.** Nine overarching themes were aligned to this concept:

1. *Incongruence with expected personal / professional norms.* This reflected the degree to which a person with a mental disorder influenced the personal / professional conventions governing a police officer's identification and response to danger.

2. *Person with potential mental health disorder.* This represented the features of danger (actual / potential) to the person, as a consequence of their (potential) mental disorder, which police officers considered significant.

3. *Role-specific response*. Within this domain, it reflected the actions of police officers when danger was anticipated or present, during their contact with a person with a mental disorder *(linked to the pre-encounter* variable, *role-specific response)*.

4. *Threats.* This represented the precursors to danger, which police officers considered significant.

5. *Seriousness of concomitant criminal offence*. The features police officers took into consideration when encountering a perpetrator with a potential mental disorder.

6. *Weapons.* The features police officers took into consideration when encountering a mentally disordered person in possession of a potentially deadly object.

7. *Public.* The danger posed to people, as a consequence of a third-party with a mental disorder.

8. *Police officer*. The danger posed to a police officer by a potentially mentally disordered person.

9. *Experiential assessment of risk.* A police officer's operationally-derived understanding of the risks posed by a potentially mentally disordered person.

7.2.6 Environment

The concept environment was theoretically defined as the contextual relevance of the environment in which a potentially mentally disordered person is encountered, during operational police contact. The operational definition was the situation awareness of relevant situational / environmental features within the following domains: broad environmental influences; geographical locations associated with a person experiencing a potential mental disorder; situational stability of the environment; effect of the physical environment and human factors; familiarity; prior experience; operational response time; congruence / incongruence of environment / situation with personal / professional norms. Seven overarching themes were aligned to this concept:

1. *Incongruence with expected personal / professional norms*. Characterised by the features of an environment, which (due to the presence of a potentially mentally disordered person), did not align to a police officer's accepted personal / professional conventions.

2. *Locations associated with a person suffering a potential mental disorder.* The specific locations a police officer associated with the presence of people with mental disorder.

3. *Immediate environment (physical).* The specific characteristics / physical features within the environment which police officers associated with a mentally disordered person.

4. *Person with potential mental health need. Immediate environment / situation (human factors).* A police officer's understanding of the impact of a potentially mentally disordered person upon others within a situation. A police officer's understanding of the effect of others upon a potentially mentally disordered person.

5. *Stability of environment.* The areas of situational focus required when responding to a potentially mentally disordered person.

6. *Speed of operational response.* The situational factors shaping the speed of a police officer's operational response.

7. *Familiarity / prior experience of situation:* A police officer's experiential understanding of the situational features associated with people suffering a potential mental disorder.

7.3 Designing the Public Psychiatric Emergency Assessment Tool-Revised (PPEAT-R) cognitive aid

Despite apparent similarity with the domains shaping the earlier Public Psychiatric Emergency Assessment Tool (Wright et al., 2008), the current data highlighted three significant differences between this, and the PPEAT-R**,** developed within this study:

1. Themes emerging within this study suggested that the presenting situation itself had a significant influence upon a police officer. A police officer's perception and assessment of danger underpinned each interaction. This often resulted in them defaulting to some form of role-specific action when they sought to control and contain a situation. A police officer's initial response was therefore shaped by pre-determined (pre-encounter) factors, closely associated with the perception of danger.

2. Within this however, police officers appeared unable to consistently disentangle the features of mental disorder from the milieu of actions and behaviours occurring during operational contact with a person. By viewing this study through the lens of Endsley's (1988) three-level categorisation of situation awareness, the emergent themes offered a newly constructed view of the features of mental disorder, police officers' perceived and comprehended as being significant within such situations, and their subsequent operational response. This enabled a concept framework to be designed to support the exploration of the usefulness of the PPEAT-R in only complex situations. It also permitted a training programme to be

designed, which prepared police officers in the use of the PPEAT-R (Appendix 26). Rather than developing the training programme from the perspective of a health professional, this training programme incorporated the police officers' view of, and response to, mental disorder, using data drawn from this study.

3. Rather than being simply a component of any cognitive aid used to help police officers identify and respond to mental disorder, data within this study strongly suggested that the identification of danger was central to, and underpinned all operational contact, and response. As such, the concept danger, was placed centrally within the cognitive aid (Figure 19), and similarly reflected within the supporting training programme.

4. Perhaps most significantly, this study highlighted the influence personal views, experience, specialist education, multi-agency relationships and professional identity exerted upon police officers' responses to a mentally disordered person, *prior* to their encounter. As such, the training programme was designed to not only address the features of mental disorder aligned to the concepts appearance, behaviour, communication, danger and environment, but also the issues appearing to shape the concept pre-encounter. Reflecting this, the concept pre-encounter is seen as separate, yet inextricably connected with police officers' situational assessment.

7.3.1 Design

When I developed the PPEAT-R (the "…implementation tool…"), I utilised a "…design with intent…" approach (Lockton, Harrison and Stanton, 2010, p.383 and 385). This approach sought to elicit a target behaviour amongst users. Within this study, this was the stimulation of perception and comprehension of the signs of mental disorder, using an ostensibly simple aide-mémoire (Lockton et al., 2010). Reflecting the work of Kleinmuntz and Schkade (1997), a cognitive aid was designed, which sought to manipulate information in such a way that it was sufficiently accurate in terms of stimulating perception / comprehension of particular signs of mental disorder, yet minimised user effort in doing so. To enable this, the PPEAT-R was required to have an appropriate form; information presented, organised and sequenced, in a meaningful, unambiguous and uncluttered way

(Lavie and Oron-Gilad, 2013). There was also a requirement for it to be supported by relevant "…procedural knowledge…" possessed by the user (Kleinmuntz and Schkade, 1997, p.225). This is the underpinning knowledge the user must possess to enable them to use the PPEAT-R.

Rather than overburden the police officer with a cognitive aid populated with potentially complex, and therefore unusable matrices, a short, acronym-based design was chosen. It was supported by a ninety-minute training programme, which sought to explore police officer perceptions of mental disorder, and provide 'procedural knowledge' for its use. The PPEAT-R was designed to fit within an 8.5cm X 5.5cm (business-card size) strip of plastic or card. This design was chosen so it could fit easily in a police officer's pocket-book, warrant card[52] or uniform / body-armour pocket.

Regarding the design aesthetics, on the front, the 'objective features' – that which provides visual stimuli – comprised a tricolour (red, white and black) colour scheme, with contrasting emboldened letters (Sonderegger and Sauer, 2010, p.403) (Figure 19). Pravossoudovitch, Cury, Young and Elliot (2014) consider red to be the most effective colour to stimulate rapid, well-ordered and organised responses. The letter D, representing the concept danger, was therefore coloured red (against a contrasting black background), reaffirming to the user its ubiquity with danger, per se (Pravossoudovitch, et al., 2014). The letters representing the concepts appearance, behaviour, communication, and environment, were white, whilst the circles enclosing them were red. Reflecting the work of Chapanis (1991), white text is associated with hazard (and therefore importance), but to a lower level than red text; the red of the circles yet emphasising the importance of the concepts, within the design (Figure 19).

[52] A Warrant Card identifies a person as a serving police officer, and provides evidence of their legal powers as a serving police officer.

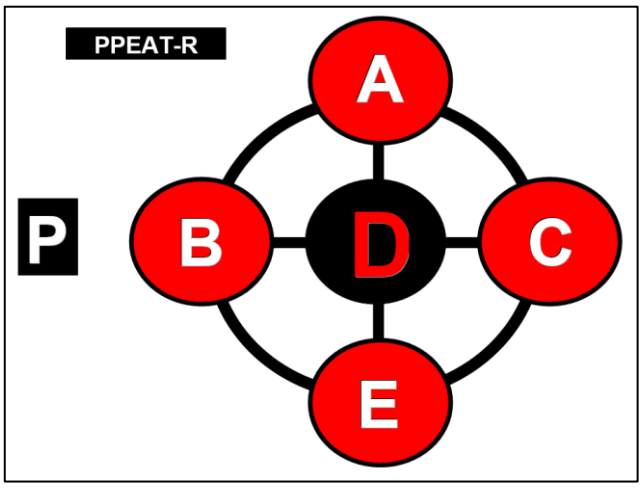


Figure 19: Front of PPEAT-R Cognitive Aid Card.

To establish a hierarchy within the design, the concept danger was placed centrally within the graphic (Berg and Kojo, 2012). It was connected to the concepts appearance, behaviour, communication and environment, so as to represent its significance within each assessment. The concepts appearance, behaviour, communication and environment were linked to one another by an arced line; this was to signify that the features of mental disorder are only meaningful when seen within a wider context, rather than in isolation (Kleinmuntz and Schkade, 1997). The graphic representing pre-encounter was presented in monochrome, to the left of the main design. This represented the training programme underpinning the use of the PPEAT-R, and serving as a possible aide-mémoire regarding the issues discussed within it. On the reverse, each concept was briefly described, seeking to provide a further aide-mémoire (Figure 20).

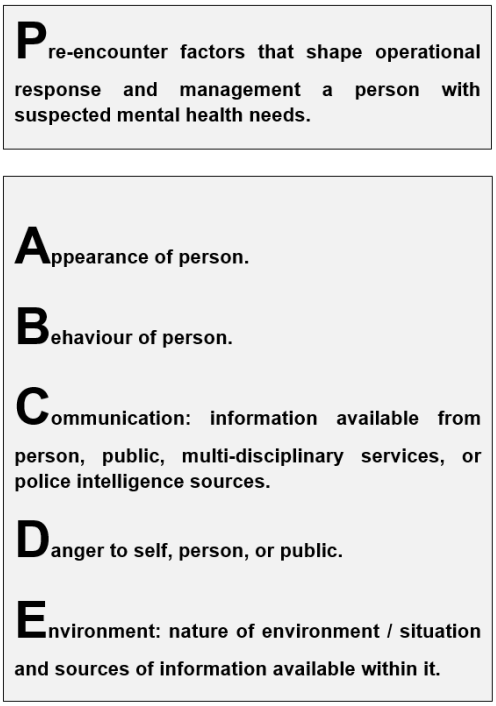


Figure 20: Reverse of PPEAT-R Cognitive Aid Card.

To investigate the usefulness of the PPEAT-R, I developed a bespoke concept and observable indicator framework (based on the concept framework) tailored to each video vignette (Appendix 33 and 34). Chen (2011) suggests that a concept framework should be structured to demonstrate how it "…achieves a particular result…illustrating its means of implementation as well as underlying mechanisms that influence it" (p.35). Addressing Chen's (2011) first point, the concept framework established a clear and distinct frame of reference, from which to explore the usefulness of the cognitive aid. It achieved this by utilising the themes, illustrative of the features police officers used to identify mental disorder. These themes were aligned to their respective concept. In doing so, they became the benchmark from which a police officer's situation awareness could be gauged within stage two of this study. Endsley (2000) notes that the features required to "…form a coherent operational picture…" vary between individuals (p.24). An evaluation of situation awareness provides a "…useful index for evaluating system design and training techniques…" when seeking to improve the consistency of response (Endsley, 2000, p.24). Addressing Chen's (2011) second point, to enable a police

officer's situation awareness to be gauged, each concept was aligned to both a theoretical and operational definition. The former provided an overarching definition for a specific concept, whilst the latter defined the expected level of police officer situation awareness, when exploring the usefulness of the PPEAT-R.

7.4 Chapter summary

Six concepts were established (pre-encounter, appearance, behaviour, communication, danger and environment). These concepts encapsulated the newly constructed view of the domains, and aligned themes, shaping specific processes police officers use to identify and manage a mentally disordered person. From this, a concept framework was established. The concept framework informed the structure and design of the cognitive aid, and provided a mechanism to explore its usefulness within stage two of this study. Within the following chapter, I describe the findings, following stage two of this study. Here, I describe the themes emerging from the focus group interviews, and notebook entries, both prior to, and following the introduction of the PPEAT-R, within the confines of a structured study day. I then describe the themes emerging, regarding its usefulness within operational policing.

CHAPTER 8

FINDINGS

STAGE TWO: TESTING THE USEFULNESS OF THE COGNITIVE AID

8 Introduction

Within this chapter, I describe the emerging themes, following the testing of the PPEAT-R. This chapter is presented in four sections. First, phase one describes the emerging themes, prior to the introduction of the PPEAT-R. Phase two describes the emerging themes, following its introduction. Within phases one and two, I draw upon focus group discussion and notebook data.[53] I describe the relationship of the emerging themes to the concepts forming the PPEAT-R. Phase three describes the emerging themes, following the use of the PPEAT-R in operational, real-world practice. Finally, I provide a summary of the chapter.

8.1 Phase one

Police officer responses were closely aligned to the concepts pre-encounter, appearance, behaviour, communication, danger and environment. Whilst police officers were able to perceive the key features associated with mental disorder, overall, there was limited ability to recognise their significance.

8.1.1 Pre-encounter

The concept pre-encounter appeared to exert a significant of influence on a police officers' methods, rules, actions and behaviours, and as such, their situation awareness. Within the situations depicted within the vignettes, not all police officers

[53] The following key refers to the type of data, and participant group:

Letters A-J:	notebook data.	group one
Letters S-Y:	notebook data.	group two
Nos 1-10: G1	focus group interview data	group one
Nos 1-7: G2	focus group interview data	group two

were open to the potential for mental disorder to be a contributory factor (*viewpoints*[54]):

> *You wouldn't walk into that scenario and necessary think oh! I better consider mental health." (Vignette one: No.4 G2)*

For some, it was because they did not recognise the features of mental disorder (*prior specialist knowledge*):

> *"Honestly, I reckon you'd walk straight past her if you hadn't been called to it." (Vignette seven: No.4, G2)*

However, some police officers would deliberately avoid contact with a person if mental disorder was suspected:

> *Some people might look and think yeah a bit odd but don't want to get involved they keep going." (Vignette seven: No.7, G1)*

Reflecting a *role-specific response*, rather than consider the presence of mental disorder, some viewed the apparent crime as the most important issue to be addressed, and their powers within the PACE Act (1984):

> *"Consider BOP."*[55] *(Vignette six: F)*

There was also an anticipation of difficulty within such situations:

> *"I would guess all the things they teach you in your nice little gyms about officer safety none of it would work, almost guaranteed that you would end up with a big roll around and nothing working." (Vignette two: No. 2, G2)*

[54] The themes, aligned to each concept, and illustrative of the key methods, rules, actions and behaviours shaping police officer situation awareness (described within chapter 7), are italicised for reference purposes.

[55] Breach of the Peace.

Whilst police officers did not have any specific training regarding the management of people with mental disorder, they had extensive tactical response training:[56]

> *"So that's one of the scenarios that we train in for level 2. You have a person who's armed in that manner and then you learn how to contain him with shields and so on."* (*Vignette two: No.4, G2*)

For some police officers however, pre-encounter factors helped them identify the presence of mental disorder. For one police officer, the *experiential response* shaped their suspicion that mental disorder may be present:

> *"As instinct, a sixth sense or unconscious behaviour traits, signals not necessarily normal or expected. Subjective." (Vignette eight: D)*

This 'sixth sense', as a mechanism to identify mental disorder, was echoed by other police officers:

> *"I think you would still have been left with a feeling that something wasn't quite right. And who would actually have gone back and checked criminal CRIS."* [57] *(Vignette four: No.4, G2)*

Some felt that once they arrested a person, they would soon be able to detect mental disorder:

> *"You'd probably, it'd be one of those ones where within about two minutes of the booking in procedure in custody having*

[56] Tactical response. Tactical options are considered the level of reasonable force a police officer uses within a given situation. The responses follow the following order, and escalate to the next level as the situation dynamic dictates:

- Announcement of police officer presence.
- Verbal / non-verbal command.
- Primary control skills: physical restraint; arm lock; pain compliance; handcuff; baton used for restraint only.
- Secondary control techniques: incapacitant spray (CS gas); Taser (conductive energy device).
- Defensive tactics: strikes with baton, followed by control skill techniques.
- Deadly force. (West Yorkshire Police, 2014, p.4)

[57] CRIS is the acronym for the crime reporting information system. A system operated within the Metropolitan Police Service, which permits all criminal incidents to be formally recorded within a central database.

started, it would become very clear that he had mental health problems." (Vignette six: No.4, G2)

For another, it shaped their personal threshold for concern:

"Ordinary members of the public, generally speaking, will try and engage with you, or if not actively try and engage with you, if you speak to them they'll speak to you back. People who don't want to, but are not aggressive, they're just "please leave me alone, please I don't want to talk to you", I always find that quite concerning because why would they be – if someone's up in your face "fuck off, I'm not going to talk to you" that's fine, that's just a stop/search." (Vignette three: No.4, G2)

Demonstrating some degree of insight, potentially illustrative of underpinning *prior specialist education*, several police officers accurately identified the conditions:

"Possible post-natal depression." (Vignette five: U)

"PTSD?" [58] *(Vignette four: W)*

In doing so, one sought to separate the features of mental disorder from criminal (forensic) behaviour:

"It's that also the, it's not like, he's wrapped his hand, you know, in the bag as a kind of, to prevent forensic whatever. He keeps taking the bag, looking at it, kind of, there's that obsessive or manic quality to it." (Vignette six: No.7, G2)

For those who valued *multi-agency relationships*, reference was made to specific health care services, which may be accessed to help the person:

"Mental health team or LAS as necessary." [59] *(Vignette five: H)*

[58] Post-traumatic stress disorder.

[59] London Ambulance Service.

One officer valued the services that were available:

> *"You want to take, you want to get ambulance there as quickly as possible and mental capacities and then take them that route, unless if you've got grounds to section, it is easier to section them because they would be in a secure unit I think, there's one in (XXXXXXX)*[60] *we only have to wait an hour security take over we usually leave so it is a good system." (Vignette eight: No.3, G1)*

Several police officers offered views on how a mentally disordered person should be managed:

> *"Local CPN."*[61] *(Vignette three: I)*

> *"MH assessment."*[62] *(Vignette six: E)*

> *"You might refer her to a GP." (Vignette five: No.5, G1)*

Some would initiate police safeguarding mechanisms:

> *"Complete vulnerable person Merlin."*[63] *(Vignette four: H)*

One police officer offered a *viewpoint* which was sympathetic to the apparent impact of a person's mental disorder:

> *"Because you do get parents or mothers who react so badly to their children with post-natal depression that they want to kill them." (No.5, G2)*

One police officer however offered a view which echoed the *role-specific response*:

[60] Redaction.

[61] Community psychiatric nurse.

[62] Mental health.

[63] Merlin is the name of the Metropolitan Police Service vulnerable person alerting system. Where a person is considered to be vulnerable, or there is a safeguarding issue by means of their mental health or social circumstances, relevant health and social services can be notified.

> *"You can't ignore that crime you can't, I don't think you should. And most crimes actually go, well she has got mental health issues, so you forget the crime. And I don't think that should be done." (No.4, G1)*

8.1.2 Pre-encounter – danger linkage

Reflecting the findings of the preparatory stage, the dominant theme, *role-specific response*, linked the concept, pre-encounter to the concept danger. Pre-encounter factors exerted a significant influence upon the response undertaken by the police officer. The theme, *role-specific response* (and its aligned subthemes), was illustrative of police officers defaulting to a pre-planned role, in which they sought to control and contain a situation. Within both notebook and focus group data, a need to establish control was a common priority. An attempt to communicate with the protagonist(s) was one of the first methods used:

> *"This would mean that I would likely try strong comms[64] rather than immediately use equipment or restraint." (Vignette eight: A)*

When communicating, police officers used language and intonation, which demanded attention:

> *"You have got to try the commands don't you, the shouting." (Vignette one: No.1 G1)*

An attempt to communicate began the process of information seeking. This was used to bring clarity to the situation:

> *"Need to establish the cause of the problem which will inform the course of action." (Vignette 1: A)*

Information seeking also informed subsequent actions:

[64] Strong comms (strong communication). This was a colloquial term used by police officers. It was described as a forceful, loud and authoritative tone of voice to issue instructions and warnings to a person. It was used as a method to gain compliance from a person.

"Obviously you take it on from there so you actually use simple you know primary investigation questions first and then depending on the reaction you get from those questions is how you are going to deal with the situation as it develops." (Vignette one: No.8, G1)

Searching the person was used as a means to gain information:

"Search S1 PACE."[65] *(Vignette four: H)*

Some officers sought operational support, before intervening:

"…you want back up. You do not want to be dealing with that on your own." (No.5, G2)

Some officers however, chose physical intervention. This could involve 'hands-on' actions to establish control:

"Break them up." (Vignette one: U)

This approach appeared confrontational:

"Square up." (Vignette four: W)

Some officers considered a more pragmatic approach:

"…the immediate feel for that is that you're not, you don't sort of wade in and try and pin her down." (Vignette eight: No.1 G1)

Such approaches reflected a police officer's sensitivity to the situational dynamics:

"Ready to increase the weight of response if rec." (Vignette two: A)

[65] Section 1, Police and Criminal Evidence Act (1984). This section refers to the police officer's power to stop and search a person.

However, not all police officers shared such pragmatic views:

> *"You go in pink and fluffy and you're going to get hurt." (Vignette eight: No. 9, G1)*

In such cases, a more elevated tactical response was considered, particularly where, weapons were present, or suspected:

> *"Consider CS[66] / baton / Tasers." (Vignette two: F)*

Despite recognition of mental disorder, a tactical response was considered if threats remained:

> *"…if she persisted S/H[67] or with threats, little choice but to restrain her with whatever force appropriate." (Vignette eight: A)*

This included the use of restraint:

> *"Handcuff prevents injury." (Vignette eight: D)*

Arrest and detention was also considered a mechanism to establish control. For one police officer, arrest and detention was a mechanism to enable them to explore issues further:

> *"Require to find out what is the situation by detaining him and talking to him." (Vignette two: V)*

For another, it was a policing response where the person did not communicate with them:

> *"If unresponsive, arrest + convey to custody." (Vignette four: H)*

[66] CS gas incapacitant spray.

[67] S/H: self-harm.

Where mental disorder was suspected, several police officers considered detention to be the most appropriate course of action. This was however applied in differing forms. For one police officer, this was through the use of restraint:

> *"Restraining MH Stat." (Vignette three: C)*

For some police officers it was via the application of S136 (MHA, 1983, revised 2007) and prompt access to healthcare:

> *"LAS, 136." (Vignette eight: I)*

For others, it was police custody, in its capacity as a 'Place of Safety':

> *"Custody is a place of safety. FME[68] can assess + refer to mental health team or LAS as necessary." (Vignette five: H)*

In some cases, arrest for a criminal offence took precedence over mental health needs:

> *"She's got a weapon there hasn't she and she is saying she is going to self-harm, she's threatening to stab you, she is threatening to stab a load of other people I'd nick her and the mental health bit can be dealt with afterwards in custody, I would bring it to the attention of the custody sergeant, but I'd nick her." (Vignette eight: No.4, G1)*

For others, it was the crime, and not the mental disorder, which was the policing priority:

> *"Arrest woman att murder." (Vignette five: D)*

A few police officers however, were able to contextualise a *threat*:

> *"Significant harm to herself." (Vignette eight: B)*

[68] Forensic medical examiner.

This reflected an *experiential assessment of risk*, which took into account the presence of mental disorder:

> *"Although she says she is going to hurt others she is unlikely to do so – only to herself." (Vignette eight: V)*

8.1.3 Appearance

Police officers focused on a person's appearance to a lesser degree. Despite this, they were able to disentangle, if not always recognise the significance of, key *features of mental disorder*, associated with the vignettes. Most police officers first established a frame of reference for the situation, briefly noting the main character(s) depicted within the vignettes:

> *"1 male 1 female." (Vignette one: C)*

Such frames of reference provided a useful, succinct description of a situation:

> *"Female, sitting, in toilet." (Vignette eight: F)*

For some police officers, the situations were incongruous. Such *incongruity* however, offered the potential for alternate (potentially accurate) views on the situation dynamics:

> *"So yes initially it does look like a domestic and then you start thinking is he, it isn't clear whether he's attacking her or restraining her." (Vignette one: No.2, G1)*

A person's *physical characteristics* were considered significant. Rather than offering broad descriptions, police officers were selective in their focus, and succinct within their descriptions. For vignette two, several police officers described characteristics associated with the person's perceived aggression, often using shared terms:

> *"…pumped up..." (Vignette two: No.3, G2)*

Police officers described significant markers associated not only with aggression, but with the *features of mental disorder*:

> *"Sweating heavily." (Vignette two: No.5, G1)*

One police officer noted a particularly significant marker:

> *"Eyes glazed and large." (Vignette two: X)*

A differing range of physical characteristics (indicative of the features of mental disorder within the vignettes) were highlighted as significant. For a few police officers, the person's respiratory rate was noted:

> *"Fast shallow breathing." (Vignette five: W)*

So too were the positioning of a person's hands:

> *"Holds her head." (Vignette five: C)*

> *"Hands between legs defensive protect genitalia." (Vignette four: W)*

> *"Holding hand on chest." (Vignette seven: E)*

Several police officers noted as significant, the particular way a person moved:

> *"Pacing up and down." (Vignette seven: I)*

> *"Rocking." (Vignette seven: Y)*

One police officer considered the person's hair noteworthy:

> *"Her hair is all over the place she was in a right state." (Vignette five: No.7, G1)*

Signs of visually apparent injury, were noted, although descriptions varied in specificity:

"Blood on females arm and on tissues." (Vignette eight: S)

"Cuts. Red marks on arms. Holding a razor blade." (Vignette eight: I)

Some offered a broad categorisation of such behaviour:

"…Self-harmer..." (Vignette eight: No.1 G1)

Features of mental disorder were noted. Features of depression were again implied, in broad terms:

"Very withdrawn." (Vignette three: No.7, G1)

Across the vignettes, a range of terms were used to describe similar features of mental disorder. Unresponsiveness was described as being:

"Haunted looking." (A)

"Appears not with it." (X)

The behaviour of a very upset person was described thus:

"…distressed…" (C, G, V)

"Agitated." (E, I)

Contrasting observations of the same vignette were noted. Such observations still however captured the features of mental disorder:

"Appears upset and erratic." (Vignette four: F)

"Withdrawn." (Vignette four: No.7, G1)

A person's *clothing* was noted. A few police officers considered the appropriateness of a person's clothing within a situation:

> *"She was dressed inappropriately for the weather as well because it was cold and raining and she only had a light jumper on."(Vignette seven: No.8, G1)*

Some police officers considered disorderly dress to be significant:

> *"Unkempt." (Vignette: 8 A)*

Others offered more detail:

> *"Scarf is hanging down and is wearing one boot which is knee length. Bare foot on other." (Vignette eight: C)*

One police officer offered a description based upon a benchmark:

> *"…quite well presented person… it is not like the person lives on the street and is kind of disheveled full stop." (Vignette eight: No.1, G1)*

One police officer implied that a person's appearance was indicative of their mental disorder being acute or chronic:

> "*Looks smart and well-presented so episode, rather than chronic, may not be known to police." (Vignette six: W)*

Reflecting the concept Pre-Encounter, one police officer considered a person's clothing, in terms of it being integral to the act of shoplifting:[69]

> *"She's also just stolen some stuff so she could have been using the coat to steal the stuff in." (Vignette four: No.3, G2)*

[69] *Section* 25 of the Theft Act (1968), Going equipped for stealing:
(1) A person shall be guilty of an offence if, when not at his place of abode, he has with him any article for use in the course of or in connection with any burglary or theft.
(3) Where a person is charged with an offence under this section, proof that he had with him any article made or adapted for use in committing a burglary or theft shall be evidence that he had it with him for such use.

Some police officers were able to recognise the significance of features associated with a person's appearance. A physical description of a person provided by police intelligence sources enabled police officers to identify a person with a mental disorder:

> *"Male matches description." (Vignette three: C)*

One police officer differentiated criminality from mental disorder:

> *"Demeanor is that of a student in distress rather than a violent criminal." (Vignette eight: A)*

Another police officer did likewise, but they offered a more colloquial description of the person:

> *"…he clearly is not trying to break into vehicle. More than likely 136." (Vignette six: V)*

8.1.4 Behaviour

Police officers paid particular attention to the protagonist's behaviour. Incongruity (*Incongruence with expected personal / professional norms*) made some consider the potential for mental disorder. Within vignette one, using somewhat colloquial terms, one police officer questioned the behaviour of the male:

> *"Is he trying to stop female from hurting herself, or is he mental." (Vignette one: X)*

One police officer noted the incongruous combination of behaviour and communication, suggestive of mental disorder:

> *"Odd behaviour where words spoken make no sense which to me would indicate some type of MH issue." (Vignette two: J)*

Reflecting pre-encounter factors, a deviation from predictable behaviours was suggestive of mental disorder:

> *"Expected behaviour, shocking behaviours a lot you know throwing the baby on the floor is shocking … is a bit shocking so this kind of thing sort of sounds the alarm bells." (Vignette five: No.4, G1)*

So was a deviation from what were considered rational, deliberate actions:

> *"…but it's not logical conscious behaviour that she was doing." (Vignette five: No.7, G1)*

Some police officers offered possible reasons for the person's behaviour:

> *"Obvious cry for help." (Vignette eight: D)*

> *"Shows signs of psychological trauma from assault."* (*Vignette four: A)*

To some police officers *Disrespect and resistance towards a police officer* was significant:

> *"Not responding to uniformed officer." (Vignette eight: G)*

So too was the presence of aggression, and its focus:

> *"I just thought he was too aggressive for someone who was just trying to restrain her." (Vignette one: No.7, G.1)*

For some police officers, their concern was one of possible *criminality*:

> *"Using a 'glove' but not in apparent effort to ward off cold – more apt [appropriate] to avoid leaving f [finger] prints." (Vignette six: A)*

Some police officers labeled the person according to the criminal act they were suspected of committing:

"Shoplifter." (Vignette seven: X)

For one police officer, a person's behaviour was seen as a method to evade arrest:

> *"She could be faking it of course there's plenty of people who are very good at doing that." (Vignette four: No.1, G1)*

For some police officers, a person's actions represented a *deviation from expected criminal behaviour*:

> *"Not average shoplifter." (Vignette four: G)*

For several police officers, the *incongruity* of a person's behaviour was significant. Some described incongruous behaviour in very broad terms:

> *"Odd strange behaviour." (Vignette seven: J)*

Others offered more detail:

> "*…but it did look very much like he was trying to prevent her from striking him and not the other way round. He had her wrists rather than, he wasn't grabbing her by the throat or anything of that..." (Vignette one: No.4, G2)*

When noting a person's behaviour, some police officers captured key *features of mental disorder* associated with a particular vignette. One police officer described disinhibition:

> *"Wasn't interested in hiding his behaviour ?????" (Vignette six: D)*

Several police officers were able to capture and describe (if not recognise the significance of) features of preoccupation:

> *"Looking away. Looking down. Not engaged." (Vignette three: W)*

Repetitious behaviour was also noted:

"He kept stepping back and pausing and then going back again and repeating it." (Vignette six: No.8, G1)

Unexpected fear was reported by some police officers:

"Frightened when approached and appears to be shocked." (Vignette four: J)

As was unexplained distress:

"She's clearly distressed by something." (Vignette five: No.3, G1)

It was described in broad terms by one police officer:

"Wild behaviour." (Vignette five: A)

Features of depression were also implied, in broad terms:

"Given up?" (Vignette three: I)

Commonly, police officers sought to classify the *features of mental disorder. Whilst* they were demonstrating an awareness of the presence of mental disorder, their descriptions varied in accuracy:

"That excited delirium." (Vignette two: No.6, G1)

"*Not criminal intention. Potentially schizophrenic?" (Vignette six: W)*

"Psychotic delusions?" (Vignette seven: T).

Self-harming behaviour was also identified by several police officers. This was based on direct observation of the person:

"Suicidal. Has razor blade in hand and is cutting herself." (Vignette eight: B)

8.1.5 Communication

There was less focus upon a person's communication, compared to their appearance and behaviour. It was still considered an important indicator, particularly with regard to information available within the PNC. Here, police officers routinely checked a person's description, name and police contact history (*information obtained from police intelligence sources):*

> *"PNC check." (Vignette four: H)*

> *"Maybe some discreet background checks is poss to est if she has any previous contact with authorities that might heighten concerns re: what she might do to self or others." (Vignette four: A)*

Information provided by police intelligence sources provided some police officers with sufficient information to comprehend the presence of mental disorder:

> *"MISPER [missing person]. Previous intel states he had used a similar environment to try to commit suicide." (Vignette three: D)*

Within the information received, some police officers recorded succinct, yet key pieces of information within their notebooks, illustrative of their situational understanding, and the perceived / identified risk to the person:

> *"1000 → walked to clear head. Wife reports severe depression. Overdose. Suicidal." (Vignette three: W)*

In all situations, police officers also noted that they would try and gather contextual *information from persons within the scene.* This was done to try and improve their situational understanding, and therefore inform their decision-making and response:

> *"Speak to shop, try to see if there is any previous." (Vignette four: V)*

This information was sought, irrespective that it may lack explicit description of the person's condition / mental disorder, or that the terms may seem somewhat pejorative:

> *"'Loner' ''Oddball' Increasingly bizarre behaviour." (Vignette eight: W)*

When encountering a person considered to have a mental disorder, several police officers made reference to the *communication style* of the person. The person's tone of voice was commonly reported. A tone of voice suggestive of mental disorder, sat at either end of the vocal spectrum:

> *"Screaming." (Vignette five: B)*

> *"Speaking in a quiet voice." (Vignette three: S)*

> *"Non-communicative." (Vignette four: G)*

Particular forms of communication were associated with the presence of mental disorder. Some forms in particular were associated with the degree of sense that the person was making:

> *"Repeating themselves." (Vignette eight: U)*

> *"Rambling / muttering to himself." (Vignette two: U)*

> *"…shouting and swearing." (Vignette eight: Y)*

The focus of the person's communication was also noted. A person talking to themselves, was considered to have some form of mental disorder:

> *"He appeared to be talking to someone else because she wasn't answering." (No.5, G1)*

Police officers noted / recorded particular words that were said within the vignettes. Some police officers noted what the person was saying, without comment upon its contextual appropriateness:

> *"Picked him up and kept him in front of her saying "no, no." (Vignette five: E)*

Some police officers gauged the significance of things that were said:

> *"Made threats. Aggressive but not seriously." (Vignette eight: W)*

One police officer first assessed for criminal intent. Then, appearing to imply *incongruity*, they considered the contextual appropriateness of what was said:

> *Repeats "not done anything wrong" in such a way to suggest no criminal act, but that something is wrong." (Vignette three: A)*

Having viewed the same vignette, the inconsistencies amongst police officers was illustrated as some police officers noted differing things that were said. Each of the following three police officers perceived the same situation, differently:

> *"Yeah he was saying stop it. Or you will hurt yourself…" (Vignette one: No.5, G1)*

> *"He said, I don't want you to kill yourself." (Vignette one: No.2, G1)*

> *"I'll kill you…stop it - He appears to be talking to someone else." (Vignette one: E)*

8.1.6 Environment

Environmental features were noted in the least depth. However police officers noted *immediate environment (physical)* features they considered significant. Some

officers made note of the type of environment within which the situation was occurring:

> *"Uni Toilets." (Vignette eight: X)*

One police officer considered a person's location particularly incongruous:

> *"Why is he at that loc?" (Vignette three: I)*

A few police officers identified actual and potential risks within the environment:

Actual - *"Danger, stairs." (Vignette one: I)*

Potential – "Lots of side rooms with open doors that people come out, knowing you've got children, could be children's classes etc., walking right into the path of this man armed with sticks." (Vignette two: No.9, G1)

Some police officers noted potentially significant relationships between the person, and specific objects in environment:

> *"Sat on floor surrounded by tissue paper." (Vignette eight: C)*

Suspecting a person to be mentally disordered, some police officers considered the relevance of information provided by police intelligence sources, to the *immediate environment (physical)*:

> *"Male is found in secluded area alone. Similar to place last found when tried to commit suicide." (F)*

Echoing the concept pre-encounter, for one police officer, an assessment of local environment conditions formed part of their assessment for a tactical response:

> *"It's a confined space with porcelain and all the rest of it, I don't want to go fighting in there." (Vignette eight: No.10, G1)*

This included an assessment of escape risk:

> *"Just consider your surroundings if he was to make off it's a car park you heard car engines start just consider that if he suddenly wants to run off." (Vignette six: No.9, G1)*

8.2 Phase two

Thirteen participants partially or fully aligned their notebook descriptions of the situations depicted within the eight vignettes, to the concepts appearance, behaviour, communication, danger and environment.[70] Four participants did not explicitly align their notebook descriptions to the concepts.[71] Their descriptions were however more structured and ordered, appearing to align to the cognitive aid framework. All participants used the cognitive aid to shape the focus group discussion.

8.2.1 Value of the PPEAT-R

Following the introduction of the PPEAT-R, two dominant themes emerged regarding its usefulness as a mechanism to shape a police officer's identification and management of a potentially mentally disordered person:

1. *Forming a picture*
2. *Structure and order.*

8.2.2 Forming a picture

The PPEAT-R was considered a useful mechanism to help police officers notice the significance of things; things which ordinarily, they would have ignored:

> *"Simple things we probably would have noticed before but not necessary thought it was important to report. Would we never have reported before that he was talking in a monotone voice being very quiet, probably not." (No.4, G1)*

[70] The following key refers to the type of data, and participant group:

Letters A-J:	notebook data.	group one
Letters S-Y:	notebook data.	group two
Nos 1-10: G1	focus group interview data	group one
Nos 1-7: G2	focus group interview data	group two

[71] The same four participants (three from group one and one from group two) did not use the PPEAT-R cognitive aid to support their assessment of the situations depicted within the eight vignettes.

For one police officer, it was a mechanism for them to stop, and refocus their view of a person:

> *"So it might be for subtler stuff… because you do stop and go hang on a second actually that is a little bit weird, should it now be considered against the mental checklist." (No.4, G2)*

For another, it was a mechanism which could have potentially averted a fatality in operational practice:

> *"I think we have all also had a situation where we have raised concerns and they've not been listened to, I can think of one in which I raised a concern and exactly what I said would happen happened and someone died as a result and I wish I'd done it in writing, which I never … and like I said if there had been this kind of system that potentially could of averted it." (No.7, G2)*

8.2.3 Structure and order

Many police officers considered the PPEAT-R a useful aide-memoir:

> *"You could possibly forget things, it actions up the memory which opens it up straight away." (No.10, G1)*

Positive comments were offered, regarding the PPEAT-R structure:

> *"There's so many mnemonics in them there isn't there and most of them you can't remember, you don't go to a scene and think what's that a SAD CHALET or something like that, you don't think in those terms, but at least this is logical from A to E and it just gives you a punchy kind of breakdown of things, so to get a good snap shot of things That's quite good one." (No.1, G1)*

> *"It's a great simple little card with a couple of suggestions on it." (No.7, G1)*

For many police officers, the PPEAT-R was considered a useful mechanism to support them in ordering and recording their observations:

> *"Simple as well it is not asking for massive amount of details. If the only thing you notice about their appearance is that they look a little bit disheveled then you write that then you move onto like the behaviour whatever comes across more but you would make a note of each thing." (No.4, G2)*

For one police officer, it was particularly useful in enabling them to abridge their notes:

> *"Rather than having scrawling notes or whatever you can just draw it up and sort of have a look at things. I think giving that it was under headings I felt more comfortable making single words, adjective descriptions which is less less less writing than a chunk of long form, rather than we're doing this doing that process it's probably a bit more easy in an understandable format." (No.4, G2)*

To some, the PPEAT-R was also a mechanism to bring some degree of consistency to note-taking:

> *"I think it's good because I think we all think the same things we all see the same things but we when we write our notes, notes can be a varying quality, with this it gives you that little prompt like." (No.8)*

The PPEAT-R was considered useful as a communication medium, during information exchange:

> *"I do a lot of hand overs on a regular basis so does number 1. We would hand over to each other. But we lack sort of structure as well, right I've uncovered this, I've uncovered*

> *this so I think from note writing and handing over I think this is brilliant." (No.10, G1)*

It was especially useful, if used when communicating with healthcare professionals:

> *"I would have been more confident saying I knew that that health care professional was expecting me to give that information in that form and would listen to it, because otherwise it's I don't I'm very conscious that I'm not a health care professional … if I can say right I'll run through the ABCDE with you this is this, this is this, this is this and give it purely factually and they note that down and go right ok that makes sense to me." (No.4, G2)*

Despite its apparent usefulness as a communication medium, there seemed to be a general view that the PPEAT-R would not alter a police officer's ultimate decision-making:

> *"I think it doesn't change your internal decision-making or observations but it's a good tool for explaining to others what you've seen and why you've reached the conclusion you have." (No.7, G2)*

Following the introduction of the PPEAT-R, police officers were better able to comprehend and respond to a mentally disordered person, compared to pre-introduction responses. Their responses were more structured, post-introduction.

8.2.4 Pre-encounter – danger linkage

By addressing pre-encounter factors during the preparatory stage, there was a positive impact upon the ability of police officers to recognise (Level 2 SA) and respond (Level 3 SA) to the features of mental disorder. Thirteen police officers fully or partially used the PPEAT-R to shape their responses. Whilst four police officers chose not to use the PPEAT-R, their responses reflected an ability to recognise and respond to the features of mental disorder. Following the introduction of the PPEAT-R, there was a greater acknowledgment of danger, as a

consequence of mental disorder. Some police officers now contextualised the *threat,* apparently posed by a mentally disordered person. Within non time-critical situations, several police officers considered the threat-potential to be minimal:

> *"D: no overt danger presented." (Vignette four: WW)*

Within time-critical situations, police officers focused upon what they considered the greatest threat, whilst still acknowledging the presence of mental disorder. For one police officer, it was a person's physical strength:

> *"Clearly a physically capable male anyway, notwithstanding MH* [mental health] *issues." (Vignette two: AA)*

Police officers however overtly considered the *threats* posed to themselves (the police officer) from a mentally disordered person:

> *"It's just unpredictable I think, she knows what she is going to do and she comes quite close." (Vignette eight: No.5, G1)*

A threat to the *public* was commonly noted, yet also was an acknowledgement that the protagonist may need assistance:

> *"Baby would come to serious harm. Mother needs help." (Vignette five: JJ)*

Several police officers described the *threats* posed to the person (with mental disorder):

> *"Danger to self. Been missing. Depressed. Missing medication." (Vignette three: DD)*

A threat to the mentally disordered person, from others within the scene, was also considered:

> *"D: danger to himself potentially from car owner." (Vignette six: FF)*

A few police officers were somewhat cautious regarding potential or unknown, *threats* posed by the mentally disordered person:

> *"D: mainly to herself. What will she do if left alone (and maybe not searched for items with which she could S/H?)." (Vignette four: AA)*

Some police officers also had a high index of suspicion for self-harm, by the *person with potential mental health need:*

> *"D: meds taken or still in passion? Suicidal attempt? Danger to himself." (Vignette three: FF)*

One police officer however, acknowledged their lack of ability to accurately assess the person's mental health needs. They were however able to identify their requirement for general medical help:

> *"I wouldn't know if he is a danger to himself or others but he is in need of medical attention well obviously." (Vignette six: No.5, G1)*

Echoing pre-encounter factors (*experiential response*), a view was expressed that all police officers should be able to respond to particular behaviours, where there was a high index of suspicion for harm:

> *"Any street copper if someone is dealing with someone and they keep looking over their shoulder they know they're going to run, he wants to get away he doesn't want to speak to a police man, he's going to hurt himself." (Vignette three: No.8, G1)*

Such situations appeared to pose legal dilemmas, when deciding how to respond:

> *"And in that situation there's no legal cause for detainment personally, particularly it's even well through 136's that is it*

going to be like you can and probably would do it, well I probably would do it." (Vignette three: No.4, G2)

Reflecting a *role-specific response*, some police officers sought to first control the situation, and then consider how the person should be managed:

"You'd still have to restrain him in some way but you'd probably give a bit more consideration to a few brain cells ticking over, where do we go from here, rather than bundle him into the back of a van?" (Vignette one: No.1, G2)

8.2.5 Appearance

Following the introduction of the PPEAT-R, several police officers were more focused within their descriptions of the *Signs of visually apparent physical injury*. Within vignette one, several police officers now noted a bandage around the female's wrist:[72]

"A: female distressed. Screaming. Bandage on left arm wrist." (JJ)

"Bandage across wrist. There is massive bandage." (DD)

In contrast to phase one, the male was seen by some as now seeking to aid, rather than detain the female:

"… it becomes really obvious he's trying to stem some bleeding, if he's administering some sort of first aid." (Vignette one: No.7, G1)

Police officers were more attuned to the recognition *of Signs of self-harm*:

"Obvious cuts (S/H) to both wrists." (Vignette eight: AA)

Some descriptions were particularly detailed:

[72] Within the vignette, a crepe bandage is wrapped around each of the female's wrists. The bandages are in place to help stem the bleeding from acts of self-harm (cutting) to the carpel / ante-brachial surface of both arms.

"Marks on arms – not lengthways. Short sideways cuts."
(Vignette eight: GG)

There was more detail within the descriptions of significant *physical characteristics* (indicative of the features of mental disorder within the vignettes). This was particularly noted within the descriptions of the scenario depicted within vignette two. Several police officers described characteristics they associated with a significant increase in physical activity; often using shared terms:

"Sweaty. Muscle pumped up." (SS)

"Pumped up. Red. Sweating." (YY)

Within vignette five, several police officers now noted specific issues with the appropriateness of the person's *clothing.* These issues were not noted within the pre-cognitive aid phase:

"A: disheveled. Only wearing one boot. Untidy dress etc."
(XX)

When compared with the pre-cognitive aid responses, police officers associated the features of mental disorder with a person's appearance to a greater degree. Their descriptions also demonstrated a combining of the concepts. Where a person's appearance and behaviour were combined, they were better able to differentiate between *criminality*, and a *deviation from expected criminal behaviour*. This differentiation seemed to be made on the basis of incongruity with a person's appearance:

"A: initially @suspicious' behaviour with a locked unattended vehicle. Does not have appearance of a 'regular' car thief."
(Vignette six: AA)

For some, there was incongruity (*incongruence with expected personal / professional norms*), as the person's standard of dress seemed at odds with the situation encountered:

> *"She's well-dressed though for somebody who is a shop lifter, she's definitely well-dressed." (Vignette four: No.5, G1)*

This incongruity, was suggestive of mental disorder:

> *"A: sitting on floor. Well dressed. Otherwise well dressed, smart even in conditions – this is at odds with someone in such despair." (Vignette eight: AA)*

For one police officer, the PPEAT-R supported their identification of mental disorder, on the basis of a person's *clothing*:

> *"First time round I didn't notice the missing boot which is so the appearance of that, so going back on what I said that's actually the one where the mnemonic did help as a diagnostic tool." (Vignette five: No.7, G2)*

Several police officers were able to identify and describe the *features of mental disorder*, on the basis of a person's appearance. These included features characteristic of preoccupation, withdrawal, fear, distress and depression:

> *"A: somebody depressed. Closed off. Looking away. Quiet." (Vignette three: WW)*

8.2.6 Behaviour

Police officers were better able to discriminate significant features of mental disorder. Often, they described them in greater depth, compared to their responses prior to the introduction of the PPEAT-R. Incongruity (*incongruence with expected personal / professional norms*) with a person's behaviour remained an indicator of mental disorder, but the responses were more detailed:

> *"You'd know that anyone that can keep it going for that amount of time is not, it's not a quick temper tantrum, there is more to it." (Vignette two: No.7 G1)*

Several police officers captured a range of behavioural features they considered incongruent:

> *"B: wringing hands. Head down. Pacing. Tapping feet. Rubbing herself as if sore – why?" (Vignette seven: VV)*

For some, incongruence continued to represent a deviation from their norms of expected behaviour. As such, it was suggestive of mental disorder:

> *"B: not normal to open a door with a plastic bag he got from pocket and put on hand." (Vignette six: XX)*

Police officers were better able to comprehend and describe the *features of mental disorder*, depicted within the vignettes:

> *"B: repetitive behaviour. Unaware of surroundings – other people. Looks like OCD. Confused state. OCD behaviour. Male needs help." (Vignette six: JJ)*

Police officers however moved away from assigning a category for the type of mental disorder depicted. Rather, they often offered deeper descriptions of particular behaviours, suggestive of mental disorder. One police officer used particularly colorful language to describe preoccupation:

> *"Stepping back and looking and then going again it seemed very much like he was considering the process that made absolute sense to him and made fuck all sense to anybody else, but he was totally intent on it." (Vignette six: No.4, G2)*

Self-harming behaviour was also noted and described to a greater extent:

> *"B: self-harmed Screaming. Histrionics." (Vignette one: II)*

Some police officers provided more precise descriptions:

> *"Cutting arm with blade." (Vignette eight: FF)*

There was greater recognition of *aggressive or violent behaviour* as a consequence of a mental disorder. Whilst several police officers described aggressive acts, they suggested a potential cause:

> *"B: shaking baby. Assault. Very little mental capacity." (Vignette five: II)*

One police officer considered aggression in the context of preoccupation:

> *"Unaware of persons. Looking straight through you. Highly aggressive." (Vignette two: JJ)*

Another associated it with hallucination:

> *"B: talking seemingly to herself "go away I need to do it" Threatening officer with blade." (Vignette eight: FF)*

Where such threats were made, several police officers were better able to differentiate between *criminality*, and a *deviation from expected criminal behaviour*:

> *"Blade being waved but no attack." (Vignette eight: GG)*

Some police officers described in greater detail why they had made this differentiation:

> *"If you're trying to jack a car then you're eyes up because you want to see if we're coming or is somebody else is coming, whereas he's doing the opposite, he's utterly disengaged from his environment in a way that you never expect a thief to be, they would be the complete opposite of that." (Vignette six: No.4, G2)*

8.2.7 Communication

Factors relating to communication remained important to police officers. Compared to their pre-cognitive aid responses, they seemed better able to comprehend the presence of mental disorder.

Information obtained from persons within scene was more meaningful to some police officers. It was used as a mechanism to contextualise the situation encountered:

> *"Being restrained, He shouts "why do you want to kill yourself. He's help so she was attempting suicide." (Vignette one: DD)*

Consistent with pre-cognitive aid responses, *Information obtained prior to arrival at scene***,** provided police officers with sufficient information to demonstrate Level 2 SA. On the basis of such information, most police officers demonstrated a high index of suspicion for harm:

> *"Info from partner he has pills and will attempt again." (Vignette two: JJ)*

For some, such information was pivotal in enabling them to recognise the presence of mental disorder:

> *"Most of the warning signals with that actually come from the information you've received beforehand, there's not a great deal in his, not a massive amount in his appearance or behaviour that would cause you to be that concerned if you didn't know what you already knew." (Vignette three: No.4, G2)*

Information obtained from police intelligence sources also generated a similar response:

> *"Intel suggests post-traumatic stress." (Vignette four: JJ)*

Police officers were more sensitive to the *communication style of the person encountered*. This was particularly noted during communication suggestive of mental disorder. For one police officer, the way in which a person communicated with others, was significant:

"C: Shouting through the baby - Seems entirely caught up in her main despair." (Vignette three: JJ)

For others, the direction in which the person directed their communication was also significant:

"C: cry for help. Female talking in direction of different places. Possibly delusions / schizophrenia." (Vignette eight: JJ)

Police officers were more sensitive to aspects of non-verbal communication as a means to identify mental disorder. Commonly, multiple aspects were now described:

"No speech. Very distant. Body language, arms pulled in." (Vignette four: GG)

Reflecting this approach, one police officer described the features of preoccupation

"The way he's not making eye contact, he's almost staring past you, and trying to move through where you are rather than coming at you." (Vignette two: No.7, G1)

For others, the range of features described suggested withdrawal, rather than disrespect towards the police officer:

"C: no comms, but no interpersonal skill. No awareness of unit." (Vignette six: AA)

The descriptions often captured significant features of mental disorder:

"Limited eye contact. Quiet. Monotone. Disorientated. Not wanting to talk." (Vignette three: DD)

This included features strongly suggesting a v*ocalised intention to deliberately self-harm:*

> *"She's saying she's going to cut herself." (Vignette eight: No.3, G2)*

The PPEAT-R made some police officers more sensitive to features of mental disorder; features they did not recognise, prior to its introduction:

> *"Before I wasn't really, I couldn't hear what he was saying for one but also I didn't notice the repetitiveness, I didn't notice the monotone, didn't notice how quietly he was speaking and now these are the things I would pay attention to." (Vignette three: No.1, G1)*

8.2.8 Environment

Compared to their pre-cognitive aid responses, police officers were better able to comprehend the significance of the environment. Having indicated their intention to detain a person, one police officer posed the question:

> "…*where do we go from here, rather than bundle him into the back of a van?" (Vignette one: No.1, G2)*

This suggested that there was some recognition now, that the police station was not an appropriate place to take a mentally disordered person:

> *"E: Police custody could cause further harm to female wellbeing." (Vignette four: FF)*

Several police officers identified features of the *immediate environment (physical)*, they considered significant. For one police officer, it was the risk of an intentional fall from height:

> *"I noticed she's not on the ground floor she was about two or three stories up, so I'd be worried that, I don't know if there is a window in there. I just thought like she a few high I wouldn't want her jumping through the window." (Vignette eight: No.8, G1)*

For another, it was the potential for the person at risk of self-harm to barricade themselves in a room:

> *"E small lockable room. No way out." (Vignette eight: HH)*

One police officer identified items which may be potentially used to deliberately self-harm:

> *"E:…Mirror and cords." (Vignette eight: BB)*

One police officer considered the significance of a person's current location to a previous suicide attempt:

> *"That's where he'd gone he had gone to an isolated place before to try and top himself." (Vignette three: No.4, G1)*

One police officer noted the effect of a confined space upon the person; an effect potentially worsened by their presence:

> *"It also could be because we've not given her a bit more space she had backed herself into that corner to get away from people." (Vignette four: No.8, G1)*

8.3 Phase three

Four overarching themes emerged, illustrative of the usefulness of the PPEAT-R in operational, real-world practice:

1. *Operational usefulness.*
2. *The PPEAT-R as a mechanism to capture the features associated with mental disorder.*
3. *Integration of the PPEAT-R within the police service.*
4. *Design considerations.*

8.3.1 Operational usefulness

This overarching theme illustrated the ways police officers used the PPEAT-R during operational practice, and their views regarding its usefulness. This overarching theme was characterised by five sub-themes:

1. *Usefulness of PPEAT-R.*
2. *The PPEAT-R as an aide memoir.*
3. *A structured approach.*
4. *A mechanism to effectively articulate observations.*
5. *Adjunct to record writing.*

All police officers expressed positive views regarding the *usefulness of the cognitive aid* in operational practice:

> *"I think it is really good personally." (No. 3)*

> *"I like it, I like the tool." (No. 16)*

Commonly, police officers found the concept structure useful in supporting their recognition of potential mental disorder in others:

> *"I read the back and look at the words and go yeah that makes sense." (No. 14)*

The concept framework offered a way to disentangle often complex situations:

> *"It makes me unpick each situation. So you would break it in to compartmentalise a person, into different areas and look at them." (No. 15)*

For one police office, the PPEAT-R shifted their view of operational situations, involving a potentially mentally disordered person:

> *"Yes I look at this see if it, oh yes, I could do that, oh my god this is good you know I could do this differently." (No.3)*

For another, it provided clarity within both their assessment, and subsequent management of a potentially mentally disordered person:

> *"I thought it was, it crystallised and focused on what it was that I'd been responding to and I thought it actually led to a clearer explanation justifying why I'd taken the actions I had than it might have done without." (No. 17)*

> *"…you know, you're focusing on the right things." (No. 16)*

The PPEAT-R provided a useful frame of reference, when encountering pressurised situations:

> *"I think that in stressful situations particularly, having a framework that you can ground it in does make it easier." (No. 14)*

Most police officers considered the PPEAT-R easy to use in operational practice:

> *"Well there it is, boom, that's really easy, and that's what I found it was just really easy to use." (No. 14)*

For several police officers, it was a mechanism which improved their response to a potentially mentally disordered person:

> *"I think if anything to make my officers look more competent." (No. 2)*

Several police officers felt that the PPEAT-R had altered their operational practice:

> *Alter my practice, it, definitely. If I am out there looking at dealing with people and that sort of thing and I think yeah he is dressed a bit strange then I might say oh ok what else is going on you know is there other things here in this model that I should be looking at, then yeah." (No. 12)*

"I prefer to use the tool." (No. 17)

All police officers reported the benefits of *the PPEAT-R, as an aide memoir*:

> *"It just puts it into context what we've been doing, it's just it's an aid memoir for us to ensure that we're hitting, for me, all the right areas." (No. 1)*

The concepts comprising the PPEAT-R were sufficient to enable the features of mental disorder to be recognised:

> *"If you use the structured headings you tend to not miss as much as what you would if you're just writing it straight from your head." (No. 18)*

The concepts, in conjunction with associated training in the use of the PPEAT-R, provided prompts, sufficient to capture the key features of mental disorder:

> *"…so it's helping me frame things in a way that will, that will trigger or, you know, key into their training, without turning me into diagnostician." (No. 17)*

One police officer considered the PPEAT-R particularly useful, when fatigued:

> *"It helps because it does clarify stuff and simplify stuff and if you're absolutely shattered 3 hours after you should have finished and you are struggling to remember just why this person was as mad as you are possibly now feeling, due to the effects of tiredness and all the rest of it, there it is, five simple steps that you can record against and go oh yeah, okay it was that, it was that, it was that." (No. 14)*

For one police officer, the PPEAT-R shaped unconscious thought-processes:

> *"I think I've used it subconsciously when I'm working." (No. 17)*

For others, it was a mechanism to make known, pre-existing, unconscious thought-processes:

> *"…everything that you were thinking of but you didn't realise you're thinking about." (No. 18)*

The PPEAT-R provided police officers with *a structured approach* to the identification and management of a mentally disordered person:

> *"Neat, yes and what is the word, I don't know, structured I think just it is there I can't, yes structured, clean." (No. 3)*

The manner in which the PPEAT-R was structured, lent itself to ease of use:

> *"So this is why this is easier, because it's ordered…" (No. 1)*

So too, did an absence of complexity within its design:

> *"…there is nothing else there's nothing hiding behind the walls it's there and there in front of you." (No. 3)*

The structure and design of the PPEAT-R therefore lent itself to ease of use:

> *"…a tool that makes things easier I think and makes it more logical." (No. 3)*

The PPEAT-R was, a useful *mechanism to effectively articulate observations* to healthcare professionals:

> *"And I found in both instances it just became a really straight forward way of saying to the doctor, these are the five reasons why…but, it kind of, it was a way of formalising my explanation of it." (No. 14)*

In some cases, the features of mental disorder may have shifted, or subsided following police intervention; features that may be potentially useful within subsequent diagnosis and management:

> *"It is getting me to focus on the stuff that they need to diagnose and to particularly when, if we've done our job well and by the time we get to the 136 suite they are nice and calm." (No. 17)*

The PPEAT-R enabled police officers to articulate their observations in a more expert manner:

> *"…it sounds professional…" (No. 1)*

For one police officer, the PPEAT-R enabled them to be more succinct within their discourse:

> *"…it is just the biggest one when we are explaining, what I have seen and what I have dealt with and that sort of thing. That's where it has really helped me sort because I am not, you know I do not talk a million times about one thing sort of thing. But for me it really just sort of helped explain what I was actually dealing with." (No. 12)*

It also expedited such discourse:

> *"…you're giving that statement of information more quickly, you know, in a more ordered way and that can't be a bad thing." (No. 1)*

Amongst police officers, there was acknowledgement that it was not necessary to assign a diagnosis when relaying their observations:

> *"…why we brought them in and we are, without, without knowing what we are talking about, you know, psychosis or, you know, paranoid schizophrenia or whatever these terms*

which I use often and probably use incorrectly, you know, it, it, it without doing that you're, you know, you're focusing on the right things." No. 17)

Despite it being unnecessary to assign a diagnosis, police officers felt that information obtained using the PPEAT-R could be of significance to healthcare professionals. This was the case even if the relevance of such information was not immediately obvious to them:

"In the mental health suite, they can more easily decode that information." (No. 1)

There was broad agreement that the PPEAT-R should not be used in isolation by police officers. Rather, it should be used as a shared communication medium with healthcare services:

"I think you need a ready checklist that is a shared, so there's a common denominator, or shared, with all the support services…so we're all singing from the same hymn sheet" (No. 1)

One police officer summed up the usefulness of the PPEAT-R, as a mechanism to effectively articulate observations:

"…handing over to mental health services, it's going to make my notes structured, it's going to make more points covered, it's going to look more professional and it's going to help the mental health services who are receiving the person from me…The more I can tell them surely the better it is." (No. 18)

All police officers considered the PPEAT-R a useful *adjunct to record writing.* The concepts forming the PPEAT-R provided a useful frame, when police officers completed their records:

"…appearance this is what they look like, this is how they were behaving… which I think is brilliant." (No. 18)

Commonly, the PPEAT-R helped police officers articulate key issues, in a more objective manner:

> *"It makes it easy. Like I'm saying, trying to justify why someone is acting strangely. If you write they're acting strangely, that doesn't mean anything it just, what, you know what's strange, what's strange to me is not strange to someone else, but if you use ABCDE, you cover all the points and you don't use the word strange but you just follow those headings and your notes they've, they sort of form themselves." (No. 18)*

The PPEAT-R lent itself to more complete records:

> *"When writing notes it just makes sure we've covered everything and we've thought about everything." (No. 2)*

It also lent itself to more succinct record writing:

> *"…and it just makes it a lot more precise, I get carried away in the stories but it just makes it go this, this and this, it is simplified." (No. 3)*

The PPEAT-R was used, following a police officer's immediate response to a situation:

> *"It comes afterwards as a way of explaining, you know, what we, why we did what we did and focussing, reminding us to say well actually that something that needs mentioning." (No. 17)*

For several police officers, the PPEAT-R helped them better validate their actions:

> *"…criteria that you can subsequently use then and then subsequently use to justify when you're doing your notes and you follow up work afterwards." (No. 1)*

For others, it was a mechanism to defend actions:

> *"It's helping me. It's increasing my, the quality of my, any notes that I write, which covers my back." (No. 18)*

One police officer encapsulated the views of all participants, regarding the *operational usefulness* of the cognitive aid:

> *"I think it is a really good plan for everyday work." (No. 16)*

8.3.2 The PPEAT-R cognitive aid as a mechanism to capture the features associated with mental disorder

Within operational practice, police officers used more than one concept to identify the features of mental disorder. The assessment of danger to the person was central to each police officer's assessment. In conjunction with this, there was increased focus upon risks within the environment:

> *"Risk to the individual yes. Yes because that is a basis of the mental health act isn't it? It's a significant risk of harm to that individual, but I guess where they are. Where, what, you know like are they near a bridge? Are they near a railway track, or are they just at home?" (No. 2)*

There was also a focus upon a person's behaviour, particularly where there was disrespect towards a police officer. To some, this disrespect was suggestive of the presence of concealed weapons:

> *"…they may have something concealed on them. And that might make them kind of aggressive or evasive. someone looking like they're about to do something which you know, that raises that kind of basic sixth sense, and is usually a danger signal I suppose." (No. 1)*

Whilst the assessment of danger underpinned interactions, the features of a person's appearance and behaviour were most commonly combined when police officers were forming a view that a person was mentally disordered:

> *"…their body posture and so forth. Things they do, that's the kind of two things I would look at and the things they do, their mannerisms the demeanour." (No. 2)*

For one police officer, this included features relating to a person's clothing, signs of physical injury and disrespect towards a police officer:

> *"People looking dishevelled and dirty and not looking after themselves or having an untreated injury …But yeah, avoidant behaviour is a thing." (No. 17)*

Incongruent behaviour, coupled to a person's appearance was also significant:

> *I would say initially it would be, the first thing would be appearance. What they look like, secondly if they're doing something that's out the ordinary…a deviation, something, someone that will catch my eye because they're not the same or doing the same as everyone else." (No. 18)*

Features characteristic of a mentally disordered person's behaviour and communication were also combined:

> *"…something a little bit over excitable about their behaviour, and you think why are they not experiencing that kind of stimulus to one of their senses that everyone else is, is that because something else is masking it perhaps, a mental health issue…then obviously once you get onto speech, you might not even be able to engage them in speech." (No. 1)*

So too were features related to a person's behaviour and its incongruous relationship to the current environment:

> *"…it's context impairment. So whatever is, it's about their behaviour in that context. So we've just come up XXXXXXX Street there, so everyone is fairly busy, everyone is moving at a rate of knots, they bump into you and, perhaps quite unapologetic for it." (No. 1)*

Where a police officer was unable to establish the presence of mental disorder on the basis of two concepts, most appeared to seek confirmation, or exclude its presence, by considering features associated with further concepts. In addition to a person's appearance and behaviour, the manner in which they communicated was commonly considered:

> *"Initially again it's going to be on how they look to me, and then obviously their behaviour will already have been the trigger for me to speak with them. And once, once I start speaking to them, that's going to set alarm bells off or it's just going to be a normal conversation." (No. 18)*

A few police officers however reported that they considered the person in relation to all concepts, when undertaking an assessment:

> *"I would listen to how they speak, I would observe how they are interacting with either myself or somebody else…Physical behaviour, dress, environmental interaction." (No. 14)*

8.3.3 Integration of the PPEAT-R cognitive aid within the police service

Reflecting the concept *pre-encounter*, this overarching theme illustrated police officer views regarding how the PPEAT-R should be integrated within the police service. This overarching them was characterised by five sub-themes:

1. *Point of integration.*
2. *Format.*
3. *Duration of training.*
4. *Content.*
5. *Delivery.*

All police officers considered the *point of integration* to be within initial police training:

> *"I think it should be part of the initial training, because the amount of mental health people we deal with is quite significant." (No. 18)*

Several police officers reported that regular training updates in its use would be required:

> *"I think police officers need refreshing, and we've recently they've gone back into a programme of giving us training sessions once a quarter roughly So we get a whole day of training where, which is where we get a bit of an input on this." (No. 15)*

Some police officers considered the PPEAT-R of such value, that they had shared it with colleagues. One police officer reported they had shared it with junior colleagues:

> *"I was training new people, people that had not even passed out of Hendon[73], on XXX and trying to explain to them, you know, you will actually deal with mental health a huge amount of the time, whether it is suspects or victims, missing persons you name it. This is a straight forward way of looking at trying to process the information that you receive."*

Another shared it with a team of police officers:

> *"…your ABCDE which I actually took back to my team, and I've given it all to my team, saying look these are the things you need to do." (No. 2)*

When considering how best to integrate the PPEAT-R within the police service, police officers offered a range of views as to the *format* for training staff in its use.

[73] 'Passing out' is the ceremony following the completion of a student police officer's eighteen-week residential basic training programme. Upon completion of residential basic training, student police officers undertake a two-year probationary period within an operational setting. Upon completion of the probationary period, they assume the rank of police constable.

Some police officers considered the training approach within this study an appropriate format:

> *"I like the way you taught with the videos, so you had the videos, people write down what they think, people gave their opinions." (No. 16)*

> *"For me that day was perfect." (No. 12)*

There were however, a range of views regarding the *duration of training*:

> *"…half an hour." (No. 2)*

> *"…40 minutes, a standard lesson…" (No. 18)*

> *"…you could make a presentation, like the way with the videos, an hour long." (No. 16)*

Police officers also suggested specific *content*, which should be included in training. Some police officers suggested guidance as to how to refer a mentally disordered person to healthcare services:

> *"…from the perspective of how do we then, hand these people over? Bit more on the training" (No. 4)*

> *"…how they are going to get them into the hospital." (No. 16)*

Others suggested guidance regarding the depth of information they should record, when using the cognitive aid to shape their notes:

> *"…not only in the training of using the card but also in how a report should be written. What, you know, how much information. Where, where it, it's covering all the boundaries." (No. 15)*

Regarding *delivery*, a multi-agency approach was the most favoured method of delivering training in the use of the cognitive aid. Police officers favoured a team, comprising staff from the healthcare disciplines they come into the closest contact with, when managing a mentally disordered person. This approach would enable a shared understanding of the issues experienced by the police and healthcare services, when managing a potentially mentally disordered person:

> *"…do the training in conjunction with, your mental health practitioners. With you're A & E* [Accident and Emergency] *nurses, so that, so it can become apparent what the issues are so everyone can understand..." (No. 4).*

One police officer also recommended the service user involvement within any training:

> *"I would also probably get somebody who's got mental health problems to come and talk to them." No. 14)*

8.3.4 Design considerations

Police officers offered a range of views regarding the utility of the PPEAT-R's design. The overarching theme *design considerations*, was characterised by three sub-themes:

1. *Size.*
2. *Layout.*
3. *Presentation*.

The *size* of the PPEAT-R was important to police officers, as they did not wish to be overburdened with a large document or tool:

> *"…it fits in a warrant card, that's what policeman want, so that they are not carrying extra bits of paper around." (No. 18)*

Police officers considered the 8.5cm X 5.5cm (business-card) sized card appropriate, as it fitted within their Warrant Card:

"…Warrant Card sized card is very important." (No. 17)

"I think those pocket sized cards are spot on." No. 2)

The size of the card therefore lent itself to ease of access, and use:

"…and it doesn't matter how long you've been in, if something, if something needs writing up really well what's the harm of just pulling a card out of your warrant card and just oh yeah! Just refreshing yourself on all your points." (No. 18)

Regarding the *layout* of the objective features within the reverse of the card, police officers considered the letter D (representing the concept danger), to be correctly positioned:

"The crucial point there is you have got danger in the middle and that is what people do need to focus on." (No. 14)

The position of the concept danger, reaffirmed its primacy when police officers undertook an assessment:

"…my eyes goes straight to danger and yeah…Yes because that is the main thing isn't it." (No. 2)

Police officers considered the *presentation* of the PPEAT-R appropriate and useful for operational use. The information contained within the PPEAT-R was presented, organised and sequenced, in a meaningful, unambiguous and uncluttered way:

"It's assisting rather than distracting." (No. 17)

The PPEAT-R was able to relay sufficient procedural knowledge to enable police officers to identify mental disorder:

"I read the back and look at the words and go yeah that makes sense. It has got what you need, I, genuinely, it's

really unusual in that respect. To kind of look at something and go, god, that makes sense." (No. 14)

"But it's there, it's, it tells you everything." (No. 15)

It was able to achieve this, with minimal user effort:

"It is not hard to read, it is an easy thing to remember." (No. 12)

8.4 Chapter summary

Within phase one, police officers were able to perceive the features of mental disorder (depicted by the people within the vignettes). There was however a limited ability to recognise their significance. Police officer responses were broadly aligned to the concepts appearance, behaviour, communication, danger and environment. The perception of danger underpinned each assessment. Their situational response, role-specific response and assessment of danger was shaped by pre-encounter factors. These pre-encounter factors reflected a police officer's role perception, their personal views, experience and depth of specialist education related to mental disorder. Pre-encounter factors exerted a significant effect upon a police officer's methods, rules, actions and behaviours, often resulting in a pre-planned, forceful response.

Following the introduction of the PPEAT-R (phase two), responses were much more closely aligned to the concepts. The police officers comprehended the features of mental disorder to a greater degree, compared to their phase one responses. Of note, their responses were less forceful, and more sympathetic to the person's mental health needs. This shift continued into real-world operational practice. During phase three of the study, the PPEAT-R provided a very user-friendly platform for the police officers to base their identification and management of a potentially mentally disordered person. It also provided a very useful frame to shape note-taking. Of significance, its operational use was not static. Rather, they used different combinations of the concepts, at different stages, to gather information necessary to identify features of mental disorder.

Within the following chapter, I discuss the study findings emerging within preparatory stage and when testing the usefulness of the cognitive aid. Against this backdrop, I will discuss the methods, rules, actions and behaviours police officers used to make sense of, and manage situations involving a potentially mentally disordered person. I will then discuss the usefulness of a cognitive aid as a mechanism to assist a police officer's situation awareness, when encountering a potentially mentally disordered person.

CHAPTER 9

DISCUSSION

9 Introduction

In this chapter, I discuss the findings of this study. This chapter is presented in two sections: the preparatory stage and testing the usefulness of the cognitive aid. Within the section entitled preparatory stage (stage one of the study), I discuss how the six concepts[74] encapsulated the newly constructed view of how police officers identified and responded to a person considered to be mentally disordered. I discuss how these concepts established the frame of reference for the PPEAT-R. Within this discussion, I first address the range of pre-encounter factors exposed within the findings. These factors underpinned and shaped a police officer's situation awareness, within the other five concepts. The findings suggested an inconsistency in the manner police officers identified and responded to a potentially mentally disordered person. Against this backdrop, I then discuss the features police officers considered indicative of mental disorder, and their relationship to the concepts appearance, behaviour, communication, danger and environment. These features were then viewed through the lens of situation awareness[75], establishing the level demonstrated by police officers. Finally I discuss how these features provided the basis for the concept framework, used to gauge the usefulness of the PPEAT-R within the following part of the study.

Within the section entitled testing the usefulness of the cognitive aid (stage two of the study), I discuss the findings prior to, and following the introduction of the PPEAT-R. This section has three parts, reflecting phases one, two and three of this stage of the study. Within phase one, police officers watched a series of eight video vignettes containing people demonstrating differing presentations of mental disorder. Using the six concepts as a frame, I discuss their responses and corresponding levels of situation awareness, prior to the introduction of the cognitive

[74] Pre-encounter, appearance, behaviour, communication, danger, environment.

[75] Endsley's (1988) three-level categorisation of situation awareness.
- Level 1 SA - perception of the elements in the environment.
- Level 2 SA - comprehension of the current situation.
- Level 3 SA - protection of future state.

aid. During phase two, police officers re-watched the same video vignettes, this time supported by the cognitive aid. I discuss their responses and corresponding levels of situation awareness, following the introduction of the PPEAT-R. This discussion is again framed within the six concepts. Finally, in phase three, I discuss the usefulness of the PPEAT-R following its use in operational, real-world practice.

9.1 The preparatory stage

The preparatory stage provided a frame of reference for the development of the PPEAT-R. Within this section, I discuss the six concepts which encapsulated the newly constructed view of how police officers identified and responded to a person who was potentially mentally disordered. I also address the themes, illustrative of the features police officers used to identify mental disorder. This discussion is conducted through the lens of situation awareness (SA).

Six overarching concepts encapsulated the breadth of cues police officers associated with mental disorder. These concepts were: pre-encounter, appearance, behaviour, communication, danger and environment. The findings revealed an array of cues, suggestive of Level 1 SA. An important finding was that a police officer's perception and response to danger underpinned their actions. However, the concept pre-encounter exerted the greatest influence upon their identification and response to a mentally disordered person. One of the most significant findings of this study, this concept shaped police officers' responses, prior to their contact with a mentally disordered person. These six concepts formed the domains of the PPEAT-R, as they encapsulated the features police officers perceived and comprehended as being associated with mental disorder. They also shaped the concept framework. This was the mechanism used to gauge the usefulness of the PPEAT-R within section two of the study.

9.2 Establishing the frame of reference

9.2.1 Pre-encounter factors

The concept pre-encounter governed a police officer's contextually determined processes (common rubric). Its effect underpinned and shaped a police officer's situation awareness within the five other concepts. This was a key finding within this study. The pre-encounter factors included a police officer's depth of specialist

education to support their identification and management of a mentally disordered person. Also included were their personal views of what mental disorder was, and how it should be managed. A police officer's experience of mentally disordered people was also a factor. So too was the degree to which their professional identity as a police officer governed their (role-specific) response to mentally disordered people. These factors populated a police officer's individually held cognitive 'toolkit': the (cognitive) tools police officers drew upon to guide their response when encountering a potentially mentally disordered person. This 'toolkit' represented the knowledge, skills, experiences and attitudes formed prior to an encounter with a mentally disordered person. This had a significant impact at the time of an encounter.

9.2.2 The knowledge deficit

The CoP (2016a) states that "Early police recognition of the possible mental health problems…is crucial to ensuring an appropriate and effective response" (Para. 1). However, within this study, the police reported their training (and therefore knowledge) was inadequate. Literature ranging from Bittner (1967) to Myers (2017) continues to identify the inadequate, often absent level of specialist education police officers receive regarding the identification and response to mentally disordered people. The findings of this study reaffirm this position. Within this study, the division between being able to identify the features of mental disorder, and recognise their significance, appeared quite distinct. Whilst the police officers were able to capture often subtle features of mental disorder, this was not always translated into recognition and a response, acknowledging the significance of the mental disorder. On several occasions, when encountering the person, they were only alerted to the presence of mental disorder by bystanders, or information available about the person within the PNC. Following detention and arrest, it was often the custody sergeant who later made them aware that the person had a mental disorder. In such cases, mental disorder was suggested and confirmed by a third party, and not as a consequence of the police officer's interpretation of the presenting features of mental disorder. As such, their 'toolkit' was somewhat deficient.

9.2.2.1 The empty toolkit

As well as concerns regarding the inadequacy of their specialist education, police officers were concerned that they did not have a mechanism to help them identify

the features associated with mental disorder. Their identification (of mental disorder) and response was based upon individual interpretation of situation variables, rather than on the basis of rigid or useful protocols to guide them. When assuming the role of what Teplin and Pruett (1992) describe as "…the streetcorner psychiatrist…" the police officers felt unprepared (p.141). Reflecting the work of Cummins (2006), the police officers recognised that an individual, situationally determined approach to the identification, recognition and response to a potentially mentally disordered person, often resulted in inconsistent assessments and decisions. Closely associated with a police officer's depth of specialist understanding of mental disorder, Hanafi et al. (2008) infer that a further dimension shapes such individually-determined approaches. That is a police officer's personal views regarding mental disorder.

9.2.3 Personal views

The personal views of the police officers were somewhat polarised, ranging from the negative, to the positive. Viewed from the 'negative' pole, Godfredson et al. (2010), Szeto, Luong and Dobson (2012), and Hansson and Markström (2014), note that despite a police officer's frequency of contact with mentally disordered people, feelings of fear, stigma, pejorativeness and labelling is common. This was reflected within this study, as mentally disordered people were in some cases considered blameworthy and responsible for their actions, even during periods of emotional crisis. Mental disorder was also reported as an excuse for anti-social or criminal activity. Furthermore, mentally disordered people were reported as being unpredictable, disrespectful, resistant and (as noted earlier), more violent compared to those considered not to be mentally disordered. Where mental disorder was suspected, the police officers described it in broad, terms. They often used a shared set of diagnostic terms, in a 'pick-and-mix' fashion. Such indexical descriptions (labels) reduced the person to a presumed clinical condition, rather than an individual. They included [*they were / are a*] *personality disorder, psychotic, bi-polar, schizophrenic, harmer, self-harmer, suicider*, *hallucinator* and *suicide*.

9.2.3.1 Describing the mentally disordered

Amongst the police officers, the terms *harmer* and *self-harmer* were used to describe people who had cut themselves in such a way as not to kill themselves, but to attract attention. In their opinion, s*uicider* and *suicide* were used to describe people who were attempting, or had attempted, to take their own life, irrespective of

the mechanism. The term *personality disorder* was used to describe people who were obstructive, resistant to command and aggressive and / or violent. The terms *psychotic, bi-polar, schizophrenic, hallucinator* were used to describe people who were acutely upset, tearful, disoriented, and in some cases aggressive and / or violent. The difference between a description of *personality disorder* and *psychotic, bi-polar or schizophrenic*, was therefore the presence of acute, upset and tearfulness.

Within the middle-ground, the personal views of the police officers reflected ambivalence. Here, the police officers held neither overtly negative or positive views / feelings, toward mentally disordered people. Towards the positive pole, police officers were more optimistic within their views. Reflecting the work of Pinfold et al. (2003), where police officers had close personal experience of mental disorder (particularly where it was experienced by a family member), they displayed more positive views and responses. The police officers holding such views sought (at least initially) to take control of the situation, through what Woody (2005) describes as de-escalation techniques[76], underpinned by "…empathy, genuineness and acceptance" (pp.58-59). In doing so, they demonstrated what Kutcher, Wei and Coniglio (2016) describe as "…mental health literacy" (p.155). This is one's ability to respond positively to a person's mental disorder, through understanding and 'unconditional positive regard'[77] (Benson, 2016, p.23). Within this study however, regularity of contact, and therefore experience with mentally disordered people, did not seem to lend itself to an overall state of mental-health literacy amongst the police officers.

9.2.4 Experience

Consistent with the observations of Hollander et al. (2012), Short et al. (2014), and Oxburgh, Gabbert, Milne and Cherryman (2016), the police officers encountered mentally disordered people almost on a daily basis. Despite this, they did not always recognise the signs characteristic of mental disorder. As such, they did not always respond (where appropriate) to a person's specific mental health need.

[76] The CoP (2017b) stress that the use of force should be used only when all other avenues of control have been exhausted, and when it is legally permitted. They advocate the use of tactical communication, prior to the use of force. Described by Weller, Quinton, Fides and Mills (2013), these skills include empathy, rapport and positive acknowledgement. They also include the use of personal names (person and police officer) to establish a relationship, avoiding negative language.

[77] Based upon the work of Rogers (1959), unconditional positive regard is the non-judgmental acceptance of another, irrespective of their thoughts, feelings, emotions or behaviour.

Work by Fry et al. (2002), Psarra et al. (2008), and Hoffman, Hirdes, Brown, Dublin and Barbaree (2016) suggested that police officers have difficulty recognising the breadth of mental disorder. Within his seminal study, Bittner (1967) explored how police officers identified people with mental disorder. Bittner (1967) noted that they did so by gathering pieces of information, filling in their knowledge gaps (relating to the recognition of mental disorder) with local knowledge and experience. The findings of this study suggested that 'intuition' (gut instinct) and pattern recognition were the common mechanisms through which police officers filled in the 'gaps.' Both of which appeared somewhat inconsistent approaches.

9.2.4.1 'Gut' instinct

Welsh and Lyons (2000) consider 'intuition' to be the process by which people are able to unconsciously detect the presence or absence of something. Where one unconsciously detects an absence or gap within what appears to be ordered or complete information, Offredy (1998) terms this "…Gestalt intuition…" (p.992). For Cioffi (1997), Nyatanga and de Vocht (2008), and Price, Zullosky, White and Pretz (2016), 'intuition' is the sudden subconscious detection of patterns within the embedded mental models, frameworks and cognitive maps within the schema. Offredy (1998) terms this "…cognitive inference…" (p.992). Colloquially termed the "…gut instinct…" (Iqbal, Kara and Hartley, 2015, p.365), or "…gut feeling…" (Pearson, 2013, p.213), one consciously becomes aware of something, directing focus toward it, without (at this stage) conscious recognition as to why (Nyatanga and de Vocht, 2008; Jeffrey, 2012). One then seeks out information to bring the subconscious processes into the conscious working memory.

Within this study, 'gut instinct' was considered a product of years of experience encountering mentally disordered people, during which time differing mental models, frameworks and cognitive maps were formed. This 'gut instinct' seemed to draw a police officer's attention to a particular person's features, actions or activities; seemingly innocuous features, actions or activities which were subconsciously significant. However, not all police officers seemed to share this view. Echoing the views of Cioffi (1997), Nyatanga and de Vocht (2008), and Pearson (2013), 'gut instinct' was considered a uniquely individual trait; its depth and usefulness varying between police officers. Furthermore, "…stereotyping, [and] prejudice…." may be imprinted within mental models, frameworks and cognitive

maps, unconsciously biasing a police officer's views, and therefore response, to a mentally disordered person (Standing, 2008, p.126).

9.2.4.2 Pattern recognition

Within pattern recognition, there is also subconscious detection of patterns within the embedded mental models, frameworks and cognitive maps (Offredy and Meerabeau, 2005; Pearson, 2013; Price et al., 2016). One is also able to consciously make associations and links between multiple cues (Standing, 2008). In doing so, one assembles a mental picture of something that is familiar, or previously experienced (Matsui and Kawaguchi, 2015). Within this study, the police officers were able to detect often subtle signs of a range of significant mental disorders. However, irrespective of the degree of experience they had with mentally disordered people, the police officers were not always able to make a connection between the signs present, and the identification of mental disorder. In some cases, they misperceived them.

The police officers felt confident identifying what they considered to be 'typical signs' of mental disorder. Examples of these were a person talking to themselves, or someone who had deliberately cut themselves. However, the police officers had difficulty identifying people with subtle or 'quiet' presentations of mental disorder. An example is people not immediately responding to police command due to preoccupation / hallucination. Often, this was identified by the police Forensic Medical Examiner in custody, following arrest and detention. Furthermore, contrary to the work of Fry and O'Riordan (2002), Psarra et al. (2008), and Hoffman et al. (2016), police officers were again, not always able to identify mental disorder, when a person appeared aggressive or violent. An example of this was a person with acute behavioural disturbance where police officers found it difficult to identify and respond to the (potentially acute) mental health needs of someone outwardly dangerous. This misperception of either the quiet or aggressive presentations of mental disorder suggested cognitive failure on the part of the police officer (Girodo, 2007).

9.2.4.3 Cognitive failure

Kahn (2015) describes cognitive failure as a "…lapse in perception, attention, memory and action" (p.140). Wagennar, Hudson and Reason (1990) suggest that a precursor to cognitive failure, is a lack of knowledge. Within this study, a police

officer's limited ability to recognise the 'quiet' signs of mental disorder, appeared (as noted earlier) as a consequence of limited specialist knowledge (education). Without such specialist knowledge, the ability for police officers to make associations and links between multiple cues is clearly compromised. Where cognitive failure occurred when police officers were faced with people demonstrating aggressive presentations of mental disorder, McElhatton and Drew (2001) consider this to be due to the effects of the "hurry-up syndrome" (Para. 2). This is the degradation of cognitive performance, when there is a requirement to respond to an actual or perceived time-critical situation.

Harvey (2013) notes that in such situations, not only do time pressures degrade cognitive ability (leading to memory lapses and situational misreading), so do the effects of the physical environment, "…scope change…" (unexpected situational shifts), a lack of specialist knowledge, and existing mental models, frameworks and cognitive maps (p.40). Within this study, cognitive failure was common when the police officers encountered mentally disordered people. When faced with a situation in which the available cues failed to alert them to the possibility that a person is mentally disordered, or the person's presentation was aggressive, their ability to effectively process information was compromised. As such, they defaulted to a familiar mental model to respond to the situation (Fornette et al., 2012; Frye and Waring, 2016). In this study, when faced with such situations, police officers defaulted to a role-specific response.

9.2.5 The role-specific response

The findings of this study revealed that a police officer's role-specific response embodied both their expected and perceived role, including role-specific rules shaping their response to a mentally disordered person. Paoline, Myers and Worden (2000), Karp and Stenmark (2011), and Cyr (2015), argue that when a person enters the police service, to a large extent, they relinquish their previous socially constructed identity and values, adopting one consistent with the identity, values and practices of their peers in the police service. Bayeri et al. (2014) explored how police officers across six European countries viewed the key features of their role. Within this study, British participants were reported to view themselves not as "…professional service providers…" or "…community-orientated civil-rights protectors…", but as "…hands–on enforcers…" (Bayeri et al., 2014, p.740). As 'hands-on enforcers' their primary role was to prevent crime, "…for which they

claimed authority for the use of force against the public" (Bayerl et al., 2014, p.734). It is a view, suggests Cyr (2015, p.904), that originates from almost continual "…exposure to negative events…" causing many police officers to believe themselves as being in a "…continual state of war…" with the criminals (Cyr, 2015, p.900). As such, there is often a disconnect from the 'community problem solver' role (Paoline, Myers and Worden, 2000; Sellars, et al., 2005, p.648). Irrespective of how police officers considered themselves, or their professional role, they were consistent in their initial response to a situation involving a mentally disordered person. This was through the establishment of a 'new normality.'

9.2.5.1 Establishing a 'new normality'

Echoing the work of Bittner (1967, p.286), who noted that police officers sought the 'restitution of control', this indexical term described a return to as near a normal pre-incident situation as possible, dependent upon the situational variables present. Daniel (2004) suggests that when faced with a mentally disordered person, front-line service providers such as police officers, first intervene to restore calm via the removal of the anxiety or strong emotion. Within this study, irrespective of whether the police officers recognised and responded to the presence of mental disorder, they demonstrated the reflexive, role-specific response of taking control of the situation. This by whatever means at their disposal, mitigating the effects of danger. This study's findings suggested that emphasis was not necessarily on the immediate need to identify and address a person's healthcare need; rather, to control any sudden situation change or deterioration. In doing so, police officers sought to establish situational stability. This was to prevent, or limit the effects of a particular behaviour or event.

Consistent with Bayerl et al. (2014), and Bittner (1967), within this study, a common view was that the management of mentally disordered people was beyond their policing role. This was because they were neither mental health nor social workers. Police officers viewed their role as being one which protected the public, maintained safety and prevented crime. This did not always extend to protecting the public from harm, as a consequence of their mental disorder. Furthermore, within this study, where police officers demonstrated what Brough, Chataway and Biggs (2016) describe as the "crime-fighting characteristic", the social distance between themselves and the mentally disordered appeared widened (p.29). This was more so for police officers who held stereotypical or prejudicial views toward them

(Litzcke, 2006; Standing, 2008). In such circumstances, the arrest and detention of the mentally disordered person (often forcibly with the application of handcuffs), appeared to be a common lawfully-enacted role-specific response.[78] In doing so, they demonstrated Abramson's (1972) "…criminalisation of the mentally disordered…" (p.16).

9.2.5.2 The gatekeeper response

Within Chapter 2, I suggested that police officers wielded the power of gatekeeper to three pathways: the criminal, healthcare, and informal action pathways (Teplin, 2000). The findings revealed that the role-specific response of arrest (and therefore entry of a mentally disordered person into the criminal pathway) occurred where there was a failure to recognise the signs of mental disorder. It occurred if there was disrespect, aggressive, threatening, or violent behaviour towards a police officer. It also occurred where the police officer viewed a criminal act as being of greater significance than any associated mental disorder. For some, it was a default response to any criminal act. However, arrest was broadly considered an expedient method of controlling a situation they were unsure of (thus, establishing a 'new normality').

In some cases, police officers considered mental disorder a shroud for criminal activity. Even if mental disorder was suspected, where there was an associated criminal offence, the person would be arrested. Seeking to temper the argument offered by Paoline et al. (2000), Karp and Stenmark (2011) and Cyr (2015), Campbell (2012) suggests that for some police officers, their adoption of the identity, values and practices is never complete. Their identity, and therefore behaviours, are always shaped to some degree by prior socio-cultural values and experiences. It appeared that more mental health-literate police officers did not arrest a mentally disordered person as a consequence of their role-specific 'crime-fighting enforcer' response. Rather, their response was in the role of a 'community problem solver' (Sellars, et al., 2005, p.648).

[78] The CoP advises that for arrest and detention to occur, two criteria must be satisfied:

- "A person's involvement, suspected involvement or attempted involvement in the commission of a criminal offence
- Reasonable grounds for believing that the person's arrest is necessary."

Whilst there are an array of conditions which require a detainee to be transported directly to hospital, beyond the person being suspected of taking a drugs overdose, or "suffering from any other medical condition requiring urgent attention" the presence of a mental disorder is not one of them (2013a, Para. 1.2.4). The CoP (2013b) further advises that when detaining or arresting a person, a police officer, if required, has to demonstrate that the level of force is "… lawful, proportionate and necessary in the circumstances." (Para. 1). In applying force, the police officer has to further demonstrate (if required) that the methods used were "…lawful, proportionate and necessary in the circumstances" (CoP, 2013b, Para.3.3.1). For example, use of handcuffs, and / or use of side-arm baton, incapacitant spray, Taser.

Irrespective of other issues, in situations where injury or illness was suspected, police officers would call an ambulance. Where the 'community problem solver' recognised the presence and significance of a mental disorder, police officers sought some form of healthcare. Police officers reported healthcare services such as mental health crisis teams, or general practitioners, to be difficult to access in the field. They would, however, call an ambulance where the person did not require any form of (continued) restraint. They would also call an ambulance where there was no suspicion of their involvement in a crime. In doing so, they passed the mentally disordered person through the healthcare gate.

Calling an ambulance was considered a more efficient way of directing a mentally disordered person towards healthcare services for three reasons. First, care was available rapidly. Second, once paramedics arrived, they assumed responsibility for the person's care, and transport to hospital (in most cases, without further police involvement). Third, the police officer did not have to spend lengthy periods of time trying to locate GPs, or mental health crisis teams; time, which drew them away from other police duties. If a (presumed) mentally disordered person required continued restraint, or where they were suspected of committing a crime, arrest occurred. In such circumstances, this was considered the only way in which to effectively control the person, and prevent harm (to the person or others), prior to seeking some form of medical aid. The mentally disordered person was then placed in a caged, prisoner van[79], transported to police custody, and detained in a cell pending review by a healthcare practitioner (custody nurse / forensic medical examiner). This was often the prelude to an investigation into not only the nature of the crime suspected or committed, but also into the nature of their mental disorder.

9.2.5.2.1 The borderline cases

Termed "…the borderline cases…" by Teplin (1984), police officers also arrested and detained mentally disordered people when they were unable to access healthcare services, or the person was considered too violent for a healthcare environment (p.55). Despite this, they felt that the person required some form of 'care' and supervision, even if it was in a police cell. It was noted that on occasions, detention until the risk subsided was continued, even when this may be a breach of legal protocol. Such approaches were considered necessary due to the difficulty

[79] The CoP (2015a) within their guidance of 'moving and transporting detainees' suggests the following precautions for transporting mentally disordered people in caged vans: "…those experiencing mental health issues, must not be placed in a cage or containment area with another detainee." (Para. 3.2).

police officers frequently experienced when attempting to gain a medical assessment of a person they considered to be suffering from a significant and ongoing mental disorder. However, the findings of this study revealed that even in these situations, arrest was considered a more expedient, and less troublesome intervention than detaining a mentally disordered person via the use of S136 of the MHA (1983, amended 2007). Furthermore, detention within a police station, rather than transfer to a hospital was considered the most common disposition.

9.2.5.2.2 Section 136 detentions

In 2013, Her Majesty's Inspectorate of Constabulary and the Care Quality Commission (2013), reported that between "…6%..." and "…76%..." of people detained via S136, were held in police custody (pp.28-29). The study noted that this wide variation was attributed to factors such as accessibility and availability of healthcare services, and local 'Place of Safety' arrangements. Of significance, two-thirds of all detentions occurred between 1800hrs and 0900hrs the following day. Against the backdrop of improving local police – health cooperation, in 2016, the National Police Chiefs' Council (NPCC) (2016a) reported there had been a reduction in people being brought to police cells. This fell from 4,537 during 2014-2015, to 2,100 during 2015-16 (NPCC, 2016a, Para.1). Despite this apparent reduction in the use of police cells, there were acknowledged flaws within the data (National Police Chiefs' Council, 2016a). Noticeably there was an absence of data regarding the patterns of detention. The National Police Chiefs' Council (2016a) noted that whilst S136 detentions were recorded, it did not record if particular individuals had been detained multiple times in the same year, and if so, why. The data did not specify if multiply-detained individuals were managed inconsistently (e.g. on some occasions, taken directly to healthcare services, whilst during other detentions, held within the cells). The time of day of detentions was not specified, neither if specific police officers had a preference for using custody, rather than accessing healthcare services. Beyond a gross reduction in people being taken to police cells following detention via S136, it is difficult to identify why some police officers chose custody over healthcare services.

Somewhat contradictory to the apparent findings of National Police Chiefs' Council (2016a), within this study, most people detained under S136, were brought into police custody, rather than taken to healthcare services. Reflective however, of Her Majesty's Inspectorate of Constabulary and the Care Quality Commission (2013)

findings, the majority were brought between 1700hrs, and 0900hrs the following morning. Although police officers had an expectancy of support and advice when managing a person with a mental disorder, they found the services difficult to access outside of traditional working hours (0900hrs-1700hrs) and weekends. When seeking the assistance of a healthcare service (e.g., within a hospital emergency department), the process was considered to be lengthy, often unproductive. In some cases, the relationship was somewhat adversarial. Police officers reported that they were often challenged by healthcare staff as to the appropriateness of their initiation of S136.

9.2.5.3 The 'table tennis effect'

Being challenged by healthcare staff appeared to be a frequent, often expected occurrence. Having established a 'new normality' the mentally disordered person was in a controlled condition (through de-escalation or restraint). Because of the police officers' interventions, the (presumed) mentally disordered person did not always demonstrate the symptoms which led to them being detained. In such situations, the healthcare staff challenged the decision-making of the police officer, the appropriateness of S136 detention, and often the method of restraint (e.g., handcuffs, presence of multiple police officers providing physical restraint, or restraint if required). Lacking detailed clinical knowledge, police officers felt disadvantaged as they could not always defend their decision to detain the person. This in some cases, led to a 'table tennis effect.' This was described as the mentally disordered person being released from S136 detention, discharged, and then brought back to the healthcare service by police officers. Sometimes this occurred more than once in a police officer's shift.

9.2.5.4 The lost opportunity

Particularly during the early hours of the morning, when police officer numbers were at their most reduced, 'mercy bookings' often occurred (Lamb et al., 2002, p.1267). 'Mercy bookings' were undertaken where the person was considered a significant risk to themselves or others. The police officer's prior experience however determined that the mentally disordered person's symptoms were vague, or incompatible with admission to hospital. In such situations, it was considered easier to arrest the person for a minor offence (e.g., Breach of the Peace), so as to legitimise the detention, yet facilitate some form of care and supervision. Police officers would then hand the 'care' of the person to the custody sergeant, in the

hope that their mental disorder would be detected during the subsequent detainee risk assessment. If detected, their mental health need would then be addressed by the custody nurse / forensic medical examiner or mental health crisis team. It was reported however, that the custody sergeant often saw through this ruse, complaining that the custody suite had become a defacto mental healthcare unit for the person. It was however noted that where police officers considered a person to be mentally disordered, but with symptoms vague enough to be challenged by the custody sergeant (and by default, their professional judgement), often they would avoid taking any formal action. Here, they would not take any action beyond making sure the potentially mentally disordered person was safe at the point of their departure from the contact scene. In most cases, a record of the interaction would not be made, as no formal action had occurred.

By not detaining the person, or referring them for medical help, the police officer chose to direct the person through the informal action gate. Where perceived, Teplin (2000) noted that each police officer defines their own boundaries of acceptable mental disorder. Without any formal guidance, they determine the threshold whereby they intervene. Within this study, there was a further determinant, in the form of fear that their decisions would be challenged. Within this study, police officers seemed fearful that their competence would be challenged by either the custody sergeant or healthcare staff. To avoid such situations, the mentally disordered person was informally managed. A further determinant emerged within the findings. This was the time of contact with a potentially mentally disordered person. Police officers considered the early hours of the morning, when approaching the end of their shift, the most likely time they would informally manage a mentally disordered person. Green, (1997), and Fry et al. (2002), suggested that a lack of accessible healthcare services predisposes to informal action. Within this study, informal action was chosen to avoid being delayed going off duty. This was due to the anticipation of a significant delay in finishing their shift, due to the completion of arrest paperwork. If a person was taken to hospital, a similar delay was expected whilst waiting to be relieved by the next shift. Informal action, however motivated, clearly represented a failed opportunity to facilitate some form of healthcare for the person.

9.2.5.5 The inconsistent gatekeeper

The findings revealed an inconsistency in the way in which police officers responded to potentially mentally disordered people. Concurring with the wider literature, when police officers encountered mentally disordered people, some facilitated some form of healthcare, whilst some acted informally. Furthermore, some police officers detained the person via S136, seeking healthcare immediately, whilst others held the person in police custody, awaiting healthcare. Some police officers however detained and arrested the person, without either recognition or consideration for the effect of their mental disorder. This aspect of the study illustrated the interlocking effects of pre-encounter factors, resulting in this inconsistency. When these findings were viewed through the lens of Endsley's (1988) three-level categorisation of situation awareness, it was possible to disentangle these interlocking effects. This exposed the specific practice accomplishments and common rubrics, associated with the manner in which police officers perceive, comprehend and respond to mentally disordered people.

9.3 Looking back through the lens of situation awareness

Situation awareness represents the degree to which one is sensitive and responsive to specific information; information available within a given time and place, whilst undertaking a particular task (Endsley, 2000; Lundberg, 2015). Sarter and Woods (1991) consider situation awareness a state whereby one both activates and utilises "…conscious knowledge…" (p.51). This 'conscious knowledge' is derived from the perception of cues, detected by one's senses of sight, smell, hearing, touch and taste (Endsley, 2000; Patterson, Procter and Toffoli, 2016). The degree to which one demonstrates situation awareness depends upon one's "…cognitive ability…" to note situationally relevant cues, recognise their significance, and determine an appropriate course of action in light of them (Patterson et al., 2017, p.683). At its fullest, it therefore represents a state of complete knowing, understanding and anticipation within a situation; a state from which an informed response may be formulated. It is however, a fragile state; one which is frequently lost during periods of high cognitive workload, within fluid and dynamic situations containing an array of information (Dekker, 2015; Green et al., 2016; Schulz et al., 2016). In such cases, one may fail to perceive, process or misinterpret the cues, responding not only inconsistently, but inappropriately (Endsley, 1999, p.269). Using Endsley's (1988) three-level categorisation of situation awareness, I was able to identify elements of

not only conscious, but also unconscious knowledge (gut instinct), relevant to the identification and response to a potentially mentally disordered person.

9.3.1.1 The building blocks of comprehension

When disentangling the interlocking effects seemingly governing this inconsistent response, Level 1[80] situation awareness represented the cues suggestive of mental disorder. These often subtle pieces of information, shrouded in the maelstrom of other information, represented the police officers' cognitive "…building blocks..." of comprehension (O'Brien and O'Hare, 2007, p.1065). Level 2 situation awareness represented the manner in which these cues were "…cemented…" together to enable the police officer to comprehend the presence of mental disorder (O'Brien and O'Hare, 2007, p.1065). This 'cementing' seemed to occur through both cognitive inference ('gut instinct / feeling'), and pattern recognition. Level 3 reflected an understanding of the 'cemented' cues in the present context, and from which the police officer determined their response (Endsley 1988; Kim and Hoffmann, 2003; O'Brien and O'Hare, 2007).

9.3.2 Framing the discussion

Whilst the study findings revealed that pre-encounter factors underpinned all responses, the overarching concepts appearance, behaviour, communication, danger and environment, encapsulated the breadth of Level 1 SA cues (the 'building blocks') police officers associated with mental disorder. The following section will explore in more detail these features. Reflecting its centrality to all responses (and therefore its position within the ABCDE hierarchy), the concept danger will be discussed first. The concepts appearance, behaviour, communication and environment will then be discussed. Within the following section, where police officers identified features suggestive of mental disorder (the "…building blocks..." of comprehension), the corresponding levels of situation awareness are presented within parentheses. E.g. (Level 1 SA).

9.4 Danger

The assessment and response to danger was central to each encounter (irrespective of the degree of situation awareness demonstrated). Anticipating the

[80] When referring to the levels of situation awareness, they will be presented as follow:
- Level 1 situation awareness will be presented as Level 1 SA.
- Level 2 situation awareness will be presented as Level 2 SA.
- Level 3 situation awareness will be presented as Level 3 SA.

potential for danger at each interaction, police officers attempted to initiate a 'new normality.' Such a response was illustrative of the police officers' heightened perception of danger within such situations. Exploring how police officers formed their impression of danger, Rozzelle and Baxter (1975) noted that when faced with "…threatening conditions…" they broadened their awareness to seek as many situational cues as possible (p.62) (Figure 21). With mental disorder seemingly representing a 'threatening condition' (Level 1 SA), police officers were vigilant for both intangible and tangible sources of danger. Akinola and Berry Mendes (2012) noted that during periods of elevated stress, increased cortisol secretion enabled police officers to be more sensitive to potential dangers, and the level of threat perceived. Illustrative of Level 1 SA, within this study, whilst not always able to qualify the specific nature of the danger or threat posed, it seemed that police officers were often able to sense something of concern. This sense was manifest as cues, suggestive of an incongruence with their expected norms. As such they remained vigilant for danger until the encounter was concluded.

9.4.1 The use of force

Vigilant to potential danger or threat (Level 1 SA), the manner in which police officers responded to a potentially mentally disordered person varied widely. More mental health-literate police officers (those demonstrating Level 2 SA) at least initially attempted calming communication and de-escalation techniques. Those aligned to the 'crime-fighting enforcer' role demonstrated the use of force from the outset. This was an option which often significantly worsened a person's distressed state (Sussman, 2012; O'Brien and Thom, 2014; Meade, Steiner and Klahm, 2017). HMIC (2011) reiterates that police officers should only resort to force when all "…non-violent methods…" have been unsuccessful (p.79). This did not appear so within the findings of this study. Rather than consistently seeking a graduated response, police officers demonstrated pre-determined ideas as to how potential dangers associated with a mentally disordered person should be controlled. The use of force as a first response, appeared common. Such an approach appeared reflective of a lack of recognition of the person as mentally disordered (Level 1 SA), or when recognised (Level 2 SA), a disregard for it.

Consistent with the work of Watson et al. (2004), O'Brien and Thom (2014), and Morabito, Socia, Wik and Fisher (2017), police officers within this study associated mental disorder with acts of physical and verbal aggression, resistance and violence

(Level 1 SA). Mentally disordered people were also considered unpredictable, and therefore dangerous, even when in 'quiet' states (Level 1 SA). Such views appeared to be shaped by pre-encounter factors. When faced with the potential for danger (actual or perceived), Shaw (2015) stated that police officers do not have the luxury of procrastination as, metaphorically speaking, "…milliseconds may mean the officer is the second one to pull the trigger" (p.42). Consequently, note Morabito, et al. (2017), through (an often, unfounded anticipation of danger), the use of force is higher when dealing with mentally disordered people, compared to non-mentally disordered people.

Within this study, police officers, when anticipating danger, prepared themselves for the possible use of some form of force. This included physical restraint, handcuffs, and the use of an extendable metal Asp baton, incapacitant spray, or Taser. Work by Rossler and Terrill (2017) noted that the use of force towards mentally disordered people resulted in injury at a rate of approximately 33%, compared to 25% for non-mentally disordered people (p.204). Markowitz (2011), and Van Brundy, Zedginidze and Light (2016), noted that the expectation of violence amongst mentally disordered people is largely fallacious (if not prejudicial). Despite this, the findings of this study noted that police officers considered force an appropriate method to establish control and a 'new normality.' The rationale offered was that danger / threat could increase, if action was not initiated. Despite the work of Rossler and Terrill (2017), within this study, through the ready use of force, police officers sought to minimise danger from, rather than to, a potentially mentally disordered person.

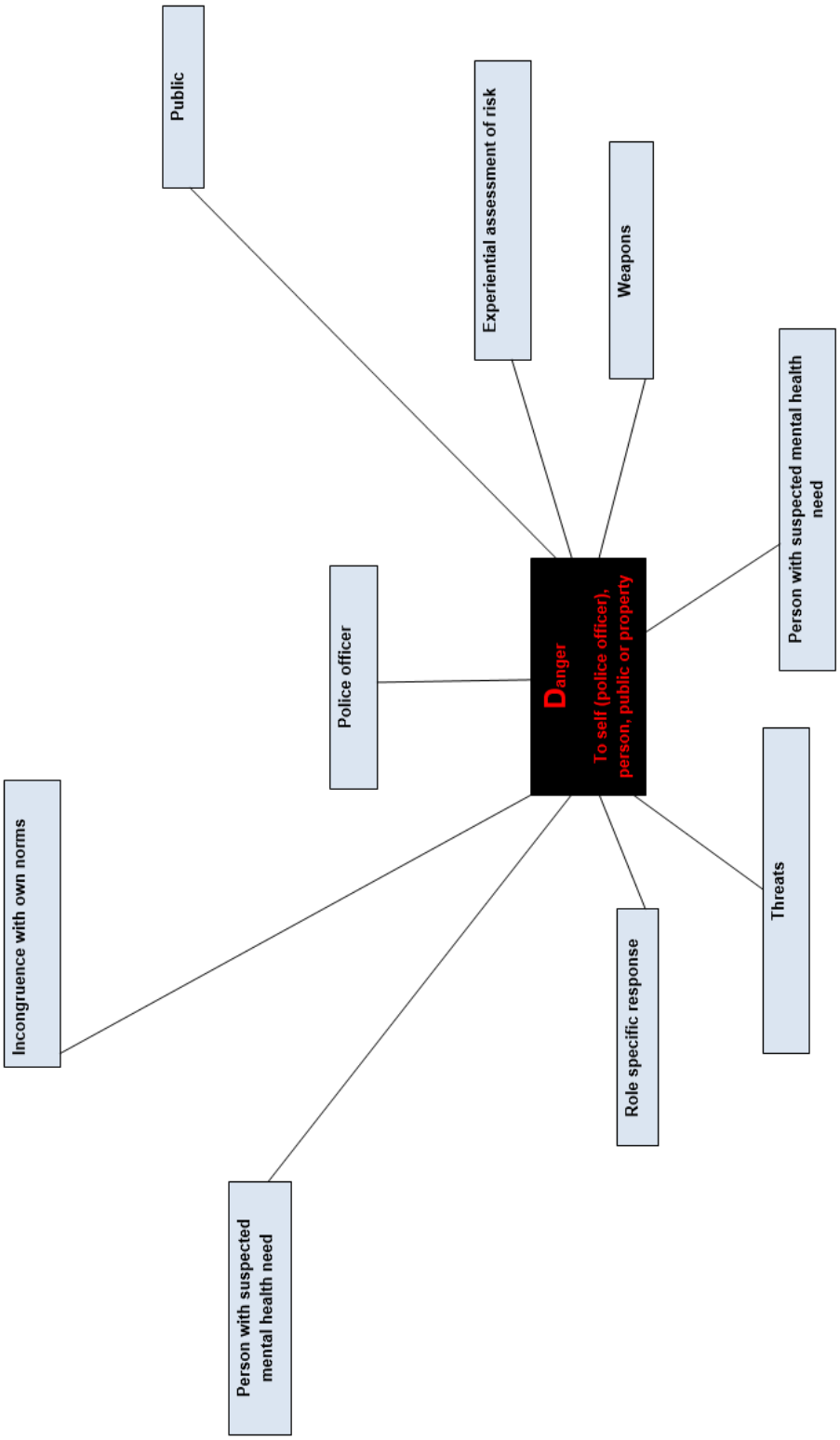


Figure 21: Cues Associated with Mental Disorder (Danger).

9.5 Appearance

Police officers encounter people (members of the public) in number of ways. They can be dispatched to an incident scene by the police control room. They can be summoned (flagged down) by members of the public whilst on patrol. They can also approach something or someone of concern. When encountering a person, their appearance yielded an array of cues. These cues suggested the presence of Level 1 SA (Figure 22). A police officer's attention was often drawn to a person who appeared 'different' to those around them, or where there were distortions of what they considered normal appearance. Commonly, "…cognitive inference…' ('gut instinct / feeling') made them suspicious of such incongruity (Offredy 1998, p.992). Lerner (2006) argues that such 'cognitive inferences' are illustrative of rapid real-world processing of fragments of information, often accurately. Through repeated exposure to particular situations, the "…intuitive processing…" of information derived from prior learning results in "…domain specific expertise" (van den Heuvel et al., 2012, p.28). For this study, domain specific expertise was the ability to perceive mental disorder. At the conscious level however, actively pursuing this instinct to seek out relevant / significant features of mental disorder was a clear indicator of Level 2 situation awareness.

9.5.1 The 'neighbourhood character' effect

As police officers tended to work within the same geographical area, they were able to identify people as being mentally disordered due to prior, often repeated contact with them. Bittner (1967), and Fry et al. (2002), considered this regularity of contact as an unavoidable aspect of contemporary policing; one which took the police officer away from their role-specific 'crime-fighting enforcer' response. Rather than detracting from their policing role, knowledge of such people appeared illustrative of an awareness of the diverse community in which they served (Teplin, 2000; Crowl, 2017). Police officers noted that people who appeared frightened without an obvious cause, were often found to be mentally disordered (Level 1 SA). Furthermore, those who appeared anxious, acutely upset, and tearful, disoriented, and in some cases aggressive and / or violent were often mentally disordered (Level 1 SA). The findings however suggest that a police officer's views on how mentally disordered people should look, was (in part) based upon their experience with such 'neighbourhood characters'. Personal viewpoints and media portrayals (rather than specialist education) also seemed to contribute to their view of how a mentally

disordered person should look (Klin and Lemish, 2008; Kimmerle and Cress, 2013; Szeto et al., 2013). This troika of experience, media portrayal and personal viewpoint seemed to contribute to a police officer's subconscious and conscious Level 1 SA. Against this backdrop, the first thing that drew a police officer's attention to a person was an incongruity with their movement or gait. Unless a person was using walking aids, a problem with walking was considered a feature of mental disorder.

9.5.2 The attention grabber

A person who was shuffling, or walking slowly, with their head down, seemed to attract a police officer's attention (Level 1 SA). For those police officers demonstrating Level 2 SA, the person was thought to be depressed, or experiencing the effects of their (mental disorder) medication (Davis, 2004; Gupta, 2009). A person who was moving their arms and body in an erratic manner was afforded descriptions ranging from anxiety, to psychosis and personality disorder (Level 2 SA). Whilst the former description of depression has some degree of accuracy, the latter, although suggestive of some form of mental disorder, was subject to a range of labels; each one referring to clinically different disorders, with differing interpretations (Gupta, 2009). Illustrative of the effect of pre-encounter factors (personal views), Ozer et al. (2017) suggest that labelling a person in this manner is not only inaccurate, it predisposes towards negativity and "…recall characteristics…" suggestive of "…dangerousness and unpredictability…" (p.225). Whilst Level 2 SA was demonstrated by some, the manner in which the mental disorder is perceived potentially generates an inconsistent Level 3 SA response. This is of concern where improperly applied diagnostic labels generate thoughts of danger (Ungar, Knaak and Szeto, 2016).

9.5.3 The uniform of the day

A police officer's attention was also drawn to a person on the basis of some form of incongruity with their clothing. Whilst police officers were unable to fully articulate the nature of their concerns, their 'gut instinct' or 'gut feeling' made them sufficiently suspicious, to investigate further. Within their study into how police officers form suspicion regarding a person's clothing, Dunham, Alpert, Stroshine and Bennett (2005), state that police officers become attuned to people wearing the "…uniform of the day…" (p.376). Where the 'uniform of the day' is taken as one's usual,

'conventional' style of dress, certain deviations (or incongruities) seemed to arouse suspicion that the person may be mentally disordered. Holgersson and Gottschalk (2008) noted that police officers are able to automatically detect such deviations from their norms, almost immediately upon contact with a person. This was because there is a breach of their "…working rules…." (Stroshine, Alpert, and Duham, 2008, p.322). These 'rules' are the values and thresholds governing their everyday operational response. Illustrative of Level 1 SA, often a mismatch in clothing would represent a breach in a police officer's 'working rules' about how a person should dress. For example, a clashing jumper / shirt / trousers would be sufficient to initially attract a police officer's attention. Where mental disorder was later identified, such style of dress was associated with a lack of interest in one's appearance as a consequence of their illness. Whilst there seemed to be an unconscious association between people's clothing and mental disorder, at a conscious level, police officers had clearer views.

Again, through the troika of experience, media portrayal and personal viewpoint, a person's clothing / standard of dress was a useful indicator of mental disorder. Ill-fitting clothing, (particularly where it appeared to be too large or small for the person), was associated with the presence of mental disorder (Level 1 SA). Clothing which was inappropriate for the environment was also considered indicative. Examples included thick coats worn on a hot summer's day, or the absence of a coat when very wet or cold. Police officers took into consideration a person's age when judging the appropriateness / inappropriateness of clothing. Whereas an elderly person wearing a thick coat on a summer's day would attract scant attention, a similarly attired young or middle-aged person would. Again, a young person out in the cold or rain without a jacket would not be unduly concerning, whereas an older / elderly person would be. Partial or complete nudity within public places was associated with mental disorders where the person had no awareness of their surroundings. A lack of pride in one's appearance, and clothing which was damaged, unclean, or soiled due to urine / faeces was also associated with mental disorder. For Muhlbauer (2008), such clothing-related features are characteristic of severe and persistent mental disorder. Despite a lack of diagnostic precision regarding the specific cause, police officers however seemed to appropriately associate these cues with an underlying and significant mental disorder.

9.5.4 The significance of self-neglect

Following on from a person's clothing, a police officer's attention was then drawn to their physical characteristics. The findings revealed that a poor standard of personal hygiene could be suggestive of mental disorder (Level 1 SA), but it could also be an indicator of just a general lack of interest in one's personal appearance.

Johnson (1991) suggests that an inability to maintain a socially acceptable standard of personal hygiene, is due to a loss of "…functional capacities…" (p.24). This loss of 'functional capacities' being closely associated with chronic, enduring, mental disorder (Johnston, 2013; Von Peter, 2013). Furthermore, it is an indicator for self-neglect (as a consequence of mental disorder) (Buckingham, Adams and Mace, 2008). Braye, Orr and Preston-Shoot (2015) define self-neglect as a "…lack of self-care… [a] lack of care of one's environment… [and a] refusal of services that would mitigate risk of self-harm and well-being" (p.4). It is a situation, note Day, Mulcahy and Leahy-Warren (2016), that may cause "…serious endangerment to the health and wellbeing of the person."

The findings revealed that as a package, the presence of unkempt hair (male and female), being unshaven, dirty (hands and face), poor oral care and (again) smelling of urine / faeces, was indicative of mental disorder. Unless the person presented with all of these features, the police officer was not unduly alerted as to the significance of self-neglect. Individual features of self-neglect (e.g. unkempt hair, poor oral care) represented only the 'building blocks' of comprehension (Level 1 SA). Unless there were multiple features, police officers failed to comprehend its deeper significance (Level 2 SA). This did not seem to be the case for people demonstrating obvious signs of self-harm.

9.5.5 Wound patterns

Police officers reported that where other features suggestive of mental disorder were suspected, they looked for the presence, nature, and extent of any deliberate-self injury (Level 2 SA). This was because they frequently encountered people who had incisional, sharp force-type wounds to their body. When exploring the specific pattern, distribution and morphology of such wounds, Dettling, Althaus and Haffner (2003), and Schmidt and Pollak (2006), inferred that it was possible to determine if they were defensive in nature (irregular slash-type injuries to palmer surfaces /

dorsum of forearm), due to combat (deep penetrative injuries into body structures and cavities), or self-inflicted. Where wounds were considered to be self-inflicted, they were described by Dettling et al. (2003, p.144) as "…tentative and hesitation injuries…" They presented as superficial, parallel and clustered incisions, self-inflicted upon exposed skin, and self-limited due to pain (Herbst and Hafner, 1999, p.195). Such wounds avoid damage to clothing, or deep penetration into body cavities and organs (Herbst and Hafner, 1999, p.195). Within this study, tentative and hesitation injuries were associated with mental disorder (Level 2 SA).

When police officers encountered a person with some form of wounding, they rapidly sought to establish the mechanism, based on the incident history, and injury pattern. Even where there was ambiguity as to the incident history, if someone presented with tentative and hesitation injuries, police officers potential mental disorder (Level 2 SA). These injuries were usually noted to be located on the dorsum and ventral surfaces of the forearm, upper arms, thighs and abdomen. Where mental disorder was suspected, not all police officers sought specialist help for the person. The police officers' response was determined by their perception of the seriousness and significance of the self-harming attempt. Irrespective of the wound morphology, or the role to which the police officer aligned themselves ('crime-fighting enforcer' / 'community problem solver'), if there was active bleeding, an ambulance would be summoned (Level 3 SA). However, their motivation in such situations was not to necessarily address mental health needs; rather, immediate medical ones. Police officers were also vigilant for the presence of scarring to a person's arms. This was considered an indicator of mental disorder, even if the person was not currently demonstrating any worrisome signs or symptoms. When looking for wounds or scarring, police officers also looked for the presence of tattoos, as they were considered a useful marker and source of information, when seeking to determine if a person was mentally disordered.

9.5.6 Tags

MacLin and Herrera (2006), Flowe and Humphries (2011), and Jacques (2017), note that police officers tend to associate the presence of tattoos with criminality. Within this study however, tattoos were regarded as markers ('tags'), from which police officers could search the PNC for confirmation of mental disorder (Level 1 SA) (Keefe, 2016, p.54). Police officers reported that when encountering a person, either prior to intervention, or once they had secured a 'new normality', they would

often radio the police CAD call handler, and ask for a PNC check of the person. To enable this, they would relay to the CAD a description of the person (e.g. height, sex, ethnicity), including any body markings, scars and tattoos. Tattoos were considered to be particularly important, as the design and positioning of tattoos are unique to the individual (Foltz, 2014; Dickson, Dukes, Smyth and Strapko (2015).

A positive match with any data held within the PNC database could indicate the following three "…information markers…" of mental disorder: "SH: self-harm…SU; suicidal…MH: mental health"[81] (NPIA, 2012, p.162). Whilst the PNC data is of undoubted value, four wider concerns emerge: first, it only provides information, supplied by police officers during prior contact (Scantlebury et al., 2017). Second, information held, relating to a person's mental health status may be inaccurate, and lacking specific detail, beyond that populated by police officers (Scantlebury et al., 2017). Third, during a PNC check, being informed that a person has a recorded mental disorder may be contextually irrelevant, yet may inappropriately sway a police officer's response. Fourth, whilst it potentially enables Level 2 SA, the provision of such information does not assure Level 3 SA.

9.5.7 Differentiating physical disorder from mental disorder

When observing a person's appearance, police officers also associated features of physical injury or illness with mental disorder. Commonly, police officers considered bloodstaining to the sleeves of clothing to be of concern (Level 1 SA), associating it with self-harm. Similarly, bandaging (particularly improvised – tissues, rags etc.) applied to one or both forearms (either dorsal or ventral surface) was of concern (Level 1 SA). Some police officers were also vigilant for the signs of head injury, which may masquerade as mental disorder. Royal Army Medical Corps (2002), the United States Department of Defence (2009), Marco and Marco (2012), and Dinsmore (2013), note that brain injury may result in cerebral bleeding, hypoxia and / or raised intracranial pressure. This may initially cause confusion, disorientation, aggression, and potentially death. In this instance, police officers seemed able to associate the presence of head injury with signs of apparent head trauma,

[81] "*Mental Health.* The subject is known to suffer from a mental condition or disorder. Psychiatric confirmation may be desirable. Likely behavioural activity or risks should be recorded.

Self-Harm. This signal should be used where information suggests that the subject may cause harm to themselves, but where the harm is not considered to be a suicide attempt. Self-mutilation history or deliberate harm in order to support allegations against the Police would be appropriate.

Suicidal. Previous history or threats (not idle threats) indicate that the individual may make a determined effort to commit suicide. Information such as method likely to be used would be desirable. This signal is not restricted to suicide attempts while in custody." (National Police Improvement Agency, 2012, p.262).

summoning urgent medical aid accordingly. Their response however was less consistent, when encountering people with marked weight loss.

Females (teenage to mid-twenties) who appeared exceptionally thin, malnourished and gaunt were considered of concern (Level 1 SA); to some police officers, they were suffering from anorexia nervosa, and as such, mentally disordered (Level 2 SA). Whilst Wooldridge and Little (2012), Sabel, Rosen and Mehler (2014), and Ming, Foo, Zainal and Yen (2017), note that anorexia can present both early and late in life, and also in males, the findings of this study suggested that police officers considered it an exclusive disorder of young females. Where exceptionally thin, malnourished and gaunt males were of concern, they were thought to be substance / alcohol abusers. In both cases, a lack of specialist education and personal views (pre-encounter factors) meant that marked weight loss (in the main) clouded their perception (Level 1 SA) and comprehension (Level 2 SA) of its significance.

The appearance of a person's clothing, their physical characteristics, and the presence of injury or illness seemed to provide useful cues, sufficient to generate Level 1 SA, and in some cases, Level 2 SA. This seemed to provide only one aspect of how police officers appeared to determine the presence of mental disorder. When viewing a person's appearance, police officers seemed to simultaneously consider their behaviour.

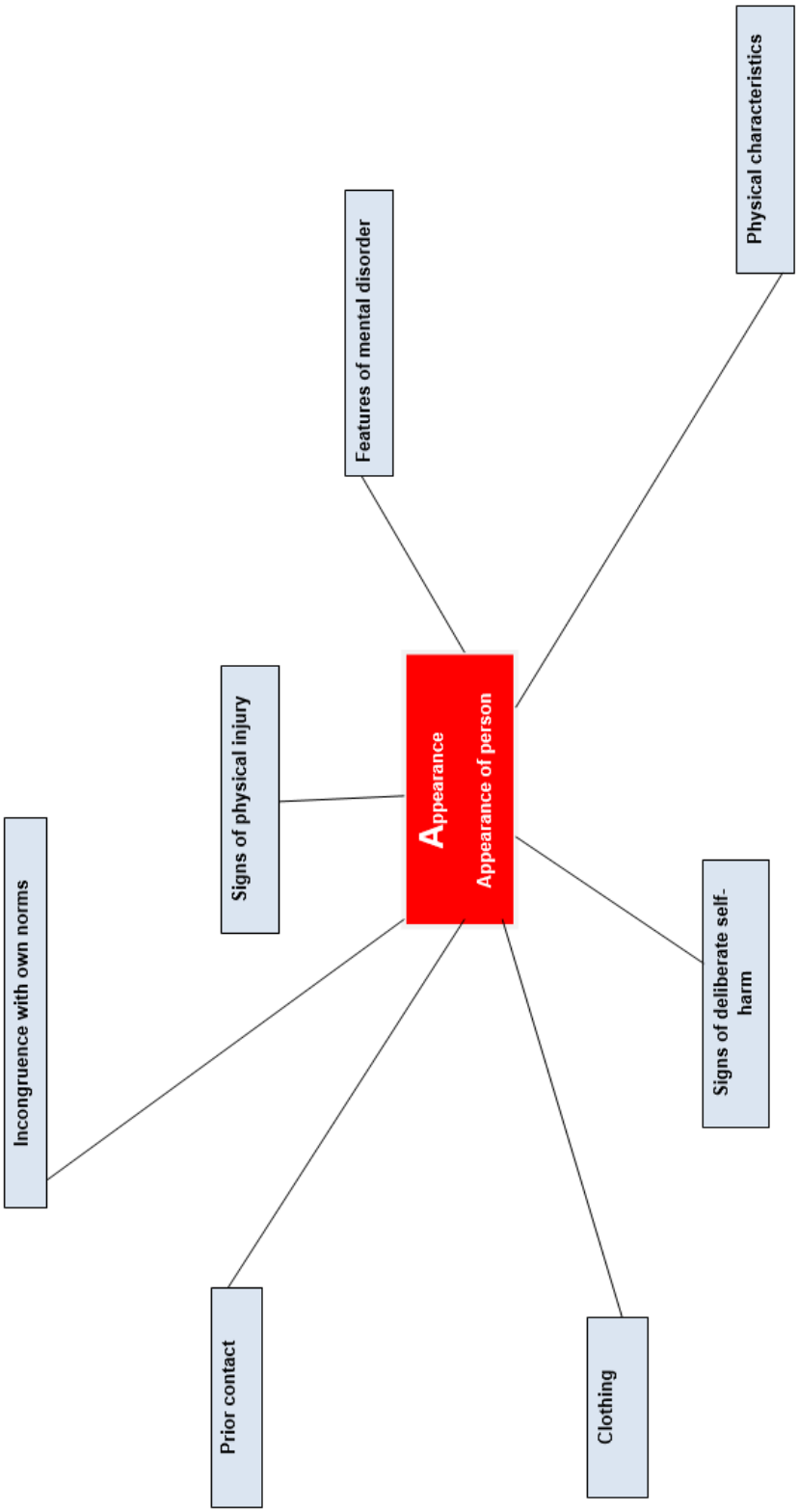


Figure 22: Cues Associated with Mental Disorder (Appearance).

9.6 Behaviour

The findings revealed that a person's appearance and behaviour were often viewed as one. By disentangling the two, I was able to make accountable the methods, rules, and actions police officers use to determine mental disorder, from a person's behaviour (Figure 23).

Common to all themes, 'cognitive inference' drew a police officer's attention to incongruity within a person's behaviour (Offredy 1998, p.992). Features of incongruous behaviour that would attract police attention (Level 1 SA) included that which 'went against the flow' and 'erratic' actions. Whilst unable to qualify what 'went against the flow', and what 'erratic' constituted, behaviours included: stopping randomly within a moving flow of people. So too was staring at people or objects, or risk-taking behaviours such as stepping out into the road without consideration for traffic flow. Irrespective of whether a police officer perceived themselves as a 'crime-fighting enforcer', or a 'community problem solver', their initial role-specific response to such incongruity was to first identify and respond to any threat of danger posed by the behaviour; second, identify if the person's behaviour demonstrated criminality.

9.6.1 'Discreditable' attributes

Goffman (1959) noted that as part of normal day-to-day existence, interaction and communication, people continually share (intentionally and unintentionally) information about themselves; information which enables them to convey their identity within a social group. Whilst most people are able to control the flow of this information to achieve stability and acceptance within the social group, some are not. As such, they demonstrate what Goffman (1963) describes as "…discreditable attributes" (p.14). These are aspects of behaviour which may serve as a specific "…warning signal…within the mass of information within the social environment" (Quinton, 2011, p.359). Goffman (1963) considered 'discreditable' attributes as those that may generate stigma within a community. Within this study, the police officer's role-specific response was to consider them as 'warning signs' of criminality (Quinton, 2011).

Within this study, police officers had views regarding the 'warning signs' of criminality. For example, a person who was behaving in such a way as to be a

nuisance or annoy others, demonstrated the offence of Anti-Social Behaviour. A person pestering or causing a disturbance to others, or behaving in a threatening manner was committing a Public Order Offence.[82] A person who had stolen something, even an item of low value, had committed theft. Whilst such behaviours demonstrated the 'warning signs' of criminality, they were also behaviours associated with the presence of mental disorder (Taylor, 2004; Vinkers, De Blurs, Barendregt, Rinne and Hoek, 2011; Moran, 2014). When faced with such behaviours, irrespective of whether police officers aligned themselves to the role-specific response (pre-encounter) of 'crime-fighting enforcer', or a 'community problem solver', the person would be approached. The person would then be questioned, and the issue investigated. This was seen as an opportunity to view the person's behaviour at close-quarters. For those who appeared to align their role with the 'crime-fighting enforcer', a 'stop-and-search'[83] seemed a likely outcome (Edwards, 2008).

9.6.2 'Stop and search' v 'stop and account'

'Stop and search' can be a useful mechanism for the detection and prevention of crime (Delsol and Shiner, 2006). It is however, a form of detention. It is one where a police officer not only stops the person and seeks information, but the person is physically searched for illegal items, or items which could be used for a criminal purpose (e.g. a screwdriver, potentially used as a weapon, an instrument to damage property or a makeshift car ignition key) (CoP, 2017c). For police officers who seemed to perceive their role as a 'crime-fighting enforcer', their primary focus was the detection of crime, irrespective of the presence of mental disorder. Stopping and searching a person (a suspect) was therefore an approach used. Where mental disorder is the catalyst for any actual / suspected criminality, 'stop and search' can however generate significant anxiety and distress, potentially worsening the person's condition, and also the dynamics of the encounter (Geller, Fagan, Tyler and Link, 2014; Rowe, Turner and Pearson, 2016; Meade et al., 2017).

[82] *Anti-social behaviour.* Within the Anti-social Behaviour, Crime and Policing Act. 2014, anti-social behaviour is defined as "conduct that has caused, or is likely to cause, harassment, alarm or distress to any person, (b)conduct capable of causing nuisance or annoyance to a person in relation to that person's occupation of residential premises, or (c) conduct capable of causing housing-related nuisance or annoyance to any person. The Home Office (2012) note that anti-social behaviour is characterised by the following: "…littering, graffiti and vandalism, to drunken, rowdy behaviour in public, to noisy, abusive or intimidating neighbours" (p.1).

*Public Order Offences***.** Threats towards others; throwing missiles; threatening, abusive or insulting words or behaviour; racially, or religiously motivated crime; shouting obscenities; rowdy behaviour; pestering people in a queue; causing alarm to vulnerable people; causing a disturbance in a residential or public area; domestic disputes. Drunkenness; Affray (Crown Prosecution Service, 2017).

[83] Stop and Search is used by police officers "…to allay or confirm suspicions about individuals without exercising their power of arrest" (Home Office, 2014c, p.4).

A consequence of such an interaction is belligerence, resistance and disrespect towards the police officer. Within this study, these were behaviours also associated with mental disorder (Level 1 SA). Despite this association, Worden and Shepard (1996), Wolf, Mesloh, Henych and Thompson (2008), Lee et al. (2010), and Gibbs and Ahlin (2013), note the greater the degree of belligerence, resistance and disrespect, the greater the potential for some form of punitive response by the police officer. In doing so, the potential for a more forceful (role-specific) response by the police officer emerged, particularly where the mentally disordered person became aggressive (Kesic et al., 2012; Rossler and Terrill, 2017).

In contrast, for those police officers who perceived their role as a 'community problem solver', the study findings suggested that a "…stop and account…" was more likely "CoP, 2017c, Para. 2). Having approached a person, "…stop and account…" is an informal mechanism, where police "officers only ask the person to ask questions and 'account' for something attracting their attention" (Police Foundation, 2012, p.3). Within this study, where police officers sought to simply communicate with mentally disordered people, it appeared that it was a vehicle, not necessarily to identify criminality. It was used to identify if there were any underpinning reasons for the action attracting their attention. In doing so, they were often able to identify behaviour that deviated from what was seemingly a criminal act. Work by van den Brink et al. (2012) noted that in 21% of interactions with people apparently committing a criminal act, (whilst not a causal link) police officers potential mental disorder as being the precipitating factor. Echoing the work of van den Brink et al. (2012), within this study, police officers appearing to align to the role of 'community problem solver', were more receptive to the features of mental disorder. As such, they seemed receptive to alternate causes for acts of Anti-Social Behaviour, Public Order Offences[84], and theft.

9.6.3 Labelling

When describing features of mental disorder, police officers continued to label a person's behaviour using broad diagnostic terms. Work by Pinfold et al. (2003)

[84] *Anti-social behaviour.* Within the Crime and Policing Act (2014), anti-social behaviour is defined as (a) "Conduct that has caused, or is likely to cause, harassment, alarm or distress to any person, (b) Conduct capable of causing nuisance or annoyance to a person in relation to that person's occupation of residential premises, or (c) Conduct capable of causing housing-related nuisance or annoyance to any person. The Home Office (2012) note that anti-social behaviour is characterised by the following: "…littering, graffiti and vandalism, to drunken, rowdy behaviour in public, to noisy, abusive or intimidating neighbours" (p.1).

Public Order Offences. Threats towards others; throwing missiles; threatening, abusive or insulting words or behaviour; racially, or religiously motivated crime; shouting obscenities; rowdy behaviour; pestering people in a queue; causing alarm to vulnerable people; causing a disturbance in a residential or public area; domestic disputes (Drunkenness; Affray Crown Prosecution Service, 2017).

noted that police officers held personal beliefs about mental disorder, largely informed by 'perceived knowledge'.[85] For example a common view amongst police officers was that schizophrenia was a split personality, their perceived knowledge being informed by television, and tabloid news (Pinfold et al., 2003, p.342). As noted earlier, when exploring personal views (pre-encounter factors), *psychotic, bi-polar, schizophrenic, hallucinatory* were used interchangeably as Level 2 SA terms, describing behaviours such as acute upset, tearfulness, disorientation, and violence and aggression. Some police officers however, seemed to use such terms as a colloquial term for aggression and violence, rather than behaviour indicative of an underlying mental disorder.

For police officers demonstrating greater mental health literacy, a range of useful features of mental disorder, capable of generating Level 1 SA were described. A person scratching or tearing at their skin with their finger nails, or doing similar with a sharp implement, was thought to be deliberately self-harming. A person placing themselves at risk was also of concern. A person appearing to step into the flow of traffic, onto a railway line, or into a river or the sea (particularly where they were seemingly oblivious to their surroundings), was thought to be attempting self-harm. Depending upon the context, a person hastily consuming what appeared to be medication could be thought to be deliberately self-harming through overdose. They could also be thought to be hiding illicit drugs through ingestion. A person repeatedly doing something (rubbing body, wringing hands, picking something up), particularly in a frenzied manner, was thought to be mentally disordered. So too was a person who appeared disoriented or confused.

To police officers, a person crying uncontrollably could initially be construed as the victim of crime (e.g., theft or assault), rather than suffering some form of significant distress / mental disorder. Acts of aggression or violence, without specific focus (e.g. behaviours not specifically directed at a person or object) were associated with mental disorder. What could be perceived as an act of Anti-Social Behaviour, waving hands and pointing at inanimate objects or people, was however associated with a person hallucinating. The findings suggested that these features, particularly acts of self-harm and hallucination, were often associated with the person being

[85] Perceived knowledge may be considered personally-held knowledge about something, an individual considers / perceives to be true, irrespective of wider information to the contrary (Radecki and Jaccard, 1995).

intoxicated, through alcohol or illicit drugs (Level 1 SA) (Forrester, Samele, Slade, Craig and Valmaggia, 2016).

9.6.4 The effects of intoxication

Within this study, police officers considered intoxication to be a common factor when encountering (potentially) mentally disordered people. When investigating the range of mental disorders exhibited by one hundred and fifty people detained by police, Baksheev, Thomas and Ogloff (2010), noted that eighty-one people (51%) had co-existing alcohol and drug dependence issues. A subsequent study of six hundred and fourteen detainees by Ogloff et al. (2011), noted that drug and alcohol abuse was a co-existing issue within three hundred and twenty-six people (53%). Kaminski, Digiovanni and Downs (2004), and Fuller and Goldsmith (2016), suggest that a police officer's response to an intoxicated, mentally disordered person is dependent upon the effect of the intoxicant, and how it shapes their behaviour. Within this study, most police officers associated an intoxicated, mentally disordered person with belligerence, aggression and often unrestrained violence towards themselves or others. Some police linked this to increased physical strength and pain tolerance, commensurate with acute behavioural disturbance. This is a condition often ending in mortality (the 'in-custody death syndrome') or serious injury, if its presence is missed, ignored or mismanaged through excessive restraint (Paquette, 2013, p.93). Noted earlier, within this study, when faced with an outwardly violent person, police officers felt that it was very difficult to differentiate between a state of extreme threat and dangerousness, and an acute health need associated with acute behavioural disturbance. The role-specific response was one which would seek to control and contain the person (establishing a 'new normality') by any means necessary.

9.6.5 Responding to violence and aggression

Aggression or violence sometimes occurred unexpectedly whilst police officers were engaging with a person. For some police officers, this somewhat incongruous and unanticipated behaviour was associated with mental disorder (Level 1 SA). Police officers aligning themselves to the role of 'community problem solver' reported that at least initially, they would attempt tactical communication before initiating more forceful methods of control. This approach would at least permit the opportunity to explore the possibility of an underlying mental disorder causing the sudden shift in

behaviour (Level 2 SA). For others however, particularly those who aligned themselves to the role of 'crime-fighting enforcer', any act of aggression or violence was seen as a criminal act. This was immediately met with interventions to control and contain the person. Where police officers encountered aggression and violence from the outset of their contact, it was difficult to immediately disentangle the presence of mental disorder. In such situations, all police officers (irrespective of role standpoint) defaulted to a role-specific response of control and containment.

The findings of this study revealed that a person's behaviour yielded useful cues, sufficient to generate Level 1 SA. Key to this was the police officer approaching the person, so they could closely investigate and observe their behaviours sufficient to generate Level 2 SA. By engaging with the person, the police officer was able to identify cues related to communication.

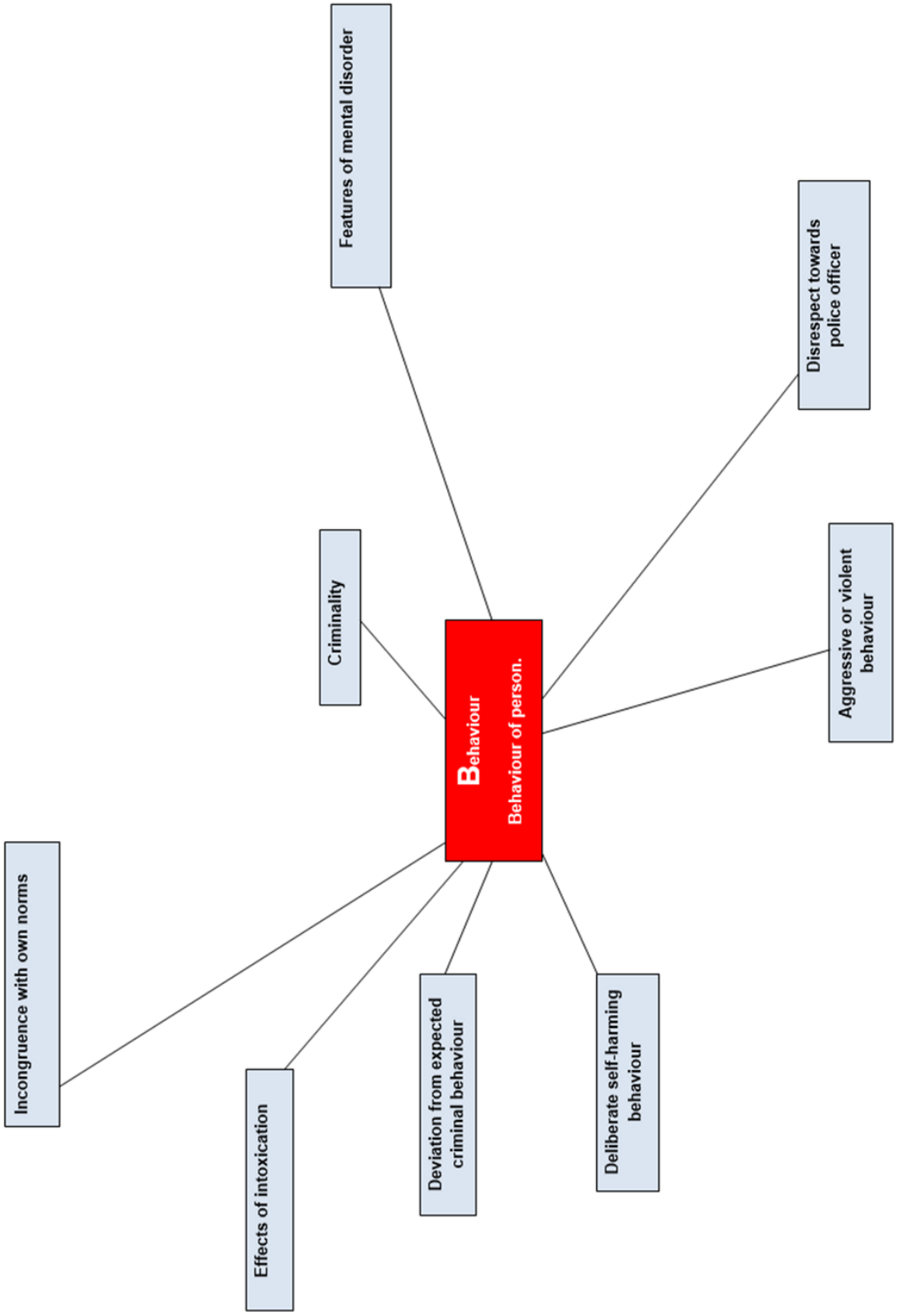


Figure 23: Cues Associated with Mental Disorder (Behaviour).

9.7 Communication

For police officers, communication was a very important method of obtaining information, and clarifying, confirming, or rejecting their suspicions. This study exposed a range of cues to elicit such information; some of which were obtainable prior to a police officer's arrival at a reported incident (Figure 24).

9.7.1 The usefulness of prior information

Police officers were frequently dispatched to situations where a mentally disordered person was reportedly involved in an incident. This was either as a victim, or alleged perpetrator of a crime. These were termed 'response calls', whereby the police officer would respond on foot or by vehicle. When dispatched, a police call handler within the CAD room would try to provide them with sufficient information to enable them to form an understanding of the incident, and to commence a risk assessment, en-route (CoP, 2017d).[86] Where a person's mental disorder was reported as a concern, the call handler would attempt to elicit the features / behaviours (of concern), relaying them to the police officer. This would immediately provide Level 2 SA. If the person involved in the incident was known (either victim or perpetrator) within the PNC, any recorded mental health 'tags' (discussed earlier) would be relayed to the police officer. This would occur, even if mental disorder was not identified by the caller as significant.

Police officers considered the information provided by the call handler to be useful, enabling them to begin to prepare their response. There were, however, some concerns (noted earlier). Whilst such information had the potential to improve their situation awareness, it also had the potential to cloud it. Ciminelli (2003), and Leeney and Mueller-Johnson (2010; 2012), noted that information provided by callers is often inaccurate, or fails to portray the full extent of the incident to be encountered. Ciminelli (2003), suggests this is due to the caller being unable to accurately describe the situation and all of the significant features, due to a number of factors. First, the "…exigencies (pressure) of the emergency situation…" (p.23). Second, a fear of retaliation if the information they have given makes them identifiable to the person to whom it relates. Third, the caller is malicious, and the

[86] The College of Policing (2017d) require a CAD call handler to do the following:
1. *When deploying the police officer:* "prioritise the safety of those at the incident, members of the public and officers; ensure that medical assistance is en route, where appropriate; make sure that support (backup) is available for the officer(s) attending the incident, where appropriate."
2. *Information provided to the police officer following deployment:* "any children or vulnerable adults present or normally resident at the address; any communication difficulties or special needs; results of background checks; any factors affecting nature of response, e.g., injury, weapons (especially firearms), drugs or alcohol; any communication difficulties or special needs; description of the suspect; incident exactly as described by caller."

information provided is false. Leeney and Mueller-Johnson (2012), note that a call handler (at best), achieves a "…brief imperfect acquisition of information…" (p.682). As such, the process is flawed. Despite call handers being required to adhere to the Association of Chief Police Officers (2005) call handling guidance, work by Leeney and Mueller-Johnson (2012) identified that the quality and depth of information obtained by the call handler is often of variable quality. Principally, this was because they did not always probe the caller in sufficient depth, or ask relevant questions, related to the reported incident (Leeney and Mueller-Johnson, 2012). This potentially resulted in flawed or inaccurate mental models and judgements about both the situation and person to be encountered. Flawed information subsequently relayed to the responding police officer.

Where call handlers alluded to mental disorder being an element, police officers aligned to the 'crime-fighting enforcer' role (particularly those with limited mental health literacy) anticipated difficulty in communication. They also anticipated a lack of credibility with the person's account (irrespective of being a caller, suspect or victim), and potential aggression / violence as a consequence of their mental disorder (Garrido, Maslip and Herrero, 2004; Ruiz and Miller, 2004; Novak and Engel, 2005; Kesic, et al., 2012; Pizio, 2014). Within this study, such police officers were resistant to altering their pre-conceived ideas about the situation. Their ideas were shaped by information provided to them (where available) but mainly by their prior-held views as to how a situation should be managed (pre-encounter factors). Their response was not to undertake an objective assessment and / or communicate with the person at the centre of the incident. Their role-specific response often sought to neutralise and contain a perceived danger. However, police officers aligned to the 'community problem solver' role were more willing to ask questions at the scene, prior to, and during their process of establishing a 'new normality.' Questioning the person was an opportunity to identify any possible features of mental disorder. These questions sought to identify features of mental disorder, and establish its significance to the overall incident. In doing so, they seemed more willing to alter any pre-conceived views they had established, as a consequence of call handler information.

9.7.2 Probing for information

When a 'new normality' had been established (irrespective of approach), police officers would attempt to communicate with the person of interest. They would first

seek the person's name, and address. They would relay this to the CAD call handler, seeking records of prior police involvement. The police officer would then seek the person's account of the incident. In doing so, they would attempt to establish (where relevant) the presence / absence of mens rea[87] through questioning the person, and any witnesses. Work by Oxburgh et al. (2016), suggested some police officers (particularly the inexperienced) and those with limited mental health-literacy had difficulty interacting with people with a (potential) mental disorder. This was due to their perceived (Level 1 SA) "…poor level of speech and a lack of understanding" (Oxburgh et al., 2016, p.141). This often led to negative perceptions and labelling of the person, with the police officer making judgements regarding the person's criminal responsibility (Oxburgh et al., 2016). For police officers aligned to the 'crime-fighting enforcer' role, arrest was a frequent outcome.

When speaking with someone, police officers seemed responsive to their tone of voice. A person who shouted at a police officer (or at a particular person) could be construed as being aggressive, and as such subject to a role-specific response. However, if they were shouting without a specific focus (e.g. moving their head and body, shouting in different directions), this was associated with mental disorder (Level 1 SA). This was particularly so, if associated with a loss of focus, or a limited attention span (Henshaw and Thomas, 2012). Amongst this, the content of a person's speech was thought significant. Where a person's use or sequence of words did not make sense to the current context, mental disorder was considered possible (Level 1 SA).

9.7.3 Differing perceptions

Incongruity with the person's communication style (either verbal or non-verbal) drew a police officer's attention to the presence of mental disorder. Level 1 SA cues suggestive of mental disorder were people talking to themselves, interacting in an 'unusual way' with inanimate objects, or seeming oblivious to events going on around them (Douglas and Cuskelly, 2012; Henshaw and Thomas, 2013). Incongruity with either verbal or non-verbal communication could however be misconstrued. To some police officers, a person who invaded their personal space when speaking to them was a threat. To others, the apparent inappropriateness

[87] Veresha (2017) defines mens rea as "a person's mental activity that shows the attitude of his or her consciousness and will to the crime, committed by the person, and its consequences" (p.122). It is the establishment of a person's intent to commit a crime.

was considered an indicator of mental disorder (Chown, 2010). A person avoiding eye contact (e.g. turning their gaze away when speaking with a police officer, fixing their gaze on something) could be preoccupied. They could also be seen as disrespectful toward the police officer (Alpert, MacDonald and Duhham, 2005; Pizio, 2014; Crane, Maras, Hawken, Mulcahy and Memon, 2016). For some, a person who was apparently oblivious to police command was incongruous, particularly if they seemed to be very distracted (e.g. hearing things). For others, it was again seen as a sign of disrespect (Henshaw and Thomas, 2013; de Tribolet-Hardy, Kesic and Thomas, 2015; Wynter and Smith, 2017). For most police officers, a person stating their intention to deliberately self-harm, expressing suicidal ideation or attempting suicide, was a clear indicator of Level 2 SA. This was followed by a Level 3 SA response, directed at preventing this. This was not a consistent view.

The findings revealed that some police officers questioned the genuineness of threats to commit suicide. This was noted if a police officer had encountered the person before for similar attempts, or there was information within the PNC regarding prior threats and attempts. A view was held amongst some police officers that if a person genuinely wished to kill themselves, they would do it without contacting anyone. Despite McHugh, Balaratnasingham, Campbell and Chapman (2017), advocating the need for police officers to recognise the genuineness of such threats (as an indicator of the level of the person's distress) and refer the person to mental health services, this was not always so. Serving to illustrate the need for such recognition and intervention, Walton, Li, Barnes and Newcombe (2017) examined the impact of police contact with a person threatening suicide in New Zealand. Within their sample of three hundred and nine reported police contacts between 2007 and 2011, 58% of the people attended, proceeded to kill themselves. Of note, this work did not however specify the time between police contact and death. Territorial, and contact-to-death-time issues aside, it nonetheless illustrated the need for police officers to intervene practically at the time of incident. It also illustrated the need to promptly refer the person to mental health services, due to the significant risk of a reattempt at suicide (Arensmann et al., 2016). This misinterpretation of suicidal intent seemed to have wider implications, particularly in relation to the police officer's assessment of a person's mental capacity.

9.7.4 Establishing capacity

Mental capacity may be considered to be one's ability to understand and retain information (in relation to a given topic, or decision to be made), assess its relevance, and communicate one's views or decisions, by any means (Johnston and Liddle, 2006, p.94). Legally, in accordance with the Mental Capacity Act (2005), a police officer must assume "…a person [aged 16 or over] has capacity to make a decision, unless it can be established that they lack capacity" (Department for Constitutional Affairs, 2007, p.40). A lack of capacity may be permanent or transient, due, to what the CoP (2016c, Para.1, 3) describes as, "…impairment or disturbance in the functioning of the mind or brain…" as a consequence of "…forms of mental ill health…dementia… delirium… symptoms of drug and alcohol abuse." The CoP (2016c, Para. 2) requires police officers to take all "…practicable steps…" to communicate with the person, and support them to communicate their views or decisions. Where a person is seemingly lacking capacity, the CoP (2016c) appears to advocate a role–specific response; police officers being required to "…make immediate decisions that relate to containing, controlling and potentially restraining an individual…" lacking capacity (Para. 4). Having 'controlled' the individual, police officers were to seek "…further input or direction from a heath or social care professional" (CoP, 2016c, Para. 4).

For police officers aligned to the 'community problem solver' role, a lack of capacity was considered a feature of some mental disorders (level 1 SA). For others, it was a feature particularly of intoxicant use. The findings suggested that containment and control could be detention, via S136 of the MHA 1983 (amended 2007). This was considered appropriate where a mentally disordered person was deemed in need of immediate care and control. However, reflecting the findings of HMIC (2014), S136 detentions solely for intoxicant use (particularly where there was violence directly attributed to their use), were not. For those who aligned to the 'crime-fighting enforcer' role, a lack of capacity was viewed as an excuse to evade prosecution. Where a crime was suspected, or the events surrounding the situation were unclear, containment and control was in the form of arrest. Echoing the work of Young, Goodwin, Sedgwick and Gudjonsson (2013), this seemed to occur, even if (by way of their mental disorder) they did not have full understanding of the current events.

9.7.5 Seeking information from others

Where mental disorder was suspected, the more mental health-literate police officers sought information from bystanders and witnesses. This approach was useful in two ways, particularly where there was ambiguity with the account offered by a potentially mentally disordered person. First, it enabled the police officer to identify the presence of family. These were people who could confirm if the person had a significant mental disorder (Level 1 SA). Second, police officers would ask witnesses / bystanders to describe the behaviour of the person. This was again considered important, as it often highlighted features that may have resolved by the time police officers arrived (Level 1 SA). Caution however was exercised, particularly when seeking information from members of the public as it could not be assured that their descriptions were accurate, complete, objective, and not based upon opinion, ignorance, personal views or stereotypes (Pescosolido, Medina, Martin and Long, 2013; Lien et al., 2015; Henderson et al., 2016; Corrigan et al., 2017).

Where time permitted, police officers sometimes tried to obtain information about a person's presumed or actual mental disorder, from relevant healthcare services. Whilst some agencies seemed amenable to requests for information, it seemed that healthcare services (largely unavailable between 1700hrs and 0900hrs) would not provide details, reportedly citing issues of privacy and data protection (Fry et al., 2002; Horspool, Drabble and O'Cathai, 2016; Payne-James, 2017). This was a source of frustration for police officers as they felt they had no support when attempting to act in the best interests of the person.

When faced with a time-critical situation however, police officers undertook a rapid, often limited assessment of the person's communication. At this stage, they ignored information from bystanders, witnesses and healthcare services. Prior to investigating further, the police officer's priority was to first establish a 'new normality' and control any actual or potential danger. Key to this was a rapid appraisal of the environment in which the person was encountered.

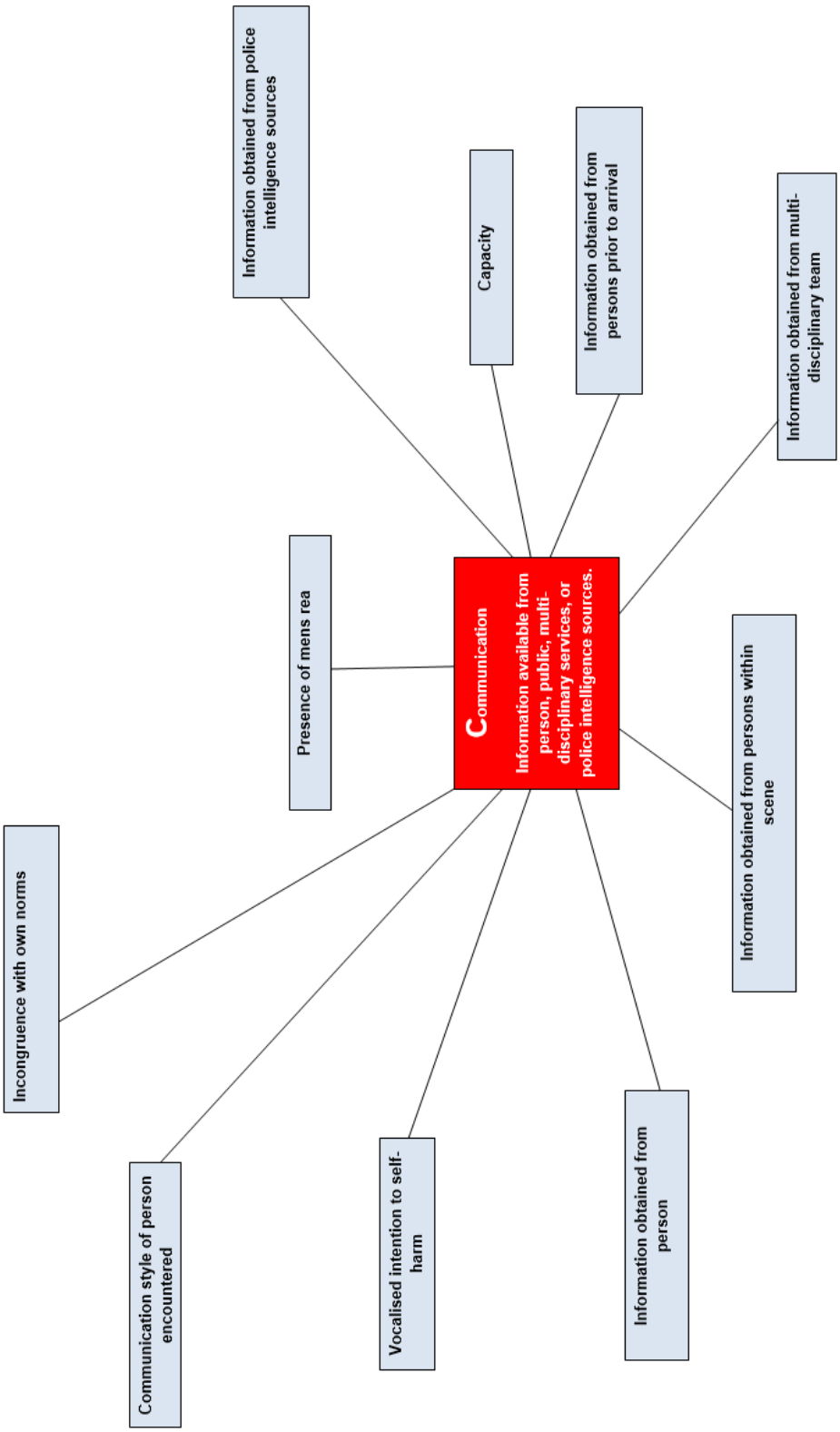


Figure 24: Cues Associated with Mental Disorder (Communication).

9.7.6 Environment

When police officers encountered a person, an array of environmental cues within the environment shaped their view that they were possibly mentally disordered (Figure 25). Routinely, police officers gathered situational information, so they could initiate a 'new normality' as quickly as possible. Closely linked to the theme danger, this was considered to be of vital importance, particularly where a situation was considered to be unstable, and time-critical. Amongst the array of cues, police officers sought to gather information and prioritise it according to their evolving views of what was occurring. Irrespective of the variables, police officers attempted to be situationally aware as soon rapidly as possible. Consistent with the work of Flin et al. (2007), this was reported to be within less than three minutes of contact.

9.7.7 The impact of the person

The findings revealed that when seeking information from the immediate physical environment, police officers observed the impact of the mentally disordered person upon their environment. Novoa et al. (2015) and Pevalin, Reeves, Baker and Bentley (2017), suggest that there is a close association between enduring mental health problems and poor housing conditions. Reflective of this, when attending a domestic property, the following features (Level 1 SA) were considered to be suggestive of the occupier being mentally disordered: poor décor, a place which is unkempt and soiled; presence of foul odours; areas of damage or poor maintenance. Echoing the features of self-neglect (discussed earlier), such features were thought to be due a loss of control and interest in one's own welfare. The presence of medication commonly associated with mental disorder was looked for. This was seen as confirmation that at least someone in the property was mentally disordered. This was confirmed if the name on the medication matched the person of interest. Police officers would also examine medication containers to see if the contents roughly matched the dispensation dates. If not, over-dosage would be suspected. They would also be vigilant for the presence of empty medicine packages, particularly in the presence of empty alcohol bottles. This would suggest over-dosage, and self-harming behaviour (Level 1 SA).

9.7.8 The impact of the environment

Police officers would also note the impact of the environment upon the person. Where people were considered to be incongruously dressed for the current weather

conditions (for example, they were missing key items of clothing, such as shoes on a cold, wet night), they would undertake a welfare check[88] (Level 1 SA). This was undertaken where they considered a person to be vulnerable, or at risk. Police officers reported that in such circumstances, it was common to find that the person was suffering some form of mental disorder. The findings revealed that it was difficult for some police officers to 'do nothing' in such situations and hence would seek medical help where indicated. This could not only be for a potential mental disorder, but also a physical one such as hypothermia or head injury. Some police officers would attempt to identify a next of kin / friend and transport the person to them. Unless there was a pressing problem, some police officers would do nothing further, and leave the scene without further action or contact.

9.7.9 The impact of others

The finding revealed that police officers considered the effect of other people within an environment. Police officers reported that they would rapidly try to establish the nature of any relationships between a mentally disordered person, and any other people present. Once a 'new normality' had been achieved, they would seek further information from them so as to assist their sense-making processes. Reflecting a role-specific response, police officers would seek information from bystanders to ascertain if any criminal offences had been committed. Where such an allegation of wrongdoing is made, Finn and Stalans (2002) suggest the account of a mentally disordered person is often treated with scepticism, due to an assumed cognitive impairment. In such situations, the account of the complainant is usually viewed as being more accurate and credible. Furthermore, work by Novak and Engel (2005), suggested that when such allegations are made, the police routinely detain and arrest the mentally disordered person. Within this study, police officers reported that for minor offences they had the power to initiate 'Neighbourhood Justice.'[89] However, consistent with the works of both Finn and Stalans (2002), and Novak and Engel (2005), this study suggested that where a bystander made an allegation against a mentally disordered person, the police officer would arrest them. This enabled the police officer to investigate the offence, and the mentally disordered person's account, in a more controlled environment (custody suite). This was done

[88] Welfare checks (also termed 'safe and well checks') are undertaken either at the request of healthcare staff (for example, a person considered at risk who may have absconded from a hospital), or where a police officer notices a person and considers them to be vulnerable in some way (CoP, 2016d). Where a check is undertaken, the police officer locates / approaches the person and investigates concerns. Where appropriate, they may summon an ambulance, arrange the attendance of the mental health crisis team, or detain the person via S136 of the MHA 1983. Police officers will however undertake welfare checks on a person if they consider them to be vulnerable, or where there are safeguarding issues.

[89] Neighbourhood Justice (also termed 'restorative justice') is applied if a prosecution for offence is not in the public interest. It is an approach which can be applied in the 'street' and which does not result in a formal charge or court hearing. It is usually applied at a police officer's discretion, taking into account the views of a victim, including any remedial / compensatory action offered by the victim (CoP, 2017e, Para. 2).

even if they anticipated that there would be no subsequent prosecution. Despite Level 2 SA being demonstrated, action was demonstrated in terms of a role-specific 'crime-fighting enforcer' response, seemingly to appease an accuser.

Police officers seemed to associate particular environments with the presence of mentally disordered people (Level 1 SA). When they encountered distressed people on motorway bridges (bridges above fast-flowing traffic), or viaducts, they considered mental disorder to be a significant factor. For some, this was through their prior experience with people threatening suicide. Police officers also considered distressed people found by railway lines, fast flowing water, or by the sea, to have some form of mental disorder. Prior experience of attempted suicide again seemed to inform such views. People encountered in such situations were considered genuinely in need of help. In these circumstances, responding to, and rescuing a person from potential death, and then facilitating some form of healthcare (Level 3 SA) was considered an appropriate policing response, irrespective of the role the police officers aligned themselves to. Commonly, their response to this was in the form of detention via S136 of the MHA (1983, amended 2007). The findings revealed that such positive responses were not always translated to other environments.

9.7.10 Making judgements

Consistent with observations by the World Health Organisation (2014), most police officers considered socio-economically disadvantaged areas also to be associated with the presence of mentally disordered people. Police officers reported that they were frequently called to social housing estates within their operational area. Where there were calls to deal with issues such as anti-social behaviour and incidents of domestic violence, police officers demonstrated Level 1 SA, as they had an expectation that the protagonist may have some form of mental disorder. Often, they knew this to be so, as they had attended the person before (Level 2 SA). Observations ranging from those of Bittner (1967), to Hartmann-McNamara, Crawford and Burns (2013), suggest that the police often become familiar with individuals, and their specific mental health problems. In doing so, they are recognised as "…social beings, with specific histories…" (Somerville, 2013, p.409). This study's findings did not reflect such a cordial relationship. Often such people were described in somewhat pejorative, rather than compassionate terms, and managed in a correspondingly dispassionate manner. Where a mentally disordered

person's behaviour impacted upon others (even where the police officer knew them), the police officer's action was seemingly demonstrated only in terms of a role-specific 'crime-fighting enforcer' response. The mentally disordered person was often detained, arrested or removed from the locale, to appease a complainant, or a potential one.

The findings revealed that supermarkets and shops were places in which mentally disordered people were often encountered. This was following reports of shoplifting. Within this study, police officers reported that when being called to attend a reported shoplifting where an adult (usually female) was involved, there was an expectation that the person would have some form of mental disorder. This was confirmed if the person was distressed, often disproportionately for the situation. Blanco, Grant, Petry, Blair and Analucia (2008), support this study's findings that shoplifting is common amongst mentally disordered people. Although Vinkers et al. (2011), offer the view that mental disorder should never be an excuse for such crimes, it should, notes Blanco et al. (2008), be considered indicative of a wider, underlying vulnerability; one deserved of some form of further exploration for the purpose of rendering help, rather than punishment. Within this study, whilst some police officers seemed to share the viewpoint of Blanco et al. (2008), most did not. In such circumstances, pre-encounter factors exerted some effect as the person was arrested for theft. Where Level 2 SA was demonstrated, action was demonstrated only in terms of a role-specific 'crime-fighting enforcer' response, rather than that of a 'community problem solver'.

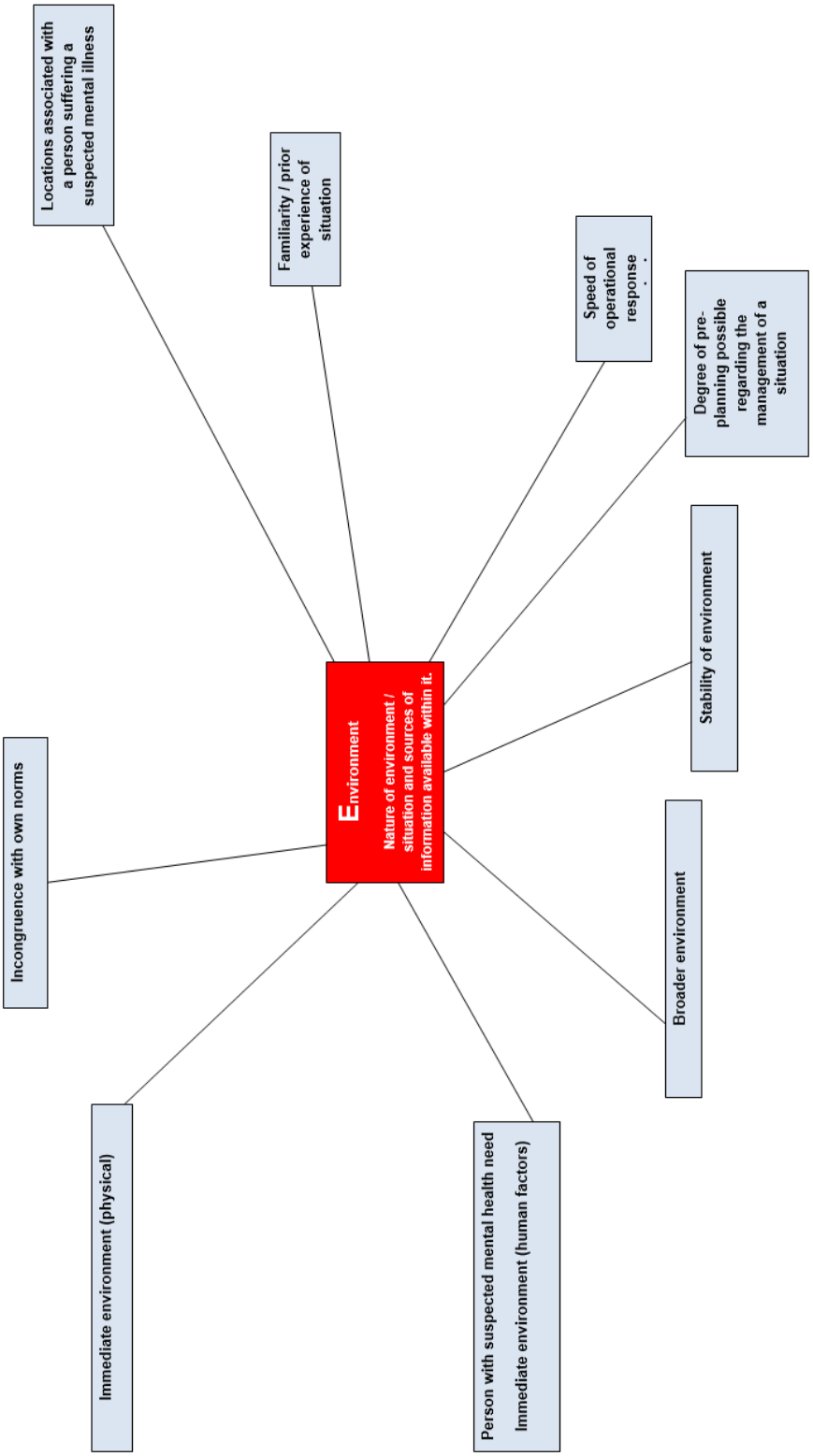


Figure 25: Cues Associated with Mental Disorder (Environment).

9.7.11 The preparatory stage: summary

The preparatory stage data afforded me a unique insight into the level of situation awareness demonstrated by police officers. I was able to expose specific cues (the cognitive "…building blocks..." of comprehension) that police officers considered suggestive of mental disorder (O'Brien and O'Hare, 2007, p.1065). I was also able to expose police officer responses, which were largely governed by pre-encounter factors, and their perception of, and response to danger. The findings revealed inconsistencies within the methods, rules, actions and behaviours amongst police officers. The findings also revealed that police officers perceived *some* of the Level 1 SA cues, *some* of the time. This was an important study finding, as it demonstrated the need for a mechanism to improve consistency of response. This was achieved through the development of the PPEAT-R, and the mechanisms to gauge its usefulness (Appendix 26, 33, 34 and 43).

9.8 Testing the usefulness of the cognitive aid

9.8.1 Phase one

Phase one demonstrated the order and structure of police officer behaviours and actions, when exposed to simulations of people demonstrating differing features of mental disorder. This was a useful frame of reference as it was possible to expose the common rubric, prior to the introduction of the PPEAT-R. It was also useful as a means to expose the indexical expressions (both within the notebooks and interviews) which made their actions intelligible and meaningful to the group.

The findings revealed that the police officers' responses closely aligned to the concepts appearance, behaviour, communication, danger and environment. Consistent with the findings of the preparatory stage, the manner in which police officers identified and responded to mental disorder (the common rubric) was however governed by the concept pre-encounter. When making entries within the notebooks, there was no particular system or pattern governing the manner in which information was recorded. The depth and focus of notebook data varied from police officer to police officer. The findings revealed that police officers briefly noted features of importance only to them, in the order in which they considered it important. Seemingly contrary to professional standards, notes were often in

abbreviated, or colloquial form.[90] During the focus group interviews, police officers actively used their notebooks, drawing and expanding upon the brief notes they made. This made it possible to gauge the level of situation awareness demonstrated.

The study revealed that the features of mental disorder noted, and the level of situation awareness demonstrated, varied within each vignette. Whilst police officers were able to perceive the key features associated with mental disorder, overall, there was a limited ability to comprehend their significance. Police officers seemed to demonstrate Level 1 SA to the greatest degree, often in broad terms. Level 2 SA was demonstrated to much lesser degree, and Level 3 SA was demonstrated minimally. The bulk of the emerging themes, suggestive of Level 1 SA, were concentrated within the concepts pre-encounter and danger, irrespective of the manner in which mental disorder was presented within the vignette.

9.8.2 Pre-encounter factors

The findings revealed that pre-encounter factors exerted great influence on the police officers' responses. Some police officers sought information to make sense of the vignettes. Others however, were dismissive of the potential, presence or influence of mental disorder. As such, their focus was directed toward possible criminal activity, rather than mental health need. For some, such views began to form when they received initial information from the CAD, prior to arrival (particularly within vignette three). For others, their views appeared pre-formed, reflecting personal, pre-existing views of mental disorder. For most however, their assessment was undertaken upon arrival. Consistent with the findings of the preparatory stage, the perception of, and response to danger was central to all interactions. However, a close linkage emerged between the concept danger, and the concept pre-encounter. The connection was the theme, role-specific response. This theme was governed by personal views, knowledge deficit, experience, as well as those governing a police officer's perception and response to danger.

[90] When completing pocketbook records, a specific standard is required for all police officers. This specifies:
- "…entries should be clear, precise and readable…" (Merseyside Police, 2015, p.5)
- "Entries must be of sufficient detail to allow a comprehensive account to be given."
- "Shorthand, languages and script other than English is not permitted" (Avon and Somerset Police, 2013, p.1)

9.8.3 The pre-encounter – danger linkage: the role-specific response

Across the vignettes, the concepts pre-encounter-danger (and their linkage) were associated with the greatest range of responses. Within all vignettes, police officers defaulted to a pre-planned role. It was one in which they sought to control and contain the person. Within both notebook and focus group data, a need to establish control was a common priority. Some police officers demonstrated a graduated response, first trying to communicate and calm the person. Then they tried to establish the circumstances (surrounding the issues depicted within the vignettes). This reflected a stop-and-account process. Overall however, a more forceful response was noted; one which did not address the person's mental health need.

Reflecting the observations of Wansbrough (2008), Shaw (2015), Brown (2016), and Van Brunt et al. (2016), this study revealed that the use of force to establish a 'new normality' was a common approach. Within this study, prior to the initiation of force, police officers first would shout at the person to gain their attention and for them to cease any current activity ('strong comms'). When investigating the use of force, the IPCC (2016), reported that such communication is used when police officers encounter or perceive violence / aggression. This was noted within this study, particularly for vignettes' one, two, five and eight). Police officers would then apply force in a variety of ways. The reported use of force included: physical searching; application of handcuffs; handcuff pain compliance[91]; rapid disarmament; striking the person with an Asp baton; physical restraint (individually, or with support of others); use of shields. Significant however, was the apparent readiness to use incapacitant spray (CS gas), or conducted energy devices (Taser).

9.8.4 The use of less lethal weapons

Termed a "…less lethal weapon…", and a 'chemical munition', the CoP (2017f) notes that CS gas[92] serves to "…reduce a person's offensive capability and the extent of their coordinated action" (S6, Para. 4). It achieves this through: "…pain and discomfort in the eyes; …excessive watering, involuntary spasm of the eyelids…"; "…blinking or closure of the eyes…"; "…sneezing, coughing, retching…"; "…stinging or burning sensation on exposed skin." Rather than reduce a person's 'offensive capability', a Taser (also termed a 'less lethal weapon') seeks to induce temporary incapacitation, via "…an electrical current which temporarily interferes

[91] Twisting of the bar of combination hinge/rigid handcuff, whilst in position, induces pain compliance (NPCC, 2015b; 2015c)
[92] CS gas (2-chlorobenzylidene malononitrile) is an incapacitant spray, developed by Corson and Stoughton in 1928. The name CS is drawn from the initials of their second names (Corson and Stoughton, 1928; Hankin and Ramsey, 2007).

with the body's neuromuscular system and produces a sensation of intense pain." CoP (2017g, Para. 1).

There is scant evidence regarding the immediate or long-term physiological impact of incapacitant spray on mentally disordered people. However, there is a risk of physical injury associated with concomitant restraint tactics (Myers, 2017; Rossler and Terrill, 2017). There is also some debate regarding the degree of physical injury that Tasers may inflict on a mentally disordered person in distress, (O'Brien and Thom, 2014; Jetelina, Jennings, Bishopp, Piquero and Gonzales, 2017). Amongst the 'risk factors' to consider for the discharge of a Taser, are "acute behavioural disturbance / excited delirium; vulnerable people" (CoP (2017g, S6, Para. 3). Of note, within this study Tasers (and CS gas) were noted as a tactical response to vignettes' one, two, five and eight. All the people depicted within these vignettes reflected the 'risk factors' to consider prior to the discharge of a Taser. Irrespective of any physical injury, Sussman (2012) notes there is scant attention paid to the psychological and emotional impact of such weapons upon the mentally disordered; weapons which can inflict "…severe unintended harm", beyond that necessary to elicit control (p.1411).

9.8.5 Role alignment: the gate keeper response

As suggested earlier, through this willingness of some to use force, police officers began to align themselves with a particular common rubric. This was either the 'crime-fighting enforcer' or the 'community problem solver'. As such, an inconsistency in situation awareness and response began to emerge. Those demonstrating the 'crime-fighting enforcer' role had a willingness to arrest the person portrayed within the vignette, irrespective of the presentation. This finding was consistent with Teplin's (2000) criminal pathway gatekeeper response. Where the police officer identified specific grounds for arrest, they were consistent with the apparent behaviour of the person. Within vignette four, arrest for theft was stated. Within vignette six, police officers noted a Breach of the Peace. Within vignette five, the woman was arrested for attempted murder of the baby. Arrest of the person portrayed within vignette eight was for possession of an offensive weapon. However, the findings revealed that some police officers would use arrest as a means of controlling and containing the person. Where mental disorder was suspected as being an underlying cause for a person's actions, rather than seek

some form of medical aid, it would be left to the custody sergeant to formally identify and address them. Such approaches reaffirmed the "…criminalisation of the mentally disordered…" (Abramson 1972, p.16).

Further illustrative of an alignment to Teplin's (2000) gatekeeper response (in this case, the healthcare gatekeeper), the police officers aligned to the 'community problem solver' role indicated that they would summon an ambulance for the people depicted within vignettes' four, six, and eight. Where such police officers did not explicitly recognise the signs of mental disorder, there was sufficient incongruity with the situation for them to consider some form of health reason underpinning, or associated with the person's actions. Cotton and Coleman (2010) view the police service as an integral component of a complex social care system; one in which the police should not function as "…autonomous entities divorced from [it] …" (p.301). Summoning an ambulance, the police officer demonstrated what Cotton and Coleman (2010) term "…a systems approach to a complex social phenomenon" (p.301). The police officers as 'community problem solvers' were open to differing possibilities for the person's actions. As such, rather than arrest the person (based upon their own interpretation of the situational features), they were willing to seek the assistance (at least initially) of other agencies. In this case, the ambulance service. For a small number of police officers who demonstrated Level 2 SA, they were able to comprehend and contextualise threats. Within vignette eight, these police officers noted an act self-harm, rather than a threat to anyone else. Whilst there was still an intention to restrain the person, it was to prevent harm to them, rather than others, and undertaken as part of the S136 procedure. This approach contrasted somewhat to those police officers restraining and arresting the person for the possession of an offensive weapon.

9.8.5.1 The shifting role

However, even with those aligned to the 'community problem solver' role, there appeared to be a shift towards that of 'crime-fighting enforcer'. This shifted the police officer's gatekeeper response. Some police officers (demonstrating Level 2 SA), correctly identified that the woman within vignette five was suffering post-natal depression. Here, there was a marked difference of opinion as to how to respond. Of those demonstrating Level 2 SA, some would intervene and restrain the woman, prior to initiating S136. The majority however would detain and arrest the woman for charges relating to abuse, assault and child endangerment. Of note, whilst the

majority of police officers (demonstrating both Level 1 and Level 2 SA) would seek immediate medical help for the baby (via ambulance), no one sought immediate medical aid for the woman.

9.8.5.2 The lost opportunity

Again, supporting Teplin's (2000) gatekeeper response, a common response was not to intervene. For vignette seven, some police officers did not feel there was an issue; some did not wish to get involved. Of note, police officers implied a level of expected oddness with people; a level which in some cases tempered their response. Reflecting the findings of the preparatory stage, police officers implied that they would not respond until the person was considered to be acutely mentally unwell. Noted by Goffman (1963), when one encounters a person, they assign them a 'social identity', judging the person's characteristics against their own "…normative expectations*..."* (viewpoints), and those held within their social group (role-specific response) (p.12). Bittner (1967), Corrigan et al. (2003) and Watson et al. (2010), note that these normative expectations develop when police officers regularly patrol an area. Doing so, they become familiar with the characteristics (and characters) of the people therein, establishing their "…tolerance for deviance…" (Watson et al, 2010, p.304). This being one's benchmark for deviation from expected and tolerated social norms.

Within this study, when some police officers regularly encountered people they considered to be mentally disordered, they assigned them a 'social identity.' They adjusted their response (their "…tolerance for deviance…), depending upon the significance of the 'deviance', their workload, and the perceived accessibility of healthcare services (Watson et al., 2010, p.304). Echoing this literature, the findings highlighted a potentially lost opportunity to assist a person with a potential mental health need. Despite the apparent inconsistency in the manner in which police officers responded to mentally disordered people, they appeared able to disentangle several key Level 1 SA features of mental disorder, associated with the vignettes. The finding suggested however, that the nature of the situation determined a police officer's direction, and depth of focus. This was of particular note when police officers noted the features of a person's appearance.

9.9 Appearance

When police officers described a person's appearance (particularly within their notebooks), their entries were brief. Across the vignettes, this did not appear to be the police officers' main area of focus when approaching a person. However, when noting a person's appearance, police officers first established a frame of reference, stating how many people were involved and their apparent gender. The focus of their attention shifted, depending upon the complexity of the situation. For police officers demonstrating Level 2 SA, they described the person's appearance in terms of diagnostic criteria. For example, the male within vignette one appeared 'psychotic' and 'manic'; the male in vignette three, 'depressed.' Within the descriptions, police officers were able to recognise the signs of self-harm within vignette eight. No-one however noted the injury to the female, depicted within vignette one. In some descriptions, reflecting both Level 2 and 3 SA, the person was dehumanized. The male within vignette six noted as being '136.' This seemed to reflect a description of the person, and management intent. The woman in vignette eight was described as 'a self-harm.'

9.9.1 A loss of situation awareness

Amongst the findings, there were differing interpretations of the vignettes. Within this, lack of Level 1 SA emerged. For police officers demonstrating Level 1 SA, obvious injury was identified within vignette eight, but not all police officers associated it with self-harm. Police officers briefly described the appropriateness of a person's clothing / dress. On occasions, judgements were offered regarding the quality of clothing. E.g. 'Well dressed.' In some cases, a person's appearance seemed based upon prior experience: "…not like the person lives on the street." However, police officers did not link their observations to the features of mental disorder. The findings revealed that police officers provided differing, somewhat contradictory, and technically inaccurate (or misleading) descriptions of the person's appearance. For vignette four, descriptions of the woman ranged from her being vacant[93] to extremely agitated[94] and for the woman in vignette eight, from withdrawn[95] to upset and erratic.[96] Consistent with the findings of the preparatory stage, when police officers noted a person's appearance, they perceived *some* of

[93] "Devoid of thought, reflection, or expression" (Merriam-Webster, 2017a).

[94] "A state of excessive psychomotor activity accompanied by increased tension and irritability" (Merriam-Webster, 2017b).

[95] "Socially detached and unresponsive (Merriam-Webster, 2017c).

[96] "Deviating from what is ordinary or standard (Merriam-Webster, 2017d).

the Level 1 SA cues, *some* of the time. However, some did not perceive them at all, or there were differing interpretations of the same theme. This suggested variability and inconsistency in the perception of the "…building blocks…" of comprehension, illustrative of failed situation awareness (O'Brien and O'Hare, 2007, p.1065).

Jones and Endsley (1996) offer a taxonomy of "…failed situation awareness" (p.504).[97] Within their study of errors within the aviation industry (a similarly complex environment), 76.3% were attributed to Level 1 errors (a failure, or misperception of available information). This failure or misperception may be due to a number of factors. These include distractions and individual priorities (differing from the actual ones). They also include an overt focus upon perceived, rather than actual hazards. Increased cognitive workload, impacting upon working memory processing was also a significant factor (Jones and Endsley, 1996; Carretta, Perry and Ree, 2002; Lubnau, 2006; Kozuba and Pila, 2015; Green et al., 2016). This was particularly so when compounded by a lack of "…foundation information…" (knowledge) (Chrimes, 2016, p.20). Viewing the findings of this study through the additional lens of Jones and Endsley's (1996) taxonomy, this variability in situation awareness was possibly due to police officers having difficulty discriminating and perceiving all of the information available within the vignettes. It may, as previously noted by Kahn (2015), be due to cognitive lapses, impacting upon otherwise well-functioning attention and memory. Individual priorities and hazard perception had an effect. The manner in which police officers articulated their observations also had an effect on their demonstrated level of situation awareness.

9.9.2 A lack of vocabulary: the use of unitary signs

Where very brief, differing, or somewhat contradictory descriptions of mental disorder were offered, a possible explanation could be a lack of 'foundation information' regarding what constitutes the features (Chrimes 2016, p.20). However, an alternate view can be posed. Rather than offering contradictory descriptions, police officers seemingly identifying some form of mental disorder simply did not have the appropriate vocabulary to describe the person's appearance. Noted by Boklund-Lagopoulos and Lagopoulos (2011), words,

[97] Level 1: *failure to perceive information or misperception of information.* Data not available; hard to discriminate or detect data; failure to monitor of observe data; misperception of data; memory loss.
Level 2: *improper integration or comprehension of information*. Lack of or incomplete mental model; use of incorrect mental model; over-reliance on default values.
Level 3: *incorrect projection of future actions*. Lack of or incomplete mental model; over projection of current trends (Jones and Endsley, 1996, p.508).

phrases and terms can represent unitary signs. This is something that means one thing, but can be used by another to signify something else. As such, they hold semiotic meaning. These are words, phrases and terms used that hold an alternate meaning, depending upon their context of use (Boklund-Lagopoulos and Lagopoulos, 2011). Rather than viewing, for example, the terms withdrawn[98], upset and erratic[99] as being inconsistent and technically inaccurate descriptions, they are perhaps better considered as unitary signs for mental disorder. As such, they represent indexical description of "…expectable features on the settings…" (Cheng, 2015, p.589). This is the language used by members to describe features with a specific context (de Montigny, 2007). Police officers are not healthcare practitioners. Therefore, there should not be an expectation of technical accuracy within their descriptions. Rather, the ability to perceive, and in some way, express the presence of mental disorder *per se,* is therefore the important factor. Adopting this standpoint was useful when exploring the police officers' responses, particularly to a person's behaviour.

9.10 Behaviour

The findings revealed that after danger, a person's behaviour was the key focus of attention. When police officers described a person's behaviour, their notebook entries were again brief, but the focus group responses were more extensive, particularly amongst those demonstrating Level 2 and 3 SA. For this group, the unitary signs noted and described were mostly clear, and unambiguous. For example, within vignette eight, the woman's behaviour was described as 'suicidal', with some police officers noting her cutting herself with the sharp object. Within vignette six, the male's behaviour was attributed to 'schizophrenia', 'obsession' and 'delusion.' The effect of prior experience (pre-encounter factors) had some effect upon one police officer's identification of potentially mentally disordered behaviour. Within vignette four, one police officer noted (with accuracy), that the female was suffering from post-traumatic stress disorder (PTSD). Whilst they had no formal training in the recognition of mental disorder, they had encountered this amongst refugees from conflict zones in Syria. Badri, Cruzen and Van den Borne (2012) undertook a cross-sectional study of one hundred and twenty-three civilians exposed to a conflict situation. Of this sample, 80.9% suffered some degree of PTSD. Amongst the spectrum of symptoms, dissociative experiences may occur,

[98] "Socially detached and unresponsive (Merriam-Webster, 2017c).

[99] "Deviating from what is ordinary or standard (Merriam-Webster, 2017d).

as demonstrated with the vignette (Nygaard, Sonne and Carlsson, 2017). In this instance, identification of PTSD was determined by an experiential response (pre-encounter), rather than by formal training / education.

Within the Level 1 SA descriptions of a person's behaviour, they appeared less detailed. Police officers were able to detect some significant unitary signs (features). Where police officers had more time to respond, their descriptions of the signs of mental disorder seemed more extensive. Police officers noted behaviour suggestive of preoccupation. Terms such as 'daydreaming', 'unaware' and 'oblivious' to the presence of the police officer were noted. Repetitive movement with hands (rubbing), feet (tapping) or by action toward an object (touching something) were also described. As a unitary sign, descriptions of wild or erratic behaviour suggested a perception of significant mental health need. However, police officer responses appeared inconsistent within the more time-critical scenarios. Their focus remained upon behaviour posing a danger or threat.

9.10.1 Behaviour posing a danger or threat

Within vignettes' one, two, five and eight, police officers provided succinct descriptions of the person's actions. Within vignette five, there were multiple, broadly similar descriptions of the woman throwing the baby to the floor. Her behaviour was broadly described as being very aggressive and uncontrolled. Similarly, within vignette two, several police officers noted the person as aggressive, but also agitated. Within vignettes' two and five, uncontrolled and agitated behaviour was not directly associated with mental disorder; rather it was viewed as a component of aggression. The majority of responses to these vignettes described aggressive actions (e.g. banging or hitting doors). Whilst such responses accurately described the behaviour depicted, they did not specifically reflect unitary signs of mental disorder. The focus seemed to highlight behaviours potentially posing danger, eliciting a role-specific response to control and contain it.

Renden et al. (2013), examined police officer self-defense and arrest responses, when faced with a potential behavioural danger. Their findings suggested that police officers' rapidly pin-pointed areas of danger / threat. In doing so, they responded to neutralize and control a person, attempting to "…get it over with as soon as possible" (Renden et al., 2013, p.110). The findings of this (current) study revealed that as well as being shaped by a role-specific response, a police officer's

initial assessment of a person's behaviour was shaped by what Henry (1995) terms, the "…psychology of survival..." (p.93). This is a police officer's "…recognition that even the seemingly most ordinary and mundane event can, ultimately, have a deadly outcome" Henry (1995, p.94). Reaffirming the findings of the preparatory stage, the perception of danger (underpinning all responses), directed the police officer's attention to key areas of policing, rather than mental health concern. This response was illustrative of a Level 1 SA failure, due to difficulty in discriminating, or misperceiving the features of mental disorder (Jones and Endsley, 1996, p.508). Further compounding this, several police officers appeared to demonstrate Level 2 SA failure. Through "improper integration or comprehension of information", the person's behaviour was associated with criminality, rather than as a consequence of their mental disorder (Jones and Endsley, 1996, p.508).

9.10.2 The perception of criminality

Noted earlier, Cotton and Coleman (2010) advocated that police officers should function as part of an integrated social care system. Through this, mental disorder can be seen as deserving of help, even if it is associated with a criminal act. Fry et al. (2002) however, suggest the reality is quite different. Consistent with the findings of this study, work by Fry et al. (2002) noted "…divergent views…" amongst police officers (pp.277-78). Some being receptive to the needs of the mentally disordered person, whilst others are not, responding only to their role as a 'social controller' ('crime-fighting enforcer'). Within vignette five, some police officers noted incongruity or signs of mental disorder. The majority however, saw criminality; for example, a belief that the woman was abusing or trying to kill her baby. Furthermore (illustrative of the pre-encounter theme, personal viewpoints), one police officer discounted the effects of mental disorder, noting that potential mental disorder was not an excuse for the actions depicted. Such views were strongly suggestive of a 'crime-fighting enforcer' role.

Within vignette four, several police officers succinctly noted that the person was a shoplifter. For some, her behaviour was a ruse to evade prosecution. Arrest was suggested by several police officers, but one police officer indicated they would simply issue a Penalty Notice for Disorder (PND)[100], and end contact, irrespective of

[100] Penalty Notice for Disorder (PND). The Ministry of Justice (2014) describes this sanction as "…a quick and effective alternative disposal option for dealing with low-level, anti-social and nuisance offending" (p.4). It is applicable for retail theft of under £100.00. It is an approach which avoids arrest, but the person is fined £90.00. A PND may not be applied if "A PND will not be appropriate where the person is unable to understand what is being given to them or there is any doubt about the person's ability to understand the procedure" (Ministry of Justice, 2014, p.12).

the person's presentation. Again, these views appeared strongly suggestive of 'crime-fighting enforcer' role. This view contrasted with a small number of police officers, who appeared more open to alternate possibilities. Whilst Dabney, Hollinger and Dugan (2004), suggest that there is no specific demographic, for one police officer, the woman within vignette four was not an 'average' shoplifter. Such disparity of view was also reflected within vignette six. Whilst several police officers considered the person depicted to be attempting to break into the car (using a bag on their hand to wipe away evidence), several considered the behaviour incongruous; behaviour atypical of a car thief, as he focused his attention upon only one car. Where there was overt focus upon a criminal act, it was again illustrative of a Level 1 situation awareness failure, due to difficulty in discriminating, or misperceiving the features of mental disorder (Jones and Endsley, 1996, p.508). Reflecting the work of Fry et al. (2002), this disparity also reaffirmed the influence of pre-encounter factors, particularly personal views and role-specific response. This influence extended into the descriptions relating to communication.

9.11 Communication

Level 2 and 3 SA was demonstrated to the greatest degree within vignette three. The information provided by the CAD generated an increased level of SA, both in recognition and response, compared to the other seven vignettes. Whilst there was broad agreement that the male required urgent medical attention due to a credible suspicion that he would deliberately self-harm (Level 3 SA), there was variation in the manner in which this would be initiated. When that male ran, some felt that he could be detained (with S136 intimated), some disagreed, and some wished to monitor his egress via CCTV. With the exception of vignette three, few police officers described information relayed to them from the CAD. Police officers demonstrating Level 2 SA succinctly noted key information relevant to the person they were looking for. Prior self-harming attempts seem of great significance to police officers. Indexical terms such as 'MISPER' (missing person) and 'MO' (modus operandi) were used within notebook descriptions. Impressions such as 'suicidal' were also expressed within the notebooks. Where Level 1 SA was demonstrated, personal views rather than objective description seemed to shape their responses. The findings revealed that most police officers (in real-world practice) found the CAD information of limited use as the situation was often different to that relayed to them. As such (reflecting the findings of the preparatory

stage), they formulated their own (pre-planned) response, based upon personal views and experience, and their own scene assessment.

Across the vignettes, the police officers noted the person's communication style. However, there continued to be a variation in the specific features (associated with mental disorder) noted. Police officers demonstrating Level 2 SA offered more coherent descriptions. For vignette three, police officers noted significant content of the man's speech (e.g. his denial of taking any medication, despite the information provided via the CAD). This was not so for those demonstrating Level 1 SA. Several police officers described a person's communication style in one or two words. For example, 'growling', 'mumbling', and 'speaking quietly.' Whilst these seemed to be unitary signs, suggestive of mental disorder, they lacked any detail, suggesting a specific comprehension of the presence of mental disorder. Not all police officers seemed able to accurately disentangle words said, though.

Within vignette one, some police officers noted the male to say that he would kill the female, or that he shouted at the female, 'kill yourself.' Several police officers however noted the male to repeatedly shout at the female to 'stop it.' This was a more accurate representation, as the male was attempting to stop a female from deliberately self-harming. However, the police officers broadly responded to this as a danger, thus eliciting a role-specific response to control and contain it. Yet again, there was a Level 1 situation awareness failure, due in this case, to difficulty in discriminating, or misperceiving the words said (Jones and Endsley, 1996, p.508). There was particular accuracy of recollection and recording when threatening words were directed toward the police officer.

9.11.1 The 'deadly mix'

Within vignette eight, several police officers accurately noted the words used by the woman, when she threatened to cut them with a sharp object. The descriptions were underpinned by a role-specific response, noting communication, suggestive of potential danger. In this case, a specific focus upon the threat directed toward them. Pinizzotto, Davis, Bohrer and Infanti (2012), discuss the concept of, "…the deadly mix…" when a police officer is threatened, (p.287). The 'deadly mix' is a triad, comprising "…the dynamic interaction of the officer, the offender [person], and the circumstances that brought them together", resulting in some form of negative outcome for either police officer or person encountered (Pinizzotto et al., 2012,

p.287). It is a state in which both police officer and the person misinterpret each other's intentions or words, resulting in some form of combative engagement (Pinizzotto et al., 2012).

From the perspective of this study, this 'deadly mix' was compounded by three things. First, by a mentally disordered person in crisis (with possible impaired thought). Second, the person encounters a police officer who either fails, or refuses, to acknowledge the presence of their mental disorder. Third, the environment is perceived by the police officer as a complex, time-critical situation (de Tribolet-Hardy et al., 2013). In such circumstances, the use of force is increasingly likely (de Tribolet-Hardy et al., 2013). Within this study, there did not seem to be difficulty in discriminating or perceiving the words. Rather, an inability for some police officers to perceive the effect of the mental disorder shaping the person's words or intentions (non-verbal communication). This situation is again suggestive of Level 1 situation awareness failure. Forming the third point of Pinizzotto et al.'s (2012), 'deadly mix' triad, are the 'circumstances that brought them together.' It is a state which implies not only the situation that led to the interaction between the police officer and the mentally disordered person, but also "…environmental determinants…" potentially shaping a forceful police response (Pinizzotto et al., 2012, p.286).

9.12 Environment

When considering the significance of Pinizzotto et al.'s (2012) 'deadly mix' triad, and the pre-encounter-danger mitigated responses noted earlier, there was limited description of features within the environment. Where described, police officers pinpointed areas of potential danger and features relevant to controlling and containing the person ('establishing a new normality'). This was noted for all the vignettes. Within vignette one, several police officers noted the stairwell as being significant. Here there was a fall risk identified for the male, the female and the police officer. Within vignette two, the safety of people in rooms adjacent to the corridor containing the male was considered. Regarding the male, police officers only considered the environment from the perspective of how they could undertake a role-specific tactical response to control and contain him. Within vignette eight, the operationally significant issue of a confined toilet area was noted. This was deemed important as it was considered a high-risk area in two ways. First, police

officers were unable to observe the woman's actions. Second, it would be difficult to control and contain her in such a confined space. Reaffirming this broad concern, one police officer noted that they did not wish "…to go fighting in there."

9.12.1 The "…we versus they…" culture

From an indexical perspective, "…to go fighting in there" is illustrative of the role-specific response aligned to the 'crime-fighting enforcer'. In its literal form, fighting may be considered a struggle with something / someone, or engaging in aggressive physical combat to overpower someone (Sinclair, 2000). By seeking to expose the environmental features police officers considered suggestive of mental disorder, the pre-encounter-danger linkage was reaffirmed. It is therefore a significant axionormative order, shaping situation awareness. Amongst the group, the term 'fighting' seemed a common, indexical expression, representing the use of force towards someone. The term seemed illustrative of a wider view, which Terrill, Paoline and Manning (2003) term a "…we versus they..." culture (p.1006). This is a culture in which police officers (within their social group) are expected to respond to people with a forceful, 'hard' policing approach (McCarthy, 2012, p.262). When viewed in terms of Pinizzotto et al.'s (2012) 'deadly mix' triad, this pre-determined 'hard' policing response almost assures some form of combative engagement (Pinizzotto et al., 2012). It is a response governed by the pre-encounter-danger linkage.

9.12.2 Phase one: summary

Phase one demonstrated the order and structure of police officer behaviours and actions. This was following exposure to simulations of people demonstrating differing features of mental disorder. This was a useful frame of reference, exposing the common rubric prior to the introduction of the PPEAT-R. It was also useful as a means to expose the indexical expressions (both within the notebooks and interviews) which made their actions intelligible and meaningful within the group. Key within the findings was the lack of consistency in the manner in which police officers demonstrated situation awareness. Police officers seemed to perceive *some* of the cues, *some* of the time, mainly at Level 1 SA. However, some did not perceive them at all, or there were differing interpretations of the same theme. This suggested not only variability, but in some cases, an absence of situation awareness. This was a theme noted within all concepts. The findings also

reaffirmed the view that despite some police officers seemingly aligning themselves to the 'community problem solver' role, the dominant characteristic amongst the police officers was that of 'crime-fighting enforcer'. As such, the elements necessary for the 'deadly mix' are present. These are the dynamic interaction between the police officer (as 'crime-fighting enforcer'), the mentally disordered person, and the environment in which a police officer threat-assesses (preparing to establish a 'new normality'). It is illustrative of failed situation awareness, due to a failure or refusal to acknowledge the presence of mental disorder, compounded by pre-encounter factor influences, particularly the pre-encounter-danger linkage.

9.13 Phase two

Consistent with the earlier findings, the police officers closely aligned their responses (common rubric) to the concepts. The police officers were able to reconsider and capture the features of mental disorder depicted by the people within the vignettes. As with phase one, the notebook data varied from police officer to police officer. Again, the notes were often in abbreviated, or colloquial form.[101] Despite this, there seemed to be broad consistency regarding the unitary signs described. There was, however, a distinct shift in the order in which police officers composed their notes. Thirteen police officers partially or fully aligned their notebook descriptions of the situations depicted within the eight vignettes, to the concepts appearance, behaviour, communication, danger and environment.[102] Four police officers did not explicitly align their notebook descriptions to the concepts. Their descriptions however, appeared more structured and ordered, reflecting an interpretation, rather than adherence to the PPEAT-R framework. Whilst some police officers demonstrated Level 1 SA (particularly within the more time-critical scenarios) there was a notable shift towards Level 2 and 3 SA amongst most participants. The linkage between the concepts pre-encounter factors and danger remained.

9.13.1 Refocussing of the pre-encounter stage

Following the introduction of the PPEAT-R, the pre-encounter–danger linkage continued to exert an influence upon police officer responses. There was an

[101] When completing pocketbook records, a specific standard is required for all police officers. This specifies:
- "…entries should be clear, precise and readable…" (Merseyside Police, 2015, p.5)
- "Entries must be of sufficient detail to allow a comprehensive account to be given."
- "Shorthand, languages and script other than English is not permitted" (Avon and Somerset Police, 2013, p.1).

[102] Where the cognitive aid was fully or partially used, police officers framed their responses against the abbreviations A, B, C, D and E.

increased mental health literacy amongst police officers. Consequently, pre-encounter factors were altered. The result was a more positive response toward the mentally disordered people depicted within the vignettes. This was demonstrated by improved situation awareness. Hansson and Markström (2014) undertook a controlled pre-post intervention study to improve mental health literacy amongst police officers. Their study sought to address personal and institutional stigma and discrimination toward the mentally disordered. Hansson and Markström (2014) noted that not only did police officers have an increased mental health literacy, but they were far more willing to engage and respond to the needs of mentally disordered people in real-world practice.

Reflecting the advice of Booth et al. (2017), caution must be exercised when drawing comparisons between studies, as their focus and methods differ. However, training (in this case, a ninety-minute introduction into the use of the PPEAT-R), had a marked effect upon police officer attitudes and responses. Significantly, there was a distinct change in approach when danger was perceived. Following the introduction of the PPEAT-R, not only did police officers clearly and objectively articulate the specific areas of concern, there was a greater acknowledgment of danger, as a consequence of mental disorder. As such, the police officers responded to the needs of the person, rather than following a pre-planned, role-specific response.

9.13.2 The "…we alongside they…" culture

The perception of danger continued to underpin all responses. However, the shift from a pre-planned, role-specific response, to one acknowledging the presence and effect of a presumed mental disorder, represented a significant movement within the previously noted axionormative order. Despite a shift away from a 'hard', 'we versus they' policing approach, the use of force to establish a 'new normality' remained. The IPCC (2016) recommends, "…sufficient emphasis is placed on the needs of vulnerable people when officers are considering using any type of force" (p.43). Alpert (2015) noted that such vulnerability (mental disorder) is identifiable only through detailed, often lengthy clinical assessment, not through unexpected interaction and observation by police officers. This recognition of vulnerability however, assumes a perception that the person is mentally disordered and, (significantly) that it is of any interest to the police officer (Teplin, 2000; Morabito and Socia, 2015).

Alpert (2015) notes that a police officer's identification and response to a potentially mentally disordered person is based upon rapid determination whether the person is "…mad, bad or sad…" (p.280). Despite this somewhat glib précis, the point that Alpert (2015) appears to make is that police officers have to make an often rapid, uninformed determination of a person's mental state, and react according to this determination. Where punitive responses occur, they significantly worsen a person's distressed state (Sussman, 2012; O'Brien and Thom, 2014; Meade et al. 2017). The reverse however occurs if police officers adopt a more considered and informed approach (Pinfold et al., 2003; Coleman and Cotton, 2014). Within this study, whilst police officers still considered the vignettes to depict time-pressured scenarios requiring rapid appraisal, the PPEAT-R and its preparation session provided them with a more informed view regarding the features of mental disorder. Following the introduction of the PPEAT-R, the use of force to establish a 'new normality' now appeared more judicious. Significantly, when applied, it was to control, contain and prevent injury (to self or others), rather than as a punitive response.

Illustrative of this was the response to vignette eight. Within phase one, there was a broad view that the woman wielding the sharp object should (as a role-specific response), be contained and disarmed. Following the introduction of the PPEAT-R, there was now a widely-held view (Level 2 SA) that the person was mentally disordered, and therefore, posed only a risk to herself. The risk to the police officer was no longer considered. The response was still to disarm the woman, but initially through the use calm communication and de-escalation. Where force was to be used, it was to facilitate medical help, rather than a punitive response. A similar shift was noted for the woman depicted within vignette five. There was now a commonly held view that the woman was mentally disordered. As well as the baby, she too was considered to be at risk, and therefore deserving of medical treatment. Furthermore, within vignette two, whilst danger from the individual was still widely perceived, there was increased recognition that it could be a consequence of drugs. A role-specific response was still demonstrated, but it was more graduated and considered, avoiding the use of weapons or incapacitants. Police officers now recognised that such forceful physical intervention could be harmful to the person. Across the vignettes, whilst rapid disarmament and restraint were still role-specific response options used to respond to danger, the following were not now considered

after the introduction of the PPEAT-R: physical searching; application of handcuffs; handcuff pain compliance[103]; striking the person with an Asp; use of shields; incapacitant spray; conducted energy devices. This shift was further illustrated by police officers not choosing to arrest anyone depicted within the vignettes.

9.13.3 Bridging the role gap

Further supporting the claim of increased mental health literacy, police officers previously aligned to the common rubric of 'crime-fighting enforcer', appeared to shift to that of 'community problem solver'. In doing so, there was now a consistency of response; one which was not present within either the preparatory stage, or phase one. The police officers now shifted away from an approach which intentionally or unintentionally criminalised the person (Abramson 1972, p.16). Key to this, note Teller et al. (2006), Morabito (2007), Crocker et al. (2009), and Shapiro et al. (2014), is an education programme which both establishes and sustains consistency, through improved mental health literacy. To be effective however, the education programme must not introduce tasks, roles or expectations which will detract from, or become burdensome to their existing operational function (Shapiro et al., 2014). Rather, it should be one which accepts the societal requirement for the police officer as a 'crime-fighting enforcer', but also a 'community problem solver'.

Within a social group of police officers, where such a duality of role exists, the education programme should therefore seek to somehow 'bridge' the two (Shapiro et al., 2014, p.617). In doing so, the 'crime-fighting enforcer' will still be permitted to enforce social order and rules, yet be willing to accept the impact of mental disorder upon a person's actions, and accept the person's deservedness for specialist care. Similarly, the 'community problem solver' will continue to acknowledge the significance of a person's mental disorder, and its influence upon their current situation. They must however be prepared to enforce social order and rules where appropriate, and be prepared to detain someone where this is the only option to facilitate specialist care. At its most fundamental therefore, a programme should prepare police officers to be person- (mentally disordered person) focussed (Coleman and Cotton, 2014; Shapiro et al., 2014). It should prepare them to be self-aware, recognising how their personal and professional views shape their

[103] Twisting of the bar of combination hinge/rigid handcuff, whilst in position, induces pain compliance (NPCC, 2015b; 2015c).

policing response. It should also make them aware how their response shapes the life and well-being of the mentally disordered person (Morant and Edwards, 2011; Chaulk, Eastwood and Snook, 2014). Key within this however, is the police officers' awareness of what mental disorder is, how it manifests and how to perceive it. This was addressed with the introduction of the PPEAT-R and its supporting preparation session.

9.13.4 The usefulness of the PPEAT-R cognitive aid

Police officers reported that the PPEAT-R did not add to their workload, detract or impact upon operational function. Reflecting Shapiro's (2014) 'bridge', they considered its lack of directedness a positive advantage. The PPEAT-R enabled them to make decisions regarding the management of the person, as the situation dictated, and importantly, as they saw fit. Within the findings, there was consensus that a tool which explicitly directed their response, in a pre-set, prescriptive manner, would be unusable. This was because it would be unable to help them respond to the full range of situations they encounter (Hoffman et al., 2016). At best, it would be unused; at worst, it would result in inappropriate decision-making. Runciman and Merry (2005) term this the "…revenge effect…." (p.158). This is where a mechanism to support practice is introduced, and its unworkable structure results in potentially negative effects. Rather than anticipating a revenge effect, the findings revealed that police officers considered the PPEAT-R (and associated preparation) a useful adjunct in two ways. First, it enabled them to perceive features of mental disorder they would previously have ignored, or dismissed (irrespective of the situation presented). Second, it permitted sufficient latitude for them to interpret the significance of the features of mental disorder, within the current context. In doing so, they could apply their own judgement as to how to manage the situation. Amongst this, there was a shift in the way that police officers perceived and comprehended the features of a person's appearance.

9.14 Appearance

When describing a person's appearance, police officers noted an array of detailed Level 1 SA features. This however seemed part of a wider shift toward Level 2 SA, where some degree of comprehension was noted. The complexity of the situation did not seem to be a barrier to the features noted. Within vignette one, police officers noted that the female was being restrained by the male, with fingers around

her wrists. Several police officers now noted the presence of a bandage around her wrist (previously not noted). Coupled with the male restraining her, police officers considered that this changed the entire dynamic of the situation. It now appeared that the male was trying to stem bleeding, preventing further harm to the female. This was a significant departure from phase one, where he was noted to be 'psychotic.' Similarly, within vignette eight, police officers seemed more attuned to the identification of deliberate-self harm, compared to phase one. Several police officers noted the presence of wounds to both arms (incisional wounds lengthways on forearm and across wrists). The accuracy and description of these wounds were suggestive of what Dettling et al. (2003) describe as "…tentative and hesitation injuries…" (p.144). These are self-inflicted and self-limited wounds, characterised by superficial, parallel and clustered incisions, upon exposed skin. When describing the appearance of wounds, context was also provided. Police officers noted the location of the female (bathroom), evidence of self-injury, and the presence of a sharp instrument in her hand, used to inflict harm upon herself, and not others.

9.14.1 Developing a shared view

There was a close alignment within the unitary signs used to describe mental disorder. Within vignette four, where there had previously been some contradictory descriptions, the woman was consistently viewed as being withdrawn and scared. When describing a person's physical characteristics, police officers described salient features. This was particularly noted within vignette two. Here, police officers noted features of a significantly increased physical / metabolic state. Sweating, reddened complexion, tensed muscles, increased respiratory rate, coupled with aggression, contributed to an (accurate) picture that the male was suffering acute behavioural disturbance. The CoP (2017h) and the Royal College of Emergency Medicine (2016) consider the early identification of this condition essential, for both the well-being of the sufferer, and police officers attempting to control them. Whilst police officers had difficulty detecting this within the preparatory stage, and failed to note it within phase one, police officers now recognised its physical manifestation.

A person's clothing was also considered more significant, compared to phase one. Within vignette four, some police officers noted the woman wearing an oversized coat. Rather than as a means to conceal shoplifted goods (suggested in phase one), it was now thought to be an attempt to desexualize herself. This was following

recognition of the significance of information provided by the CAD. Consistent with phase one, police officers continued however to make value judgments regarding a person's clothing. Douglas and Cuskelly (2012) suggest that police officers view the mentally disordered as having a "…distinct appearance…" (p.38). This 'distinct appearance' is characterised by mentally disordered people dressing unattractively, in "…odd clothes…" (Henshaw and Thomas, 2012, p.624). This was illustrated within vignette four, where the woman was considered to be too clean, too well-manicured and too well-dressed to be a shoplifter. Despite this, within vignette five, the state of the person's clothing was now considered a significant indicator of her mental disorder. The absence of the woman's boot was considered significant by several police officers. Whilst the person was considered well-dressed, her apparent dishevelment was again considered significant. It was that the women's dress was incongruent to the situation, making it a notable feature, suggestive of mental disorder. Of note, there was little comment regarding how the men depicted within the vignettes were dressed. Within this study, the appropriateness of dress seemed confined to women.

Viewing a person's appearance through the lens of the PPEAT-R, several of the descriptions alone were sufficient to demonstrate Level 2 and 3 SA. Where Level 1 SA was demonstrated, the descriptions were very clear. Police officers now began to form a more mental health-literate picture (O'Connor, Casey and Clough, 2014). This was also noted within the descriptions aligned to behaviour.

9.15 Behaviour

As with phase one, a person's behaviour remained a key focus of attention. Using the PPEAT-R as a frame, the descriptions were more focused. The findings revealed a shift towards objectively describing what was seen, rather than offering diagnostic criteria or speculation. Within the notebooks, note-taking became more coherent, as multiple features within the concept were recorded. This provided a clearer picture of how a police officer's situation awareness had shifted. This was reaffirmed within the subsequent focus group discussions. Whereas in phase one, the woman in vignette eight was described as 'suicidal' or a 'self-harmer', her behaviour was now described in more objective terms. For example, a common theme within the descriptions was that the person was cutting her arm, and repeatedly turning away from police officers. Police officers now formed a view that

the woman was not posing a threat to others, rather, she was demonstrating behaviour which rejected assistance. A shift in situation awareness was also noted for vignette six.

Previously, the majority of police officers described the man's behaviour as repetitive, trying the car doors. His behaviour was suggestive of forcing entry into a car, and therefore criminal. Now, there was broad agreement that the man was concentrating on the door handles, oblivious to his surroundings. This was considered indicative of a potential mental disorder rather than a criminal attempt to force entry into the vehicle. In contrast to phase one, a plastic bag was now observed to be repeatedly put on and removed from his hand. Several police officers correctly described that he was wiping the car door handles in a repetitive and focused manner, rather than trying to force entry into the vehicle and remove his fingerprints / DNA. This was now considered a situation deserved of enquiry and support, rather than one of forceful control, arrest and criminalisation. This informed approach continued when the police officers noted aggressive behaviour.

9.15.1 'Course of action' assistance

Consistent with the preparatory stage and phase one, police officers rapidly pin-pointed areas of danger / threat (Renden et al., 2013). Rather than ignoring or misperceiving the features of mental disorder (with resultant forceful / punitive response), police officers now described aggression within the context of other significant features. For vignette five, aggression was noted, but as part of a list, which included throwing the baby and constant, unusual movement of the woman. Amongst their list, several police officers viewed her behaviour as a consequence of mental disorder, noting a lack of capacity, and a need for help. This was similarly noted for vignette two. Within phase one, police officers demonstrated a role-specific response, highlighting behaviours potentially posing danger. The descriptions within phase two however, supported the view that the male was preoccupied, suffering (as noted earlier) acute behavioural disturbance. Within this concept, it was further acknowledged that intervention may cause harm. From a situation awareness perspective, the PPEAT-R therefore demonstrated its value in 'course of action' assistance (Orasanu and Martin, 1998, p.104). 'Course of action' assistance is something which prompts the user to view a potentially time-critical situation from a different perspective. Doing so enables the user to consider an alternative viewpoint, "…prior to jumping to action" (Orasanu and Martin, 1998,

p.105). In this instance, 'jumping to action' being the pre-determined, forceful role-specific response, to establish a 'new normality.'

The findings revealed a further significant shift in a police officer's situation awareness, in relation to vignette seven. Within phase one, there was less observation and recognition of the woman's behaviour. Whilst anxiety was considered a cause, this was now a unanimous view. Police officers however qualified this view, with broadly consistent descriptions of her repetitive hand movements, rubbing, and rocking motions. Where police officers would have previously ignored her (intentionally or unintentionally) and moved on, she was now approached, and enquiries would be made regarding her well-being. Within the findings, the broad recognition that a person's behaviour was somehow determined by mental disorder illustrated the shift within the axionormative order from 'crime-fighting enforcer' to 'community problem solver'. This view was further supported through police officers no longer considering the presence of criminality within any of the vignettes. This shift was also noted within police officer descriptions relating to communication.

9.16 Communication

Adebowale (2013), in his review of mental health and policing, stressed the importance of police officers being able to identify and respond to the needs of mentally disordered people. Key to this was their ability to be sensitive to the manner in which such people communicated their needs (Crane et al., 2016). With the shift to Level 2 and 3 SA, there was increased sensitivity, demonstrating improved mental health literacy regarding factors relating to communication. Within the findings, descriptions of factors relating to communication, were more focused and objective. Note-taking was again more coherent and structured. Multiple features within the concept were documented, and highlighted within the subsequent focus group discussion.

Where there was little or no prior information from the CAD, the linkage between communication and the features of mental disorder were still defined. Within vignette two, whilst there was previously a range unitary of terms to describe the person's communication, police officers consistently described him as incoherent. This manner of communication, coupled with his behaviour and appearance,

reinforced the belief that he was suffering from acute behavioural disturbance. Responding to vignette three, police officers noted key information regarding the person they were looking for. Whilst they still afforded significance to the information provided by the CAD, they now perceived and described significant features of the man's communication. For example, monotone speech; limited eye contact; repeated denials of possession of medication; reluctance to speak to police officer. These descriptions provided a very clear frame for reference. For the police officers, the CAD information coupled with the manner in which the man communicated again established high index of suspicion for further self-harm.

Where there was CAD information, police officers seemed to afford more significance to it. Within vignette four, police officers seemed more attentive to the person's prior history of being a victim of a serious sexual assault. When coupled with a more structured description of the woman's communication style (e.g. non-communicative, no eye contact, defensive body position), police officers made linkages suggestive of Level 2 SA. Rather than being evasive following alleged shoplifting, several police officers considered her communication style to be indicative of a reaction associated with on-going issues from the sexual assault. Further illustrating the shift in the axionormative order, where arrest and detention was previously advocated, it was now considered detrimental to her well-being. Access to the Sapphire sexual offence team[104] for on-going support, was now widely advocated. This desire to understand became a common feature of police officer responses.

9.16.1 Empathy

The study findings revealed that police officers were more attuned to how and what was said by the people depicted within the vignettes. Within vignette five, an elevated tone of voice was previously associated with aggression towards the baby. There was now consensus that her pitch (screaming) and the words said, were themselves indicators of a very serious mental disorder. Previously the woman in vignette eight had been perceived as a threat to police officers. Within phase two, police officers now perceived threats such as, for example, "I'll slit your throat" to lack specific direction or intent. Rather than being a threat to them or others, they were viewed as being part of a hallucination. Whilst police officers seemed more

[104] Sapphire sexual offence team. This is the Metropolitan Police Service SCO2 rape and serious sexual assaults command team. Its purpose is to investigate serious sexual assault and provide on-going victim support through partner services within the Greater London area (MPS, 2012).

attuned to the relevance of verbal commination, there was a significant focus now upon the relevance of non-verbal communication.

Across the vignettes, police officers noted not only the avoidance of eye contact, but the direction of the person's focus. When coupled with behaviours demonstrating oblivion to the presence of the police officer, or others (e.g. vignettes' six and seven), this was associated with preoccupation, and therefore a significant feature of mental disorder. Within vignette four, several police officers noted that the woman's arms were pulled tight to her body, with her hands between her legs. Her non-verbal communication suggested that she was trying to make herself small, or given her history (of sexual assault), subconsciously protect herself. Inzunza (2012), suggests that when police officers become attuned to potentially subtle communication signs, they are capable of demonstrating three levels of awareness: first, "…self-other awareness…", second, "…perspective taking...", and third "…emotion regulation..." (p.66)

Within self-other awareness, one becomes aware of the emotions of others, and is able to differentiate one's own feeling from that of another. It is a state, "…allowing for reactions that are more tuned into the other's state than one's own." (Geangu et al., 2011, p.451). Within perspective-taking, note Beitel, Ferrer and Cecero (2005) and Duran, Dale and Galati (2015), one is able to understand and acknowledge another's viewpoint. Emotion regulation, however is the process of "…monitoring, evaluating, altering, and modulating [ones] emotions" within a particular social context (Greenberg, Kolasi, Hegsted, Berkowitz, and Jurist 2017, p.2). Being attuned to the emotions of another, understanding their significance, and adjusting one's emotional response to that of acceptance, one demonstrates the essential characteristics of empathy (Inzunza, 2015). Within phase two, police officers were now becoming attuned to, and understanding of, the verbal and non-verbal emotions demonstrated by the people depicted within the vignettes. They were becoming empathetic.

9.16.2 Breaking the triad

Illustrative of increased mental health literacy and empathy, police officers appeared to shelve their personal views. The people depicted within the vignettes were now viewed as deserving help, rather than some form of forceful or punitive role-specific response. With the shift in the axionormative order, increased mental health literacy

and the presence of empathy, there was now a shift away from Pinzzotto et al.'s (2012) 'deadly mix' triad.[105] Representing the first two points of the triad, the mentally disordered person (with possible impaired thought), was now encountering a police officer who demonstrated an elevated level of situation awareness; one who now acknowledged and accepted the person, irrespective of circumstances. This shift continued within the third point of the triad, characterised by the "…environmental determinants…" (Pinizzotto et al., 2012, p.286).

9.17 Environment

Reflecting the findings of the preparatory stage and phase one, the perception of danger was central to their approach. Consequently, the police officers remained vigilant for the dangers posed by the environment. However, they now took into account the effect of the environment upon the well-being of the potentially mentally disordered person. This was clearly demonstrated for vignette four. Within phase one, there were no comments regarding the environment, beyond it being described as a stockroom. Within phase two, however, police officers now considered the claustrophobic effect of the stockroom environment upon the woman's well-being. Police officers expressed concern that the woman's condition may be worsened if she felt backed into a corner due to the confined environment, combined with the close proximity of the security guard and police officer. Both of whom who were blocking the only point of egress. Similar concerns were also expressed toward the woman depicted within vignette eight.

For this vignette, police officers were still concerned that if the woman entered the toilet area, they would be unable to view her actions. They now noted an array of features which may worsen what was now considered a significant mental disorder. The noise from an active hand-dryer was thought to be something which exacerbated the woman's reaction. Towels on the floor were thought to be a slip risk (as she was not wearing shoes). The fire extinguisher propping the door open was thought a risk, if accidentally discharged by the woman. The double doors to the left of the toilet were thought to pose two specific risks. First, a risk to people entering the environment, provoking a response from the woman depicted (also worsening her condition). Second, an escape risk into an uncontrolled environment. This second point was of particular significance. Police officers noted that their

[105] The 'deadly mix' triad.' "…the dynamic interaction of the officer, the offender [person], and the circumstances that brought them together" (Pinizzotto et al., 2012, p.287).

close proximity to the woman may be provocative, worsening the situation. A withdrawal down the corridor was considered the best option, but this opened up the opportunity of escape. In relation to the third point of the 'deadly mix' triad, police officers demonstrated situation awareness as to the significance and impact of the environment. Significantly, rather than explicitly viewing the environment from the perspective of control and containment, it was now viewed from one of de-escalation, protection and understanding.

9.17.1 The co-construction of understanding

Within all six concepts, there was distinct shift in the degree of situation awareness demonstrated. Significantly, there had also been a shift within the attitude of police officers toward the mentally disordered people depicted within the vignettes. Within the focus group interviews, police officers questioned, challenged and made comments regarding the scenarios depicted within the vignettes. Through this, they appeared to engage with a process of reforming and "…co-constructing… [new] …understanding", of not only what constituted mental disorder, but how they viewed it (Arya, Christ and Chiu, 2014, p.123). This approach seemed to contribute to the value they ascribed to the PPEAT-R. Through this, two dominant themes emerged regarding the usefulness of the PPEAT-R: forming a picture, and structure and order.

9.18 Forming a picture

The theme, forming a picture was illustrative of Level 2 SA. This represented the 'cementing' together of the 'building blocks' (cues), suggestive of mental disorder (O'Brien and O'Hare, 2007). This reflected an understanding of the 'cemented' cues, in the present context, shaping the policing response (Level 3 SA) (Endsley 1988; Kim and Hoffmann, 2003; O'Brien and O'Hare, 2007; Wickens, 2008). Amongst the findings, police officers broadly reported that the PPEAT-R enabled them to comprehend the significance of features; features of mental disorder (illustrative of Level 1 SA) they would ordinarily notice, yet ignore. The PPEAT-R directed them to consider the person as a whole, intentionally focusing upon a person's appearance, their behaviour and communication, and the relationship of the person to and within the environment. It also directed them to consider the reasons why a person may pose a danger to others or themselves.

Police officers considered the PPEAT-R design to be logical, accessible and easy to follow. This was reported to be a significant factor in police officers using it to guide their assessment, and thus form a picture of the person. McDoughall, Curry and de Bruijn (2001), and Promann, Wei, Qian and Chen (2016), suggest that when developing a cognitive aid, one must be conscious of "...aesthetic properties…" (pp.311-12). This includes colour balance, icon design and visual literacy, representing the imagery and metaphors the design generates. Whilst a well-structured cognitive aid can "…reduce cognitive load…and encourage communication efficiency...", a poorly designed one can be burdensome and potentially counterproductive (Promann et al., 2016, p.311).

9.18.1 The knowledge elicitation structure

Rather than a burden, the PPEAT-R seemed to demonstrate characteristics associated with a "…knowledge elicitation structure" (McDoughall et al., 2001, p.59). This is a mechanism which seeks to converge (align and focus) the mental model of a specific group of people (McDoughall et al., 2001; Biggs et al., 2011). Its purpose is to enable them to see and do the same thing, in relation to "…a given standard…" (McDoughall et al., 2001, p.60). Specifically, this is through the process which Bower and Morrow (1990) term "…memory access to focussed concepts…" (p.45). This is the process by which specific patterns within the embedded mental models, frameworks and cognitive maps within the schema, are accessed when a concept (in this case, something which acts as a referent) directs one's attention toward them. Reflecting the work of Capelo and Dias (2009), a 'knowledge elicitation structure', in the form of a cognitive aid, is capable of improving the response of both the individual and group to "…dynamically complex…" situations (p.630). By interacting with the PPEAT-R design, police officers interacted with the concepts. In turn, this created a mental model which improved their ability to perceive and comprehend the features of mental disorder, thus 'forming a picture.' Key to this, was the PPEAT-R's ability to provide 'structure and order', particularly during note-taking.

9.19 Structure and order

Makany, Kemp and Dror (2009), state that note-taking is an effective mechanism to regulate and prioritise the flow of information within one's short-term memory. By regulating this flow, one is better able to access specific patterns within the

embedded mental models, frameworks and cognitive maps within the schema. Note-taking is improved by the use of a framework (mnemonic[106]) to structure and order one's focus, directing it in a particular (cognitive) direction (Vanneman, 2017). Police officers reported that the PPEAT-R enabled them to record specific information about areas of potential mental disorder, following a defined ABCDE structure. Police officers reported that the 'simple' and unambiguous structure of the PPEAT-R lent itself to ease, and importantly, willingness of use.

9.19.1 The PPEAT-R cognitive aid as an internal and external memory aid

As a mnemonic, ABCDE (and its aligned concepts) was reported to be easy to recall, even when the card may not be readily available. Reflecting the work of Harris (1980), the PPEAT-R demonstrated value as both an internal and external memory (cognitive) aid. As an internal aid, the ABCDE structure provided short, easily "…learned schemes for remembering specific types of information" (Harris, 1980, p.31). As an external aid, the ABCDE structure was a mechanism capable of "…external manipulation of the environment", directing police officers' attention to key areas of focus (Harris, 1980, p.31). Its structure therefore enabled use, both with or without the card; something of vital importance within time-critical situations where it would be difficult to review the PPEAT-R card (Paskett, 2013). Police officers also considered it to be a tool which would lend itself to a uniform (standardised), rather than individual approach to note-taking. In doing so, police officers felt that as a group, they were better prepared to identify and record the features of mental disorder, both individually, and as a group. This appeared illustrative of not only improved individual situation awareness, but also the development of group (Team) situation awareness (Demir, McNeese and Cooke, 2017).

9.19.2 Team situation awareness

Endsley (1995) defines team situation awareness as "…the degree to which every team member possesses the SA required for his or her responsibilities" (p.39). Within the context of this study, it is the degree to which every police officer possesses the situation awareness required to identify and respond to a mentally disordered person. By achieving this state, the PPEAT-R exposed a further important axionormative order; one capable of producing similar patterns of

[106] Mnemonic: drawn from the Mnemosyne, the Greek goddess of memory (Bourne, Dominowski, Loftus and Healy, 1986). Noted by Laing (2010, p.349), mnemonic "…means to aid memory."

behaviour amongst differing members (police officers) when encountering a potentially mentally disordered person (Sztompka, 1986). This shared approach and response was considered of importance when information sharing amongst other police officers and / or across differing groups, such as healthcare staff.

9.20 Phase two: summary

Within this stage of the study, there was a shift from predominantly Level 1 SA in phase one, to Level 2 and 3 SA. This only represented one aspect of the changes that occurred following the introduction of the PPEAT-R. Noted within the findings, there was an increased mental health literacy. There was a more positive and understanding attitude towards the mentally disordered people depicted within the vignettes. There was also a greater understanding and a recognition of the effects of mental disorder upon a person. This resulted in the avoidance of unnecessary force and criminalisation. Within the findings, there was a noticeable shift from the police officer as 'crime-fighting enforcer', to that of 'community problem solver'. As a consequence of this shift, police officers demonstrated a more informed and empathetic response to a person with a potential mental disorder.

9.21 Phase three

Following use of the PPEAT-R in operational practice, a number of significant findings emerged. The theme operational usefulness, encapsulated the police officers' views regarding the everyday usability and utility of the PPEAT-R. Reflecting the findings of phase two, the PPEAT-R provided a very useful platform for police officers to base their identification and management of a mentally disordered person. To this extent, all police officers within this phase of the study had adopted it into their usual practice. Whilst the design of this study did not specifically explore the level of situation awareness police officers achieved using the PPEAT-R, their qualitative comments demonstrated their achievement of Levels 2 and 3 SA. They reported that they were now confident in perceiving and comprehending a range of features illustrative of possible mental disorder. This finding revealed that these were features they had been unable to comprehend prior to the use of the PPEAT-R. Consistent with the findings of phase two, the PPEAT-R continued to provide a very useful frame to shape note-taking.

9.21.1 Shifting focus

Police officers reported that the PPEAT-R was used during day-to-day operational encounters. They expressed very positive views regarding its usefulness. Chrimes (2016), notes the value of a cognitive aid rests with its "…technical content and how that content is presented" (p.21). The police officers considered the concept structure clear, relevant and beneficial to the point where it had caused a significant shift in their operational practice. Due to the frequency in which the police officers encountered people they presumed mentally disordered, they used the PPEAT-R in some form during every encounter. Furthermore, prior to the introduction of the PPEAT-R, police officers reported that they would assess a person on the basis of the incident / crime reported or encountered. When doing so, they would only note features of mental disorder if they were immediately recognisable to them. They would focus upon features relevant to a potential crime or wrongdoing. This approach had now altered.

9.21.2 Delving beneath the obvious

From a trauma management perspective, the American College of Surgeons (1997) advises that when one is faced with an 'obvious' physical injury, it should not detract attention from the 'occult', that is, injuries that are not immediately obvious, but are potentially more significant or life-threatening. To ensure such 'occult' injuries are identified, the American College of Surgeons (1997) advocates that one undertakes a structured assessment. This assessment should prompt the assessor to look for features which outwardly appear innocuous or insignificant, but when viewed within a particular context (pattern of injury), highlight something of great significance. The police officers reported the PPEAT-R prompted them to delve beneath the 'obvious' (incident / crime). Doing so, they were often able to identify and respond to an 'occult', potentially significant mental disorder. It was reported that in several cases, it was one they would not have identified had they not used the PPEAT-R.

The PPEAT-R, as a mechanism to capture the features associated with mental disorder, was therefore regarded as a very useful and effective adjunct. Critically, its operational use was not static. To gather information necessary to identify features of mental disorder, the police officers used different combinations of the concepts at different stages of an interaction. A five-stage pattern of concept use was identified, followed by the recording of findings (Figure 26).

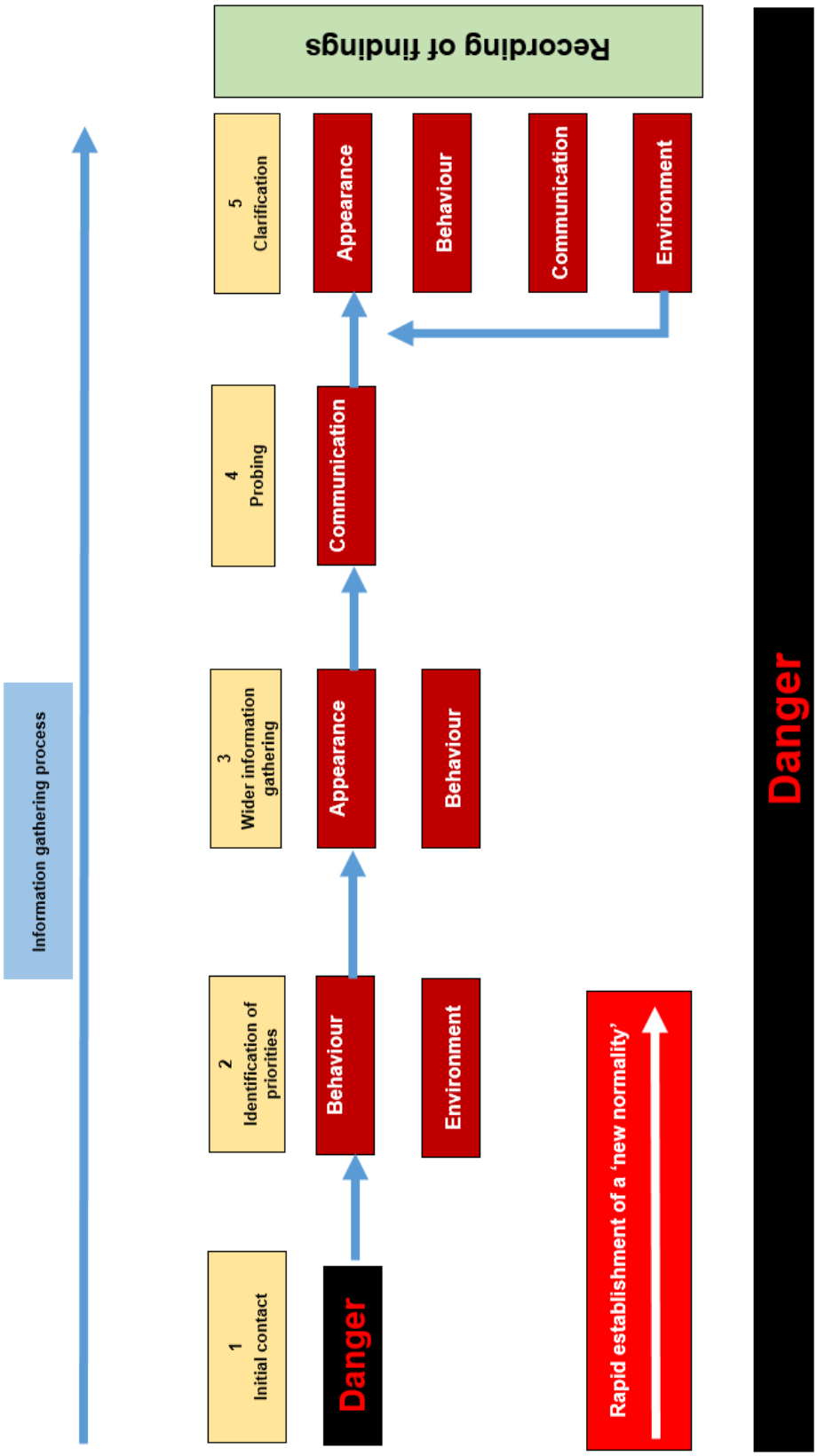


Figure 26: PPEAT-R Concept Use.

At *initial contact* the information gathering process commenced.[107] The perception of danger underpinned the police officers' initial approach whilst they sought to establish a 'new normality.' The perception of danger remained central to the information gathering process and throughout all contact with the person. At *initial contact,* the police officer had not always gathered sufficient information to support a view that a person was mentally disordered. Underpinned by the perception of danger, they then sought to gather information relating to a person's behaviour and the immediate environment. Whilst doing this, the police officer sought the *identification of priorities.* Specifically, this was any immediate danger posed by the person to themselves or others. Whilst actively looking for features of potential mental disorder (aligned to the concepts), they were vigilant for the movement of a person's body, noting attempts to draw a weapon which could be used against others, or the person themselves. The movement of the body, arm, legs and head was noted, so as to identify the focus of threats, or features suggestive of mental disorder (e.g., drawing arm back, directing a fist toward a person, or a non-specific target). The police officers were also sensitive to potential dangers posed to the person (or others) by features within the environment and now, the effect of the environment upon the person.

The findings revealed that a common reported risk to a potentially mentally disordered person was from other people within the immediate situation. Be it through misinterpretation, misunderstanding, stigma, or as a direct result of an action, police officers reported that the public were often antagonistic or aggressive toward a mentally disordered person (Stier and Hinshaw, 2007; Pescosolido et al., 2013; Coman and Sas, 2016). In such circumstances, 'establishing a new normality' could include the prevention of wider public order violations (e.g. assault) toward a potentially mentally disordered person (Pizio, 2014). There was now greater emphasis upon removing any threat posed to the (potentially mentally disordered) person, or removing them from the threat. The police officers attempted to establish a 'new normality' as soon as possible. Establishing a 'new normality' therefore included establishing an environment that was as calm as possible, as soon as possible, for the potentially mentally disordered person (Figure 26). From here, they could undertake a more detailed assessment to determine if there were any 'occult' features.

[107] Reflecting the findings of Scantlebury et al. (2017), even where dispatch information was provided by the CAD, police officers were often sceptical about its accuracy. As such, they began their own information gathering process.

9.21.3 Taking a wider view

Within this stage, police officer assessments and actions were often driven by 'gut-instinct.' There was however a recognition that this was a uniquely individual trait. Whilst potentially useful, it was also potentially disadvantageous, distorting the true situational picture (Cioffi, 1997; Nyatanga and de Vocht, 2008; Pearson, 2013). The PPEAT-R was therefore considered useful in preventing a view which was sufficiently distorted to result in an inappropriate outcome for the person. It achieved this by prompting the police officer to pause, and undertake a structured view of the person within multiple domains. This provided an opportunity for police officers to pattern recognise, accessing patterns within the embedded mental models, frameworks and cognitive maps within the schema (Bower and Morrow, 1990).

Having established the 'new normality', police officers focussed upon a person's appearance and again, their behaviour. This represented the *wider information gathering* stage. Consistent with previous findings, when exploring a person's appearance, the police officers noted the manner in which a person was dressed as being indicative of underlying mental disorder. So too was their degree of personal hygiene. The police officers were vigilant for the presence of wounds / injuries, suggestive of some form of deliberate-self harm, or injuries requiring immediate attention. Not previously identified within the study, the presence of an untreated injury or obvious illness was also deemed a significant feature. Echoing the observations of Zlotnick, Zerger and Wolfe (2013), and Nikoo et al. (2015), this was based on prior experience, particularly with the homeless community.

When noting a person's behaviour, the features reported were again consistent with earlier findings. Operationally however, there appeared to be a sustained change in relation to the manner in which police officers responded to belligerent, aggressive individuals. Whilst still prepared to undertake some form of role-specific response to address it, police officers now sought out features of mental disorder. In doing so, they sought to identify an underlying cause for their behaviour; one which may be deserved of a healthcare response, rather than a punitive one.

9.21.4 Probing and clarifying

Police officers next focussed upon a person's communication. This involved *probing* for more information. The police officers would ask specific questions (relevant to the encounter) to help them make sense of it. They would also seek a PNC check to identify if there were any 'tags' (NPIA, 2012). The findings revealed that whilst doing this, they were vigilant for both verbal and non-verbal cues suggestive of potential mental disorder. Where appropriate, they would also seek information from people within the immediate environment to support or refute a view that a person had a significant mental disorder.[108] Where police officers were unable to identify the features of mental disorder on the basis of the concepts selected, a *clarification* assessment was undertaken. *Clarification* was a failsafe assessment, undertaken to ensure that the police officer had not missed anything during their initial review of the person. The police officers also undertook this claificatory assessment if the person's condition altered.

9.21.5 Methods of using the PPEAT-R cognitive aid

The findings revealed that the information gathering process was not completed within a specific time frame, due to the unpredictability of each situation. Reflecting the work of Flin et al. (2007), the identification of priorities and the establishment of a new normality usually took less than three minutes. *Wider information gathering, probing* and *clarification* however, took longer. Assessments were reported to range from a few seconds where 'obvious' features were present, to several minutes where they were more 'occult.' It was identified within the findings that during stages one to five of the information gathering process (Appendix 26), the police officers used the PPEAT-R as a mnemonic (internal aid) (Harris, 1980). Marshall (2013), suggests a cognitive aid should be able to both guide and support users in periods of operational stress; periods when one's own "…cognitive resources are limited" (p.1162). Whist trying to establish a new normality and gather information, it was inappropriate for the police officers to stop and refer to their PPEAT-R (external aid) card. The police officers did however use the PPEAT-R card to broadly structure their pocket book notes in the following manner (Figure 27). Using a structured approach, they were often able to reflect upon the features observed (within each concept). The findings revealed that by doing so, the police

[108] The presence of a potential mental disorder may, in itself, be irrelevant, but police officers should be aware of the "contexts" in which a person's mental disorder must be taken into consideration.

officers were often able to identify ‘occult’ signs of mental disorder; features they would ordinarily have not perceived as significant.

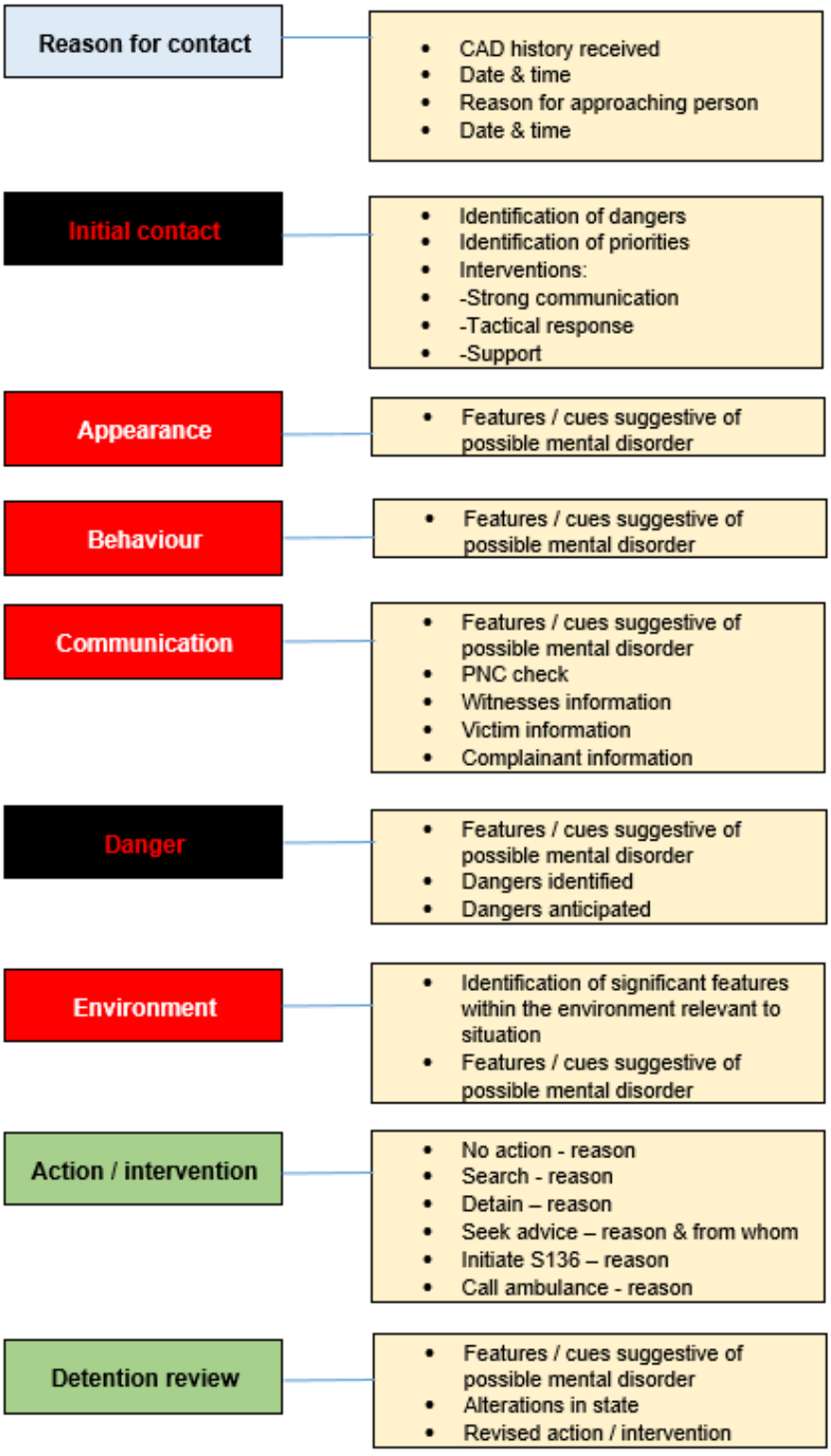


Figure 27: Structure of Pocket Book Notes.

9.21.6 From criminalisation to care

Using the PPEAT-R, the police officers felt better equipped to identify people considered sufficiently mentally unwell to require hospital attention. Having used the PPEAT-R where mental disorder was suspected, two people were detained via S136 (MHA, 1983, amended 2007) powers. Prior to its introduction, it was felt that these people would have been detained and arrested. Only through the use of the tool were police officers able to identify significant 'occult' features of mental disorder. Similarly, one police officer encountered a very violent male who failed to respond to pacification. Prior to the introduction of the PPEAT-R, this person would have been controlled forcefully. Using the PPEAT-R initially as a mnemonic enabled the police officer to correctly identify features of acute behavioural disturbance. Rather than being forcefully detained and arrested (the previous expected role-specific response), the person was taken to hospital. Seeing beyond the 'obvious' to the 'occult', there was care, rather than "…criminalisation of the mentally disordered…" (Abramson, 1972, p.16).

9.21.7 From care to criminalisation

Despite improved mental health literacy, police officers were nonetheless prepared to arrest people if they felt there was justification. The PPEAT-R was however still used. Instead of arresting someone as part of a pre-determined, role-specific response, some police officers undertook a further clarification review. Whilst the PPEAT-R was intended as a structured mechanism to prompt recall and recognition of the features of mental disorder, it was now used as a structured mechanism to exclude them. Where police officers (using this approach) were unable to detect 'obvious' or 'occult' features within any of the domains, they felt better able to justify their decision to arrest the person as they felt they had excluded contributory factors. A further shift in the axionormative order was again noted. Rather than defaulting to role-specific responses, police officers were now using the PPEAT-R to make considered decisions regarding the most appropriate, rather than the most expedient, gateway (criminal or healthcare) the mentally disordered person should be passed through (Teplin, 2000).

9.21.8 The opportunist

The findings revealed that the PPEAT-R structure made police officers generally more sensitive to the features of mental disorder. Using the PPEAT-R as a

mnemonic, the police officers reported that they were more prepared to undertake welfare checks on people they observed whilst they were on patrol. Whilst they would have previously walked or driven past someone without any concern, they now undertook opportunistic welfare checks. When doing so, it was because they felt (in relation to one or more of the concepts) that the person was demonstrating some form of mental disorder. The police officers reported that on several occasions, the person was demonstrating features of concern, requiring (in their view) some form of healthcare intervention. In some cases, they informally managed the situation by advising the person to seek help. They documented this (whereas before they would not). For some cases, this information was entered within the Merlin system.[109] Where they actively intervened, they called members of the person's family, or their general practitioner to arrange help (during working hours), and occasionally the mental health crisis team, or an ambulance.

Informal management of the person was not always the end of their contact. Mentally disordered people were encountered demonstrating features not sufficiently severe (in their opinion) to warrant either access to healthcare, or no action. Using the cognitive aid, police officers generated a sufficiently high index of suspicion for the person's well-being, to make a safeguarding referral to mental health services. An entry was also made within the PNC to assist police officers during future encounters. The police officer was therefore a better equipped first point of contact for a person with a significant, and often as yet undiagnosed mental disorder (Short et al., 2014; House of Commons Home Affairs Committee, 2015). Through this, they were better equipped within their gatekeeping role.

9.21.9 The consistent gatekeeper

Seeking to counter this view, the House of Commons Home Affairs Committee (2015) state "…it is not the job of the police to be that first point of contact; they should be the last resort" (p.8). Ogloff et al. (2011), and Forrester, Samale, Slade, Craig and Valmaggia (2017) however, note that of the people referred to mental health services from police custody, between 32% - 45% have no pre-existing diagnosis of mental disorder. Such figures do not however account for those informally managed, or those referred directly to mental health services by the police officer in the field (Reuland, 2010; Watson and Fulambarker, 2012).

[109] Merlin is the name of the Metropolitan Police Service vulnerable person alerting system. Where a person is considered to be vulnerable, or there is a safeguarding issue by means of their mental health or social circumstances, relevant health and social services can be notified.

However, despite the opinion that the police should be the last resort, they demonstrate a valuable, if not always welcomed, role in highlighting and referring people with significant mental disorder to health services. Indeed, the Department of Health and Concordat Signatories (2014) view the police officer as an equal partner within the social care framework. This is supported by the (CoP, 2015d) view of their role as one which actively works to safeguard the public, within the social care framework.

To this end, the findings revealed that the PPEAT-R strengthened and supported police officers within this operational role. Demonstrating a further shift in the axionormative order, police officers used the PPEAT-R to not only proactively safeguard the public, but also address wrongdoing (by excluding mental disorder). Echoing the work of Shapiro et al. (2014), the PPEAT-R bridged the societal requirement for the police officer to act as a 'crime-fighting enforcer', but also with the requirement for a 'community problem solver'. Bridging this gap, they appeared more consistent gatekeepers. However, despite the optimistic outlook of the Department of Health and Concordat Signatories (2014), and the CoP (2015d), the police officers reiterated a fundamental problem with care services. This was poor interagency communication.

9.21.10 The healthcare interface

Echoing the work of Hollander et al. (2012), the police officers expressed dismay that there was no standardised framework to help them share professional concerns with members of health and social care staff. Noted within the findings of the preparatory stage, police officers often had a somewhat adversarial relationship with such staff. This reported relationship was compounded by healthcare staff challenging them over the clinical accuracy of their suspicion of mental disorder (Gillig, Dumaine, Widish Stammer, Hillard and Grubb, 1990). Whilst the findings revealed that the police officers were overtly negative regarding the current relationship with healthcare staff, some positive experiences had occurred when using the PPEAT-R. When explaining a mentally disordered person's condition to paramedics and hospital staff (following enactment of S136 MHA 1983, amended 2007), the police officers were complimented on the structure, focus, and detail of their narrative. Whilst unsure of the explicit relevance of the information they had observed and noted, police officers considered it to be of use to the on-going care of

the person they had encountered. However, it did not dovetail into mechanisms used by ambulance staff, emergency departments, mental health crisis teams, or the criminal justice team (following detention and entry into the criminal justice system). The findings revealed that police officers felt this was an area for future development to improve the quality of the mentally disordered person's transition through healthcare services.

9.22 Study's end: a time to reflect

As this study approaches its concluding chapter, it is appropriate to reflect upon my explicit learning from conducting this research and the research process employed. At this study's inception, my bold, perhaps naïve aim was to investigate the methods, rules, actions and behaviours shaping the situation awareness police officers used to identify and respond to a potentially mentally disordered person. Not content with this, I then sought to redevelop a cognitive aid to support police officers during such encounters (the PPEAT). Finally, I sought to investigate the extent to which a police officer's identification and response to a potentially mentally disordered person, was shaped by the re-developed cognitive aid. Seeking to investigate these three areas, I laid the foundations for what was to become a very complex methodology.

The methodology is the blueprint for the research process. It provides the "…rules, principles and formal conditions which ground and guide…" the study (Gelo, Braakmann and Benetka, 2008, p.270). Furthermore, it provides the framework, connecting its philosophical and methodological assumptions (Gelo et al., 2008; Crotty, 2012). The nature of this union determines the degree to which "…credible, accountable and legitimate answers to the research question" are ultimately obtained (Gelo et al., 2008, p.272). From the outset, I sought 'answers' to the question of how police officers identified and responded to potentially mentally disordered people. I wanted to find out what they did and if I could help them with this aspect of their role. This quest for knowledge underpinned the ontology of the study. I thought that the most appropriate way to do this was through an exploration of their collective "…frameworks of meaning…" using a qualitative research method (White, 2004, p.9). Gerrish (2011) suggests that once the study focus is decided, the researcher begins a journey of methodological challenges and tensions, when seeking to obtain answers (findings) that are credible, accountable, and legitimate.

However, it is better described as the point where I entered the "…messy qualitative research milieu…" (Mifsud, 2016, p. 864).

Philosophically, I (epistemologically) positioned this study within the constructivist paradigm, supported by a relativist ontology. Chamberlain, Cain, Sheridan and Dupuis (2011) consider the study's ontological view to be of the utmost importance as its "…assumptions…underpin the entire research project…" (p.152). With a relativist ontology, I sought credible, accountable, and legitimate answers/ findings, based upon an assumption that individuals perceive, and therefore construct reality, based upon their experience of the world (Ravenek and Rudman, 2013: Nicholas and Hathcoat, 2014). Through the epistemological lens of social constructionism, and the theoretical lens of symbolic interactionism, I sought to explore how police officers constructed their reality. This was through their perception and interpretation of the social symbols, suggestive of potential mental disorder. However, by seeking to view this socially constructed world through the Endsley's (1988) three-level categorisation of situation awareness, I encountered a significant ontological tension as a consequence of my methodological approach.

From a methodological perspective, Endsley's (1988) three-level categorisation of situation awareness was the only coherent framework I found suitable to frame the descriptions (from the emerging data) of how police officers' perceived, comprehended and responded to the features of a potential mental disorder. However, by utilising Endsley's (1988) categorisation within stage one of the study, I deviated from an exclusively inductive approach as Endsley's categorisation is deductive. Consequently, an ontological tension occurred due to the shift from relativist to realist position. This was a move from a philosophical (relativist) assumption that people construct their realties (and as such, realities are multiple and context-bound), to the assumption that "…reality exists independently of our perceptions, theories, and construction" (Maxwell and Mittapalli, 2010, p.145). Whilst I had used methodological approaches which accepted the contribution of the researcher (narrative synthesis and semi-structured interviews), by viewing emerging themes through the lens of Endsley's (1988) three-level categorisation of situation awareness, I now used an approach which sought to limit or isolate it (Ravenek and Rudman, 2013). The potential danger of such ontological deviation, note Clarke et al. (2015), was that "…opposing approaches may have rendered the

findings incommensurable and incoherent" (p.183), hence the narrative needed to be robust and to maintain the cohesiveness of the mixed approach taken

Using a mix of inductive and deductive approaches, I constructed the PPEAT-R cognitive aid. I also constructed the concept framework (Appendix 43), and the concept and observable indicator framework (Appendix 33 and 34). These frameworks established a clear and distinct frame of reference, from which to explore the usefulness of the cognitive aid during stage two of the study. During stage two, I used a pre-post-test design to test the usefulness of the cognitive aid (prior to and following its introduction). Note-taking activities and focus group discussions generated data, which were explored inductively. Using the findings of this inductive approach, the concept frameworks were the benchmarks to gauge (deductively) a police officer's situation awareness. Through this methodological approach, I now firmly established an ontological tension, influencing data collection and analysis during the rest of this study. I was aware that such ontological tension might bring into question the legitimacy, integrity, competence, utility, and therefore quality, of this research process (Sandelowski, 1986; Morse, Barrett, Mayan, Olson and Spiers, 2002; Seale, 2002; Tobin and Begley, 2004; Saumure and Given, 2008; Ryan-Nicholls and Will, 2009; Thomas and Magilvy, 2011). However, such tensions can be reconciled to enable new insights, through the careful and judicious "…juxtaposition of divergent ideas and ways of seeing" (Kincheloe, 2005, p.344).

Within this study, I juxtaposed the inductive and deductive approach by adopting a position of "…analytical pluralism…" (Clark et al., 2015, p.183). Doing so, I intentionally engaged "…with multiple ontological [and epistemological positions…" to enable a "...coherent theoretical understanding and explanation…" of the processes shaping the situation awareness police officers used to identify and respond to a potentially mentally disordered person, and the subsequent usefulness of a cognitive aid. Doing so, I was able to retain the study's philosophical orientation of constructivism and relativism, despite an apparent shift toward the positivist / post-positivist paradigms. I did this by reflecting the work of Bradley et al. (2006), and incorporating the use of taxonomies within the study's methodology.

Within this the 'messy qualitative research milieu', Bradley et al. (2006), note that there is no single unified way of data analysis; there is only the "…appropriate matching of the research question to the methods used…" (Ravenek and Rudman,

2013, p.12). For this study, taxonomies provided "…a formal system [method] for classifying multifaceted, complex phenomena according to a set of conceptual domains" (Bradley, et al., 2006, p.1760). Endsley's (1988) categorisation, the concept framework, and the concept and observable indicator framework became the taxonomies from which to classify the features shaping a police officer's situation awareness, when encountering a potentially mentally disordered person. These taxonomies provided the backdrop to the subsequent exploration of the usefulness of the cognitive aid, prior to and, following its introduction (pre-post-test). Whilst the classification of this data (phenomena) followed a deductive approach, my initial exploration of the study data was inductive. When aligning this (inductively obtained) data to particular taxonomies, I was able to offer a more detailed, "…sophisticated approach to specifying the complexity [of police officer responses], rather than simple dichotomous characterisations…" associated with deductive approaches (Bradley, et al., 2006, p.1765). Rather than detract from the credibility, accountability and legitimacy of the findings, this approach allowed me to construct "…rich, multi-layered, multiperspective readings of… [the] …qualitative data set…" (Coyle, 2010, p.81).

When reflecting upon study, it has demonstrated the complex issues which can be encountered when entering the "…messy qualitative research milieu…" (Mifsud, 2016, p. 864). Throughout this study, I have endeavoured to maintain a close, reflexive relationship with the philosophical and methodological assumptions underpinning it. In doing so, I have been able to justify my decision to adopt a stance of academic pluralism. Perhaps my greatest learning was that I am now acutely aware of the fine line that exists between a study's coherence and incoherence, if the researcher uses methods which cause ontological tensions. Taken literally, a tension implies an unease within a relationship. Within the context of this study, it was the tension that existed between the underpinning philosophical and methodological approaches. It was therefore essential that I structured and managed the study to prevent such tension being translated into something more destructive. In this case, findings which could have been "…incommensurable and incoherent" (Clarke et al., 2015, p183).

9.23 Phase three: summary

Within this final stage of the study, the findings revealed that the PPEAT-R (as either an external or internal aid) was a very useful adjunct to the police officers' operational practice. Used as either an internal or external aid, the PPEAT-R enabled police officers to view the person as a whole (within the boundaries of the concepts ABCDE). It also enabled them to comprehend the features of mental disorder; features they previously would have failed to recognise. Whilst still prepared to undertake some form of role-specific response, police officers now sought out features of mental disorder. In doing so, they sought to identify an underlying cause for their behaviour; one which may be deserved of a healthcare response, rather than a punitive one. Of significance, police officers used different combinations of the concepts, at different stages, to gather information necessary to identify features of mental disorder. Within the following chapter, I conclude this study. I present the unique contribution this study has made to the existing body of knowledge, and the new insights that it provides.

CHAPTER 10

CONCLUDING THE STUDY

10 Introduction

Within this chapter, I conclude the study. This chapter is presented in six sections. I first present the unique contribution this study has made to the existing body of knowledge, and the new insights it provides. Next, I discuss the strengths and limitations of this study. I then offer my recommendations for practice, and further study and dissemination of the study findings. Finally, I offer my concluding remarks.

10.1 Contribution to the existing body of knowledge

This was the first study to examine the specific processes (the methods, rules, actions and behaviours) shaping the situation awareness which police officers used to identify and manage a potentially mentally disordered person. From this, a cognitive aid was re-developed to support police officers during such encounters. This study has therefore made a unique contribution to the existing body of knowledge relating to police officers and their professional response within this area.

I provided a new insight into this area, through the development of a new analytical approach. I adopted the theoretical perspective of symbolic interactionism, and its relationship to Endsley's (1988) three-level categorisation of situation awareness. This was in conjunction with an ethnomethodology design. Using this approach, I exposed the specific, often subtle Level 1 SA cues (the cognitive "…building blocks..." of comprehension) which police officers considered suggestive of mental disorder (O'Brien and O'Hare, 2007, p.1065). Through the use of Endsley's (1988) three-level categorisation of situation awareness, this study highlighted how police officers bond these cues together to comprehend and respond to mentally disordered people. This approach revealed that police officers perceived *some* of the Level 1 SA cues suggestive of mental disorder, *some* of the time. I exposed the manner in which these cues were 'cemented' together to enable the police officer to

comprehend the presence of mental disorder (O'Brien and O'Hare, 2007, p.1065). This enabled me to determine what constituted Level 2 SA. I also exposed the manner in which these cues were cemented together and the corresponding response by the police officer. This enabled me to determine what constituted Level 3 SA. Through this, I was able to make a paradigm shift. This shift was from a paradigm defined by an assumption of criminality, to one defined by the interpersonal; one in which police officers recognised and responded to a person's mental health and well-being.

Despite the apparent similarity with the domains shaping the Public Psychiatric Emergency Assessment Tool (PPEAT) (Wright et al., 2008), this study established a newly constructed view of the specific methods, rules, actions and behaviours used by police officers. Doing so, I re-established the domains (appearance; behaviour; communication; danger; environment) as newly constructed concepts, capturing in detail the broad areas of focus police officers consider when they encounter a potentially mentally disordered person. A significant and unique finding was that a police officer's ability to perceive, comprehend and respond to such people was not only determined by the presenting situation. It was determined to a large extent by the concept pre-encounter.

The concept pre-encounter governed a police officer's contextually determined processes (common rubric). Its effect underpinned and shaped a police officer's situation awareness within the five other concepts. This was a key finding within this study. Pre-encounter factors represented the knowledge, skills, experiences and attitudes (personal and professional) formed *prior* to an encounter with a mentally disordered person, yet which had a significant impact *at the time* of an encounter. One dominant theme, the role-specific response, linked the concept pre-encounter to the concept danger; a concept which in its own right also exerted significant influence upon a police officer's methods, rules, actions and behaviours. The theme role-specific response (and its aligned subthemes), was illustrative of police officers defaulting to a pre-planned role in which they sought to control and contain a situation. In light of this finding, the concept danger was placed centrally within the PPEAT-R, illustrating its significance.

Having determined the concepts, I provided further new insights, through the development of the concept framework (Appendix 43). This provided the

associated definitional propositions (theoretical and operational definitions), themes, and observable indicators[110], necessary for the development of the PPEAT-R, its preparation programme, and the mechanisms to gauge its usefulness.

Further new insights were generated following the introduction and training in the PPEAT-R. The PPEAT-R achieved several shifts in the existing common rubrics and axionormative orders governing a police officer's identification and response to potentially mentally disordered people. First, there was an increased mental health literacy. The PPEAT-R (as either an external or internal aid) was a very useful adjunct to the police officers' operational practice, achieving not only individual, but team situation awareness. Police officers used different combinations of the concepts, at different stages of their interaction, to gather information necessary to identify features of mental disorder. This enabled police officers to view the person as a whole (within the boundaries of the concepts ABCDE). It also enabled them to comprehend the features of mental disorder; features they previously would have failed to recognise.

Significantly, I was able to make a paradigm shift from the police officer as 'crime-fighting enforcer', to that of 'community problem solver'. This shift was from a paradigm defined by an assumption of criminality, to one defined by the interpersonal; one in which police officers recognised and responded to a person's mental health and well-being. In doing so, the police officer also shifted from an inconsistent gatekeeper of the healthcare, criminal and informal pathways, to a consistent one; one capable of a more informed, understanding and empathetic response to a person with a potential mental disorder.

10.2 Strengths of the study

This was a very complex study. The strength of this study was its unique design. A further strength was the use of the literature review as part of the methodological apparatus. The literature review in the form of the narrative synthesis enabled me to undertake a systematic review of multiple studies, and gain a newly constructed view based upon the available literature. By incorporating it into the methodological

[110]
- The concept framework represents an organised ordered and organised frame of reference.
- Theoretical definitions provide clear description and frame of reference for each concept,
- Operational definitions defined how each concept would be measured during subsequent (phase two) data analysis.
- Observable indicators represented the more refined, specific behaviours, characteristics and features emerging from the data.

apparatus, I was able to analyse and use the data to support the development of the PPEAT-R. In conjunction with this, individual semi-structured interviews provided a more detailed and contextually grounded understanding, and a constructed description of specific processes police officers reportedly used to identify and respond to a potentially mentally disordered person. When combining this data, using a concept mapping approach, I was better able to highlight conceptual and semantic relationships, connections, interconnections and juxtapositions. This established a newly constructed view of the specific processes police officers use to identify and manage a mentally disordered person, culminating in an 'output.' This was in the form of the concept framework. Representing a further strength, the concept framework provided the basis for the PPEAT-R, its preparation programme, and the concept and observable indicator framework (used to support detailed data analysis and concept mapping in phase two).

A key strength of this study was that I was able to identify the specific features police officers associate with mental disorder. I was also able to identify the factors which shaped their perception and comprehension (pre-encounter factors). Using the study findings, I was able to address the pre-encounter factors during the PPEAT-R preparation session. The findings revealed that there was increased mental health literacy as a consequence of this. Within stage two, a strength was that I could initially explore the usefulness of the PPEAT-R within a controlled classroom environment. This enabled me to identify any potential problems which may have rendered its operational use inappropriate in phase three.

10.3 Limitations of the study

There were several acknowledged limitations within this study (Polit and Beck, 2012). Within the narrative synthesis, there was no literature relating to the management of mentally disordered people by British police officers; the underpinning studies were drawn from Scotland, Canada, Australia, and the USA. Whilst the approaches to policing within such publicly mandated, civilian police services share several similarities, the respective guiding legislature, legal frameworks and operational protocols can be difficult to translate to wider territories. Within the selected nine studies, there was variability in their explicit area of focus, their design, method, recruitment, sampling, data analysis, clarity, and generalisability. As such, it was left to me to analyse the studies and draw some

meaning in relation to the aim of this work. The potential for bias, misinterpretation and error within this process is therefore recognised. The potential for this also existed during the various stages of data analysis and reconstruction within the rest of the study.

Within stage one, the final sample for the individual semi-structured interviews was eight, rather than the intended sixteen. This represented 0.54% of the serving police officers within Durham Constabulary at the time of the study. Within stage two, the final sample for the focus group interviews was seventeen rather than the intended twenty. This represented 0.052% of the serving police officers within the Metropolitan Police Service at the time of the study. Of this seventeen, ten police officers undertook the follow-up individual semi-structured interviews. This represented 58% of the available sample. Such a narrow sample can result in "…erroneous conclusions" (Polit and Beck, 2012, p.275). This is further compounded by the potential for sampling bias in the form of overrepresentation within the sample of participants with an interest in the management of persons suffering a potential mental disorder.

Whilst undertaking phases one and two of this study, the police officers viewed the same video vignettes prior to and following the introduction of the PPEAT-R. Whilst the police officers did not share their notebook notes, they all participated in the focus group discussion regarding the scenarios depicted within each vignette. This introduces the potential for what Maruyama and Deno (2011, p.103), and Polit and Beck (2012, p.210), term "…contamination of treatments...." This is the effect of distorting results through the "…co-mingling…" of participants who share information. Similarly, by re-viewing the video vignettes, this introduces the potential for '"expectation bias" (Polit and Beck, 2012, p.212). This is an expectation of something, potentially skewing the findings. Having previously viewed the video vignettes in phase one, the potential existed for police officers to expect the particular features of mental disorder when viewing the vignettes for a second time. This was as a consequence of the phase one focus group discussion.

Within phase two, police officers underwent a ninety-minute introduction to the use of the PPEAT-R. The closeness of this introductory session to the testing of the usefulness of the PPEAT-R could have potentially introduced 'measurement bias' (Peat, 2011, p.72). This is the 'misclassification of study data', again potentially

skewing data. Reflecting the advice of Peat (2011), this is minimised by using "…standardised methods…" This was achieved by using the Concept and Observable Indicator Framework.

Arensmann et al. (2016), and Scantlebury et al. (2017), note that the value of mental health training to police officers is only demonstrated if it is sustainable. To determine the degree of misclassification (and therefore sustainability), a further viewing of the video vignettes at a later date may have provided a clearer view as to the accuracy of the findings. From a methodological perspective, the decontextualised nature of the individual semi-structured interviews, focus group interviews and video vignettes used did not reflect the degree of fidelity to which a study undertaken within a naturalistic, operational environment may have afforded. As such, this study may not have captured all potential situational variants and variables. I was again left to analyse the data and draw meaning, thus introducing the potential for bias, misinterpretation, and error.

10.4 Practice recommendations

I undertook this study so I could contribute to society. I hoped to contribute by creating something meaningful and useful enough to be used for the betterment of others. My intention is to share this work, in its entirety, with the following organisations.

10.4.1 Police

In 2016, Reveruzzi and Pilling (2016) published their evaluation of the street triage schemes. Also in 2016, the CoP (2016e) published overarching guidance, entitled *Mental health*.[111] To date, there have been no national guidelines regarding the implementation of street triage, or the approach to be used. There are also reported issues regarding the uptake of the College of Policing mental health guidance. The House of Commons Home Affairs Committee (2016) observes there to be an "…alarming lack of consistency across [British police] forces..." in terms of their uptake of the College of Police standards (p.8). The National Police Chiefs'

[111] This included guidance in relation to the following: introduction and strategic considerations; mental vulnerability and illness; mental health – detention; mental capacity; AWOL patients; safe and well checks; crime and criminal justice; suicide and bereavement response; sources of support. Such sources have been referred to throughout this thesis.

Council[112] (2016b) however, seeks concordance of national standards by 2025. I make two recommendations:

1. That the College of Policing considers the use of the PPEAT-R, and its preparation programme. The PPEAT-R has the capability to equip police officers with the situation awareness necessary to identify and respond to a potentially mentally disordered person. Whilst a useful mechanism in its own right, it will provide a useful adjunct to street triage, when it is formally introduced.

2. That the National Police Chiefs' Council lead for mental health and policing considers the use of the use of PPEAT-R, and its preparation programme across the British police services. Not only would this provide a mechanism to support police officers within their operational role, it would facilitate consistency of response whilst the College of Policing standards are taken up.

10.4.2 Associated professionals

The findings of this study revealed that police officers were using the PPEAT-R to frame their observations, but it did not dovetail into mechanisms used by ambulance staff, mental health crisis teams and hospitals, or members of the Criminal Justice Team, following detention. To improve the quality of the mentally disordered person's transition through healthcare services, it is a recommendation of this study that the PPEAT-R, and its preparation programme be introduced within front-line healthcare services. I make one recommendation:

1. That the College of Paramedics Education Advisory Committee considers the use of the PPEAT-R, and its preparation programme, for use within the ten English NHS Ambulance Trusts.[113]

[112] Formally the Association of Chief Police Officers (ACPO).

[113]
1. North East Ambulance Service NHS Foundation Trust.
2. Yorkshire Ambulance Service NHS Trust.
3. North West Ambulance Service NHS Trust.
4. West Midlands Ambulance Service NHS Foundation Trust.
5. East Midlands Ambulance Service NHS Trust.
6. South West Ambulance Service NHS Foundation Trust.
7. South Central Ambulance Service NHS Foundation Trust.
8. South East Coast Ambulance Service NHS Foundation Trust.
9. London Ambulance Service NHS Trust.
10. East of England Ambulance Service NHS Trust.

Recognising the position of the police service with the Criminal Justice Service, I make one final recommendation:

1. That the Home Office Research and Analysis Service adopts the PPEAT-R, and its preparation programme, for use within the National Offender Management Service (NOMS). This includes the Probation Service and Her Majesty's Prison Service.

10.5 Recommendations for further study

This study demonstrated that the PPEAT-R had a positive effect on the way in which police officers identify and respond to a potentially mentally disordered person. This study provides the basis for future research into the long-term usefulness of the PPEAT-R. It is a recommendation that this study is initially replicated across multiple sites (police services). This would provide better insight into the usefulness of the PPEAT-R, if the study design was adapted to permit more long-term evaluation.

Prior to this study, police officer situation awareness had not been investigated in relation to their recognition of mental disorder. This study provides the basis for future research to better understand the situation awareness demonstrated by police officers, when encountering a potentially mentally disordered person. Against the backdrop of the observations of the House of Commons Home Affairs Committee (2016) and the National Police Chiefs' Council[114] (2016), future study has significant policy implications for the education of police officers in this area.

Police officers often come into professional contact with healthcare and criminal justice teams. It is important to recognise that the police are an integral component within a complex social care system; one where they should not function as "…autonomous entities divorced from [it] …" (Cotton and Coleman, 2010, p.301). If the PPEAT-R is to be introduced across such disciplines, an important area of research would be the investigation of how they integrate and use it. It is a recommendation that this forms part of a longer-term research plan to support and integrate the PPEAT-R across differing disciplines.

[114] Formally the Association of Chief Police Officers (ACPO).

10.6 Dissemination plans

10.6.1 Conference

As stated (section 10.4), I seek to embed the PPEAT-R as a common communication framework amongst members of the social care system, with whom the police service directly interface. A conference paper is an effective way to disseminate the study findings to managers, strategists and educationalists, within a particular discipline. As such, it is my intention to disseminate the study findings within national and international conferences aligned to the following professional disciplines: College of Policing; Mental Health Nursing Research; Royal College of Nursing Accident and Emergency Nursing Association; College of Paramedics. It is also my plan to present the study findings within the Home Office criminal justice management conference. This would be the ideal venue to disseminate the findings to national offender management and wider criminal justice service personnel.

10.6.2 Publication

It is my intention to publish this work within peer-reviewed international journals, relevant to policing, mental health, emergency care and criminal justice services. Fundamentally however, the aim of this study was to review and re-develop a cognitive aid to be used by operational police officers. These are the practitioners of their profession who, doing their day-to-day roles, may have limited access to more academically focussed peer-reviewed journals. They will however have access to the professional journals associated with their role (for example, Police Professional, Emergency Nurse). Whilst such professional journals are still peer-reviewed, they may have a limited (if any) citation index. Despite this, their advantage is that they are more readily accessible to operational staff. This aids dissemination amongst the group for which the PPEAT-R was (will be) intended for use.

10.6.3 Application development

Whilst the PPEAT-R, in its current form, fits within a police officer's pocketbook, it is my intention to develop a native application[115] for use across multiple smartphone platforms (Luterbach and Hebbell, 2015). This would enable both the PPEAT-R and

[115] A native application uses the operating system of the device (e.g., tablet, smartphone) rather than the web. This makes the application usable if there is no internet access (Luterbach and Hebbell, 2015).

supporting material to be made available, thus further supporting police officers (or other professionals) when encountering a potentially mentally disordered person.

10.7 Conclusion

I undertook this study to investigate the processes which shaped a police officer's situation awareness, when encountering a potentially mentally disordered person. I wished to build upon the work of Wright et al. (2008), and develop a more structured, robust and evidence based cognitive aid; one which better supported police officers within their identification and response when encountering such people. To do this, it was necessary for me to completely re-investigate the ways in which police officers identified and responded to such people. To enable this, I adopted a different philosophical position, design and method, to those adopted within the initial work. Despite apparent similarity with the domains shaping the earlier Public Psychiatric Emergency Assessment Tool, this study has provided a newly constructed view of how police officers identify and respond to a potentially mentally disordered person.

Within this study, I used an ethnomethodological design, viewed through the theoretical lenses of symbolic interactionism and Endsley's (1988) three-level categorisation of situation awareness. Through these lenses, I was able to expose how police officers derived and ascribed meaning, when encountering a potentially mentally disordered person. Using an ethnomethodology design, I explored the nature of this meaning, for the purpose of constructing the PPEAT-R. I subsequently undertook a very complex and detailed study. Through a very detailed preparatory process, the Public Psychiatric Emergency Assessment Tool has evolved into the current PPEAT-R. Having done this, I undertook a very detailed pre-post-test, to establish if it was capable of improving a police officer's situation awareness. The operational usefulness of the PPEAT-R was then explored. This approach provided several new insights into this aspect of police practice.

Within the preparatory stage (stage one of the study), I first sought to investigate the methods, rules, actions and behaviours shaping situation awareness, which police officers used to identify and respond to a potentially mentally disordered person. Data drawn from a narrative synthesis and individual semi-structured interviews,

reaffirmed the earlier work of Wright et al. (2008), highlighting the five[116] broad areas police consider when they encounter a potentially mentally disordered person. However, the different philosophical position, design and method enabled me to create a newly-constructed view of the specific features police officers associate with mental disorder. This newly-constructed view allowed me to expose the hitherto hidden common rubric. This was the concept pre-encounter. This reflected a police officer's knowledge, skills, experiences and attitudes (personal and professional) formed *prior* to an encounter with a mentally disordered person, yet which had a significant impact *at the time* of an encounter. As such, the concept pre-encounter had a significant effect upon police officer situation awareness. Significant within the findings was the link between the pre-encounter factors and a police officer's response to danger. This link was their role-specific response.

The findings revealed that police officers' pre-existing knowledge, skills, experiences and attitudes (pre-encounter factors), governed their assessment and response to danger, within every situation encountered. The assessment of danger was undertaken before any other assessment and this determined their role-specific response. Whilst a police officer's response was to some degree governed by situational dynamics, the findings suggested that they defaulted to a series of pre-set behaviours to control and contain a situation before undertaking further enquiries. These behaviours were either pre-learned / pre-learned as part of their training, or learned experientially. The findings further revealed that when defaulting to this pre-planned / pre-learned role, their response was usually forceful, without significant concern for the presence of a potentially significant mental disorder.

These findings informed the development of the concept framework, the PPEAT-R, and the apparatus required to gauge the usefulness of the PPEAT-R, when tested within phase two of the study. When developing the PPEAT-R, the concept danger was placed centrally within the design. This acknowledged its centrality within all interactions. The concepts appearance, behaviour, communication and environment were linked to danger and to one another by an arced line. This was to signify that the features of mental disorder are only meaningful when seen within a wider context, rather than in isolation. The concept P sat alone, symbolically representing the training programme underpinning the use of the PPEAT-R. It was the study data itself that informed the training programme to support the introduction of the

[116] Appearance, behaviour, communication, danger and environment.

PPEAT-R; a training programme designed to also address the pre-encounter influences held by police officers.

When testing the usefulness of the PPEAT-R (stage two of the study) there was a notable shift from predominantly Level 1 SA within phase one[117], to Level 2 and 3 SA within phase two.[118] Significant was an increase in mental health literacy. This resulted in a more positive and understanding attitude towards the mentally disordered people depicted within the vignettes. There was also an avoidance of unnecessary force and criminalisation. This demonstrated a significant shift within the pre-encounter-danger linkage, and a move away from default role-specific responses. This was as a consequence of a greater understanding and recognition of the effects of mental disorder upon a person.

These themes were continued into phase three[119] of the study. Here, police officers considered the PPEAT-R a useful adjunct, utilised during every contact. Significantly, using different combinations of the concepts, at different stages enabled them to delve beneath the obvious, identifying the 'occult' (hidden) features of mental disorder. Viewing features of mental disorder related to the concepts (rather than as isolated signs), enabled them to pattern recognise and respond to a greater range of features of mental disorder. These were features they previously would have failed to recognise. Further new insights were generated following the introduction and training in the PPEAT-R. The PPEAT-R achieved several shifts in the existing common rubrics and axionormative orders governing a police officer's identification and response to a person with a potential mental disorder.

Last, and perhaps most significant, I was able to make a paradigm shift from the police officer as 'crime-fighting enforcer', to that of 'community problem solver'. This shift was from a paradigm defined by an assumption of criminality, to one defined by the interpersonal; one in which police officers recognised and responded to a person's mental health and well-being. In doing so, the police officer also shifted from an inconsistent gatekeeper of the healthcare, criminal and informal pathways, to a consistent one; one capable of a more informed, understanding and empathetic response to a person with a potential mental disorder.

[117] Prior to the introduction of the cognitive aid.

[118] Following the introduction of the cognitive aid.

[119] Use of the cognitive aid in operational, real-world practice.

REFERENCES

Abramson, M. F. (1972). The criminalization of mentally disordered behaviour: possible side-effect of a new mental health law. *Hospital and Community Psychiatry. 23*(4), 101-105.

Ackermann, F. (2008). Cognitive mapping. In R. Thorpe, & R. Holt (Eds.), *The Sage dictionary of qualitative management research* (pp. 43-44). London, United Kingdom: Sage.

Adams, M. J., Tenny, Y. J., & Pew, R. W. (1995). Situation awareness and the cognitive management of complex systems. *Human Factors, 37*(1), 85-104.

Adebowale, V. (2013). *Independent commission on mental health and policing report*. London, United Kingdom: Independent Commission on Mental Health and Policing.

Adobe. (2012). *Adobe Creative Suite 6 Production Premium* [Computer software].

Aggestam, M. (2010). Ethnomethodology. In A. J. Mills, G. Durepos, & E Wiebe (Eds.), *Encyclopedia of case study research* (pp. 352-353). Thousand Oaks, CA: Sage.

Akinola, M., & Berry Mendes, W. (2012). Stress-induced cortisol facilitates threat-related decision making among police officers. *Behavioural Neuroscience, 126*(1), 167-174.

Al-Adawi, S., Ali, B. H., Al-Zakwani, I. (2016). Research misconduct: The peril of publish or perish. *Oman Medical Journal, 31*(1), 5–11.

Al-Yateem, N. (2012). The effect of interview recording on quality of data obtained: A methodological reflection. *Nurse Researcher, 19*(4), 31-35.

Alpert, G. P. (2015). Police use of force and the suspect with mental illness: A methodological conundrum. *Criminology & Public Policy, 14*(2), 277-283.

Alpert, G. P., MacDonald, J. M., & Dunham, R. G. (2005). Police suspicion and discretionary decision making during citizen stops. *Criminology, 43*(2), 407-434.

Alvesson, M. (2003). Beyond neopositivists, romantics and localists: A reflexive approach to interviews in organisational research. *Academy of Management Review, 28*(1), 13-33.

American College of Surgeons. (1997). *Advanced trauma life support for doctors* (6th ed.). Chicago, IL: First Impressions.

Anderson, L. (2008). Reflexivity. In R. Thorpe, & R. Holt (Eds.), *The Sage dictionary of qualitative research management research* (pp. 184-186). London, United Kingdom: Sage.

Andersson, G. B. J., Chapman, J. R., Dekutoskl, M. B., Dettori, J., Fehlings, M. G., Fourney, D. R., Norvell, D., & Weinstein, J. N. (2010). Do no harm: the balance of beneficence and non-maleficence. *Spine, 3*(9), 2-8.

Angermeyer, M. C., & Schulze, B. (2001). Reinforcing stereotypes: How the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. *International Journal of Law and Psychiatry, 24,* 469-486.

Anti-social Behaviour, Crime and Policing Act. (2014). Chapter 12. Retrieved from http://www.legislation.gov.uk/ukpga/2014/12/pdfs/ukpga_20140012_en.pdf

Antoniou, E. E., Draper, H., Reed, K., Burls, A., Southwood, T. R., Zeegers, M. P. (2011). An empirical study on the preferred size of the participant information sheet in research. *Journal of Medical Ethics, 37,* 557-562.

Arai, L., Britten, N., Popay, J., Roberts, H., Petticrew, M., Rodgers, M., & Sowden, A. (2007). Testing methodological developments in the conduct of narrative synthesis: A demonstration review of research on the implementation of smoke alarm interventions. *Evidence & Policy, 3*(3), 361-383.

Arensmann, E., Coffey, C., Griffin, E., Van Audenhove, C., Scheerder, G., Gusmao, R., Costa, S., Larkin, C., Koburger, N., Maxwell, M., Harris, F., Postuvan, V., & Heger, U. (2016). Effectiveness of depression–suicidal behaviour gatekeeper training among police officers in three European regions: Outcomes of the optimising suicide prevention programmes and their implementation in Europe: (OSPI-Europe) study. *International Journal of Social Psychiatry, 62*(7), 651–660.

Arminio, J. L., & Hultgren, F. H. (2002). Breaking out from the shadow: The question of criteria in qualitative research. *Journal of College Student Development, 43(*4), 446–460.

Arya, P., Christ, T., & Chiu, M. M. (2014). Facilitation and teacher behaviours: An analysis of literacy teachers' video-case discussions. *Journal of Teacher Education, 65*(2), 111–127.

Asbury, J. (1995). Overview of focus group research. *Qualitative Health Research, 5*(4), 414-420.

Association of Chief Police Officers (2005). *National call handling standards.* London, United Kingdom: Home Office Communication Directorate.

Association of Public Health Laboratories. (2007). *Indications of public health in the English regions. 7: Mental health*. York, United Kingdom: Association of Public Health Observatories

Atkins, L., & Wallace, S. (2012). Writing a literature review. In L. Atkins, & S. Wallace (Eds.), *Qualitative research in education* (pp. 65-82). London, United Kingdom: Sage.

Avon & Somerset Police. (2013). *Procedural guidance: Pocket note book.* Retrieved from https://www.avonandsomerset.police.uk/media/20889830/pocket-note books-procedural-guide-1193.pdf

Ayres, L. (2008). Thematic coding and analysis. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 868-869). Thousand Oaks, CA: Sage.

Badri, A., Cruzen, R., & Van den Borne, H. W. (2012). Exposures to war-related traumatic events and post-traumatic stress disorder symptoms among displaced Darfuri female university students: An exploratory study. *BioMed Central Public Health, 12*(603),1-10. Retrieved from https://bmcpublichealth. biomedcentral.com/articles/10.1186/1471-2458-12-603

Bain, A., & Thomas, M. (2008). What use insanity? *International Journal of Police Science & Management, 10*(3), 280-288.

Baker, C. (2004). Membership categorisation and interview accounts. In D. Silverman (Ed.), *Qualitative research: Theory, method and* practice (2nd ed.) (pp. 162-176). Wolverhampton, United Kingdom: Sage.

Bakker, J. I. (2010). Interpretivism. In A.J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopaedia of case study research* (pp. 487-493). Thousand Oaks, CA: Sage.

Baksheev, G. N., Thomas, S. D. M., & Ogloff, J. R. P. (2010). Psychiatric disorders and unmet needs in Australian police cells. *Australian & New Zealand Journal of Psychiatry, 44,* 1043 – 1051.

Ball, M., & Smith, G. (2011). Ethnomethodology and the visual: Practices of looking, visualization, and embodied action. In E. Margolis, & L. Pauwels (Eds.), *The Sage handbook of visual research methods* (pp. 392-413). London, United Kingdom: Sage.

Ballinger, C. (2008). Accountability. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 4-5). Thousand Oaks, CA: Sage.

Barath, I. (2017). Perspective: Police officer wellness training: The road to mental readiness. *FBI Law Enforcement Bulletin, January.* Retrieved from https://leb.fbi.gov/articles/perspective/perspective-police-officer-wellness-training

Barbour, R. (2007). *Doing focus groups.* Trowbridge, United Kingdom: Sage.

Barnett-Page, E., & Thomas, J. (2009). *Methods for the synthesis of qualitative research: A critical review.* Retrieved from http://eprints.ncrm.ac.uk/690/1/0109%2520Qualitative%2520synthesis%2520methods%2520paper%2520NM.pdf

Barter, C., & Renold, E. (1999). 'I wanna tell you a story': Exploring the application of vignettes in qualitative research with children and young people. *Social Research Methodology, 5*(4), 307-323.

Battaglia, M. P. (2008). Purposive sampling. In P.J. Lavrakas (Ed.), *Encyclopaedia of survey research methods* (p. 646). Thousand Oaks, CA: Sage.

Bayerl, P. S., Horton, K. E., Jacobs, G., Rogiest, S., Reguli, Z., Gruschinske, M., Costanzo, P., Stojanovski, T., Vonas, G., Gasco, M., & Elliot, K. (2014). Perspectives on the police profession: an international investigation. *Policing: An International Journal of Police Strategies & Management, 37*(4), 728-745.

Bayley, D. H., & Shearing, C. D. (1996). The future of policing. *Law & Society Review, 30*(3), 585-606.

Beale, B., Cole, R., Hillage, S., McMaster, R., & Nagy, S. (2004). Impact of in-depth interviews on the interviewer: Roller coaster ride. *Nursing and Health Sciences, 6,* 141-147.

Beaubien, J. M, & Baker, D. P. (2004). The use of simulation for training teamwork skills in health care: how low can you go? *Quality and Safety in Health Care, 13,* 51-56. Retrieved from http://qshc.bmj.com/cgi/content/full/13/suppl_1/i51?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=simulation+for+training+teamwork+&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT

Bedney, G., & Meister, D. (1999). Theory of activity and situation awareness. *International Journal of Cognitive Ergonomics, 3*(1), 63-72.

Beitel, M., Ferrer, E., & Cecero, J. J. (2005). Psychological mindedness and awareness of self and others. *Journal of Clinical Psychology, 61*(6), 739–750.

Benson, J. (2016). Positive regard. *Educational Leadership, 73,* 22-26.

Berg, M., & Kojo, I. (2012). Integrating complex information with object displays: Psychophysical evaluation of outlines. *Behaviour & Information Technology, 31*(2), 155-169.

Biggs, J. (2003). *Teaching for quality learning at university* (2nd ed.). Maidenhead, United Kingdom: Open University Press.

Biggs, D., Abel, N., Knight, A. T., Leitch, A., Langston, A., & Ban, N. C. (2011). The implementation crisis in conservation planning: could “mental models” help? *Conservation Letters, 4,* 169–183.

Birks, M. (2014). Quality in qualitative research. In J. Mills, & M. Birks (Eds.), *Qualitative methodology: a practical guide* (pp. 221-236). London, United Kingdom: Sage.

Bittner, E. (1967). Police discretion in emergency apprehension of mentally ill persons. *Social Problems, 14*(3), 278-292.

Blaauw, E. (2001). Police custody: An area of concern? *The British Journal of Forensic Practice, 3*(2), 3–10.

Blaikie, N. (2004a). Induction. In M. S. Lewis-Beck, & T. Futing Liao (Eds), *The sage encyclopaedia of social science research methods* (p. 487). Thousand Oakes, CA: Sage.

Blaikie, N. (2004b). Deduction. In M. S. Lewis-Beck, & T. Futing Liao (Eds), The sage *encyclopaedia of social science research methods* (pp. 243-244). Thousand Oakes, CA: Sage.

Blanco, C., Grant, J., Petry, N. M., Blair, S. H., Analucia, A. (2008). Prevalence and correlates of shoplifting in the United States: Results from the national epidemiologic survey on alcohol and related conditions (NESARC). *The American Journal of Psychiatry, 165*(7), 905-913.

Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2001). *Focus groups in social research.* Trowbridge, United Kingdom: The Cromwell Press.

Bloor, M., & Wood, F. (2006a). Reflexivity. In M. Bloor, & F. Wood (Eds.), *Keywords in qualitative methods* (pp. 146-148). London, United Kingdom: Sage.

Bloor, M., & Wood, F. (2006b). Vignettes. In M. Bloor, & F. Wood (Eds.), *Keywords in qualitative methods* (pp. 184-186). London, United Kingdom: Sage.

Blumer, H. (1969). *Symbolic interactions: Perspective and method.* Berkeley, CA: University of California Press.

Boals, A. & Banks, J. B. (2012). Effects of traumatic stress and perceived stress on everyday cognitive functioning. *Cognition and Emotion, 26*(7), 1335-1343.

Boje, D. M. (2001). Causality analysis. In D. M. Boje (Ed.), *Narrative methods for organizational & communication research* (pp. 93-108). London, United Kingdom: Sage.

Boklund-Lagopoulos, K., & Lagopoulos, A. (2011). Semionotics. In M.S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 1017-1018). Thousand Oaks, CA: Sage.

Bolstad, C. A., Endsley, M. R., Costello, A. M., & Howell, C. A. (2010). Evaluation of computer-based situation awareness training for general aviation pilots. *The International Journal of Aviation Psychology, 20*(3), 269-294.

Bonfine, N., Ritter, C., & Munetz, M. R. (2014). Police officer perceptions of the impact of crisis intervention team (CIT) programs. *International Journal of Law and Psychiatry, 37*, 341-350.

Booth, A., Scantelbury, A., Hughes-Morley, A., Mitchell, N., Wright, K., Scott, W., & McDaid, C. (2017). Mental health training programmes for non-mental health trained professionals coming into contact with people with mental ill health: a systematic review of effectiveness. *BioMed Central Psychiatry, 17*(196), 1-25. Retrieved from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-017-1356-5

Borum, R., Williams Deane, M., Steadman, J., & Morrissey, J. (1998). Police perspectives of responding to mentally ill people in crisis: Perceptions of programme effectiveness. *Behavioural Sciences and the Law, 16,* 393-405.

Bourne, L. E., Dominowski, R. L., Loftus, E. F., & Healy, A. F. (1986). *Cognitive processes* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.

Bower, G. H., & Morrow, D. G. (1990). Mental models in narrative comprehension. *Science, 247*(4938), 44-48.

Bower, D. L., & Pettit, G. (2001). The Albuquerque police department's crisis intervention team. *FBI Law Enforcement Bulletin*, (February), 1-6.

Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Research and Educational Trust, 42*(4), 1758-1771.

Brauer, P. M., Hanning, R. M., Arocha, J. F., Roayall, D., Goy, R., Grant, A., Dietrich, L., Martino, R., & Horrocks, J. (2009). Creating case scenarios or vignettes using factorial study design methods. *Journal of Advanced Nursing, 65*(9), 1937-1945.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3,* 77-101.

Braye, S., Orr, D., & Preston-Shoot, M. (2015). Learning lessons about self-neglect? An analysis of serious case reviews. *The Journal of Adult Protection, 17*(1), 3-18.

Brewer, J. D. (2000). *Ethnography*. Buckingham, United Kingdom. Open University Press.

Brewer, J. (2003a). Deduction. In R. L. Miller, & J. Brewer (Eds.), *The a-z of social research* (pp. 67-68). London, United Kingdom: Sage.

Brewer, J. D. (2003b). Reflexivity. In R.L. Miller, & J.D. Brewer (Eds.), *The A-Z of social research* (pp. 260-263). London, United Kingdom: Sage.

Brophy, S., Snooks, H., & Griffiths, L. (2008). Collecting data. In S. Brophy, H. Snooks, & L. Griffiths (Eds.), *Small-scale evaluation in health* (pp. 75-101). London, United Kingdom: Sage.

Brough, P., Chataway, S., & Biggs, A. (2016). 'You don't want people knowing you're a copper!' A contemporary assessment of police organisational culture. *International Journal of Police Science & Management, 18*(1), 28-36.

Brown, G. (2016). The danger of not following police orders when approached. *Association of Black Nursing Faculty Journal, 27*(2), 25-27.

Buckingham, C. D., Adams, A., & Mace, C. (2008). Cues and knowledge structures used by mental-health professionals when making risk assessments. *Journal of Mental Health, 17*(3), 299-314.

Burbank, P. M., & Martins, D. C. (2009). Symbolic interactionism and critical perspective: Divergent or synergistic? *Nursing Philosophy, 11*, 25-41.

Burr, V. (2004). Constructivism. In M.S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 186-187). Thousand Oaks, CA: Sage.

Burstrom, L., Starrin, B., Engstrom, M., & Thulesis, H. (2013). Waiting management at the emergency department – a grounded theory study. *BioMed Central Health Services Research, 13(*95), 1-10.

Button, G. (Ed.) (1991). *Ethnomethodology and the human sciences.* Cambridge, United Kingdom: Cambridge University Press.

Campbell, M. (2012). Constructs of self within the emerging professional identity of beginning police officers. *Cultural-Historical Psychology, 1,* 77-82.

Canales, C. (2012). Prisons: The new mental health system. *Connecticut Law Review, 44*(5), 1723-1762.

Canvin, K., Bartlett, A., & Pinfold, V. (2002). A 'bittersweet pill to swallow': learning from mental health service users' responses to compulsory community care in England. *Health and Social Care in the Community, 10*(5), 361–369

Capelo, C., & Dias, J. F. (2009). A feedback learning and mental models perspective on strategic decision making. *Educational Technology Research and Development, 57,* 629-644.

Care Quality Commission. (2014). *A safer place to be: Findings from our survey of health-based places of safety for people detained under section 136 of the Mental Health Act.* Newcastle-upon-Tyne, United Kingdom: Care Quality Commission.

Carretta, T. R., Perry, D. C., & Ree, M. J. (2002). Prediction of situational awareness in F-15 pilots. *The International Journal of Aviation Psychology, 6*(1), 21-41.

Caserta, R. J., & Singer, R. N. (2010). The effectiveness of situational awareness learning in response to video tennis match situations. *Journal of Applied Sports Psychology, 19*, 125-141.

Casey, D., & Murphy, K. (2009). Issues in using methodological triangulation in research. *Nurse Researcher, 16*(4), 40-55.

Chamberlain, K., Cain, T., Sheridan, J., & Dupuis, A. (2011). Pluralisms in qualitative research: From multiple methods to integrated methods. *Qualitative Research in Psychology, 8*, 151–169.

Chapanis, A. (1991). To communicate the human factors message, you have to know what the message is and how to communicate it. *Human Factors Society, 34,* 1-4.

Charette, Y., Crocker, A. G., & Billette, I, (2011). The judicious judicial dispositions juggle: Characteristics of police interventions involving people with a mental illness. *The Canadian Journal of Psychiatry, 56*(11), 677-685.

Charon, J. M. (2012). *Symbolic interactionism: An introduction, an interpretation, an integration.* Boston, MA: Prentice Hall.

Chaulk, S. J., Eastwood, J., & Snook, B. (2014). Measuring and predicting police caution comprehension in adult offenders. *Canadian Journal of Criminology and Criminal Justice, 56*(3), 324-340.

Chauvin, L., Genest, D., & Loiseau, S. (2009). Ontological cognitive map. *International Journal on Artificial Intelligence Tools, 18*(5), 697-716.

Chen, H. (2011). A conceptual framework of program theory for practitioners. In H. Chen (Ed.), *Practical program evaluation* (pp. 15-43). Thousand Oaks, CA: Sage.

Cheng, L. Y. (2015). Ethnomethodology reconsidered: The practical logic of social systems theory. *Current Sociology, 60*(5), 581–598.

Cheu-Ley, G. L. (2012). Reconsidering constructivism in qualitative research. *Educational Philosophy and Theory, 44*(4), 403-412.

Chopko, B. A. (2010). Posttraumatic distress and growth: An empirical study of police officers. *American Journal of Psychotherapy, 64*(1,), 55-72.

Chown, N. (2010). 'Do you have any difficulties that I may not be aware of?' A study of autism awareness and understanding in the UK police service. *International Journal of Police Science and Management, 12*(2), 256–273.

Chrimes, N. (2016). The Vortex: a universal 'high-acuity implementation tool' for emergency airway management. *British Journal of Anaesthesia, 117*(Supplement 1), s20-s27.

Ciminelli, M. L. (2003). Police response to anonymous emergency calls. *FBI Law Enforcement Bulletin,* (May), 23-32*.*

Cioffi, J. (1997). Heuristics, servants to intuition, in clinical decision-making. *Journal of Advanced Nursing, 26*, 203–208.

Clarke, N. J., Willis, M. E. H., Barnes, J. S., Caddick, N., Cromby, J., McDermott, H., & Wiltshire, G. (2015). Analytical pluralism in qualitative research: A meta-study. *Qualitative Research in Psychology*, *12,* 182-201.

Clay-Williams, R., & Colligan, L. (2015). Back to basics: checklists in aviation and healthcare. *British Medical Journal Quality & Safety, 244,* 28-431.

Clayfield, J. C., Fletcher, K. E., & Grudzinskas, A. J. (2011). Development and validation of the mental health attitude survey for police. *Community Mental Health, 47*, 742-751.

Cleverbridge, A. G. (2012). *MAXQDAplus* [Computer software]. Retrieved from http://www.maxqda.com/

Clifford, K. (2010). The thin blue line of mental health in Australia. *Police Practice and Research, 11*(4), 355–370.

Cohen, M. D., & Bacdayan, P. (1994). Organizational routines are stored as procedural memory: evidence from a laboratory study. *Organization Science, 5*(4), 554-568.

Coleman, T. G., & Cotton, D. H. (2010). Reducing risk and improving outcomes of police interactions with people with mental illness. *Journal of Police Crisis Negotiations, 10*, 39–57.

Coleman, T. G., & Cotton, D. H. (2014). TEMPO: A contemporary model for police education and training about mental illness. *International Journal of Law and Psychiatry, 37*, 325–333.

College of Policing. (2013a). *Detention and custody: Response, arrest and detention.* Retrieved from https://www.app.college.police.uk/app-content/detention-and-custody-2/response-arrest-and-detention/

College of Policing. (2013b). *Detention and custody: Control, restraint and searches*. Retrieved from https://www.app.college.police.uk/app-content/detention-and-custody-2/control-restraint-and-searches/

College of Policing. (2014). *Mental ill-health training reviewed.* Retrieved from http://www.college.police.uk/News/archive/2014may/Pages/Mental-ill-health trainingreviewed.aspx

College of Policing. (2015a). *Detention and custody: Moving and transporting detainees.* Retrieved from https://www.app.college.police.uk/app-content/detention-and-custody-2/response-arrest-and-detention/moving-and-transporting-detainees/#transfer-of-high-risk-detainees

College of Policing. (2015b). *Detention and custody: Mental ill health and learning disabilities.* Retrieved from https://www.app.college.police.uk/app-content/detention-and-custody-2/detaineecare/mental-ill-health-and-learning-disabilities/

College of Policing. (2015c). *Operations.* Retrieved from https://www.app.college.police.uk/app-content/operations/operational-planning/coreprinciples/#role-of-the-police

College of Policing. (2015d). *College of Policing analysis: Estimating demand on the police service*. Retrieved from http://www.college.police.uk/News/College-news/Documents/Demand%20Report%2023_1_15_noBleed.pdf

College of Policing. (2016a). *Mental health: Mental vulnerability and illness*. Retrieved from https://www.app.college.police.uk/app-content/mental-health/mental-vulnerability-and-illness/#signs-of-mental-ill-health-or-learning-disabilities

College of Policing. (2016b). *Mental health: Mental health – detention.* Retrieved from https://www.app.college.police.uk/app-content/mental-health/mental-health-detention/

College of Policing. (2016c). *Mental health: Mental capacity.* Retrieved from https://www.app.college.police.uk/app-content/mental-health/mental-capacity/

College of Policing. (2016d). Mental health: Safe and well checks. Retrieved from https://www.app.college.police.uk/app-content/mental-health/awol-patients/safe-and-well-checks/

College of Policing. (2016e). *Mental health.* Retrieved from https://www.app.college.police.uk/app-content/mental-health/

College of Policing. (2017a). *Prosecution and case management: Possible justice outcomes following investigation*. Retrieved from https://www.app.college.police.uk/app-content/prosecution-and-casemanagement/justice-outcomes/#restorative-justice

College of Policing. (2017b). *Safer resolution – supporting officers and staff to manage conflict without force*. Retrieved from https://www.app.college.police.uk/about-app/guideline-committee/safer-resolution-supporting-officers-and-staff-to-manage-conflict-without-force/pilot-documentation/

College of Policing. (2017c). *Stop and search*. Retrieved from https://www.app.college.police.uk/app-content/stop-and-search/#value-of-using-thepowersAppropriately

College of Policing. (2017d). *Major investigation and public protection: Quick reference guide*. Retrieved from https://www.app.college.police.uk/app-content/major-investigation-and-publicprotection/domestic-abuse/call-handler-and-front-counter-staff-response/call-handler-quickreference-guide/

College of Policing. (2017e). *Prosecution and case management: Possible justice outcomes following investigation.* Retrieved from https://www.app.college.police.uk/app-content/prosecution-andcasemanagement/justice-outcomes/

College of Policing. (2017f). *Armed policing: Weapons and equipment.* Retrieved from https://www.app.college.police.uk/app-content/armed-policing/weapons-and-equipment/

College of Policing. (2017g). *Armed policing: Conducted energy devices (Taser).* Retrieved from https://www.app.college.police.uk/app-content/armed-policing/conductedenergy-devices-taser/

College of Policing. (2017h). *Detention and custody: Risk assessment*. Retrieved from https://www.app.college.police.uk/app-content/detention-and-custody-2/riskassessment/

Coman, A., & Sas, C. (2016). A hybrid intervention for challenging the stigma of mental illness. *Bulletin of the Transylvania University of Braşov, 9*(58), 73-80.

Committee on Standards in Public Life. (1995). *Guidance: The 7 principles of public life.* Retrieved from https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2

Committee on Standards in Public Life. (2013). *Standards matter: A review of best practice in promoting good behaviour in public life: Fourteenth Report of the Committee on Standards in Public Life*. London, United Kingdom: The Stationery Office.

Coniglio, S. (2010). Air superiority options. *Military Technology, 7,* 82-96.

Cooper, V. G., Mclearen, A. M., & Zapf, P. A. (2004). Dispositional decisions with the mentally ill: Police perceptions and characteristics. *Police Quarterly, 7*(3), 295-310.

Cope, R. (1995). Mental health legislation. In D. Chiswick, & R. Cope (Eds.), *Seminars in practical forensic psychiatry* (pp. 272-309). London, United Kingdom, Gaskell.

Corrigan, P., Markowitz, F. E., Watson, A. Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behaviour, 44,* 162-179.

Corrigan, P. W., Schmidt, A., Bink, A., Nieweglowski, K., Al-Khouja, M. A., Qion, S., & Discont, S. (2017). Changing public stigma with continuum beliefs. *Journal of Mental Health, 26*(5), 411-418.

Corson, B., & Stoughton, R. W. (1928). Reaction of alpha beta-unsaturated dinitriles. *Journal of the American Chemical Society, 50*(10), 2825-2837.

Cotton, D. (2004). The attitudes of Canadian police officers toward the mentally ill International. *Journal of Law and Psychiatry, 27,* 135-146.

Cotton, D. & Coleman, T. G. (2010). Canadian police agencies and their interactions with persons with a mental illness: a systems approach. *Police Practice and Research, 11*(4), 301–314.

Coulon, A. (1995). *Ethnomethodology: Qualitative research methods series 36*. Thousand Oaks, CA: Sage.

Counter-Terrorism Act. (2008). Chapter 28: An Act to confer further powers to gather and share information for counter-terrorism and other purposes. Retrieved from https://www.legislation. gov.uk/ukpga/2008/28/pdfs/ukpga_ 20080028_en.pdf

Cowley, R. (2011). *The history of the British police: From its earliest beginnings to the present day*. Stroud, United Kingdom: The History Press.

Coyle, A. (2010). Qualitative research and anomalous experience: A call for interpreative pluralism. *Qualitative Research in Psychology, 7*, 79-83.

Crabtree, B. F., & Miller, W. L. (Eds.). (1999). *Doing qualitative research* (2nd ed.). Thousand Oakes, CA: Sage.

Cramer, D., & Howitt, D. (2004). Moderating or moderator effect or variable, moderated relationship. In D. Cramer, & D. Howitt (Eds.), *The Sage dictionary of statistics* (p. 105). London, United Kingdom: Sage.

Crandall, B., Klein, G., & Hoffman, R. R. (2006). *Working minds: A practitioner's guide to cognitive task analysis*. Cambridge, MA: The MIT Press.

Crane, L., Maras, K. L, Hawken, T., Mulcahy, S., & Memon, A. (2016). Experiences of autism spectrum disorder and policing in England and Wales: Surveying police and the autism community. *Journal of Autism & Developmental Disorders, 46,* 2028–2041.

Cresswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Crichton, S., & Childs, E. (2005). Clipping and coding audio files: A research method to enable participant voice. *International Journal of Qualitative Methods, 4*(3), 1-9.

Crime and Disorder Act. (1998). Chapter 37: An Act to make provision for preventing crime and disorder. Retrieved from https://www.legislation.gov.uk/ukpga/1998/37/pdfs/ukpga_19980037_en.pdf

Critical Appraisal Skills Programme. (2011). *10 questions to help you make sense of qualitative research.* Retrieved from http://www.casp-uk.net/.

Crocker, A. G., Hartford, K., & Heslop, L. (2009). Gender differences in police encounters among persons with and without serious mental illness. *Psychiatric Services, 60*(1), 86-93.

Cronjé, J. (2006). Paradigms regained: Toward integrating objectivism and constructivism in instructional design and the learning sciences. *Educational Technology Research & Development, 54*(4), 387-416.

Crotty, M. (2012). *The foundations of social research: Meaning and perspectives in the research process.* London, United Kingdom: Sage.

Crowl, J. N. (2017). The effect of community policing on fear and crime reduction, police legitimacy and job satisfaction: an empirical review of the evidence. *Police Practice and Research, 18*(5), 449-462.

Crown Prosecution Service. (2017). *Public Order Offences incorporating the Charging Standard.* Retrieved from http://www.cps.gov.uk/legal/p_to_r/public_order_offences/# Section_4

Cruikshank, J. (2012). Positioning positivism, critical realism and social constructionism in the health sciences: A philosophical orientation. *Nursing Inquiry, 19*(1), 71-82.

Cruz, E. V., & Higginbottom, G. (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36-43.

Cummins, I. (2006). A path not taken? Mentally disordered offenders and the criminal justice system. *Journal of Social Welfare & Family Law, 28*(3-4), 267-281.

Cummins, I. D. (2013). Policing and mental illness in the era of deinstutionalisation and mass incarceration: A UK perspective. *International Journal of Criminology and Sociological Theory, 6(*4), 92-104.

Cutcliffe, J. R., & McKenna, H. P. (1999). Establishing the credibility of qualitative research findings: The plot thickens. *Journal of Advanced Nursing, 30*(2), 374-380.

Cyr, K. (2015). The police officer's plight: The intersection of policing and the law. *Alberta Law Review, 52*(4), 889-926.

Dabney, D. A., Hollinger, R. C., & Duggan, L. J. Q. (2004). Who actually steals? A study of covertly observed shoplifters. *Justice Quarterly, 21*(4), 693-728.

Daniel, A. E. (2004). Commentary: decision-making by front-line service providers—attitudinal or contextual. *The Journal of the American Academy of Psychiatry and the Law, 32*(4), 386-389.

Daniel, J. (2012). *Sampling essentials: Practical guidelines for making sampling choices*. Thousand Oaks, CA: Sage.

Darwin, C. (1859). *The origin of the species.* Ware, United Kingdom: Wordsworth Editions.

Data Protection Act. (1998). Chapter 29: An Act to make new provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information. Retrieved from https://www.legislation.gov.uk/ukpga/1998/29/pdfs/ukpga_19980029_en.pdf

Davies, P. (2012). 'Me', 'me', 'me': The use of the first person in academic writing and some reflections on subjective analyses of personal experiences. *Sociology, 46*(4), 744-752.

Davis, B. (2004). Assessing adults with mental disorders in primary care. *Nurse Practitioner, 29*(5), 19-27.

Dawson, J. (2010). Thick description. In A.J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopaedia of case study research* (pp. 943-945). Thousand Oaks, CA: Sage.

Day, M. R., Mulcahy, H., & Leahy-Warren, P. (2016). Prevalence of self-neglect in the caseloads of public health nurses. *British Journal of Community Nursing, 21*(1), 31-35.

DeForge, R., & Shaw, J. (2011). Back-and fore-grounding ontology: Exploring the linkages between critical realism, pragmatism and methodologies in health & rehabilitation sciences. *Nursing Inquiry, 19*(1), 85-95.

de Montigny, G. (2007). Ethnomethodology for social work. *Qualitative Social Work, 6*(1), 95-120.

de Tribolet-Hardy, F., Kesic, D., & Thomas, S. D. M. (2015). Police management of mental health crisis situations in the community: Status quo, current gaps and future directions. *Policing and Society, 25*(3), 294-307.

Dean, E. (2013a). More nurses to help police manage people with mental health problems. *Emergency Nurse, 21*(6), 9.

Dean, E. (2013b). Nurses work with police to cut unnecessary arrests. *Emergency Nurse, 17*(1), 8.

Dean, M. (2010). What is society? Social thought and the arts of government. *The British Journal of Sociology, 61*(4), 677-695.

Dekker, S. W. (2015). The danger of losing situation awareness. *Cognition, Technology & Work, 17*, 159-161.

Delsol, R., & Shiner, M. (2006). Regulating stop and search: A challenge for police and community relations in England and Wales. *Critical Criminology, 14,* 241–263.

Demir, M., McNeese, N. J., & Cooke, N. J. (2017). Team situation awareness within the context of human-autonomy teaming. *Cognitive Systems Research, 46,* 3–12.

Dempsey, C. (2017). Beating mental illness: Crisis intervention team training and law enforcement response trends. *Southern California Interdisciplinary Law Journal, 26*(2), 323-340.

Dennis, A. (2011). Symbolic interactionism and ethnomethodology. *Symbolic Interaction, 34*(3), 349-356.

Denzin, N. K., & Lincoln, Y. S. (Eds) (2003). *The landscape of qualitative research: Theories and issues* (2nd ed.). Thousand Oaks, CA: Sage.

Department for Constitutional Affairs. (2007). *Mental Capacity Act 2005: Code of practice.* London, United Kingdom: The Stationery Office.

Department of Health. (2008). *Improving health, supporting justice: A consultation document. A strategy for improving health and social services for people subject to the criminal justice system.* London, United Kingdom: Department of Health.

Department of Health. (2009). *The Bradley report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* London, United Kingdom: Department of Health.

Department of Health. (2012). *Mental Health Act 1983.* Retrieved from http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_4002034

Department of Health. (2013). *Extending the street triage scheme: New patrols with nurses and the police.* Retrieved from https://www.gov.uk/government/news/extending-the-street-triage-scheme-new-patrols-withnurses-and-the-police

Department of Health. (2015). *Mental Health Act 1983: Code of practice.* Norwich, United Kingdom: The Stationery Office.

Department of Health and Concordat Signatories. (2014). *Mental health crisis care concordat: improving outcomes for people experiencing mental health crisis*. London, United Kingdom: Gov.UK.

Department of Health and the Home Office. (2014). *Review of the Operation of Sections 135 and 136 of the Mental Health Act 1983: Review Report and Recommendations*. London, United Kingdom: Gov.uk.

Derefeldt, G., Skinnars, O., Alfredson, J., Eriksson, L., Andersson, P., Westlund, J., Berggrund, U., Holmberg, J., & Stantesson, R. (1999). Improvement of situation awareness with colour-coded horizontal-situation displays in combat aircraft. *Displays, 20,* 171-184.

Dettling, A., Althaus, L., & Haffner, H-Th. (2003). Criteria for homicide and suicide on victims of extended suicide due to sharp force injury. *Forensic Science International, 134,* 142–146.

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education, 40*, 314-321.

Dick, P. (2000). The social construction of the meaning of acute stressors: A qualitative study of the personal accounts of police officers using a stress counselling service. *Work & Stress, 14*(3), 226–244.

Dickerson, S. S., & Kemeny, M. E. (2004). Acute stressors and cortisol responses: A theoretical integration and synthesis of laboratory research. *Psychological Bulletin, 130*(3), 355-391.

Dickson, L., Dukes, R. L., Smyth, H., & Strapko, N. (2015). To ink or not to ink: The meaning of tattoos among college students. *College Student Journal, 49*(1), 106-120.

Dingwall, R. (2001). Notes toward an intellectual history of symbolic interactionism. *Symbolic Interaction, 24*(2), 237-242.

Dinsmore, J. (2013). Traumatic brain injury: An evidence-based review of management. *Continuing Education in Anaesthesia, Critical Care & Pain, 13*(6), 189-195.

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy, 10*(1), 45–53.

Domsky, D. (2004). Keeping a place for metaethics: Assessing Elliot's dismissal of the subjectivism / objectivism debate in environmental ethics. *Metaphilosophy, 35*(5), 675-694.

Doody, O., & Noonan, M. (2012). Preparing and conducting interviews to collect data. *Nurse Researcher, 20*(5), 28-32.

Dorfman, E. (2013). Naturalism, objectivism and everyday life. *Royal Institute of Philosophy 72*(Supplement), s117-s133.

Douglas, L., & Cuskelly, M. (2012). A focus group study of police officers' recognition of individuals with intellectual disability. *Psychiatry, Psychology and Law, 19*(1), 35–44.

Dowling, M. (2005). From Husserl to van Manen: A review of different phenomenological approaches. *International Journal of Nursing Studies, 44*, 131-142.

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher, 13*(3), 7-21.

Dowling, M. (2007). Ethnomethodology: Time for a revisit? A discussion paper. *International Journal of Nursing Studies, 44,* 826-833.

Dowling, M. (2008). Reflexivity. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative methods* (pp. 748-749). Thousand Oaks, CA: Sage.

Dowling, M., & Cooney, A. (2012). Research approaches related to phenomenology: negotiating a complex landscape. *Nurse Researcher, 20*(2), 21-27.

Dreachslin, J. L. (1998). Conducting effective focus groups in the context of diversity: Theoretical underpinnings and practical implications. *Qualitative Health Research, 8*(6), 813-820.

Duggleby, W. (2005). What about focus group interaction data? *Qualitative Health Research, 15,* 832-840.

Dunham, R. G., Alpert, G. P., Stroshine, M. S., & Bennett, K. (2005). Transforming citizens into suspects: Factors that influence the formation of police suspicion. *Police Quarterly, 8*(3), 366–393.

Duran, N., Dale, R., & Galati, A. (2016). Toward integrative dynamic models for adaptive perspective taking. *Topics in Cognitive Science, 8,* 761–779.

Durcan, G. (2014). *Review of Sections 135 & 136 of the Mental Health Act: The views of professionals, service users and carers on the codes of practice and legislation*. London, United Kingdom: Centre for Mental Health.

Durham Constabulary. (2013). *Specialist units*. Retrieved from https://www.durham.police.uk/About-Us/Our-organisation/Specialist-Units/Pages/default.aspx

Durso, F. T., Hackworth, C. A., Truitt, T. R., Crutchfield, J., Nikolic, D., & Manning, C. A. (1998). Situation awareness as a predictor of performance for en-route air traffic controllers. *Air Traffic Control Quarterly, 6(1), 1-20.*

Durso, F. T., & Sethumahavan, A. (2008). Situation awareness: Understanding dynamic environments. *Human Factors, 50*(3), 442-448.

Ealy, L. T. (2011). Justice, beneficence and the modern age. *Society, 48,* 403-406.

Earle, V. (2010). Phenomenology as research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy, 11*, 286-296.

Eberle, T. S. (2011). Phenomenological life-world analysis and ethnomethodology's program. *Human Studies, 35*, 279-304.

Eberl, T. S., Koers, L., Van Haperen, M., & Preckel, B. (2017). Cognitive aids: 'a must' for procedures performed by multidisciplinary sedation teams outside the operation room? *British Medical Journal Case Reports,* 1-3. Retrieved from http://casereports.bmj.com/content/2017/bcr2017221645.abstract?hwshib 2=authn%3A1512990471%3A20171210%253A8aa743cb-12dc-4539-80a7-745406216e6b%3A0%3A0%3A0%3AuMow5IzpoVPy7jB2IzvW6w%3D%3D

Eddy, M. D. (2014). How to see a diagram: A visual anthropology of chemical affinity. *The History of Science Society, 29,* 178-196.

Eide, P. (2008). Recruiting participants. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods*. Thousand Oaks, CA: Sage.

Elmir, R., Schmied, V., Jackson, D., & Wilkes, L. (2011). Interviewing people about potentially sensitive topics. *Nurse Researcher, 19*(1), 12-16.

Emsley, C. (1996). *The English police: A political and social history* (2nd ed.). Harlow, United Kingdom: Pearson Education Limited.

Emsley. C. (2009). *The great British bobby: A history of British policing from the 18th century to the present.* London, United Kingdom: Quercus.

Endsley, M. R. (1988). Design and evaluation for situation awareness enhancement. *Proceedings of the Human Factors Society Annual Meeting,* (32nd), 97-101.

Endsley, M. R. (1995). Toward a theory of situation awareness in Dynamic systems. *Human Factors, 3*7(1), 32-64.

Endsley, M. R. (1999). Situation awareness in aviation systems. In D.J. Garland, J.A. Wise, & V.D. Hopkins (Eds.), *Handbook of aviation human factors* (pp. 257-276). Mahwah, NJ: Lawrence Erlbaum Associates.

Endsley, M. R. (2000). Theoretical underpinnings of situation awareness: A critical review. In M.R. Endsley, & D.L. Garland (Eds.), *Situation awareness analysis and measurement* (pp. 3-32). Mahwah, NJ: Lawrence Erlbaum Associates.

Endsley, M. R., & Bolstad, C. A. (1994). Individual differences in pilot situation awareness. *The International Journal of Aviation Psychology, 4*(3), 241-264.

Endsley, M. R., Bolte, B., & Jones, D. G. (2003). *Designing for situation awareness: An approach to user-centred design.* Ranton, FL: Taylor & Francis.

Engel, R. S. (2015). Police encounters with people with mental illness. Use of force, injuries, and perceptions of dangerousness. *Criminology & Public Policy, 14*(2), 247-251.

Equality and Human Rights Commission. (2015). *Preventing Deaths in Detention of Adults with Mental Health Conditions.* London, United Kingdom: Equality and Human Rights Commission.

Erdner, A., & Piskator, R. (2013). Police experiences of committing people with mental illness to a hospital. *Issues in Mental Health Nursing, 34*, 550–555.

Eyal, N. (2014). Using informed consent to save trust. *Journal of Medical Ethics, 40*, 437-444.

Fawcett, J., & Downs, F. S. (1992). *The relationship of theory and research* (2nd ed.). Philadelphia, PA: F.A. Davis Company.

Fedack, K., & Fedack, J. M. (2008). Fixed wing transport airway management utilising a situational awareness paradigm. *Air Medical Journal, 27*(1), 30-36.

Federico, P. (1995). Expert and novice recognition of similar situations. *Human Factors, 37*(1), 105-122.

Fernandez, R., & Griffiths, R. (2007). Portable MP3 players: innovative devices for recording qualitative interviews. *Nurse Researcher, 15*(1), 7-15.

Fienup-Riordan, A., Brown, C., & Braem, N. M. (2013). The value of ethnography in times of change: The story of Emmonak. *Deep-Sea Research, 94*, 301-311.

Finch, J, (1987). The vignette technique in survey research. *Sociology, 21,* 105-114.

Fink, A. (2003). Target populations and samples. In A. Fink (Ed.), *How to sample in surveys* (pp. 2-24). Thousand Oaks, CA: Sage.

Finn, M. A., & Stalans, L. J. (2002). Police handling of the mentally ill in domestic violence situations. *Criminal Justice and Behaviour, 29*, 278-307.

Flin, R., Pender, Z., Wujec, L., Grant, V., & Stewart, E. (2007). Police officers' assessment of operational situations. *Policing: An International Journal of Police Strategies & Management, 30*(2), 310-323.

Flowe, H. D., & Humphries, J. E. (2011). An examination of criminal face bias in a random sample of police lineups. *Applied Cognitive Psychology, 25*, 265–273.

Foltz, K. A. (2014). The millennial's perception of tattoos: Self-expression or business faux pas? *College Student Journal, 48*(4), 589-602.

Forrester, A., Samele, C., Slade, K., Craig, T., & Valmaggia, L. (2016). Suicide ideation amongst people referred for mental health assessment in police custody. *Journal of Criminal Psychology, 6*(4), 146-156.

Forrester, A., Samale, C., Slade, K., Craig, T., & Valmaggia, L. (2017). Demographic and clinical characteristics of 1092 consecutive police custody mental health referrals. *The Journal of Forensic Psychiatry & Psychology, 28*(3), 295-312.

Forrester-Jones, R., Carpenter, J., Coolen-Schrijner, P., Cambridge, P., Tate, A., Hallam, A., Beecham, J., Knapp, M., & Wooff, D. (2012). Good friends are hard to find? The social networks of people with mental illness 12 years after deinstitutionalisation. *Journal of Mental Health, 21*(1), 4-14.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 36*, 717-732.

Fornette, M., Bardel, M., Lefrançois, C., Fradin, J., El Massioui, F., & Amalberti, R. (2012). Cognitive-adaptation training for improving performance and stress management of air force pilots. *The International Journal of Aviation Psychology, 22*(3), 203–223.

Foss, C., & Ellefsen, B. (2002). The value of combining qualitative and quantitative approaches in nursing research by means of method triangulation. *Methodological Issues in Nursing Research, 40*(2), 242-245.

Foucault, M. (1977). *Discipline & punish: The birth of the prison* (2nd ed.). New York, NY: Random House.

Fox, S. (2006). Inquiries of every imaginable kind: Ethnomethodology, practical action and the new socially situated learning theory. *The Sociological Review, 54*(3), 427-445.

Fracker, M. L. (1988). A theory of situation assessment: Implications for measuring situation awareness. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting,* (32nd), 102-106.

Frances, D., & Hester, S. (2004). *An invitation to ethnomethodology: Language, society and interaction.* London, United Kingdom: Sage.

Franz, S., & Borum, R. (2011). Crisis Intervention Teams may prevent arrests of people with mental illnesses. *Police Practice and Research, 12*(3), 265–272.

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

Frye, L. M., & Waring, A. J. (2016). A model of metacognition for bushfire fighters. *Cognition, Technology & Work, 18,* 613–619.

Fuller, G., & Goldsmith, S. (2016). The nature of risk during interactions between the police and intoxicated offenders. *Trends & Issues in Crime and Criminal Justice, 525,* 1-17.

Gaba, D. M. (2004). The future vision of simulation in health care. *Quality and Safety in Health Care, 13,* 2-10. Retrieved from http://qshc.bmj.com/cgi/content/full/13/suppl_1/i2?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=gaba&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&sortspec=relevance&resourcetype=HWCIT

Gaba, D. M., & Howard, S. K. (1995). Situation awareness in anaesthesiology. *Human Factors, 37(*1), 20-31.

Gagon, A. J., Carnevale, F., Mehta, P., Rousseau, H., & Stewart, D. (2013). Developing population interventions with migrant women for maternal-child health: A focused ethnography. *BioMed Central Public Health, 13(*471), 1-14. Retrieved fromhttps://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-471

Gallacher, K. (2007). Clinical judgement and decision making in palliative care. *Primary Health Care, 17*(3), 40-43.

Gardner, A., Fedoruk, M., & McCutcheon, H. (2007). Discovering constructivist grounded theory's fit and relevance to researching contemporary mental health nursing practice. *Australian Journal of Advanced Nursing, 30*(20), 66-74.

Garfinkel, H. (1967). *Studies in ethnomethodology.* Cambridge, United Kingdom, Polity.

Garfinkel, H., & Sacks, H. (1970). On formal structures of practical actions. In J.C. McKinney, & E.A.Tiryakian (Eds.), *Theoretical sociology: Perspectives and developments* (pp. 337-366). New York, NY: Meredith Corporation.

Garrido, E., Maslip, J., & Herrero, C. (2004). Police officers' credibility judgments: Accuracy and estimated ability. *International Journal of Psychology, 39*(4), 254–275.

Geangu, E., Baritiu, G., Benga, O., Stahl, D., Striano, T., & Plank, M. (2011). Individual differences in infants' emotional resonance to a peer in distress: Self–other awareness and emotion regulation. *Social Development, 20*(3), 450-470.

Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York, NY: Basic Books. Individual Differences in infants' emotional resonance to a peer in distress: Self–other awareness and emotion regulation. *Social Development, 20*(3), 450-470.

Geller, A., Fagan, J., Tyler, T., & Link, B.G. (2014). Aggressive Policing and the mental health of young urban men. *American Journal of Public Health, 104*(12), 2321-2327.

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological and Behavioural Science, 42*, 266-290.

Gergen, K. J., & Gergen, M. M. (2007). Social construction and research methodology. In W. Outhwaite, & S. P. Turner (Eds.), *The Sage handbook of social science* (pp. 461-478). London, United Kingdom: Sage.

Gerrish, K. (2011). Methodological challenges in qualitative research. *Nurse Researcher, 19*(1), 4-5.

Gibbs, J. C., & Ahlin, E. M. (2013). The relationship between fairness and police-citizen hostility. *Journal of the Institute of Justice & International Studies, 13,* 1-20.

Gibson, W. J., & Brown, A. (2011). *Working with qualitative data*. London, United Kingdom: Sage.

Gilbert, A., & Sliep, Y. (2009). Reflexivity in the practice of social action: from self-to inter-relational reflexivity. *South African Journal of Psychology, 39*(4), 468-479.

Gilburt, H., Peck, E., Ashton, B., Edwards, N., & Naylor, C. (2014). *Service transformations: Lessons from mental health*. London, United Kingdom: The King's Fund.

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal, 204,* 291-295.

Gillig, P. M., Dumaine, M., Widish Stammer, J. R., Hillard & Grubb, P. (1990). What do police officers really want from the mental health system? *Hospital and Community Psychiatry, 41*(6), 663-665.

Gillon, R. (1985). Beneficence: Doing good for others. *British Medical Journal, 291*, 44-45.

Gillon, R. (1995). Defending the four principles approach to biomedical ethics. *Journal of Medical Ethics, 21*(6), 323-324.

Girodo, M. (2007). Personality and cognitive processes in life and death decision making: An exploration into the source of judgment errors by police special squads. *International Journal of Psychology, 42*(6), 418–426.

Given, L. M., & Saumure, K. (2008). Trustworthiness. In L. M. Given (Ed.), T*he Sage encyclopaedia of qualitative research methods* (pp. 896-897). Thousand Oaks, CA: Sage.

Glock, H. (2009). Concepts: Where subjectivism goes wrong. *Philosophy, 84*(1), 5-9.

Godfredson, J. W., Ogloff, J. R. P., Stuart, D. M., & Luebbers, S. (2010). Police discretion and encounters with people experiencing mental illness: The significant factors. *Criminal Justice & Behaviour, 37*, 1392-1405.

Godfredson, J. W., Ogloff, J. R. P., Stuart, D. M., Luebbers, S. (2011). Police perceptions of their encounters with individuals experiencing mental illness: A Victorian survey. *Australian & new Zealand Journal of criminology, 44*(2), 180-195.

Goffman, E. (1959). *The presentation of self in everyday life.* Garden City, NY: Anchor Books.

Goffman, E. (1963). *Stigma: Noted of the management of spoiled identity.* Englewood Cliffs, NJ: Prentice-Hall Inc.

Goffman, E. (1972). *Interaction ritual.* Harmondsworth, United Kingdom: The Penguin Press.

Goldberg, D. (1999). The future pattern of psychiatric provision in England. *European Archives of Psychiatry and Clinical Neuroscience, 249*, 123-127.

Goldkuhl, G., & Cronholm, S. (2010). Adding theoretical grounding to grounded theory: Toward multi-grounded theory. *International Journal of Qualitative methods, 9*(2), 187-205.

Goldman, A. (2001). Social routes to belief and knowledge. *Monist, 84*(3), 346-368.

Gooding, D. C. (2010). Visualising scientific inference. *Topics in Cognitive Science, 2*, 15-35.

Gould, D. (1996). Using vignettes to collect data for nursing research studies: How valid are the findings? *Journal of Clinical Nursing, 5,* 207-212.

Grawitch, M. J., Barber, L .K., & Kruger, M. H. (2010). Role identification, community socio-economic status demands, and stress outcomes in police officers. *Anxiety, Stress, & Coping, 23*(2), 165-180.

Green, H. E. (2014). Use of theoretical and conceptual frameworks in qualitative research. *Nurse Researcher, 21*(6), 34-38.

Green, T. M. (1997). Police as frontline mental health workers: The decision to arrest or refer to mental health agencies. *International Journal of Law and Psychiatry, 20*(4), 469–486.

Green, B., Parry, D., Oeppen, R. S., Plint, S., Dale, T., & Brennan, P. A. (2016). Situational awareness – what it means for clinicians, its recognition and importance in patient safety. *Oral Diseases, 23*, 721–725.

Green, J. & Thorogood, N. (2004). *Qualitative research methods for health research*. Trowbridge, United Kingdom: Sage.

Greenberg, D. M., Kolasi, J., Hegsted, C. P., Berkowitz, Y. Y., & Jurist, E. L. (2017). Mentalized affectivity: A new model and assessment of emotion regulation. *Public Library of Science, 18,* 1-27. Retrieved fromhttp://journals.plos.org/plosone/article?id=10.1371/journal.pone.0185264

Grimshaw, J., Campbell, M., Eccles, M., & Steen, N. (2000). Experimental and quasi-experimental designs for evaluating guideline implementation strategies. *Family practice, 17*(Supplement 1), s11-s16.

Guba, E. G., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oakes, CA: Sage.

Gupta, R. K. (2009). Major depression: An illness with objective physical signs. *The World Journal of Biological Psychiatry, 10*(3), 196-201.

Gur, O. M. (2010). Persons with mental illness in the criminal justice system: Police interventions to prevent violence and criminalization. *Journal of Police Crisis Negotiations, 10*, 220–240,

Gurses, A. P., Ozok, A. A., & Pronovost, P. J. (2011). Time to accelerate integration of human factors and ergonomics in patient safety. *British Medical Journal Quality & Safety, 21*, 347-351.

Haggerty, K. (2008). Trust. In L. M. Given (Ed.) *The Sage encyclopaedia of qualitative research methods* (pp. 895-896). Thousand Oaks, CA: Sage.

Halcomb, E. J., & Andrew, S. (2005). Triangulation as a method for contemporary nursing research. *Nurse Researcher, 13*(2), 71-82.

Hales, B. M., & Pronovost, P. J. (2006). The checklist—a tool for error management and performance improvement. *Journal of Critical Care, 21*, 231– 235.

Hall, H., Griffiths, D., & McKenna, L. (2012). From Darwin to constructivism: The evolution of grounded theory. *Nurse Researcher, 20*(3), 17-21.

Hankin, S. M., & Ramsey, C. H. (2007). Investigation of accidental secondary exposure to CS agent. *Clinical Toxicology, 45,* 409-411.

Hammersley, M. (2004). Reflexivity. In M.S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 934-936). Thousand Oaks, Ca: Sage.

Hanafi, S., Bahora, M., Demir, B. N., & Compton, M. T. (2008). Incorporating crisis intervention team (CIT) knowledge and skills into the daily work of police officers: A focus group study. *Community Mental Health Journal, 44*, 427-432.

Hansard. (1982). *Brixton Disorders: The Scarman Report*. Retrieved from http://hansard.millbanksystems.com/lords/1982/feb/04/brixton-disorders-the-scarman-report

Hanson, S., & Jones, A. (2017). Missed opportunities in the evaluation of public health interventions: a case study of physical activity programmes. *BioMed Central Public Health, 17*(674), 674-684. Retrieved from https://www.repository.cam.ac.uk/bitstream/handle/1810/267785/12889_2017_Article_4683.pdf?sequence=3&isAllowed=y

Hansson, L., & Markström, U. (2014). The effectiveness of an anti-stigma intervention in a basic police officer training programme: A controlled study. *BioMed Central Psychiatry*, *14*(55), 1-15. Retrieved from http://www.biomedcentral.com/1471-244X/14/55

Harris, J. E. (1980). Memory aids people use: Two interview studies. *Memory & Cognition, 8*(1), 31-38.

Hartford, K., Heslop, L., Stitt, L., & Hoch, J. S. (2005). Design of an algorithm to identify persons with mental illness in a police administrative database International. *Journal of Law and Psychiatry*, 28, 1-11.

Hartmann-McNamara, R., Crawford, R. & Burns, R. (2013). Policing the homeless: policy, practice, and perceptions. Policing: *An International Journal of Police Strategies & Management, 36*(2), 357-374.

Harvey, T. (2005). Reducing the frequency & severity of human error: Optimizing performance. *Professional Safety,* (November), 39-42.

Heap, J. L. (1980). Description in ethnomethodology. *Human Studies, 3,* 87-196.

Henderson, C., Robinson, E., Evans-Lako, S., Corker, E., Rebollo-Mesa, I., Rose, D., & Thornicroft, G. (2016). Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatrica Scandinavia, 134*(Supplement 446), s23-s33.

Henry, V. E. (1995). The police officer as survivor: Death confrontation and the police subculture. *Behavioural Sciences and the Law, 13*, 93-112.

Henshaw, M., & Thomas, S. (2012). Police encounters with people with intellectual disability: prevalence, characteristics and challenges. *Journal of Intellectual Disability Research, 56*(6), 620-631.

Her Majesty's Inspectorate of Constabulary. (2006). *The history of Her Majesty's Inspectorate of Constabulary*. London, United Kingdom: Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services.

Her Majesty's Inspectorate of Constabulary. (2011). *The rules of engagement: A review of the August 2011 disorders.* London, United Kingdom: Her Majesty's Inspectorate of Constabulary.

Her Majesty's Inspectorate of Constabulary. (2014). *Joint thematic inspection: The welfare of vulnerable people in police custody*. London, United Kingdom: Her Majesty's Inspectorate of Constabulary.

Her Majesty's Inspectorate of Constabulary. (2017*). Use of the Police National Computer: An inspection of the ACRO Criminal Records Office*. London, United Kingdom: Her Majesty's Inspectorate of Constabulary.

Her Majesty's Inspectorate of Constabularies and the Care Quality Commission. (2013). *A Criminal use of police cells?* London, United Kingdom: Her Majesty's Inspectorate of Constabularies and the Care Quality Commission.

Herbst, J., & Hafner, H-Th. (1999). Tentative injuries to exposed skin in a homicide case. *Forensic Science International, 102,* 193-196.

Heritage, J. (1984). *Garfinkel and ethnomethodology.* Cambridge, United Kingdom: Polity Press.

Hersberg, R. M. (2014). Constructivism. In D. Coghlan, & M. Brydon-Miller (Eds.), *The Sage encyclopaedia of action research* (pp. 183-186). London, United Kingdom: Sage.

Hillen, M. A., van Vliet, L. M., de Haes, C. J. M., & Smets, M. A. E. (2013). Developing and administering scripted video vignettes for experimental research of patient-provider communication. *Patient Education and Counselling, 91,* 295-309.

Hoffman, R., Hirdes, J., Brown, G. P., Dublin, J. A., & Barbaree, H. (2016). The use of a brief mental health screener to enhance the ability of police officers to identify persons with serious mental disorders. *International Journal of Law and Psychiatry, 47*, 8–35.

Holgersson, S. & Gottschalk, P. (2008). Police officers' professional knowledge. *Police Practice and Research, 9*(5), 365–377.

Hollander, Y., Lee, S. J., Tahtalian, S., Young, D., & Kulkarni, J. (2012). Challenges relating to the interface between crisis mental health clinicians and police when engaging with people with a mental illness. *Psychiatry, Psychology and Law, 19*(3), 402–411.

Home Office. (2003). *Healthcare professionals in custody suites - guidance to supplement revisions to the codes of practice under the Police and Criminal Evidence Act 1984*. Retrieved from https://www.gov.uk/government/publications/healthcare-professionals-in-custody-suites-guidance-to-supplement-revisions-to-the-codes-of-practice-under-the-police-and-criminal-evidence-act-1984

Home Office. (2005). *Neighbourhood Policing your police; your community; our commitment*. London, United Kingdom: Home Office Communication Directorate.

Home Office. (2011). *User guide to Home Office crime statistics.* London, United Kingdom: Her Majesty's Stationery Office.

Home Office. (2012). *Putting victims first: More effective responses to anti-social behaviour.* London, United Kingdom: The Stationery Office.

Home Office. (2013). *Crime and Courts Bill: Fact Sheet 12 of 12 on the National Crime Agency abolition of the National Policing Improvement Agency (NPIA).* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98451/fs-nca-npia.pdf

Home Office. (2014a). *Revised code of practice for the detention, treatment and questioning of persons by police officers: Police and Criminal Evidence Act 1984 (PACE) – code c.* London, United Kingdom: Her Majesty's Stationery Office.

Home Office. (2014b). *Police national Computer (PNC): Guidance.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488515/PNC_v5.0_EXT_clean.pdf

Home Office. (2014c). *Revised code of practice for the exercise by: Police officers of statutory powers of stop and search: Police officers and police staff of requirements to record public encounters: Police and Criminal Evidence Act 1984 (PACE) – Code.* Retrieved from https://www.gov.uk/governmentt/uploads/system/uploads/attachment_data/file/384122/PaceCodeAWeb.pdf

Home Office. (2015). *Crime recording general rules*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/656791/count-general-nov2017.pdf

Home Office. (2017). *List of UK police forces*. Retrieved from https://www.police.uk/forces/

Home Office and The Rt Hon Theresa May. (2011). *Home secretary outlines plans for newpolice professional body*. Retrieved from https://www.gov.uk/government/news/home-secretary-outlines-plans-fornew-police-professionalbody

Horspool, K., Drabble, S. J., & O'Cathai, A. (2016). Implementing street triage: A qualitative study of collaboration between police and mental health services. *BioMed Central Psychiatry, 16(*313), 1-11. Retrieved from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-016-1026z

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher, 20*(4), 12-17.

House of Commons Home Affairs Committee. (2015). *Policing and mental health*. London, United Kingdom: The Stationery Office.

House of Commons Home Affairs Committee. (2016). *College of Policing: three years on: Government and College of Policing responses to the Committee's Fourth Report of Session 2016–17*. London, United Kingdom: The Stationery Office.

Hosking, D., & Morley, I. E. (2004). Social constructionism in community and applied social psychology. *Journal of Community & Applied Social Psychology, 14*, 318-331.

Howard, P. (2000). *The Times book of quotations*. Glasgow, United Kingdom: HarperCollins Publishers.

Høye, S., & Severinsson, E. (2007). Methodological aspects of rigor in qualitative nursing research on families involved in intensive care units: A literature review. *Nursing and Health Sciences, 9,* 61–68.

Huckabay, L. M. (2009). Clinical reasoned judgment and the nursing process. *Nursing Forum, 44*(2), 72-78.

Huggins, C. (2014). Arranging and conducting elite interviews: Practical considerations. *Sage research Methods Cases,* (March), 1-18. Retrieved from http://methods.Sagepub.com.ezproxy.uclan.ac.uk/base/download/Case/arranging-and-conducting-elite-interviews-practical-considerations

Hughes, R. (1998). Considering the vignette technique and its application to a study of drug injecting HIV risk and safer behaviour. *Sociology of Health & Illness, 20*(3), 381-400.

Independent Commission on Mental Health and Policing. (2013). *Independent commission on mental health and policing report.* Independent Commission on Mental Health and Policing.

Independent Police Commission. (2013). *Policing for a better Britain: Report of the Independent Police Commission*. London, United Kingdom: Independent Police Commission

Independent Police Complaints Commission. (2008). *Police custody as a "Place of Safety": Examining the use of section 136 of the Mental Health Act 1983.* London, United Kingdom: Independent Police Commission.

Independent Police Complaints Commission. (2010). *Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09.* London, United Kingdom: Independent Police Commission.

Inzunza, M. (2015). Empathy from a police work perspective. *Journal of Scandinavian Studies in Criminology and Crime Prevention, 16*(1), 60-75.

Iqbal, I. Z., Kara, N., & Hartley, C. (2015). Gut instinct: a diagnostic tool? *The Journal of Laryngology & Otology, 129,* 365–368.

Jackson, W. (1999). Many people are not "participants" in sense that this term was initially defined. *British Medical Journal, 318*(7191), 1141.

Jacob, E. (1987). Qualitative research traditions: A review. *Review of Educational Research, 57*, 1-50.

Jacques, S. (2017). What criminals' tattoos symbolize: Drawing on Darwin, Durkheim, and Lombroso. *Deviant Behaviour, 38*(11), 1303-1317.

Jefferson, G. (Ed.) (1992). *Harvey Sacks: Lectures on conversation volume 1*. Cambridge, MA: Blackwell.

Jeffrey, A. (2012). The clinical intuition exploration guide: A decision-making tool for counsellors and supervisors. *The Family Journal: Counselling and Therapy for Couples and Families, 20*(1), 37-44.

Jensen, D. (2008a). Credibility. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 139-140). Thousand Oaks, CA: Sage.

Jensen, D. (2008b). Dependability. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 209-210). Thousand Oaks, CA: Sage.

Jensen, D. (2008c). Transferability. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (p. 887). Thousand Oaks, CA: Sage.

Jensen, R. S. (1997). The boundaries of aviation psychology, human factors, aeronautical decision making, situation awareness, and crew resources management. *The International Journal of Aviation Psychology, 7(*4), 259-267.

Jeon, Y. (2004). The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences, 18*, 249-256.

Jetelina, K. K., Jennings, W. G., Bishopp, S. A., Piquero, A. R., & Gonzales, J. R. (2017). Dissecting the complexities of the relationship between police officer–civilian race/ethnicity dyads and less-than-lethal use of force. *American Journal of Public Health, 107*(7), 1164-1170.

Johannsdottir, K. R., & Herdman, C. M. (2010). The role of working memory in supporting driver's situation awareness for surrounding traffic. *Human Factors, 52*(6), 663-673.

Johnson, L. A. (2013). Social stratification. *Biblical Theology Bulletin, 43*(3), 155–168.

Johnson, P. J. (1991). Emphasis on quality of life of people with severe mental illness in community-based care in Sweden. *Psychosocial Rehabilitation Journal, 14*(4), 23-37.

Johnston, E. L. (2013). Vulnerability and just desert: A theory of sentencing and mental illness. *The Journal of Criminal Law & Criminology, 103*(1), 147-229.

Johnston, C., & Liddle, J. (2006). The Mental Capacity Act 2005: a new framework for healthcare decision making. *Journal of Medical Ethics, 33,* 94-97.

Jones, D. G., & Endsley, M. R. (1996). Sources of situation awareness errors in aviation. *Aviation, Space and Environmental Medicine, 67*(4), 507-512.

Jones, S. L., & Mason, T. (2002). Quality of treatment following police detention of mentally disordered offenders. *Journal of Psychiatric and Mental Health Nursing*, 90, 73–80.

Junginger, J., Claypole, K., Laygo, R., & Crisanti, A. (2006). Effects of serious mental illness and substance abuse on criminal offenses. *Psychiatric Services, 57*(6), 879-882.

Jupp, V. (2006). Reflexivity. In V. Jupp (Ed.), *The Sage dictionary of social research methods* (pp. 258-260). London, United Kingdom: Sage.

Kahn, A. (2015). Cognitive failure and self-efficacy in episodic prospective memory. *Journal of Psychosocial Research, 10*(1), 139-148.

Kalberg, S. (1980). Max Weber's types of rationality: Cornerstones for the analysis of rationalisation processes in history. *The American Journal of Sociology, 85*(5), 1145-1179.

Kalsbeek, W. D. (2008). Stratified sampling. In P. J. Lavrakas (Ed.), *Encyclopaedia of survey research methods* (pp. 850-852). Thousand Oaks, CA: Sage.

Kaminski, R. J., Digiovanni, C., & Downs, R. (2004). The use of force between the police and persons with impaired judgement. *Police Quarterly, 7*(3), 311–338.

Kane, M., & Trochim, W. M. (2009). Concept Mapping for Applied Social Research. In L. Bickman, & D. J. Rog (Eds.), *The Sage handbook of applied social research methods* (pp. 435-474). Thousand Oaks, CA: Sage.

Kappeler, V. E., & Kraska, P. B. (1998). A textual critique of community policing: Police adaption to high modernity. *Policing: An International Journal of Police Strategies & Management, 21(*2), 293-313.

Karp, S., & Stenmark, H. (2011). Learning to be a police officer. Tradition and change in the training and professional lives of police officers. *Police Practice and Research, 12*(1), 4–15.

Keefe, P. R. (2016). Total recall. *The New Yorker* (August 22), 48-57.

Kennedy, B. L. (2018). Deduction, induction and abduction. In U. Flick (Ed.), *The sage handbook of qualitative data collection* (pp. 49-64). London, United Kingdom: Sage.

Kesic, D., Thomas, S. D. M., & Ogloff, J. R. P. (2012). Estimated rates of mental disorders in, and situational characteristics of, incidents of nonfatal use of force by police. *Social Psychiatry and Psychiatric Epidemiology, 48*, 225-232.

Kim, Y. J., & Hoffmann, C. M. (2003). Enhanced battlefield visualization for situation awareness. *Computers & Graphics, 27,* 873–885.

Kimmerle, J., & Cress, U. (2013). The effects of TV and film exposure on knowledge about and attitudes toward mental disorders. *Journal of Community Psychology, 41*(8), 931–943.

Kincheloe, J. E. (2005). On the next level: Continuing the conceptualisation of the bricolage. *Qualitative Inquiry, 11*(3), 323-350.

King, W. R., & Dunn, T. M. (2004). Dumping: Police-initiated transjurisdictional transport of troublesome persons. *Police Quarterly, 7*(3), 339–358.

Kirkby, H. M., Calvert, M., McManus, R.J ., & Draper, H. (2013). Informing potential participants about research: Observational study with an embedded randomized controlled trial. *Public Library of Science, 8*(10), 1-9. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0076435

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103-121.

Kitzinger, J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal, 311, 299-305.*

Kleider, H. M., Parrott, D. J., & King, T. Z. (2009). Shooting behaviour: How working memory and negative emotionality influence police officer shoot decisions. *Applied Cognitive Psychology, 24,* 707-717.

Klein, G. (2000). Using cognitive task analysis to build a cognitive model. *Proceedings of the Human Factors and Ergonomics Society Annual Meeting, 1*, 596-599.

Kleinmuntz, D. N., & Schkade, D. A. (1997). Information displays and decision processes. *Psychological Science, 4*(4), 221-227.

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of Health Communication, 13*(5), 434-449.

Klinger, D. A. (1997). Negotiating order in patrol work: An ecological theory of police response to deviance. *Criminology*, 35(2), 277-306.

Knox, S., & Burkard, A. W. (2009). Qualitative research interviews. *Psychotherapy Research, 19*(4-5), 566-575.

Koch, T. (1994). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 19,* 976-986.

Kozuba, J., & Pila, J. (2015). Chosen aspects of pilot's situational awareness. *Naše more – International Journal of Maritime Science & Technology, 62*(3), 175-180.

Krameddine, Y. L., & Silverstone, P. H. (2015). How to improve interactions between police and the mentally ill. *Frontiers in Psychiatry, 5*(186), 1-5.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214-222.

Krishan, S., Bakeman, R., Broussard, B., Cristofaro, S. L., Hankerson-Dyson, D., Husbands, L., Watson, A. C., & Compton, M. T. (2014). The influence of neighbourhood characteristics on police officers' encounters with persons suspected to have a serious mental illness. *International Journal of Law and Psychiatry, 37,* 359–369.

Krueger, R. A. & Casey, M. A. (2007). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oakes, CA: Sage.

Kutcher, S., Wei, Y. W., & Coniglio, C. (2016). Mental health literacy: past, present, and future. *The Canadian Journal of Psychiatry, 61*(3), 154-158.

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). Thousand Oakes, CA: Sage.

Laing, G. K. (2010). An empirical test of mnemonic devices to improve learning in elementary accounting. *Journal of Education for Business, 85,* 349–358.

Lamb, H. R., Weinberger, L. E., & DeCuir, J. R. (2002). The police and mental health. *Psychiatric Services, 53*(10), 1266-1271.

Lamb, H. R., Weinberger, L. E., & Gross, B. H. (2004). Mentally ill persons in the criminal justice system: Some perspectives. *Psychiatric Quarterly*, 75(2), 108-125.

Lanza, M. L., Carifio, J., Pattison, I., & Hicks, C. (1997). Validation of a vignette simulation of assault on nurses by patients. *Journal of Nursing Scholarship, 29*(2), 151-154.

Lapadat, J. C. (2010). Thematic analysis. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopedia of case study research* (pp. 926-927). Thousand Oaks, CA: Sage.

Larkin, J. H., & Simon, H. A. (1987). Why a diagram is (sometimes) worth ten thousand words. *Cognitive Science, 11*, 65-99.

Laverty, S.M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods, 2*(3), 1-29.

Lavie, T., & Oron-Gilad, T. (2013). Perceptions of electronic navigation displays. *Behaviour & Information Technology, 32*(8), 800-823.

Lawton, R., Gardner, P., & Plachcinski, R. (2010). Using vignettes to explore judgements of patients about safety and quality of care: The role of outcome and relationship with the care provider. *Health Expectations, 14,* 296-306.

Lawton-Smith, S., & McCulloch, A. (2013). *A brief history of mental health services.* Retrieved fromhttps://web.archive.org/web/20150404105121/http://www.mentalhealth.org.uk/content/assets/pdf/publications/starting-today-background-paper-1.pdf

Lecas, J. (2006). Behaviourism and the mechanization of the mind*. Compets Rendus Biologies, 329*, 386–397.

Lee, H., Jang, H., Yun., Lim, H., & Tushaus, D. W. (2010). An examination of police use of force utilizing police training and neighbourhood contextual factors: A multilevel analysis. *Policing: An International Journal of Police Strategies & Management, 33(*4), 681-702.

Leech, N. L., & Onwuegbuzie, A. J. (2008). Conceptual ordering. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 110-112). Thousand Oaks, CA: Sage.

Leeney, G., & Mueller-Johnson, K. (2010). Examining the link between the forensic quality and customer service quality of police call centre interviews. *International Journal of Police Science & Management, 12*(1), 69-80.

Leeney, G., & Mueller-Johnson, K. (2012). Examining the forensic quality of police call-centreInterviews. *Psychology, Crime & Law, 18*(7), 669-688.

Lemm, K. M. (2010). Stratified sampling. In N. J. Salkind (Ed.), *Encyclopaedia of research design* (pp. 1452-1455). Thousand Oaks, CA: Sage.

Lerner, C. S. (2006). Reasonable suspicion and mere hunches. *Vanderbilt Law Review, 59*(2), 405-473.

Lien, Y., Kao, Y., Liu., Y., Chang, H., Tzeng, N., Lu, C., Lin, S., & Loh. C. (2015). Relationships of perceived public stigma of mental illness and psychosis-like experiences in a non-clinical population sample. *Social Psychiatry and Psychiatric Epidemiology, 50,* 289-298.

Lincoln, Y. S. (2004). Trustworthiness criteria. In M.S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 1145-1146). Thousand Oaks, Ca: Sage.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic enquiry.* Newbury Park, CA: Sage.

Litwin, M. S. (2003). Pilot testing. In M.S. Litwin (Ed.), *How to assess and interpret survey psychomentrics* (pp. 58-67). Thousand Oaks, Ca: Sage.

Litzcke, S. M. (2006). Attitudes and emotions of German police officers towards the mentally ill. *International Journal of Police Science & Management, 8*(2), 119-132.

Liu, Y. C. (2012). Ethnomethodology reconsidered: The practical logic of social systems theory. *Current Sociology, 60*(5), 581-598.

Lockton, D., Harrison, D., & Stanton, N. A. (2010). The design with intent method: A design tool for influencing user behaviour. *Applied Ergonomics 41,* 382–392.

Loft, S., Bowden, V., Braithewaite, J., Morrell, D. B., Huf, S., & Durso, F. T. (2015). Situation awareness measures for simulated submarine track management. *Human Factors, 57*(2), 298-310.

Loftus, B. (2009). *Police culture in a changing world. Oxford.* United Kingdom: Oxford University Press.

Longstaff, A., Willer, J., Chapman, J., Czarnomski, S., & Graham, J. (2015). *Neighbourhood policing: Past, present and future. A review of the literature*. London, United Kingdom: The Police Foundation.

Lubnau, T. (2006). Situational awareness: Avoiding the “Charge of the Light Brigade.” *Fire Engineering,* (March), *139-145.*

Lukes, S. (Ed.). (1982). *The rules of sociological method by Emile Durkheim*. New York, NY: The Free Press.

Lundberg, J. (2015). Situation awareness systems, states and processes: a holistic framework. *Theoretical Issues in Ergonomics Science, 16*(5), 447-473.

Lurigio, A. J., Smith, A., & Harris, A. (2008). The challenge of responding to people with mental illness: Police officer training special programmes. *Police Journal, 81*(4), 295-309.

Lurigio, A. J., & Watson, A. C. (2010). The police and people with mental illness: New approaches to a longstanding problem. *Journal of Police Crisis Negotiations, 10*, 3-14.

Luterbach, K. J., & Hebbell, K. R. (2015). Capitalizing on app development tools and technologies. *TechTrends, 59*(4), 62-70.

Lynch, M. (2002). Ethnomethodology's unofficial journal. *Human Studies, 25,* 485-494.

Lynn, P. (2004). Stratified sample. In M.S. Lewis-Beck, A. Bryman, & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 1086-1087). Thousand Oaks, Ca: Sage.

MacLin, M. K., & Herrera, V. (2006). The criminal stereotype. *North American Journal of Psychology, 8*(2), 197-208.

Maharaj, R., Gillies, D., Andrew, S., & O'Brien, L. (2011). Characteristics of patients referred by police to a psychiatric hospital. *Journal of Psychiatric and Mental Health Nursing*, *18,* 205-212.

Makany, T., Kemp, J., & Dror, I. E. (2009). Optimising the use of note-taking as an external cognitive aid for increasing learning. *British Journal of Educational Technology, 40*(4), *619-635.*

Maran, N. J., Glavin, R. J. (2003). Low- to high-fidelity simulation – a continuum of medical education? *Medical Education, 3*(Supplement 1), s22-s28.

Marco, C. A., & Marco, J. L. (2012). Traumatic brain injury. *Trauma Reports, 13*(6), 1-11.

Maréchal, G. (2012a). Constructivism. In A.J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopaedia of case study research* (pp. 221-225). Thousand Oaks, CA: Sage.

Markowitz, F. E. (2006). Psychiatric hospital capacity, homelessness, and crime and arrest rates. *Criminology, 44*(1), 45-72.

Markowitz, F. E. (2011). Mental illness, crime, and violence: Risk, context, and social control. *Aggression and Violent Behaviour, 16*, 36–44.

Markowitz, F. E, & Watson, A. C. (2015). Police response to domestic violence: situations involving veterans exhibiting signs of mental illness. *Criminology, 53*(2), 231-252.

Marks, D. F., & Yardley, L. (2004). Content and thematic analysis. In D. F. Marks. & L. Yardley (Eds.), *Research methods for clinical and health psychology* (pp. 56-68). London, United Kingdom: Sage.

Marshall, S. (2013). The use of cognitive aids during emergencies in anaesthesia: A review of the literature. *Anaesthesia & Analgesia, 117*(5), 1162–1171.

Martin, S. J. (2006). Staff use of force in U.S. confinement settings: Lawful control tactics versus corporal punishment. *Social Justice 22*(4), 182-190.

Mathison, S. (2005). Credibility. In S. Mathison (Ed.), *Encyclopaedia of evaluation* (p. 92). Thousand Oaks, CA: Sage.

Martinez, L. E. (2010). Police departments' response in dealing with persons with mental illness. *Journal of Police Crisis Negotiations, 10*, 166–174.

Maruyama, G., & Deno, S. (2011). Implementing the research: Hoping for the best and coping with the worst. In G. Maruyama, & S. Deno (Eds.), *Research in educational settings* (pp. 96-110). Newbury Park, CA: Sage.

Mathison, S. (2011). Constructivism. In S. Mathison (Ed.), *Encyclopaedia of evaluation* (pp. 81-82.). Thousand Oaks, CA: Sage.

Matsui, K., & Kawaguchi, K. (2015). The differences of subjective findings in pattern recognition among experts, novices and students: A quasi-delphi technique. *Education in Medicine Journal, 7(*1), 22-29.

Mauthner, N. S., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology, 37*(3), 4130431.

Maxwell, J. A. (2018). Collecting qualitative data: A realist approach. In U. Flick (Ed.), *The Sage handbook of qualitative data* (pp. 19-31). London, United Kingdom: Sage.

Maxwell, J. A., & Mittapalli, K. (2008). Thick description. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research* (p. 881). Thousand Oaks, CA: Sage.

Maxwell, J. A., & Mittapalli, K. (2010). Realism as a stance for mixed methods research. In A. Tashakkori, & C. Teddlie (Eds.), *Sage handbook of mixed methods in social & behavioural research* (pp. 145-168). Thousand Oaks, CA: Sage.

May, T., and the Home Office. (2014a). *Home Secretary at the policing and mental health summit.* Retrieved from https://www.gov.uk/government/speeches/ home-secretary-at-the-policing-and-mentalhealth-summit

May, T., and the Home Office. (2014b). *Home Secretary: Vulnerable people need better support and care*. Retrieved from: https://www.gov.uk/government /news/home-secretary-vulnerable-people-need-bettersupport-and-care

Maynard, D. W., & Clayman, S. E. (1991). The diversity of ethnomethodology. *Annual Review of Sociology, 17,* 385-418.

McAnally, K. I., Morris, A. P., & Best, C. (2017). Metacognitive monitoring and control in visual change detection: Implications for situation awareness and cognitive control. *Public Library of Science, 12*(9), 1-19. Retrieved from http://eds.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=12&sid=bca6af83 -cde9-4b48-936d 6270278e8827%40sessionmgr101

McBrien, B. (2008). Evidence-based care: enhancing the rigour of a qualitative study. *British Journal of Nursing, 17*(20), 1286-1289.

McCaffery, D. (1990). *Air aces.* Toronto, Canada: James Lorimer & Company.

McCaig, C., & Dahlberg, L. (2015). Dissemination. In L. Dahlberg, & C. McCaig (Eds.), *Practical research and evaluation: A start-to-finish guide for practitioners* (pp. 219-237). London, United Kingdom: Sage.

McCarthy, D. J. (2012). Gendering 'soft' policing: multi-agency working, female cops, and the fluidities of police culture/s. *Policing & Society, 23*(2), 261-278.

McDoughall, S. J. P., Curry, M. B., & de Bruijn, O. (2001). The effects of visual information on users' mental models: An evaluation of pathfinder analysis as a measure of icon usability. *International Journal of Cognitive Ergonomics, 5*(1), 59–84.

McElhatton, J., & Drew, C. (2001). *Hurry-up syndrome.* Retrieved from https://asrs.arc.nasa.gov/publications/directline/dl5_hurry.htm

McGinn, M. K. (2010). Credibility. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *The encyclopaedia of case study research* (pp. 243-245). Thousand Oakes, CA: Sage.

McHugh, C., Balaratnasingham, S., Campbell, A., & Chapman, M. (2017). Suicidal ideation and non-fatal deliberate self-harm presentations in the Kimberley from an enhanced police–mental health service notification database. *Australasian Psychiatry, 25*(1) 35–39.

McLaren, P. G. (2010). Inductivism. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopaedia of case study research* (pp. 458-459). Thousand Oakes, CA: Sage.

McLean, N., & Marshall, L. A. (2010). A front line police perspective of mental health issues and services. *Criminal Behaviour and Mental Health,* 20, 62–71.

Mead, G. H. (1934). *Works of George Herbert Mead, Volume 1: Mind, self & society: From the standpoint of a social behaviourist.* Chicago, IL: University of Chicago Press.

Meade, B., Steiner, B., & Klahm, C. F. (2017). The effect of police use of force on mental health problems of prisoners. *Policing and Society, 27,* 2, 229-244.

Mental Capacity Act. (2005). Chapter 9: Persons who lack capacity. Retrieved from https://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

Mental Health Act. (1959). Chapter 72: Part 9. Powers and proceedings of mental health review tribunals. Retrieved from http://www.legislation.gov.uk/ukpga/1959/72/pdfs/ukpga_19590072_en.pdf

Mental Health Act. (1983a, amended 2007). Chapter 20: Miscellaneous provisions. Section 135. Warrant to search for and remove patients. Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf

Mental Health Act. (1983b, amended 2007). Chapter 20: Miscellaneous provisions. Section 136. Mentally disordered persons found in public places. Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/pdfs/ukpga_19830020_en.pdf

Mental Health Act. (1983c). Chapter 20: Miscellaneous provisions. Retrieved from https://www.legislation.gov.uk/ukpga/1983/20/contents/enacted

Mental Health Act. (2007). Chapter 12: Amendments to Mental Health Act 1983. Retrieved from https://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpga_20070012_en.pdf

Menzies, R.J. (1987). Psychiatrists in blue: Police apprehension of mental disorder and dangerousness. *Criminology, 25*(3), 429-453.

Merriam-Webster. (2015). *Crime.* Retrieved from http://www.merriam-webster.com/dictionary/crime

Merriam-Webster. (2017a). *Vacant.* Retrieved from https://www.merriam-webster.com/dictionary/vacant

Merriam-Webster. (2017b). *Agitation.* Retrieved from https://www.merriam-webster.com/medical/agitation

Merriam-Webster. (2017c). *Withdrawn.* Retrieved from https://www.merriam-webster.com/dictionary/withdrawn

Merriam-Webster. (2017d). *Erratic.* Retrieved from https://www.merriam-webster.com/dictionary/erratic

Merry, A. F., & Mitchell, S. J. (2016). Advancing patient safety through the use of cognitive aids. *British Medical Journal Quality & Safety, 25*, 733-735.

Merseyside Police. (2015). *Pocket notebook: policy & procedure.* Retrieved from https://www.merseyside.police.uk/media/12780/pocket-notebook-policy-procedure-2015-07-29.pdf

Metropolitan Police Service. (2012). *Police staff information pack: Experienced officers substantive detective constables.* Retrieved from http://www.metpolicecareersm.co.uk/media/doc/vacancies/officer/dc_info_pack3.pdf

Metropolitan Police Service. (2014). *Policing and mental health: Operational guidance for police officers and staff responding to incidents involving someone with a mental illness.* London, United Kingdom: Metropolitan Police Service.

Metropolitan Police Service. (2015). *History of policing.* Retrieved from http://content.met.police.uk/Site/historypolicing

Mifsud, D. (2016). Data representation with a dramatic difference: Negotiating the methodological tensions and contradictions in qualitative inquiry. Confessions of a budding playwright. *International Journal of Qualitative Studies in Education, 29*(7), 863-881.

Milliken, P. J., & Screiber, R. (2012). Examining the nexus between grounded theory and symbolic interactionism. *International Journal of Qualitative Methods, 11*(5), 684-694.

Mind & Victim Support. (2013). *Police and mental health: How to get it right locally*. London, United Kingdom: Mind & Victim Support.

Ming, T. S., Foo, V. K. K., Zainal, K.A., & Yen, L. H. (2017). Late-vs. early-onset anorexia nervosa in Asia: Nosological, aetiological, and therapeutic implications. *International Journal of Mental Health, 46(*3), 227-242.

Ministry of Justice. (2009). *Lord Bradley's report on people with mental health problems or learning disabilities in the Criminal Justice System: The Government's response.* London, United Kingdom: Ministry of Justice.

Ministry of Justice. (2013). *Quick reference guides to out of court disposals.* London, United Kingdom: Ministry of Justice.

Ministry of Justice. (2014). *Penalty notices for disorder (PNDs).* Retrieved fromhttps://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403812/penalty-notice-disorder-police-guidance.pdf

Mittwede, S. K. (2012). Research paradigms and their use and importance in theological inquiry and education. *Journal of Education & Christian Belief, 17*(2), 301-324.

Moore, R. (2010). Current trends in policing and the mentally ill in Europe: A review of the literature. *Police Practice and Research, 11*(4), 330–341.

Morabito, M. S. (2007). Horizons of context: Understanding the police decision to arrest people with mental illness. *Psychiatric Services, 58*(12), 1582-1587.

Morabito, M. S., & Socia, K. M. (2015). Is dangerousness a myth? Injuries and police encounters with people with mental illnesses. *Criminology & Public Policy, 14*(2), 253-276.

Morabito, M. S., Socia, K., Wik, A., & Fisher, W. H. (2017). The nature and extent of police use of force in encounters with people with behavioural health disorders. *International Journal of Law and Psychiatry, 50,* 31–37.

Moran, J. E. (2014). Mental disorder and criminality in Canada. *International Journal of Law and Psychiatry, 37,* 109–116.

Morant, N., & Edwards, E. (2011). Police responses to diversity: A social representational study of rural British policing in a changing representational context. *Journal of Community & Applied Social Psychology, 21,* 281-296.

Morgan, D. L. (1995). Why things (sometimes) go wrong in focus groups. *Qualitative Health Research, 5*(4), 561-523.

Morgan, D. L. (2008). Stratified sampling. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (p. 835). Thousand Oaks, CA: Sage.

Morgan, D. L. (2012). Focus groups. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 353-354). Thousand Oaks, CA: Sage.

Morse, J. M. (2004). Purposive sampling. In M. S. Lewis-Beck, A. Bryman & T. Futing Liao (Eds.), *The Sage encyclopaedia of social science research methods* (pp. 885-886\0. Thousand Oaks, CA: Sage.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1-19.

Muhlbauer, S. (2008). Caregiver perceptions and needs regarding symptom attenuation in severe and persist ant mental illness. *Perspectives in Psychiatric Care, 44*(2), 99-109.

Mulvey, P., & White, M. (2014). The potential for violence in arrests of persons with mental illness. *Policing: An International Journal of Police Strategies & Management, 37*(2), 404–419.

Munduteguy, C. (2011). A contribution to situation awareness analysis: Understanding how mismatched expectations affect read safety. *Human Factors, 53*(6), 687-702.

Myers, C. (2017). Police violence against people with mental disabilities. The immutable duty under the ADA to reasonably accommodate during arrest. *Vanderbilt Law Review, 70*(4), 1393-1426.

National Police Chiefs Council. (2015a). *Conflict management.* Retrieved from http://library.college.police.uk/docs/college-of-policing/PSM/PSM-MOD-0CONFLICT-MANAGEMENT.pdf

National Police Chiefs Council. (2015b). *Personal safety manual.* Retrieved from http://library.college.police.uk/docs/college-of-policing/PSM/PSM-MOD-01-INTRODUCTION.pdf

National Police Chiefs Council. (2015c). *Handcuffing.* Retrieved from http://www.npcc.police.uk/documents/FoI%20publication/Disclosure%20Logs/Uniformed%20Operations%20FOI/2013/003%2013%20Att%2008%20of%2015%20Police%20Officer%20Safety%20Manual%20Module%208.pdf

National Police Chiefs Council. (2016a). *Use of police cells for those in mental health crisis more than halves.* Retrieved from https://news.npcc.police.uk/releases/use-of-police-cells-for-those-in-mental-health-crisis-more-than-halves

National Police Chiefs Council. (2016b). *Policing vision 2025.* Retrieved from http://www.npcc.police.uk/documents/policing%20vision.pdf

National Police Improvement Agency. (2010). *Guidance on responding to people with mental ill health or learning disabilities*. London, United Kingdom: National Police Improvement Agency.

National Police Improvement Agency. (2012). *The PNC user manual*. Retrieved from http://webarchive.nationalarchives.gov.uk/20140122165729/http://www.levesoninquiry.org.uk/wp-content/uploads/2012/04/Exhibit-KW-NIPA3.pdf

Nee, C., & Witt, C. (2013). Public perceptions of risk in criminality: The effects of mental illness and social disadvantage. *Psychiatry Research, 209*, 675–683.

Neisser, U. (1976). *Cognition and reality: Principles and implications of cognitive psychology.* San Francisco, CA. WH Freeman & Company.

Netanda, R. S. (2012). Mixed methods-triangulation war: Hidden challenges to their conceptual survival. *Journal of Applied Global Research, 5(*14), 45-55.

NHS Confederation. (2014). *Key facts and trends in mental health: 2014 update*. London, United Kingdom: NHS Confederation.

NHS Confederation and Association of Chief Police Officers. (2015). *Mental health and policing: Improving crisis care*. London, United Kingdom: NHS Confederation.

Nicholas, M. C., & Hathcoat, J. D. (2014). Ontology. In D. Coghlan, & M. Brydon-Miller (Eds.), *The Sage encyclopaedia of action research* (pp. 571-572). London, United Kingdom: Sage.

Nicholson, D. (2013). Taking epistemology seriously: Truth, reason and justice revisited. *The international Journal of Evidence & Proof, 17*, 1-46.

Nikoo, N., Motamed, M., Strehlau, V., Neilson, E., Saddicha, S., & Krausz, M. (2015). Chronic physical health conditions among homeless. *Journal of Health Disparities Research and Practice, 8*(1), 81 – 97.

Noga, H. L., Walsh, E. C. L., Shaw, J. J., & Senior, J. (2014). The development of a mental health screening tool and referral pathway for police custody. *European Journal of Public Health, 25*(2), 237-242.

Novak, K. J., & Engel, R. S. (2005). Disentangling the influence of suspects' demeanour and mental disorder on arrest. *Policing: An international Journal of Police Strategies & Management, 28*(2), 493-512.

Novoa, A. M., Ward, J., Malmusi, D., Diaz, F., Darnell, M., Trilla, C., Bosch, J., & Borrell., C. (2015). How substandard dwellings and housing affordability problems are associated with poor health in a vulnerable population during the economic recession of the late 2000s. *International Journal for Equity in Health, 14*(120), 1-11.

Nyatanga, B., & de Vocht, H. (2008). Intuition in clinical decision-making: a psychological penumbra. *International Journal of Palliative Nursing, 14*(10), 492-496.

Nygaard, M., Sonne, C., & Carlsson, J. (2017). Secondary psychotic features in refugees diagnosed with post-traumatic stress disorder: A retrospective cohort study. *BioMed Central Psychiatry, 17*(5), 1-12. Retrieved from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-016-1166-1

O'Brien, K. S., & O'Hare, D. (2007). Situational awareness ability and cognitive skills training in a complex real-world task. *Ergonomics, 50*(7), 1064-1091.

O'Brien, A. J., & Thom, K. (2014). Police use of TASER devices in mental health emergencies: A review. *International Journal of Law and Psychiatry, 37*, 420–426.

O'Connor, M., Casey, L., & Clough, B. (2014). Measuring mental health literacy – a review of scale-based measures. *Journal of Mental Health, 23*(4), 197-204.

O'Dirico, J. C. (2005). Air superiority. *Air & Space Power Journal,* (fall), 55-63.

O'Leary, Z. (2004). *The essential guide to doing research*. London, United Kingdom, Sage.

O'Leary, Z. (2007). Reflexivity. In Z. O'Leary (Ed.), *The social science jargon buster* (pp. 223-224). London, United Kingdom: Sage.

O'Reilly, K. (2009). Inductive and deductive. In K. O'Reilly (Ed.), *Key concepts in ethnography* (pp. 104-109). London, United Kingdom: Sage.

O'Sullivan, R. G. (2011). Collaborative data gathering. In R.G. O'Sullivan (Ed.), *Practicing evaluation* (pp. 86-112). Thousand Oaks, Ca: Sage.

Official Secrets Act. (1989). Chapter 6: An Act to replace section 2 of the Official Secrets Act 1911 by provisions protecting more limited classes of official information. Retrieved from https://www.legislation.gov.uk/ukpga/1989/6/contents

Offredy, M. (1998). The application of decision making concepts by nurse practitioners in general practice. *Journal of Advanced Nursing, 28*(5), 988-1000.

Offredy, M., & Meerabeau, E. (2005). The use of 'think aloud' technique, information processing theory and schema theory to explain decision-making processes of general practitioners and nurse practitioners using patient scenarios. *Primary Health Care Research and Development, 6,* 46–59.

Ogloff, J. R. P., Thomas, S. D. M., Luebbers, S., Baksheev, G., Elliott, I., Godfredson, J., Kesic, D.,…Moore, E. (2013). Policing services with mentally ill people: Developing greater understanding and best practice. *Australian Psychologist, 48*, 57-68.

Ogloff, J. R. P., Warren, L., Tye, C., Blaher, F., & Thomas, S. (2011). Psychiatric symptoms and histories among people detained in police cells. *Social Psychiatry and Psychiatric Epidemiology, 46,* 871–880.

Oliver, C. (2012). The relationship between symbolic interactionism and interpretive description. *Advancing Qualitative Methods, 22*(3), 409-415.

Orasanu, J., & Martin, L. (1998). Errors in aviation decision making: A factor in accidents and incidents. *Human Error, Safety and Systems Development 2nd Workshop on Human Error*, 100-107. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.127.3972&rep=rep1&type=pdf

Oxburgh, L., Gabbert, F., Milne, R., & Cherryman, J. (2016). Police officers' perceptions and experiences with mentally disordered suspects. *International Journal of Law and Psychiatry, 49,* 138–146.

Ozer, U., Varlik, C., Ceri, V., Ince, B., & Delice, M. A. (2017). Change starts with us: Stigmatising attitudes towards mental illness and the use of stigmatising language among mental health professionals. *The Journal of Psychiatry and Neurological Sciences, 30*, 224-232.

Pace, R., Pluye, P., Bartlett, G., Macaulay, A. C., Salsberg, J., Jagosh, J.,…Solomon, M. J. (2017). Quality assessment of primary research studies. In M. Heyvaert, K. Hannes, & P Onghena (Eds.), *Using mixed methods research synthesis for literature reviews* (pp. 113-158). Thousand Oaks, CA: Sage.

Paddam, A., Barnes, D., & Langdon, D. (2010). Constructing vignettes to investigate anger in multiple sclerosis. *Nurse Researcher, 17*(2), 60-73.

Palys, T. (2008). Purposive sampling. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 698-699). Thousand Oaks, CA: Sage.

Panzarella, R., & Alicea, J. O. (1997). Police tactics in incidents with mentally disturbed persons. *Policing: An International Journal of Police Strategies & Management, 20*(2), 326-338.

Paoline, E. A., Myers, S. M., & Worden, R. E. (2000). Police culture, individualism, and community policing: Evidence from two police departments. *Justice Quarterly, 17*(3), 575-605).

Paquette, M. (2013). Excited delirium: Does it exist? *Perspectives in Psychiatric Care, 39*(3), 93-94.

Parliament.UK. (2015). *Police and health service collaboration: Street triage*. Retrieved from http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/202/20206.htm

Parsons, T. (1937). *The structure of social action*. Glencoe, IL: The Free Press.

Paskett, C. (2013). Memory aids, mnemonics, and acronyms: A company officers' perspective. *Fire Engineering,* (July), 71-74.

Patch, P. C., & Arrigo, B. A. (1999). Police officer attitudes and use of discretion in situations involving the mentally ill. *International Journal of Law and Psychiatry, 22*(1), 23-35.

Patterson, C., Procter, N., & Toffoli, L. (2016). Situation awareness: when nurses decide to admit or not admit a person with mental illness as an involuntary patient. *Journal of Advanced Nursing, 72(*9), 2042-2053.

Patterson, C., Procter, N., & Toffoli, L. (2017). When I say . . . situation awareness. *Medical Education, 51,* 683-684.

Pawson, R. (2006). Digging for nuggets: How 'bad' research can yield 'good' evidence. *International Journal of Social Research Methodology*, 9(2), 127-142.

Payne-James, J. (2017). Healthcare and forensic medical services in police custody–to degrade or to improve? *Clinical Medicine, 17*(1), 6–7.

Pearson, H. (2013). Science and intuition: do both have a place in clinical decision making? *British Journal of Nursing, 22*(4), 212-215.

Peaslee, L. (2009). Community policing and social service partnerships: lessons from New England. *Police Practice and Research, 19*(2), 115-131.

Peat, J. K. (2011). Planning the study. In J.K. Peat (Ed.), *Health science research* (pp. 13-80). London, United Kingdom: Sage.

Peck, E., & Hills, B. (2000). Provider arrangements for mental health services in 'The New NHS. *Health and Social Care in the Community, 8*(5), 325–33.

Perlin, M. L., & Lynch, A. J. (2016). “Had to be held down by big police": A therapeutic jurisprudence perspective on interactions between police and persons with mental disabilities. *Fordham Urban Law Journal, 43*(3), 686-711.

Pescosolido, B. A., Medina, M. A., Martin, J. K., & Long, J. S. (2013). the “backbone” of stigma: Identifying the global core of public prejudice associated with mental illness. *American Journal of Public Health, 103*(5), 853-860.

Petterson, D. (2012). Where the sidewalk ends: The limits of social constructionism. *Journal for the Theory of Social Behaviour, 42*(4), 445-484.

Pevalin, D. J., Reeves, A., Baker, E., & Bentley, R. (2017). The impact of persistent poor housing conditions on mental health: A longitudinal population-based study. *Preventive Medicine, 105,* 304–310.

Phelan, J. C., & Link, B. G. (2004). Fear of people with mental illnesses: The role of personal and impersonal contact and exposure to threat or harm. *Journal of Health and Social Behaviour, 45*(1), 68-80.

Pinfold, V., Huxley, P., Thornicroft, G., Farmer, P., Toulmin, H., & Graham, T. (2003). Reducing psychiatric stigma and discrimination: Evaluating an educational intervention with the police force in England. *Social Psychiatry and Psychiatric Epidemiology, 38,* 337-344.

Pinizzotto, A. J., Davis, E. F., Bohrer, S. B., & Infanti, B. J. (2012). Law enforcement restraint in the use of deadly force within the context of ‘the deadly mix’. *International Journal of Police Science & Management, 14*(4), 285-298.

Pizio, W. (2014). London Metropolitan Police: experiences and perceptions of citizen disrespect. *Police Practice and Research, 15*(3), 249–260.

Plieger, T., Felten, A., Diks, E., Tepel, J., Mies, M., & Reuter, M. (2017). The impact of acute stress on cognitive functioning: A matter of cognitive demands? *Cognitive Neuropsychiatry, 22*(1), 69-82.

Ploug, T., & Holm, S. (2013). Informed consent and routinisation. *Journal of Medical Ethics, 39,* 214–218.

Police Act. (1996). Chapter 16: An Act to consolidate the Police Act 1964, Part IX of the Police and Criminal Evidence Act 1984, Chapter I of Part I of the Police and Magistrates' Courts Act 1994 and certain other enactments relating to the police. Retrieved from https://www.legislation.gov.uk/ukpga/1996/16/pdfs/ukpga_19960016_en.pdf

Police Foundation. (2010). The briefing: Antisocial behaviour. *The Police Foundation, 1*(9), 1-11. Retrieved from http://www.police-foundation.org.uk/2017/wp-content/uploads/2010/02/asb_briefing.pdf

Police and Criminal Evidence Act. (1984). Chapter 60: An Act to make further provision in relation to the powers and duties of the police, persons in police detention, criminal evidence, police discipline and complaints against the police; to provide for arrangements for obtaining the views of the community on policing and for a rank of deputy chief constable. Retrieved from https://www.legislation.gov.uk/ukpga/1984/60/contents/enacted

Police Foundation. (2012). The briefing: Stop and search. *The Police Foundation, 2*(3), 1-11. Retrieved from http://www.police-foundation.org.uk/uploads/catalogerfiles/stop-and-search/stop_and_search_briefing.pdf

Police Policy Studies Council. (2004). Officers train to handle mentally ill in crises. Retrieved from http://www.theppsc.org/Archives/EDPs/officers_train_to_handle_mentally_ill.htm

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott, Williams & Wilkins.

Pollner, M. (2012). Reflections of Garfinkel and Ethnomethodology's program. *American Sociologist, 43*, 36-54.

Pollner, M., & Emerson, R. M. (2001). Ethnomethodology and ethnography In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of ethnography* (pp. 118-135). London, United Kingdom: Sage.

Popay, J., & Mallinson, S. (2010). Qualitative research review and synthesis. In I. Bourgeault, R. Dingwall, & R. De Vries (Eds.), *The Sage handbook of qualitative methods in health research* (pp. 289-305). London, United Kingdom: Sage.

Popay, J., Roberts, H., Sowden, A., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews.* Lancaster, United Kingdom: Lancaster University.

Powell, K. (2010). Making sense of place: mapping as a multisensory research method. In J. Hughes (Ed.), *Sage visual methods* (pp. 313-338). London, United Kingdom: Sage.

Pravossoudovitch, K., Curry, F., Young, S. G., & Elliot, A. J. (2010). Is red the colour of danger? Testing an implicit red–danger association. *Ergonomics, 57*(4), 503-510.

Prevention of Terrorism Act. (2005). Chapter 2: Control orders. Retrieved from https://www.legislation.gov.uk/ukpga/2005/2/pdfs/ukpga_20050002_en.pdf

Price, A., Zullosky, K., White, K., & Pretz, J. (2016). Accuracy of intuition in clinical decision-making among novice clinicians. *Journal of Advanced Nursing, 73*(5), 1147-1157.

Progrebin, M. R. (1986). Police responses for mental health assistance. *Psychiatric Quarterly, 58*(1), 66-73.

Promann, M., Wei, S., Qian, Z. C., & Chen, Y. V. (2016). The role of aesthetics and perception in raising situation awareness: Lessons from SpringRain. *International Journal of Human–Computer Interaction, 32,* 308–324.

Psarra, V., Sestrini, M., Santa, Z., Petsas, D., Gerontas, A., Garnetas, C., & Kontis, K. (2008). Greek police officers attitudes towards the mentally ill. *International Journal of Law & Psychiatry, 31*(1), 77-85.

Puchta, C., & Potter, J. (2002). Manufacturing individual opinions: Market research focus groups and the discursive psychology of evaluation. *British Journal of Social Psychology, 41,* 345–363.

Puolakka, K., Haapasalo-Pesu, K., Kiikkala, I., Astedt-Kukuri, P., & Paavilainen, E. (2013). Using grounded theory to create a substantive theory of promoting schoolchildren's mental health. *Nurse Researcher, 20*(1), 22-27.

Quayle, A. (2010). Objections to radical constructivism. *Constructivist Foundations, 6*(1), 12-18.

Quinton, P. (2011). The formation of suspicions: Police stop and search practices in England and Wales. *Policing & Society, 21*(4), 357-368.

Race, R. (2012). Literature review. In L.M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods, Vol.2* (pp. 488-489). London, United Kingdom: Sage.

Radecki, C. M., & Jaccard, J. (1995). Perceptions of knowledge, actual knowledge, and information search behaviour. *Journal of Experimental Psychology, 31*(2), 107-138.

Ravenek, M. J., & Rudman, D. L. (2013). Bridging conceptions of quality in moments of qualitiative research. *International Journal of Qualitative Research, 12*(1), 346-356.

Redondo, R. M., & Currier, G. W. (2003). Characteristics of patients referred by police to a psychiatric emergency service. *Psychiatric Services, 54*(6), 804-806.

Reed, J., & Payton, V. R. (2002). Focus groups: Issues of analysis and interpretation. *Journal of Advanced Nursing, 26*(4), 765-771.

Reed, J., & Roskell, V. (1997). Focus groups: Issues of analysis and interpretation. *Journal of Advanced Nursing, 28*, 765-771.

Renden, P. G., Landman, A., Daalder, N. R., de Cock, H. P., Savelsbergh, G. J. P., & Oudejans, R. R. (2013). Effects of threat, trait anxiety and state anxiety on police officers' actions during an arrest. *Legal and Criminological Psychology, 22*, 116–129.

Rethink. (2015). *Section 135: Being taken to a place of safety from a private place*. London, United Kingdom: Rethink.

Reuland, M. (2010). Tailoring the police response to people with mental illness to community characteristics in the USA. *Police Practice and Research, 11*(4), 315-329.

Reveruzzi, B., and Pilling, S. (2016). *Street Triage: Report on the evaluation of nine pilot schemes in England (March 2016).* Retrieved from https://www.ucl.ac.uk/pals/research/cehp/research-groups/core/pdfs/street-triage

Richman, J., & Mercer, D. (2002). The vignette revisited: Evil and the forensic nurse. *Nurse Researcher, 9(*4), 70-82.

Ring, N., Ritchie, K., Mandava, L., & Jepson, R. (2011). *A guide to synthesising qualitative research for researchers undertaking health technology assessments and systematic reviews*. Stirling, United Kingdom: NHS Quality Improvement Scotland.

Ringhoff, D., Rapp, L., & Robst, J. (2012). The criminalization hypothesis: Practice and policy implications for persons with serious mental illness in the criminal justice system. *Best Practices in Mental Health, 8*(2), 1-19.

Ritchie, J., & Lewis, J. (Eds.) (2004). *Qualitative research practice: A guide for social science students and researchers*. London, United Kingdom: Sage.

Ritter, C., Teller, J. L. S., Marcussen, K., Munetz, M. R., & Teasdale, B. (2010). Crisis intervention team officer dispatch, assessment, and disposition: Interactions with individuals with severe mental illness. *International Journal of Law and Psychiatry, 34*, 30-38.

Robertson, M., Kerridge, I., & Walter, G. (2009). Ethnomethodological study of the values of Australian psychiatrists: towards an empirically derived RANZCP code of ethics. *Australian & New Zealand Journal of Psychiatry, 43*(5), 409-19.

Robinson, N. (1999). The use of focus groups methodology–with selected examples from sexual health research. *Journal of Advanced Research, 29(*4), 905-913.

Robson, L. S., Shannon, H. S., Goldenhar, L. M., & Hale, A. R. (2001). *Guide to evaluating the effectiveness of strategies for preventing work injuries: How to show whether a safety intervention really works*. Cincinnati, OH: National Institute for Occupational Safety and Health.

Rodgers, M., Sowden, A., Petticrew, M., Arai, L., Roberts, H., Britten, N., & Popay, J. (2009). Testing methodological guidance on the conduct of narrative synthesis in systematic reviews: Effectiveness of interventions to promote smoke alarm ownership and function. *Evaluation, 15*(1), 49-74.

Rogers, C. (1959). A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science. Vol. 3: Formulations of the person and the social context.* New York, NY: McGraw Hill.

Rossler, M. T., & Terrill, W. (2017). Mental illness, police use of force, and citizen injury. *Police Quarterly, 20*(2), 189-212.

Rothgeb, J. M. (2008). Pilot test. In P.J. Lavrakas (Ed.), *Encyclopedia of survey research methods* (pp. 584-585). Thousand Oaks, Ca: Sage.

Roulston, K. (2010). *Reflective interviewing: A guide to theory & practice.* London. United Kingdom: Sage.

Roulston, K. (2017). Qualitative interviewing and epistemics. *Qualitative Research,* (August), 1-20. Retrieved from http://journals.Sagepub.com/doi/pdf/10.1177 /146 8794117721738

Rowe, M., Turner, T. E., & Pearson, G. (2016). Learning and practicing police craft. *Journal of Organizational Ethnography 5*(3), 276-286.

Royal Air Force. (2013). *First World War flying training - taking flight.* Retrieved from https://www.rafmuseum.org.uk/research/onlineexhibitions/takingflight/historic alperiods/first-world-war-flying-training.aspx

Royal Army Medical Corps. (2002). Battlefield Trauma Life Support. *Journal of the Royal Army Medical Corps, 148*, 151-158.

Royal College of Emergency Medicine. (2016). *Acute behavioural disturbance: guidelines on management in police custody*. Retrieved from http://library.college.police.uk/docs/appref/acutebehavedisturbance_jan16.pd f

Rozelle, R. M., & Baxter, J. C. (1975). Impression formation and danger recognition in experienced police officers. *The Journal of Social Psychology, 96,* 53-63.

Ruiz, J., & Miller, C. (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. *Police Quarterly, 7*(3), 359–371.

Runciman, W. B., & Merry, A. F. (2005). Crises in clinical care: an approach to management. *Quality and Safety in Healthcare, 14,* 156-163.

Ryan, F., Coughlan, M., & Cronin, P. (2009). Interviewing in qualitative research: the one-to-one interview. *International Journal of Therapy and Rehabilitation, 16*(6), 309-314.

Ryan-Nicholls, K. D., & Will, C. I. (2009). Rigour in qualitative research: Mechanisms for control. *Nurse Researcher, 16*(3), 70-85.

Sabel, A. L., Rosen, E., & Mehler, P. S. (2014). Severe anorexia nervosa in males: Clinical presentations and medical treatment. *Eating Disorders, 22*, 209–220.

Sainsbury Centre for Mental Health. (2009). *Diversion: A better way for criminal justice and mental health.* London, United Kingdom: The Sainsbury Centre for Mental Health.

Salmon, P., Stanton, N., Walker, G., & Green, D. (2006). Situation awareness measurement: A review of applicability for C4i environments. *Applied Ergonomics 37,* 225–238.

Sandelowski, M. (1986). The problem with rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27.37.

Sanford, A. J., & Garrod, S. C. (1981). *Understanding written language: Explorations in comprehension beyond the sentence.* Plymouth, United Kingdom: John Wiley & Sons Ltd.

Sarter, N. B., & Woods, D. D. (1991). Situation awareness: A critical but ill-defined phenomenon. *The International Journal of Aviation Psychology, 1*(1), 45-57.

Saumure, K., & Given, L. M. (2008). Rigor in qualitative research. In L. M. Given (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp. 796-797). Thousand Oaks, CA: Sage.

Saus, E., Johnsen, B. H., Eid, J., Riisem, P. K., Andersen, R., & Thayer, J. F. (2006). The effect of brief Situational Awareness training in a police shooting simulator: An experimental study. *Military Psychology, 18*(Supplement), s3-s21.

Scantlebury, A., Faifhurst, C., Booth, A., McDaid, C., Moran, N., Parker, A.,…Hewitt, C. (2017). Effectiveness of a training program for police officers who come into contact with people with mental health problems: A pragmatic randomised controlled trial. *Public Library of Science, 12*(9), 1-17. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0184377

Scarman. L. (1981).*The Scarman report: the Brixton disorders, 10-12 April 1981: Report of an Inquiry by the Right Honourable Lord Scarman*. London, United Kingdom: The Stationery Office.

Schegloff, E. E., & Sacks, H. (1973). Opening up closings. *Seminotica, 7*, 289-327.

Schmidt, U., & Pollak, S. (2006). Sharp force injuries in clinical forensic medicine: Findings in victims and perpetrators. *Forensic Science International, 159*, 113–118.

Schneider, J., Wooff, D., Carpenter, J., Brandon, T., & McNiven, F. (2002). Community mental healthcare in England: associations between service organisation and quality of life. *Health and Social Care in the Community 10*(6), 423–434.

Schulz, C. M., Krautheim, V., Hackermann, A., Kreuzer, M., Kochs, E. F., & Wagner, K. J. (2016). Situation awareness errors in anaesthesia and critical care in 200 cases of a critical incident reporting system. *BioMed Central Anaesthesiology, 16*(4), 1-10. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4715310/

Schultze, U., & Avital, A. (2011). Designing interviews to generate rich data for information systems research. *Information and Organisation, 21*, 1-16.

Schwabe, L., Joels, M., Roozendaal, B., Wolf, O. T., & Oizl, M. S. (2011). Stress effects on memory: An update and integration. *Neuroscience and Biobehavioural Reviews, 36,* 1740–1749.

Schwandt, T. A. (2007a). Reflexivity. In T. A. Schwandt (Ed.), *The Sage dictionary of qualitative inquiry* (pp. 261-262). Thousand Oaks, CA: Sage.

Schwandt, T. A. (2007b). Trustworthiness criteria. In T. A. Schwandt (Ed.), *The Sage dictionary of qualitative inquiry* (pp. 299-301). Thousand Oaks, CA: Sage.

Seale, C. (2002). Quality issues in qualitative inquiry. *Qualitative Social Work, 1*(1), 97-110.

Segall, N., Kaber, D. B., Taekman, J. M., & Wright, M. C. (2013). A cognitive modelling approach to decision support tool design for anaesthesia provider crisis management. *International Journal of Human-Computer Interaction, 29*(2), 55-66.

Sellars, C.l., Sullivan, C. J., Veysey, B. M., & Shane, L. M. (2005). Responding to persons with mental illnesses: Police perspectives on specialized and traditional practices. *Behavioural Sciences and the Law*, 23, 647-657.

Shank, G. (2008). Deduction. In L. M. Given (Ed.), *The sage encyclopaedia of qualitative research methods* (p. 208). Thousand Oakes, CA: Sage.

Shapiro, G. K., Cusi, A., Kirst, M., O'Campo, P., Nakhost, A., & Stergiopoulos, V. (2014). Co-responding Police-mental health programs: A review. *Administration and Policy in Mental Health and Mental Health, 42,* 606-620.

Shaw, C. M. (2015). Police perspective. *The New American,* (September 21), 39-42.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63–75.

Shepard Engel, R., & Silver, E. (2001). Policing mentally disordered suspects: A re-examination of the criminalisation hypothesis. *Criminology, 39*(2), 225-252.

Shibutani, T. (1955). Reference groups as perspectives. *American Journal of Sociology, 60*(6), 562-569.

Shih, F. (1998). Triangulation in nursing research: Issues of conceptual clarity and purpose. *Journal of Advanced Nursing, 28*(3), 631-641.

Short, T. B. R., MacDonald, C., Luebbers, S., Ogloff, J. R. P., & Thomas, S. D. M. (2014). The nature of police involvement in mental health transfers. *Police Practice and Research*, *15*(4), 336-348.

Sim, J. (1998). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28*(2), 345-352.

Sim, J. (2010). Addressing conflicts in research ethics: consent and risk of harm. *Physiotherapy Research International, 15,* 80-87.

Simon, H. A. (1996). *The sciences of the artificial* (3rd ed.). Cambridge, MA: MIT Press.

Sinclair, J. M. (2000). *The Times English dictionary.* Glasgow, United Kingdom: HarperCollins Publishers.

Skeem, J., & Bibeau, L. (2008). How does violence potential relate to crisis intervention team responses to emergencies? *Psychiatric Services, 59*(2), 201-204.

Skinner, B. F. (1985). Cognitive science and behaviourism. *British Journal of Psychology, 76,* 291-301.

Sleed, M., Durrheim, K., Kriel, A., Solomon, V., & Baxter, V. (2002). The effectiveness of the vignette methodology: A comparison of written and video vignettes in eliciting responses about date rape. *South African Journal of Psychology, 32*(3), 21-28.

Smith, K., & Hancock, P.A. (1995). Situation awareness is adaptive, externally directed consciousness. *Human Factors, 37*(1), 137-148.

Sneddon, A., Mearns, K., & Flin, R. (2006). Situation awareness and safety in offshore drill crews. *Cognition, Technology & Work, 8*, 255-267.

Sommerville, P. (2013). Understanding Homelessness. Housing, *Theory and Society, 30*(4), 384–415.

Sonderegger, A., & Sauer, J. (2010). The influence of design aesthetics in usability testing: Effects on user performance and perceived usability. *Applied Ergonomics, 41,* 403–410.

Spick, M. (1988). *The ace factor: Air combat and the role of situational awareness.* Shrewsbury, United Kingdom: Airlife Publishing Ltd.

Staller, K. M. (2010). Qualitative research. In N. J. Salkind (Ed.), *Encyclopedia of research design* (pp. 1159-1163). Thousand Oaks, CA: Sage.

Standing, M. (2008). Clinical judgement and decision-making in nursing – nine modes of practice in a revised cognitive continuum. *Journal of Advanced Nursing, 62*(1), 124-134.

Stanton, N. A., Chambers, P. R. G., & Piggott, J. (2001). Situational awareness and safety. *Safety Science, 39,* 189-204.

Stanyon, W., Whitehouse, M., & Goodman, B. (2014). Using simulation to educate police about mental illness. *Journal of Community Research and Engagement, 7*, 52-66.

Stewart, D. D., Shamdasani, P. N., & Rook, D. W. (2007). *Focus groups: Theory and practice* (2nd ed.). Thousand Oaks, CA: Sage.

Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist, 42*(2), 106 –117.

Stone-Romero, E. F. (2007). Moderator variable. In N. J. Salkind, & K. Rasmussen (Eds.), *Encyclopedia of measurement and statistics* (pp. 625-627). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory proceedings and techniques*. Newbury Park, CA: Sage.

Stroshine, M., Alpert, G., & Dunham, R. (2008). The influence of “working rules” on police suspicion and discretionary decision making. *Police Quarterly, 11*(3), 315-337.

Stubbings, L., Chaboyer, W., & McMurray, A. (2012). Nurses’ use of situation awareness in decision-making: An integrative review. *Journal of Advanced Nursing, 68*(7), 1443–1453.

Suffolk Police (2006) *Chief Constable’s performance report to the Suffolk Police Authority for the 3 months ending 30th June 2006*. Retrieved from http://www.suffolk.police.uk/NR/rdonlyres/A03ED555-85CE-495E-8980CA 9C26FB858A/0/PerformanceReportJune30th2006.pdf

Sulistyawati, K., Wickens, C. D., & Chui, Y. P. (2011). Prediction in situation awareness: Confidence bias and underlying cognitive abilities. *The International Journal of Aviation Psychology, 21*(2), 153-174.

Sussman, A. (2012). Shocking the conscience: What police Tasers and weapon technology reveal about excessive force law. *UCLA Law Review, 59,* 1342-1415.

Sussman, S., & Ashby Wills, T. (2001). Rationale for program development methods. In S. Sussman (Ed.), *Handbook of program development methods for health behaviour research and practice* (pp. 2-30). Thousand Oaks, CA: Sage.

Sutrop, M. (2011). Viewpoint: How to avoid a dichotomy between autonomy and beneficence: from liberalism to Communitarianism and beyond. *Journal of Internal Medicine, 269,* 370–382.

Swedberg, R. (2016). Can you visualise theory? On the use of visual thinking in theory pictures, theorising diagrams, and visual sketches. *Sociological Theory 34*(3), 250-275.

Sweeney, F. (2015). Street triage –what, why and how? *The British Psychological Society, 28*, 674-677.

Szeto, A. C. H., Luong, D., & Dobson, K. S. (2012). Does labelling matter? An examination of attitudes and perceptions of labels for mental disorders. *Social Psychiatry & Psychiatric Epidemiology, 48*, 659-671.

Sztompka, P. (1986). Some aspects of Florian Znaniecki's philosophy of the social sciences. *Philosophy of the Social Sciences, 16,* 441-457.

Taylor, P. J. (2004). Mental disorder and crime. *Criminal Behaviour and Mental Health, 14,* 31-36.

Teller, J. L. S., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services, 57*(2), 232-237.

ten Have, P. (2004). *Understanding qualitative research and ethnomethodology.* London, United Kingdom: Sage.

ten Have, P. (2008). Ethnomethodology. In L.M. Givern (Ed.), *The Sage encyclopaedia of qualitative research methods* (pp 294-296). Thousand Oaks, CA: Sage.

Teplin, L. A. (1984). Criminalizing mental disorder: The comparative arrest rate of the mentally ill. *American Psychologist, 39*(7), 794-803.

Teplin, L. (2000). Keeping the peace: Police discretion and mentally ill persons. *National Institute of Justice Journal*, *July*, 9-15.

Teplin, L., & Pruett, N. (1992). Police as streetcorner psychiatrist: Managing the mentally ill. *International Journal of Law and Psychiatry, 15*, 139-156.

Terrill, W., Paoline, E. A., & Manning, P. K. (2003). Police Culture and Coercion. *Criminology, 41*(4), 1003-1034.

Tessier, S. (2012). From field notes, to transcripts, to tape recordings: Evolution or combination? *International Journal of Qualitative Methods, 11*(4), 447-460.

Theft Act. (1968). Chapter 60: An Act to revise the law of England and Wales as to theft and similar or associated offences. Retrieved from https://www.legislation.gov.uk/ukpga/1968/60/pdfs/ukpga_19680060_en.pdf

Thiétart, R., & Wauchope, S. (2001). Constructing the research problem. In R. Thiétart, & S. Wauchope (Eds.), *Doing management research* (pp. 31-51). London, United Kingdom: Sage.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Paediatric Nursing, 16*, 151-155.

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Methodological Issues in Nursing Research, 48*(4), 388-396.

Trad, P. V. (1991). The ultimate stigma of mental illness. *American Journal of Psychotherapy, 45*(4), 463-466.

Tucker, A. S., Van Hasselt, V. B., Vecchi, G. M., & Browning, S. L. (2011). Responding to persons with mental illness. *FBI Law Enforcement Bulletin,* (October), 1-6.

Tuckett, A. G. (2005). Part II: Rigour in qualitative research: complexities and solutions. *Nurse Researcher, 13*(1), 29-42.

Tuohy, D., Cooney, A., Dowling, M., Murphy, K., & Sixsmith, J. (2012). An overview of interpretive phenomenology as a research methodology. *Nurse Researcher, 20*(6), 17-20.

Ungar, T., Knaak, S., & Szeto, A. C. (2016). Theoretical and practical considerations for combating mental illness stigma in health care. *Community Mental Health Journal, 52,* 262–271.

United States Department of Defence. (2009). *Blows to the head an injury, not a mental Illness.* Washington, DC: Federal Information & News Dispatch, Inc. Retrieved from https://search.proquest.com/docview/190364473?accountid=17233

University of Central Lancashire. (2014). *University code of conduct for research*. Retrieved from https://www.uclan.ac.uk/research/environment/Assets/Code_of_Conduct_or_Research_2008.pdf

University of Central Lancashire. (2015). *Ethical principles for teaching, research, consultancy, knowledge transfer and related activities.* Retrieved from https://www.uclan.ac.uk/research/environment/assets/Research_ethical_principles_Sept2015.pdf

Usher, K., & Trueman, S. (2015). Stop the shooting: It is time for partnerships between police and mental health nurses. *International Journal of Mental Health Nursing, 24,* 191–192.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences, 15,* 398–405

Van Brundy, B., Zedginidze, A. A., & Light, P. A. (2016). The unfit parent: Six myths concerning dangerousness and mental illness. *Family Court Review, 54*(1), 18–28.

Van den Brink, R. H. S., Broer, J., Tholen, A. J., Winthorst, W. H., Visser, E., & Wiersma, D. (2012). Role of the police in linking individuals experiencing mental health crises with mental health services. *BioMed Central Psychiatry, 12*(171), *1-7.* Retrieved from http://www.biomedcentral.com/1471-244X/12/171

Van den Heuvel, C., Alison, L., & Power, N. (2012). Coping with uncertainty: police strategies for resilient decision-making and action implementation. *Cognition, Technology & Work, 16,* 25-45.

Van Maanen, J. (1978). The asshole. In P. K. Manning, & J. Van Maanen (Eds.), *Policing: a view from the street* (pp. 221-238). Santa Monica, CA: Goodyear.

Van Vliet, L. M., Hillen, M. A., van der Wall, E., Plum, N., & Bensing, J. M. (2013). How to create and administer scripted video-vignettes in an experimental study on disclosure of patient breast cancer diagnosis. *Patient Education & Counselling, 91*(1), 56-64.

Vanneman, S. (2017). Note taking as easy as… ABC LOU. *School Library Monthly, 27*(4), 23-25.

Veresha, R. (2017). Criminal and legal characteristics of criminal intent. *Journal of Financial Crime, 24*(1), 118-128.

Vinkers, D. J., De Blurs, E., Barendregt, M., Rinne, T., & Hoek, H. W. (2011). The relationship between mental disorders and different types of crime. *Criminal Behaviour and Mental Health, 21,* 307–320.

Vogt, W. P. (2005). Constructivism. In W. P. Vogt (Ed.), *Dictionary of statistics & methodology* (p. 58). Thousand Oaks, CA: Sage.

Von Peter, S. (2013). 'Chronic' identities in mental illness. *Anthropology & Medicine, 20*(1), 48-58.

Wagenaar, W. A., Hudson, P. T., & Reason, J. T. (1990). Cognitive failures and accidents. *Applied Cognitive Psychology, 4,* 273-294.

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

Waltz, C. F., Strickland, O. L., & Lenz, E. R. (1991). *Measurement in nursing research* (2nd ed.). Philadelphia, PA: F.A. Davis Company.

Wansbrough, L. (2008). Less than legal force? An examination of the legal control of the police use of force in New Zealand. *Auckland University Law Review, 14,* 76-216.

Warfield Rawls, A. (2002). Editor's introduction. In A. Warfield Rawls, (Ed.), *Harold Garfinkel: Ethnomethodology's programme: Working out Durkheim's aphorism* (pp. 1-64). Lanham, ML: Rowman & Littlefield Publishers Ltd.

Warfield Rawls, A. (2011). Garfinkel, ethnomethodology, and the defining questions of pragmatism. *Qualitative Sociology, 34,* 277-282.

Wasserman, R. (2013). Ethical issues and guidelines for conducting data analysis in psychological research. *Ethics & Behaviour, 23*(1), 3–15.

Waters, I. (2007). Policing, modernity and postmodernity. *Policing & Society, 17*(3), 257-278.

Watson, J. B. (1913). Psychology as the behaviourist views it. *Psychology Review, 20,* 158-177.

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

Watson, A. C., Corrigan, P. W., & Ottati, V. (2004). Police responses to persons with mental illness: Does the label matter? *The Journal of the American Academy of Psychiatry and Law, 32,* 378-385.

Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: A primer for mental health practitioners. *Best Practices in Mental Health*, *8*(2), 71-81.

Watson, A. C., Ottati, V. C., Morabito, M., Draine, J., Kerr, A. N., & Angell, B. (2010). Outcomes of Police Contacts with Persons with Mental Illness: The impact of CIT. *Administration and Policy in Mental Health*, *37*, 302-317.

Watson, A. C., Ottati, V. C., Morabito, M., Draine, J., & Morabito, M. (2011). CIT in context: The impact of mental health resource availability and district saturation on call dispositions. *International Journal of Law and Psychiatry, 34*, 287-294.

Watson, A. C., Swartz, J., Bohrman, C., Kriegel, L. S., & Draine, J. (2014). Understanding how police officers think about mental/emotional disturbance calls. *International Journal of Law and Psychiatry, 3*7(4), 351–358.

Webb, C., & Kevern, J. (2000). Focus groups as a research method: A critique of some aspects of their use in nursing research. *Journal of Advanced Nursing, 33*(6), 798-805.

Welcome Library. (2017). *Lunacy and Mental Treatment Acts 1890-1930*. Retrieved from*https://wellcomelibrary.org/item/b24960020#?c=0&m=0&s=0&cv=0&z=0.4226%2C0.1199%*2C1.9244%2C1.2088

Weller, L., Quinton, P., Fildes, A., Mills, A. (2013). *The Greater Manchester Police procedural justice training experiment: Technical report.* Retrieved from http://library.college.police.uk/docs/college-of-policing/Technical-Report.pdf

Wellington, J. J., Bathmaker, A., Hunt, C., McCulloch, G., & Sikes, P. (2005). Reviewing the literature. In J. J. Wellington, A. Bathmaker, C. Hunt, G. McCulloch, & P. Sikes (Eds.), *Succeeding with your doctorate* (pp. 73-91). London, United Kingdom: Sage.

Wells, W., & Schafer, J. A. (2006). Officer perceptions of police response to persons with a mental illness. *Policing: An International Journal of Police Strategies and Management, 29*(4), 578-601.

Welsh, I. & Lyons, C. M. (2000). Evidence-based care and the case for intuition and tacit knowledge in clinical assessment and decision making in mental health nursing practice: an empirical contribution to the debate. *Journal of Psychiatric and Mental Health Nursing, 8*, 299–305.

Werner, J. (2009). *The knight of Germany.* Newbury, United Kingdom: Casemate.

West Yorkshire Police. (2014). *Use of force.* Retrieved from https://www.westyorkshire.police.uk/sites/default/files/files/disclosurelogs/2014_218_foi2014514185_use_of_force_policy2.pdf

Westminster Briefing. (2015). *The Cleveland mental health street triage pilot*. Retrieved from http://www.westminster-briefing.com/features/feature-detail/newsarticle/the-clevelandmental-health-street-triage-pilot

Whitcher, J. (2008). Legal responsibilities: Consent in emergency treatment. *Nursing Standard. 23*(9), 35-42.

White, R. (2004). Discourse analysis and social constructionism. *Nurse Researcher, 12*(2), 7-16.

Whiting, L. S. (2008). Semi-structured interviews: Guidance for novice researchers. *Nursing Standard, 22*(23), 35-40.

Wickens, C. D. (2008). Situation awareness: Review of Mica Endsley's 1995 articles on situation awareness theory and measurement. *Human Factors, 50*(3), 397-403.

Wiener, E. L., & Curry, R. E. (1980). Flight-deck automation: Promises and problems. *National Aeronautics and Space Administration Memorandum 81206*,1-24. Retrieved from https://ntrs.nasa.gov/archive/nasa/casi.ntrs.nasa.gov/19800017542.pdf

Wilcox, N. (2015). *FBI Law Enforcement Bulletin: FBI — the importance of mental health training in law enforcement.* Retrieved from https://leb.fbi.gov/articles/featured-articles/the-importance-of-mental-health-training-in-law-enforcement

Wilkinson, S. (1998). Focus groups in health research: Exploring the meanings of health and illness. *Journal of Health Psychology, 3*(3), 329-348.

Wilks, T. (2004). The use of vignettes in qualitative research into social work values. *Qualitative Social Work, 3,* 78-87.

Williams, D. (2005). Reflexivity. In S. Mathison (Ed.), *Encyclopaedia of evaluation* (p. 369). Thousand Oaks, CA: Sage.

Willment, J. H. (2010). Cognitive mapping. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopaedia of case study research* (pp. 161-164). Thousand Oaks, CA: Sage.

Wolcott, H. F. (2009). Finishing up. In H.F. Wolcott (3rd ed.), *Writing up qualitative research* (pp. 121-150). Thousand Oak, CA: Sage.

Wolf, R., Mesloh, C., Henych, M., & Thompson, L. F. (2008). Police use of force and the cumulative force factor. *Policing: An International Journal of Police Strategies & Management, 32*(4), 739-757.

Woody, M. S. (2005). The art of de-escalation. *The Journal,* (summer), 56-62. Retrieved from http://www.olytac.com/wp-content/uploads/2013/12/Woody.-2005.-The-Art-of-De-Escalation-.pdf

Wooldridge, T., & Little, P. (2012). An Overview of Anorexia Nervosa in Males. *Eating Disorders, 20, 368–378.*

Worden, R. E., & Shepard, R. L. (1996). Demeanour, crime and police behaviour: A re-examination of the police services study data. *Criminology, 34*(1), 83-105.

World Health Organisation. (2014). *Social determinants of mental health*. Geneva, Switzerland: WHO Document Production Services.

World Medical Association. (2013). *Declaration of Helsinki: Ethical principles for medical research involving human subjects.* Retrieved from https://www.wma.net/wp-content/uploads/2016/11/DoH-Oct2013-JAMA.pdf

Wright, S. M., & Fallacaro, M. D. (2011). Predictors of situation awareness in student registered nurse anaesthetists. *American Association of Nurse Anaesthetists, 79*(6), 484-490.

Wright, K., McGlen, I., Croll D., & Haumueller, M. (2008). Managing mental health situations. *Police Professional, 131,* 18-20.

Wynter, R., & Smith, L. (2017). Introduction: historical contexts to communicating mental health. *Medical Humanities, 43,* 73–80.

Young, S., Goodwin, E. J., Sedgwick, O., & Gudjonsson, G. H. (2013). The effectiveness of police custody assessments in identifying suspects with intellectual disabilities and attention deficit hyperactivity disorder. *BioMed central Medicine, 11*(248), 1-25. Retrieved from https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-11-248

Zimmerman, D. H. (1978). Ethnomethodology. *The American Sociologist, 13*(1), 6-15.

Znaniecki, F. (1934). *The method of sociology*. New York, NY: Rinehart & Company, Inc.

Zlotnick, C., Zerger, S., & Wolfe, P. D. (2013). Health care for the homeless: What we have learned in the past 30 years and what's next. *American Journal of Public Health, 103*(Supplement 2), s199-s205.

GLOSSARY

Cognitive aid: a mechanism to provide a brief prompt, during times of cognitive stress.

Concept: something that symbolises or identifies an abstract idea or mental image.

Concept Framework: a mechanism which organised the concepts into an ordered frame of reference.

Concept and observable indicator framework: used to support data analysis during stage two (phases one and two) of the study. A concept and observable indicator framework was developed for each video vignette. They contained the features directly, or indirectly, suggestive of the presence of mental disorder, for the specific scene depicted. These features were then aligned to the appropriate concept, its respective overarching themes, and observable indicators. Each participant's response was aligned to the framework, prior to, and following, the introduction of the cognitive aid.

Definitional propositions: the theoretical and operational definitions associated with the concept framework.

Ethnomethodology: the description of how sense-making actions are undertaken, rather than why.

Mental disorder: "…any disorder or disability of the mind" (Mental Health Act (1983a, amended 2007, 12, (1).)

Mnemonic: a mechanism which aids memory.

'New normality': the process of actively taking control of a situation, so as to restore as nearly as possible a normal pre-incident situation.

Observable indicator: representing the more refined, specific behaviours, characteristics and features emerging from the data, which shaped a police officer's situation awareness.

Operational definition: defined how each concept would be measured.

Place of safety: a place of safety is defined as any specified "residential accommodation provided by a local social services authority; a hospital; an independent hospital or care home for mentally disordered persons; a police station; or any other suitable place where the occupier is willing to temporarily receive the patient" (Department of Health and the Home Office, 2014, p.16).

Section 135 of the Mental Health Act (1983, amended 2007): Section 135 is enacted when a person is considered at significant risk or in crisis by nature of their mental disorder and located within a private property or residence. Where an Approved Mental Health Professional has significant concerns regarding a person's well-being, S135, they may apply to a court for a warrant to enter the premises to assess the person and, if necessary, have them removed to a place of safety.

Section 136 of the Mental Health Act (1983, amended 2007): Section 136 is enacted if a police officer considers someone to be in mental health crisis, and in need of "…immediate need of care or control…" for their own protection, or the protection of others. When enacting Section 136, the police officer may remove the person to a place of safety for assessment and care.

Situation awareness: defined as "…the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future" (Endsley, 1988, p.97).

Situation awareness failure: a three stage process, characterised by a "failure to correctly perceive the situation" (Level 1 failure); a "failure to comprehend the situation" (Level 2 failure); a "failure to project the situation into the future" (Level 3 failure) (Jones & Endsley, 1996, pp.507-508).

Tags: markers ('tags') relating to a person's appearance / identity from which police officers could search the Police National Computer (PNC) for confirmation of: "bail conditions; convictions; custodial history; wanted or missing reports; warning markers; pending prosecutions; disqualified driver records; cautions; drink drive related offences; reprimands; formal warnings; mental disorder (National Police

Improvement Agency, 2012; Home Office, 2014b, p.5; Her Majesty's Inspectorate of Constabulary 2017).

Theoretical definition: a clear description and frame of reference for each concept.