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Policing the mentally ill:

Making sense of links in the chain of

interagency collaboration in the community

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ABSTRACT

The shift to community care through the deinstitutionalisation movement in New Zealand has been criticised for producing fragmented and uncoordinated service provision for those with mental illness in the community. As a result, the police are coming into increased contact with the mentally ill, often in times of crisis, positioning police at the junction between mental health services and the criminal justice system. Barriers to access for integrative, comprehensive mental health care in the community have led to police understanding their position as the 'ambulance at the bottom of the cliff'. While previous research has attended to police officer attitudes and points of interaction with those with mental illness in the community, little has been said regarding understandings of the collaborative relationships from the vantage point of those officers policing the mentally ill. The current research sought to address this gap in the literature by exploring how police make sense of their experiences with those with mental illness in the community using a Foucaultian form of discourse analysis. The discourses that co-articulated and produced understandings of the position(s) of police in community service provision for the mentally ill and the power relationships between the police, the mental health system and the mentally ill can be understood through 'links in the chain'; 'the (un) identifiable other'; 'no-man's land'; 'underdogs'; and 'the cure'. These systems of meaning making from the police vantage point reproduced and re-institutionalised constructions of the mentally ill as 'criminal' or 'disordered', necessitating mechanisms of power and control to address the 'risk' mental illness posed to the community. Through such understandings the police, as society's institutional response to 'threat', necessarily occupy the position of the 'ambulance at the bottom of the cliff' at the institutional boundaries between disorder and criminality. And it is here that the institutional response to mental illness re-emerges as re-institutionalisation.

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TABLE OF CONTENTS

INTRODUCTION	1
Deinstitutionalisation	3
History of the movement	3
Criticisms of the movement	8
The ‘threat’ of those with mental illness in the community.....	16
Perceptions and attitudes of the general public	16
Literature on the ‘dangerousness’ of those with mental illness	18
Police interactions with those with mental illness	24
Nature of contact with the mentally ill	24
Police attitudes towards the mentally ill	28
Discretion and the power to arrest	32
Policy and legal considerations	36
Police as mental health workers	39
Training and skills for working with the mentally ill	42
Time management and resources	46
Relationships with mental health service providers	49
The current research	52
METHODOLOGY AND METHOD.....	55
Social Constructionism	57
Discourse Analysis	61
Foucaultian Discourse Analysis	64
Reflexivity	71
Discourses relating to police	72
Discourses concerning the mentally ill.....	78
Sampling and recruitment	82
Data collection	87
Transcribing	90

Ethical considerations	93
Analysis	96
ANALYSIS	103
Links in the chain.....	103
The first link – handing them on	105
The middle link – babysitting	118
The last link – the buck stops here.....	130
The (un) identifiable other	137
Raising the flag.....	138
The hidden danger	149
Sitting up and taking notice	155
No-man’s land.....	159
The unticked box.....	161
Cracks in the system	172
Underdogs	178
Making do	179
Underdogs stick together	189
The cure.....	199
Taking control	201
Medicating the sickness.....	213
DISCUSSION	223
REFERENCES	237
APPENDICES	249
Appendix A: Information Sheet.....	249
Appendix B: Participant Consent Form	251
Appendix C: Interview Questions	252
Appendix D: Authority for the Release of Transcripts	253

INTRODUCTION

*In its function, the power to punish is not essentially
different from that of curing or educating – Michel Foucault*

This thesis was inspired from a Police News article that reported frontline police officers in New Zealand felt like “the ambulance at the bottom of the cliff” (Plowman, 2006, p. 114) in regards to their interactions with those with mental illness in the community. Upon reading Plowman’s article I became concerned with the impact of the deinstitutionalisation movement on a service provider that one would not necessarily assume has an increasingly important role to play in supporting those with mental illness in the community. I began to ask myself: how have police officers come to feel like the ambulance at the bottom of the cliff? What is the ‘cliff’? How did those with mental illness ‘fall’? The dramatic imagery of Plowman’s quote implied that ‘policing the mentally ill’ was a practice that had many ‘casualties’, not just of those with mental illness, but also the service providers they interacted with and the mental health system that appeared to be struggling under the weight of deinstitutionalisation. I began to question if the institutional practices of the criminal justice system had replaced the mental asylum and how the effects of such a ‘re-institutionalisation’ were experienced by the officers who adopted this ‘ambulatory’ position. Plowman further noted that a recent mental health report discussing inter-agency relations involved in service provision for those with mental illness did not mention the significant contribution of the police in supporting the mentally ill in the community and that “there was no mention of the valuable work they do in picking up the pieces of [a]

mental health system, which has failed its own” (p. 117). From the concerns raised in this article, and the questions that were generated from it, this thesis was set in motion to attempt to explicate and understand the system of relationships involved in ‘policing the mentally ill’ from a police officers’ vantage point.

The shift from the asylum to the community has required the efforts of varying different agencies and service providers within the community to respond to the needs of those with mental illness. As a result of deinstitutionalisation, police have become increasingly responsible for the provision of services to a population that have both specific and complex needs, a population that can be understood as ‘vulnerable’ to stigma, prejudice and discrimination, and a population that police, through their interactions, have the power to promote and strengthen healthy relationships and mental health outcomes in the community setting. Police are in a position of great responsibility and how this responsibility is experienced and understood by officers will affect their approach to both those with mental illness and the delivery of service. Because of the significant influence police may have on successful community integration for those with mental illness, the current research seeks to understand what those experiences mean for the police, how they construct their ‘role’ in the provision of services, and how they understand, interact and coordinate with the network of partner-agencies in the community to facilitate comprehensive and effective community care.

The following chapter will explore deinstitutionalisation, the intentions behind the movement and why it has not yet realised its full potential to provide comprehensive, quality services in the community. I will then discuss how those with mental illness are constructed in relation to issues of threat and safety and how this can affect the position of

the mentally ill subject in society. Police relationships and interactions with those with mental illness in the community will be explored, with particular attention to the nature of those contacts, the expectations and understandings associated with policing, and also the institutional constraints on police when attempting to provide service to those with mental illness. Finally, relationships between the police and partner-agencies will be examined with attention paid to how those relationships are experienced and enacted as a system or network of service providers for those with mental illness in the community.

Deinstitutionalisation

History of the movement

The beginnings of mental health care in 19th century New Zealand was adopted from colonial history, with a Victorian approach based on caring for those with mental illness in ‘uncaring’ institutions (Joseph & Kearns, 1996). Although the inceptions of institutionalisation in New Zealand appeared favourable, with relatively smaller numbers of patients than in later years, scenic surroundings, good relationships with local towns and communities, and a concern for humane methods of treatment, the milieu of mental asylums in late 19th century New Zealand began to darken with many in-patients suffering the effects of overcrowding, isolation, stigmatisation and abuse. In addition, many of those admitted did not suffer from serious mental illness, yet due to lack of treatment alternatives, funding and access to well-paid treatment professionals, they were absorbed into a general construction of a ‘mentally ill’ subject position with little-to-no consideration of individual needs or wants (Brunton, 1986). Institutional based mental health care predominated treatment options into the 20th century, with the Mental Health Act (1911)

cementing psychiatric hospitals as the main provider of mental health services in New Zealand (Joseph & Kearns, 1996).

Attitudes towards the containment and treatment of mental illness in New Zealand began to shift with the first world war as many civilian men returned from battle with mental health problems such as shell shock and 'nervous' disorders now commonly understood through a PTSD spectrum of disorder. Concerns arose over the stigmatisation, mistreatment and isolated 'containment' of soldiers who were suffering as an effect of the trauma experienced while serving and protecting their country (Brunton, 1986). Against this history, public constructions of the 'mentally ill' were beginning to change, opening up to the possibility that those with mental illness were worthy of sympathy and care rather than fear and stigmatisation. This produced a need for 'half-way houses', intermediate mental health care facilities where middle-class and respected citizens could receive mental health care without requiring admission to an asylum (Brunton, 1986). In the 1920s further reforms to mental health care were introduced that paved the path to deinstitutionalisation, such as the responsibility of mental health care shifting to general hospitals, access to outpatient clinics for certain disorders and the availability of short-term inpatient services as opposed to long-term commitment (Brunton, 1986). While this post-war concern regarding the changing construction of the 'mentally ill subject' produced a shift in the focus and operation of mental health services, it wasn't until the 1950s that the deinstitutionalisation movement began to gain momentum with the advent of psychotropic medications that gave service providers working with serious mental illness optimism that it was possible to see dramatic improvement in those previously considered 'untreatable' (Goodwin, 1997).

Internationally, the move from institutional-based treatment for those with mental illness to community-placed care was underpinned by various concerns. One concern was embedded in human rights discourse, where the wellbeing of patients in such settings, many of whom received inhumane treatment and abuse as well as suffering stigma and prejudice, came under scrutiny (Bennie, 1993; Lamb & Bachrach, 2001). The Human Rights Watch (2003) note that the deinstitutionalisation movement freed people, many of whom had been admitted involuntarily, from over-crowded institutions where they were often receiving inadequate, little or even cruel treatment for long periods of time, if not the rest of their lives. Hoult (1986) notes that in many institutions the treatment provided, if indeed any treatment was provided at all, did not produce positive gains for the mental health patient. There were also economic concerns that large scale institutions were not cost-effective and that community care may provide improved treatment at less cost (Bennie, 1993). The introduction of psychotropic medications enabled many mental health patients to better control their symptoms and live within community settings, while the interest in new therapies and social psychology provided hope that patients could recover from their illness if given adequate treatment that could be supported by the community (Bennie, 1993; Hoult, 1986). These various concerns combined to produce an understanding that community care would be mutually beneficial to those with mental illness and those that provided mental health services. However, it could be argued that the impact of deinstitutionalisation on other service agencies not directly linked to the provision of mental health care, yet vital for the community support of those with mental illness may have been overlooked in these early formations. Questions can be asked as to how this has affected the experiences involved with policing the mentally ill, given that the police force is responsible for promoting safety and wellbeing in the community and, as discussed later, have an increased 'role' as a service provider for those with mental illness following deinstitutionalisation.

The mid 1900s saw New Zealand begin an 'organised' deinstitutionalisation movement with the number of those residing in psychiatric institutions peaking in 1944 and rates of institutionalisation reducing by over half by 1982 (Joseph & Kearns, 1996). Motivation for this movement was embraced by many different service sectors, including those working with the intellectually disabled and the elderly, and gained momentum through changes in practices surrounding mental health care alongside expansion in the number and quality of professional mental health staff (Brunton, 1986). However, Joseph and Kearns (1996) describe the organisation of this change in New Zealand as a piecemeal effort rather than a comprehensive deinstitutionalisation movement. What is meant by this is that many different geographical areas implemented the goals and processes of deinstitutionalisation with differing momentum and vision across New Zealand, staggering the closure of hospitals and the establishment of community care services. Unity in movement may have been hindered by a lack of legislation that addressed the goals of deinstitutionalisation (Brunton, 1986). The 1969 Mental Health Act did not specify any policy regarding the care of those with mental illness in the community, but instead outlined standards for care in existing psychiatric institutions. However, it did outline the transfer of care to local hospital boards from central government. While the relationship between governmental policy and local hospital boards still emphasised institutional-based care, the 1969 Mental Health Act did open up the freedom for diversity of service provision within the various regions of New Zealand and served to stagnate further development of institutions for the mentally ill (Brunton, 1986). Despite inpatient numbers reducing dramatically by 1982, many regions still utilised hospital-based care for psychiatric patients and government funding for mental health services reflected this focus (Joseph & Kearns, 1996). Mason (1988) suggests that the reduction in inpatient figures may have been more a product of the tendency for shorter hospital-stay durations rather than a true indication of a decrease in admissions into inpatient services.

The early 1980s saw those involved in the mental health sector in New Zealand grow increasingly concerned with the minimal progress made towards the goal of deinstitutionalisation, in particular the lingering overreliance on institutional hospital-based treatment services. The production of the New Zealand welfare state in the mid 80s further propelled the examination of the provision of available, accessible mental health services in the community in an organised and concentrated effort (Joseph & Kearns, 1996). Changes in legislation with the 1992 Mental Health (Compulsory Treatment and Assessment) Act helped build a more solid commitment in New Zealand to the deinstitutionalisation movement by directing a change in the locus of care for those with mental illness from psychiatric institutions to all hospital settings while also producing more stringent criteria for admittance into hospital care. The aim was to enable mental health treatment focussed more towards the benefit of the patient while simultaneously enforcing the concept of community care. In 1993 four appointed Regional Health Authorities replaced elected area health boards, enabling the purchase of care from providers and seeing a more localised system for making decisions and creating and implementing policies and procedures, producing a swifter embracement of deinstitutionalisation than before (Joseph & Kearns, 1996). Unfortunately, this change in legislation coincided with hard economic times in New Zealand at the end of the 1980s, which negatively affected those with mental illness in the community due to high rates of unemployment, service provision cuts, reduction to income support and housing shortages (Bennie, 1993). In addition, Bennie (1993) notes that in the late 80s and early 90s many of those with mental illness who had complex needs were transferred into the community, increasing the strain and pressure on services and support agencies to ensure those with complex needs received the care required to successfully adapt to community living.

The theory of deinstitutionalisation as a movement consisted of three components. Firstly, people were to be transferred from living in, and being cared for by institutions to the community. Secondly, new admissions would be diverted directly to the community where possible rather than hospitals and thirdly, community-based mental health services were to be developed and implemented for community care (Lamb & Bachrach, 2001). Therefore, deinstitutionalisation involved not only returning people to the community, but also the provision of services to meet their needs in that community. Lamb and Bachrach (2001) argue that the development of community-based service alternatives to the institution was *assumed* to inevitably follow as result of the change in location of residence and treatment, yet it appears this last step of deinstitutionalisation has not followed as quickly as would be desired, and provisions and services have tended to lag behind the need for such services (Lamb & Bachrach, 2001). An examination of *how* alternative care services have been constructed and implemented may enable a greater understanding as to why they have not been able to meet the expectations placed upon them in the conceptualisation of deinstitutionalisation. Was the complexity and comprehensiveness of mental health care in the community underestimated? Has there been an emphasis on the locus of care rather than what 'quality care' needs to encompass? What unforeseen understandings of community living were overlooked in the drive to replace the institution? The following section will discuss how limits to collaborative and coordinated community service provision for those with mental illness have prevented community care from emerging less successfully than intended.

Criticisms of the movement

It has been suggested that New Zealand may not have had as much success implementing the deinstitutionalisation movement than other western countries (Fakhoury & Priebe,

2002). Fakhoury and Priebe (2002) believe that a retention of focus on inpatient units attached to general hospitals and underdeveloped community health services has resulted in those with mental illness not being able to access the help and support in the community they need. Combined with a shortage of trained mental health professionals, New Zealand's progress in the establishment of community care can be considered to have been disappointing and has not enabled a realisation of the ideals and goals of the deinstitutionalisation movement (Fakhoury & Priebe, 2002). The 1997 publication *Moving Forward: The National Mental Health Plan for More and Better Services* (Mental Health Commission, 1998) acknowledged the lack of an established service infrastructure that could coordinate and supply comprehensive health services, and the Mental Health Commission (2005) report that while the quality of community mental health services has improved greatly over the 10 years prior to the publication, the delivery of these services is still problematic. They believe this may be due to overcrowding as well as limited service options and an over-reliance on medication and inpatient treatment as opposed to psychological intervention. Hall (1986) notes that those given the task of providing community mental health services were allocated an almost impossible job, one that perhaps was destined for some degree of disappointment given the high expectations and low provisions allocated to the industry. Questions can be asked concerning the processes and practices that have needed to emerge for the provision of successful community care. Given that community care *is* the current model of mental health service, what current barriers and limitations prevent successful community care? How has that impacted on the wellbeing of the mentally ill? How has it affected agencies such as the police that have needed to increase the quantity and quality of service provision to address those failings? How have relationships between various service providers been produced to attempt effective community, care and under what understandings do such relationships operate?

Access to service provision is vital when considering that timely access to quality services can dramatically halt disruptive and adverse consequences for those with mental illness in the community (Mental Health Commission, 2005). Quality services will struggle to produce favourable results for those with mental illness if accessibility of care is difficult to obtain (Provan & Milward, 1995). Corrigan (2004) notes that many of those with mental illness in the community do not receive mental health services, with survey results from the United States finding less than 10% of those with mental illness had access to services such as case management, treatment or rehabilitation , and 40% of those diagnosed with serious illnesses, such as schizophrenia, were not receiving any treatment at all. A large scale New Zealand mental health survey reported that access to services is extremely low, with only just over half of those with a serious mental illness, and even less of those with mild to moderate mental illness, accessing services (Oakley Browne, Wells, & Scott, 2006). If those with mental illness are limited in their ability to access services, how might this impact on the police? How would this affect how the police understand both the needs of the mentally ill and the quality of mental health service provision in the community? How would those at the interface make sense of their role and expectations with those with mental illness in the face of such barriers to access?

Finding an appropriate agency or service provider that can meet the needs (often complex and multi-faceted) of those with mental illness may be difficult in light of barriers to access. Although the goal of deinstitutionalisation was to replace the institution with a network of services and systems that could provide integrated and cohesive care in the community, such a structure and system of organisations has not necessarily been achieved (Provan & Milward, 1995). Fakhoury and Priebe (2002) note that those who are diagnosed with multiple disorders require the attention and assistance of many different health care agencies and services, both in the private and public sector. Indeed, the New Freedom

Commission in the United States identified as many as 42 different service agencies that emerged following deinstitutionalisation reforms, each provided for by separate agencies and possessing different eligibility and application standards, requiring mental health patients and their families to coordinate and negotiate this complex terrain, often in times of crisis (Hogan, 2003). Huzziff (1995) and Provan and Milward (1995) note that requiring those with mental illness to coordinate and integrate different services, often in different geographical locations, is problematic because many may have difficulty applying the required skills and abilities to coordinate such services without help. Indeed, a survey of adults with serious mental illness in New Zealand reported that one of their main needs was better integration and responsiveness of mental health care services (Mental Health Commission, 1998). Not only do such services need to be integrated and responsive, but there needs to be adequate assistance and provision of services across all sectors, for if one service is lacking, such as housing support, it can adversely affect the quality and effectiveness of other service provision (Mental Health Commission, 1998). The issue here seems not to lie in bad intentions or poor quality of staff, but in the *structural systems* of service providers that enable access and availability of services to those in need (Human Rights Watch, 2003). In the current research, there will be an examination of how the police make sense of the structural networks involved in mental health service provision and their understandings of what this means to both them as police officers and for those struggling with mental illness in the community.

Funding is a dominant concern when discussing issues associated with adequate and quality service provision following the deinstitutionalisation of those with mental illness (Mason, 1988). Mills and Cummins (1982) suggest deinstitutionalisation may have been adopted by governments in an effort to reduce spending by discarding state-funded institutions and replacing them with locally funded community health care centres. In New

Zealand government spending has indeed been reduced for mental health from 20% in the days of hospital-based care to 9% in the late 90s (Kearns & Joseph, 2000). A decrease in institutional care, however, is not synonymous with a decrease in the need for government funding of mental health services. Kearns and Joseph (2000) list various services that are necessary when shifting from institutional-based care including quality staff and programmes for community care centres as well as additional support services not directly related to mental health, but none-the-less vital for success in community living such as housing and income support. These service and support agencies all require adequate funding in order to effectively care for the mentally ill in the community and Bennie (1993) suggests that instead of deinstitutionalisation proving a cost-cutting measure, once all the hidden and not so hidden costs are taken into consideration the movement should cost as much, if not more, than previous mental health care systems. In this research, I am interested whether such a lack of funding is a problem that police face in their daily experiences of policing the mentally ill.

Although more recently there has been an increase in funding for a community response to caring for the mentally ill, at the same time there has been mounting pressure to increase 'beds' in inpatient facilities. While an increase in crisis inpatient services may also be necessary to the community response to mental illness, long term maintenance of wellbeing through alternative and preventative community-based services are less supported (Mental Health Commission, 2005).

Fakhoury and Priebe (2002) argue that constructions of practices post-deinstitutionalisation may have placed too much focus on *where* care was located, instead of the nature and quality of treatment that should be provided. Lamb and Bachrach (2001)

suggest that this understanding has produced service provision goals of shorter lengths of stay in emergency facilities and discharge from care, rather than caring for and treating the problem at hand and ensuring improved quality of life for the mentally ill in the community. This emphasis on length of stay can result in individuals being released from hospital care before any provisions or coordination of services can be established, therefore opening up potential for a revolving door style of treatment where the patient returns to crisis state and the resulting need for acute care after failing to address and resolve the presenting problem initially (Fakhoury & Priebe, 2002). What is problematic with the revolving door is a dependence on crisis, and the allocation of a client to available, not necessarily preventative, services. In this way, the mentally ill in the community are required to adapt to the requirements of the 'system' (Lamb & Bachrach, 2001). How police understand their experience of policing those who re-present time and again in the process of crisis is of interest to this study.

Furthermore, it is not a simple relation between living with mental illness successfully in the community and locating an appropriate agency or service provider to enable this. Mills and Cummins (1982) note that prior to deinstitutionalisation, institutions served many functions beyond treatment provision such as housing, catering, socialisation and medical care. These are complex and difficult areas to provide comprehensive and efficient support for in the community and require the coordination of many different service providers. Indeed, the New Zealand Mental Health Commission (2005) acknowledged mental health services need to expand into many different territories in order to facilitate successful community integration including social support, financial, occupational and housing services, and community projects to reduce stigmatisation. However, a lack of coordination and integration between various service providers has produced cracks and inconsistencies regarding the provision of community mental health services which prevents those with

mental illness from receiving the full benefit of services on offer to them (Mental Health Commission, 1998). Therefore, community care services may be criticised as inadequate if they are unable to stretch out and navigate the complicated interweaving of needed services and agencies as part of a collaborative response, but Mills and Cummins (1982) note that such difficulties may be less a reflection on individual service providers than a realistic result of the complicated and multifaceted task of treating and supporting those with mental illness in the community and the delineation of such services by systemic boundaries. Proven and Milward (1995) draw attention to the futility of looking for success and / or failure located in individual service providers, and argue an examination of the networks of relationships and coordination between various agencies, and how they can best function to optimal standards as a system of service provision, may prove more useful in strengthening and improving community support for those with mental illness. Of interest to this study is how police understand the network of relationships within which they are but one.

Furthermore, a focus on individual service providers draws attention away from the social and cultural barriers to successful community living by isolating the individual and service agencies from the community in which they are part of, and ignoring potential sources of strength and support that could be utilised to improve the wellbeing of the mentally ill. Lamb and Bachrach (2001) note that many societal factors may play a role in the difficulty of those with mental illness to live successfully in the community, such as access to drugs and alcohol, stigma and prejudice from other community members, lack of service provision in certain geographical areas and substandard housing options. Housing and rental costs are increasing, even in subsidised accommodation, and there is the risk that those with mental illness will be pushed into 'ghettos' with substandard living conditions

and where access to services may be difficult. Poverty is also a serious issue for those with mental illness in the community, especially when considering poverty is a risk factor that may be associated with poor mental health outcomes and potential criminal behaviour (Bennie, 1993). A focus on 'failings' in service providers encourages the avoidance of examining social and cultural influences which may play an important role in the improvement of the mental health and community living for those with mental illness.

Before concluding this section, it is also important to critically reflect upon how power relations informing the practices and purposes of institutions produced certain subject positions and the effects on the community. Psychiatric institutions provided the illusion of protecting the community from the 'dangerous other' and to that end served a form of social control, removing the undesirable 'other' from the community and alleviating the sense of fear they produced for the 'normal' public (Rock, 2001). Furthermore, institutions positioned those with mental illness as passive 'recipients' of treatment, they were in an environment that offered them no control or agency over any facet of daily living and instead all aspects of their life, from what they ate to the treatment they received, was decided on by others and at times through force. The new generation of those with mental illness have not been 'conditioned' into passivity as were the institutionalised generation and while this is a positive effect of deinstitutionalisation, it may also contribute to increasing attention to issues of noncompliance with medications and treatment, as well as a refusal to understand their lives through mental illness (Lamb & Bachrach, 2001). These concerns have become understood through popular discourse as a threat to safety, as the public are now offered no (illusionary) guarantees that those with mental illness are either receiving the 'cure' or are under control. So, like Rock (2001), this research is interested in the experience of public and political pressure to 'control' the behaviours of the mentally ill

and how current systems and practices have emerged to address this threatened sense of safety in the community.

The ‘threat’ of those with mental illness in the community

Perceptions and attitudes of the general public

How others react to and interact with those with mental illness is to some degree influenced by the construction of what it means to be ‘mentally ill’ and what effects this construction produces. If those with mental illness are indeed a threat, or are constructed as so, relationships and interactions that occur between them and other members of the community will necessarily be influenced by responses to this ‘threat’. It is useful, then, to revisit literature that considers how dominant this construction of ‘danger’ is when considering those with mental illness in order to gain a sense of the impact such constructions can produce. Before an examination of the literature regarding the ‘threat’ that those with mental illness pose to the community, it is important to explore what preconceptions or thoughts are produced by popular knowledge and culture regarding the risks to safety care in the community may pose.

Dear and Taylor (1982) note that since the late 50s, public knowledge regarding mental illness has increased, producing a reduction in harsh judgment and criticism towards those living with mental illness, and a recent review of literature concerning public perceptions and attitudes towards the mentally ill found that the majority of participants reported pro-

social views, that is they felt sympathy for their illness and desired to help those affected (Angermeyer & Dietrich, 2006).

Despite this shift in attitude towards more acceptance of some mental illnesses, there are many who still believe those with mental illness are unpredictable, dangerous and fear-provoking (Corrigan & Cooper, 2005). Hinshaw and Cicchetti (2000) note that in spite of increased awareness and education about mental illness, the desire for social distance and the belief that the mentally ill are dangerous remains strong. Some disorders invoked this fear response more than others, with diagnoses of schizophrenia and alcohol related disorders considered more dangerous and unpredictable than diagnoses such as anxiety or depression. These responses may in part be fuelled by media representation and misinformation. Television shows and newspaper articles often misrepresent mental illness in order to fuel drama, provide exciting entertainment and increase sales. The common constructions of those with mental illness in both television and newsprint use discourses of danger, unpredictably, aggression, lack of intelligence, and compromised reasoning and social skills (Coverdale, Nairn, & Claasen, 2002; Diefenbach & West, 2007; Wilson, Nairn, Coverdale, & Panapa, 1999). Such representations are concerning as negative portrayals of the mentally ill on television has been linked to negative attitudes towards those with mental illness and the belief that community mental health services put citizens at danger when community care facilities are located in residential areas (Diefenbach & West, 2007).

The construction and portrayal of those with mental illness in the community as a 'threat' can complicate the process of deinstitutionalisation through opposition to the creation of community residential facilities, not only resulting in stigma and prejudice, but also in

alienation. Members of the public may adopt a 'not in my backyard' attitude and there are many who believe that segregation in institutions is still the best way to treat those with serious mental illness (Corrigan & Watson, 2002). Zippay and Lee (2008) found that up to half of neighbourhoods oppose newly established psychiatric housing in their community and a Canadian study on community residents opposed to group residential homes cited the following beliefs surrounding the establishment of community care residences: it is impossible for deinstitutionalised people to be reintegrated into the community; residents are unwilling and unable to integrate themselves; the residents could not, and would never be able to be contributing members of the community; and it is not the community's responsibility to help these individuals, but instead the government's in the form of institutions and other organisations such as prisons (Piat, 2000). Furthermore, most opponents believed that such homes should be located in lower-socioeconomic locations where the residents would feel more 'at home' and have more in common with the local community members (Piat, 2000). While public opinion is generally positive in relation to social responsibility and community care for the mentally ill population (Zippay & Lee, 2008), the disparity between social responsibility and stereotypes reproduce 'dangerousness' when a community's sense of safety is understood as compromised (Phelan & Link, 2004).

Literature on the 'dangerousness' of those with mental illness

Visiting the literature that has attempted to ascertain whether those with mental illness are 'dangerous' or not is like looking through a kaleidoscope – it all depends on the way in which you turn it or hold it that it produces its shape and form. The 'dangerousness' of those with mental illness has been a subject of interest for many studies over the years, producing divergent results and opinions. Harris and Lurigio (2007) tracked historical

changes in how research positioned those with mental illness in regards to threat or danger to others and found that studies in the era of the deinstitutionalisation movement constructed the mentally ill as no more dangerous than the general public. A shift to position those with mental illness as 'dangerous' occurred in the post-deinstitutionalisation period, and more recently there has been a focus on the complex myriad of relationships that assessment needs to take into account.

When considering the risk the mentally ill pose to the community, one should start with what the academic community 'knows' on the topic based on research. It is known that: rates of violence are higher in the mentally ill population than in the mentally well (Choe, Teplin, & Abram, 2008); family members and acquaintances are more at risk from violence than strangers, and violent incidents most often occur in the home environment (Simpson, McKenna, Moskowitz, Skipworth, & Barry-Walsh, 2003); certain variables, or risk factors, associated with mental illness increase the risk of violence in the mentally ill population, such as psychotic symptoms (for example command hallucinations), personality and adjustment disorders (Monahan et al., 2001), and substance dependence and schizophrenia-spectrum disorders (Arsenault, Moffitt, Caspi, Taylor, & Silva, 2000).

Looking indirectly at the 'dangerousness' of the mentally ill by examining criminal justice system research continues to paint a rather dark picture regarding the risk of violence and disorder of those with mental illness. In the United States, by the mid 1990s the Los Angeles county jail supplied the largest amount of inpatient psychiatric care in the region (Fisher, Silver, & Wolff, 2006), and in 2003 the Human Rights Watch reported that there were three times as many mentally ill in the prison system than there were in mental

health hospitals (Human Rights Watch, 2003). An American study of mental illness in the prison population found that over half of those in jail or prison had problems associated with mental illness and a disturbingly high number of those incarcerated suffered from mental illness at rates three to five times higher than found in the general population (Griffin, 2007). The Human Rights Watch (2003) note that the seriousness of mental illness in prisons is increasing, with many prisoners not able to recall the reasons why they were initially placed in the prison system. In the New Zealand prison population, most major mental illnesses were represented in much higher percentages than found in the general population (Simpson, Brinded, Laidlaw, Fairley, & Malcolm, 1999). This study found that 89% of inmates suffered from a substance abuse disorder during their lifetime, one quarter had suffered from major depressive disorder and a third from a range of other diagnosable mental illnesses. 90% of those diagnosed with a major mental illness also had a substance use disorder. There were inmates diagnosed with schizophrenia-spectrum disorders and manic episodes of bipolar depressive disorder and 60% of inmates were diagnosed with a personality disorder from clusters A and B of the DSM (Simpson et al., 1999).

Reports of large numbers of person's that meet mental illness criteria and suffer serious mental illness present within the prison population can be interpreted as an indication of the 'dangerousness' of those with mental illness in the community given that those individuals had reason to come into contact with the criminal justice system. It has been suggested that there has been a transition of those who would formally have resided in mental health institutions to residing in correctional facilities, with the criminal justice system providing the 'last resort' to those who are difficult to treat or are disadvantaged, building bigger prisons from the bricks of the dismantled mental asylum (Griffin, 2007). Possible reasons for this increased contact between those with mental illness and the

criminal justice system will be discussed further in sections exploring police interactions with those with mental illness, but it is important to note here that many of those with mental illness in the prison system are there for minor deviance and non-violent crimes rather than serious or violent criminal behaviour (Hiday & Wales, 2003). Therefore, interpretation of prison statistics, and indeed most statistics, must be conducted with a critical eye and degree of inquisitive scepticism.

Monahan et al. (2001) have criticised research examining the risk of violence those with mental illness pose on methodological grounds, voicing concern that measures of violence, such as arrest rates and broad self-report questions, have been weak in the past and for ignoring the contextual element and dynamic nature of violence in the mentally ill population. Harris and Lurigio (2007) raise questions regarding whether the association between offending and mental illness can be explained by demographic and historical variables and suggest that once these factors are considered the relationship between crime and mental illness vanishes. In the United States MacArthur Study of Mental Disorder and Violence, Monahan et al. (2001) attempted to address past research weaknesses and provide a contextualised and detailed analysis of the 'dangerousness' of those with mental illness. They discovered that factors such as substance abuse, prior criminal history, neighbourhood conditions, non-delusional suspiciousness, violent thoughts and anger were all related to an increased risk for violence. Examining these risk factors, it is obvious that they are not exclusive to the mentally ill population, raising the issue that it may not be the 'mental illness' itself that produces the raised risk of violence in this population, but instead socio-cultural environmental influences that can be shared by the mentally well. Furthermore, examining variables and risk factors does little to explain and explore the processes through which those with mental illness come to be over-represented in the

criminal justice system in the first place. If those who would have once been placed in mental institutions are now re-institutionalised in prison, how has the systemic and structural organisation of service provision in the community enabled this to occur?

It must be acknowledged here that these socio-cultural and historical factors are not unimportant. For instance, in a New Zealand mental health survey (Oakley Browne et al., 2006) it was noted that disadvantaged populations, such as those living in poverty, are at higher risk of being diagnosed with a mental illness. Also, looking back at the previously discussed prison figures, substance abuse and prior criminal history can also be associated with mental illness. Therefore, there is some 'truth' in the inference that those with mental illness pose a higher risk for violent behaviour considering the socio-cultural and historical risk factors that often accompany mental illness. Where the real danger lies is in the misinterpretation and generalisation of the information presented in the literature regarding the dangerousness of the mentally ill. Furthermore, it is important to note that any discussion regarding the 'dangerousness' of those with mental illness draws focus and attention away from the important socio-cultural components of the production of 'risk' and locates responsibility and accountability solely in the individual, neglecting acceptance and attention directed towards social causes of crime (Silver, Mulvey, & Monahan, 1999). Indeed, Coombes and Te Hiwi (2007) argue that such a focus on the 'dangerousness' of individuals, specifically measurement of the prediction of risk certain members of the community may pose, "engender a false sense of security while at the same time enabling the public to ignore important social issues contributing to violent events" (p. 385).

Corrigan and Cooper (2005) warn that literature regarding the dangerousness of the mentally ill can cause the public to generalise from disorders that may raise risk (such as schizophrenia and substance disorders) to all 'mental illness', effectively increasing the sense of 'threat' to all who are diagnosed as 'mentally ill'. Base rates need to be considered, as although more serious disorders may contribute to the risk of violence, these disorders make up a very small number of the mentally ill population (Diefenbach & West, 2007). When considering the impact of deinstitutionalisation on the safety of our neighbourhoods, while the absolute number of homicides committed by people with a serious mental illness have remained static since deinstitutionalisation, rates of homicide by non-mentally ill persons have increased, therefore, comparatively, the percentage of mentally ill homicides per year has decreased (Simpson et al., 2003). Furthermore, research suggesting family members and acquaintances are more at risk from the mentally ill, whereas strangers have more to fear from the mentally well, dispels the stereotype of the 'crazed murderer stalking neighbourhoods'. In fact, the risk of victimisation for the mentally ill is just as high, if not higher, than for the general population (Sced, 2006), so perhaps those with mental illness have more to fear from the mentally well than vice versa.

Despite where the 'truth' regarding the relationships between mental illness and 'dangerousness' lies, the implications of such associations can have damaging consequences for those with mental illness that come into contact with the criminal justice system. The transition from constructing the individual as 'mentally ill' to 'criminal' as a result of such interactions can stigmatise even further those who attempt to battle mental illness in the community. Coombes and Te Hiwi (2007) argue that the expectations for 'rights' and fair treatment for those occupying a 'criminal' position are often undervalued by society, enabling unjust and oppressive treatment to occur that would be opposed by

the public if actioned upon the more 'disabled' classes of community members. In effect, if an individual enters the criminal justice system and the resulting label of 'criminal' is connected to their identities, they are at further risk of discrimination, stigmatisation and unjust treatment. It is to the interactions and consequences between those with mental illness and the police that attention now turns.

Police interactions with those with mental illness

Nature of contact with the mentally ill

In light of the effects and issues related to deinstitutionalisation, New Zealand's commitment to a community policing approach to service provision (New Zealand Police, 2006) gives rise for a need to explore the ways in which increased numbers of, and contact with, those with mental illness in the community is understood and experienced by police officers. A focus on community policing allows police officers to form stronger and more effective relationships between themselves, those with mental illness and mental health service providers, while increasing the ability to provide locally-responsive and proactive assistance that is focussed towards meeting the specific community's needs (Greene, 2000). Sced (2006) notes that this move to increase community policing and presence serves to bring officers into increasing interactions with the mentally ill as they live their lives in the community milieu. This increased presence raises issues as to how the police negotiate and navigate 'disordered' subjects in their community and what effects such understandings have on the relationships involved in the service provision for those with mental illness.

Research suggests that the numbers of those with mental illness police are coming into contact with are larger than before (Patch & Arrigo, 1999). However, this assertion is difficult to quantify given that there were a lack of quality studies conducted prior to deinstitutionalisation to enable a comparison of figures (Lamb & Bachrach, 2001). Furthermore, many incidences with the mentally ill are not recorded unless serious implications follow, such as arrest or injury, which, as discussed later, is a relatively small percentage of interactions with the mentally ill (Wylie & Wilson, 1990). However, it follows that interactions have increased through observations of the high presence of mental illness in the prison population, and the manner in which those with mental illness in prisons resemble those who used to be institutionalised (Lamb & Bachrach, 2001). Furthermore, given the limited, or even nonexistent, rehabilitative services within prison settings, many untreated mentally ill inmates are returned to the community with an increased risk of reoffending (Griffin, 2007).

Lurigio and Fallon (2007) note that the increased numbers of mentally ill entering the criminal justice system can be in part be explained by fragmented and uncoordinated mental health service provision established in the community which produces barriers to access and treatment for those with mental illness and the police officers they interact with. They note that most mental health agencies and services are designed to treat 'pure' diagnoses which results in those presenting with multiple disorders or treatment issues being denied entry into service provision. Furthermore, many providers are unwilling or unable to treat mental health patients who have a substance related disorder (Rock, 2001). Returning to the previous discussion of mental illness in the prison population, one can see that co-morbidity, especially when considering alcohol and substance disorders, is a common occurrence (Simpson et al., 1999) and therefore it may be difficult for those

whose problems are complex to meet the criteria of any agency's jurisdiction or responsibility.

The production of barriers to access for specialist mental health services has been acknowledged as an undesirable institutional practice. The 1998 Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 1998) proposed that to address this issue all community mental health workers should be able to assess and treat substance related disorders (and conversely those in the treatment area of alcohol and drug related problems need to be competent at identifying and addressing mental health needs), and that professionals skilled in treating those with co-morbid mental health and substance issues be present on community mental health teams. Te Tāhuhu, the New Zealand Mental Health and Addiction Plan (Ministry of Health, 2005), echoed these sentiments by advocating that “any door is the right door” (p. 15) when addressing the intersecting needs of those with both a mental illness and an addiction disorder. However, given the numbers of mentally ill in prison, one can ask: is the criminal justice ‘door’ the current practice? If so, how effective is this practice at providing access to comprehensive mental health services, and at what cost to those with mental illness and the police they come into contact with?

Furthermore, dual-diagnosis and treatment in community settings cannot address the issue of increased criminal justice system contact alone. Police are an emergency crisis contact service and therefore require the services of mental health crisis teams to admit those with co-morbid mental health and substance issues into their care. However, in New Zealand crisis team criteria excludes from services those who are believed to have a substance

abuse disorder as the dominant presenting problem and in incidences where substance is deemed to be the current contributing factor the person is referred to alcohol and drug services (Bay of Plenty District Health Board, 2010), resulting in the care and responsibility for such individuals located with the police for the duration of the crisis situation. Without adequate mental health service response it seems likely that contact with police services will increase due to a lack of alternative agencies available to admit those with mental illness into their care. Therefore, individuals who would ideally be admitted into mental health services and referred to more suitable means of intervention may be left unrecognised and unaided in the community, resulting in increased numbers of mentally ill being channelled through criminal justice avenues.

If interactions between the mentally ill and police are increasing, it is important to understand the nature of such relationships. Police work often involves responding to calls from the public concerning behaviour that is deemed illegal, threatening or disruptive and therefore it is reasonable to assume that most police will interact with those with mental illness predominantly in times of crisis. Indeed, the Mental Health Commission (2005) note that due to overloading of mental health services, many people can only gain access to service provision in moments of crisis or acute illness. Furthermore, Rowe (2001) reports that those with mental illness who acknowledge, and seek treatment for their disorder are less likely to be in contact with police, and Novak and Engel (2005) note that the mentally ill are more likely than the general population to be intoxicated, homeless, disrespectful and resistant when interacting with police officers. Also, the effects of substance abuse, such as drug-induced psychosis, can produce a more volatile and frightening offender for the police to respond to (Plowman, 2006). Indeed, Rowe (2001) found that many police view interactions with the mentally ill as fearful and dangerous, with the majority of police

reporting they felt at increased risk of violence and distress responding to callouts involving the mentally ill.

It has also been noted that many of those with mental illness police come in contact with have a history of traumatic experiences and may react with higher than normal levels of stress or agitation when confronted by police or restraining procedures, in turn potentially escalating tension and aggressiveness between the police and the mentally ill (Schwarzfeld, Reuland, & Plotkin, 2008). This suggests a dynamic relationship between police officers and those with mental illness at the very point of interaction. To examine different influences contributing to relationships between police and the mentally ill, it is useful to reflect upon previous research studying the attitudes and beliefs police officers bring with them to such interactions.

Police attitudes towards the mentally ill

Research on police officer attitudes towards those with mental illness has produced mixed and often contradictory results, even from the same set of data analysed. In a New Zealand study of officer attitudes concerning those with mental illness, Rowe (2001) found overall positive and accepting attitudes towards the mentally ill, while also revealing that the large majority of officers (78.5%) disliked attending callouts involving those with mental illness, 92.8% believed the mentally ill were unpredictable, 68.2% believed they were at greater risk for violence, 77.2% believed they personally were at increased risk in such callouts, and 84.6% believed that interactions with the mentally ill contributed stress to their job.

Watson, Corrigan and Ottati (2004) found officers responding to a vignette concerning a person diagnosed with schizophrenia believed that person to be more deserving of

sympathy, less responsible for his actions and more worthy of assistance, yet acknowledged that stigma (such as constructions of those with mental illness as dangerous) and discrimination were also produced. One disturbing finding by Watson, Ottati, Lurigio and Heyrman (2005) is that police officers find those with mental illness less credible than the mentally well and are less likely to act on behalf of mentally ill persons, even when it is more commonly the case that those suffering mental illness are at a higher risk than the general population of being victimised against (Sced, 2006).

Although such studies are able to report the presence of certain attitudes and even the appearance of contradictions between differing beliefs, they are constrained in their ability to explore *how* such understandings and contradictions occur and how the differing meanings attached to interactions with the mentally ill interact, inform and affect each other. These interactions and contradictions between expressed attitudes may be related to a separation in how police officers view and understand mental illness and how they need to 'behave' as part of their policing duties. Here, it may be the case that police officers hold positive and sympathetic attitudes towards those with mental illness, but find that the requirements of the situation often force a contradiction between attitude and action. For example, Cotton (2004) found that police believe working with the mentally ill to be an accepted part of their job, and attitudes towards working with such individuals were positive and helpful, however their actual behaviour when interacting with those with mental illness was more rigid and socially restrictive.

The disjointed association between reported attitudes and behaviour may stem from the experiences gathered through the practice of policing the mentally ill. One theory is that the work experiences of police engagements with the mentally ill may produce negative

constructions of such interactions, which can in turn effect how officers respond to such situations (Watson et al., 2005). If, as suggested earlier, the majority of interactions between police and the mentally ill are during times of crisis and disorder, this could encourage the construction of those with mental illness that police encounter during their duties as dangerous, unpredictable and as a population of the community they dislike interacting with. This theory may be supported by the finding that the more experienced officers tend to have less positive attitudes towards those with mental illness (Cotton, 2004), however it has also been found that younger and less trained officers perceived more danger from the mentally ill (Watson & Angell, 2007). Furthermore, it has been noted that increased exposure to mental illness has a positive effect on attitudes, and that this effect still remains, although weakened somewhat, in the face of dangerous or violent encounters with those with mental illness (Phelan & Link, 2004).

Another possibility is that formulating stereotypes of 'mentally ill offenders', whether positive or negative in nature, may enable police to conduct their duties in a quick and safe manner. Corrigan (2004) notes that stereotypes can be considered an efficient tool for categorisation because they allow the user to quickly produce expectations and impressions for certain groups of people enabling quick action and reaction. The police may be motivated to produce readily accessible stereotypes in order to deal with the nature of their job which calls for quick thinking on their feet and formulating assessments of risk or danger when entering a situation. However, the construction of those with mental illness as 'dangerous' is potentially harmful to the provision of police services as it has been associated with avoidance behaviour and unwillingness to help, as well as positive attitudes towards coercive treatment and segregation (Corrigan & Cooper, 2005). Conversely, police officers may be more eager to extract all relevant and accurate information from the specific situation at hand in order to make an educated and well-informed decision.

Furthermore, it is important to note the difference between stereotypes and prejudice, as it is when these stereotypes result in negative actions and treatment of the group in question that prejudice and discrimination occur (Corrigan, 2004).

It could be possible that constructions of a police identity and the institutional practices of the police force constrain the available options for action and the examination and discussion of police officer attitudes towards those with mental illness should not solely locate the source and presence of beliefs 'inside' the officer. Rather, an examination of the nature and effect of interactions with the mentally ill may better understand the dynamic forces at play. The nature of police duties is to ensure the safety and wellbeing of members of the community and it seems reasonable to assume that officers enter the workforce with these ideals in mind. Perhaps when dealing with the mentally ill it is harder to achieve those goals to the police officers' satisfaction and this, coupled with repeated dealings with those mentally ill that may be hostile or resistant, produces expressions of negativism towards the population. There have been concerns that fragmented service provision for those with mental illness in the community resulting in poor mental health and crisis may construct the identity of those with mental illness as 'troublesome', 'problematic', 'a nuisance' and 'bad' (Fisher et al., 2006; Watson, Morabito, Draine, & Ottati, 2008). This can have practical implications on interactions between those with mental illness and the police through a reluctance of the police to interact with those with mental illness and difficulties in establishing positive working relationships between all parties involved: the police, the individual with mental illness, and mental health services.

Sellers, Sullivan, Veysey and Shane (2005) found that while holding positive attitudes towards the mentally ill, police felt frustration at the options available to them to resolve

such situations. The majority of police feel dissatisfaction at the discretionary options available for access when dealing with the mentally ill, with frustration building at not being able to choose the option they feel is most appropriate, which is often admission to mental health services (Wells & Schafer, 2006). It may be the case that role conflict also contributes to the varied picture of police attitudes, with the need to protect the community from someone who is creating a disturbance on the one hand, and on the other hand compassion and sympathy for the mentally ill in the face of inadequate service provision (Psarra et al., 2008).

It appears that studies attempting to identify attitudes and beliefs concerning policing the mentally ill are limited in their ability to incorporate and explain the multiple tensions that are produced by the differing and puzzling results. Perhaps a focus on how such 'attitudes' are produced and the processes through which they take shape, interact and contradict each other might augment and aid previous research and help explain and understand the dynamics and implications of such meanings. Despite the literature on police attitudes attempting to 'reveal' the 'truth', it is obvious that any examination of 'attitudes' is incomplete without also exploring the possibilities for action and behaviour that can contribute to, and result from, such constructions. It is this practical, material aspect of policing the mentally ill that attention will now turn to.

Discretion and the power to arrest

When responding to a call involving an individual with mental illness, police must assess the situation and make the decision as to whether they will arrest the individual, seek a mental health evaluation or attempt to resolve the matter informally. Furthermore, any decision

needs to uphold the delicate and complicated balance between the protection of an individual's rights and freedom, and the maintenance of public safety and security. Relevant to interactions with those with mental illness, police need to act as 'parens patraie', a protector for those who cannot protect themselves (Lamb, Weinberger, & DeCuir Jr, 2002) by acknowledging and addressing the possibility that police actions, and the consequences of those actions, may harm those in the community who have a 'disability'. As Watson and Angell (2007) note, how police treat marginalised groups is extremely poignant to these populations and can either further marginalise them, or give them a feeling of support, acceptance and worth in society. Bell and Brookbanks (2005) propose that the police can offer a special and influential role in the lives of the mentally ill as they are professionals trained in the art of de-escalating danger and reducing harm, either actualised or threatened. In this regard, they have the ability to create positive outcomes in the face of events that may otherwise prove harmful and negative to the safety and well-being of those with mental illness.

Once such harmful event is criminalisation: the construction of psychiatric symptoms as criminal behaviours which therefore require criminal justice system responses such as arrest (Fisher et al., 2006). There have been concerns that arrest rates may be higher for the mentally ill due to a lack of knowledge regarding symptoms of mental illness (Teplin, 2000). In these instances, behavioural symptoms, such as verbal aggression, may not be recognised as indicators of a mental illness, prompting arrest when diversion to mental health services would be more appropriate. Lack of knowledge regarding mental illness may also produce uncertainty as to the best course of action for dealing with the mentally ill, and may lead to a tendency to follow a criminal justice path in order to enable more qualified personnel, such as the court system, to determine whether mental illness was a mitigating factor in the situation at hand (Bell & Brookbanks, 2005). Although the concept

of criminalisation appears to suggest a negative attitude towards mental illness, it can also spring from a desire to help and protect. Indeed, Sellers et al. (2005) report that, overall, police have positive views of the mentally ill and find the restrictions on their options for the care and protection of those with mental illness frustrating. Often arrest or detainment is the only option available (as discussed later in the 'relationships with mental health service providers' section), and therefore the choice to 'criminalise' may be seen as an act of protection and empathy on behalf of the officer.

Police may also choose to take a more lead role with those with mental illness due to an understanding that involving mental health services will not produce a satisfactory resolution to the current situation. Morabito (2007) noted that police officers are less likely to utilise mental health services if they believe those services are inadequate, and a survey conducted in the United States found that although police officers were aware of an available mental health liaison they could contact, they often did not utilise this relationship as they believed the liaison would be of no help (Cooper, Mclearen, & Zapf, 2004). Regardless of the intentions or reasons behind a decision to arrest, such action can have negative effects on the lives of those with mental illness, such as establishing a criminal record which will in turn affect future employment and future dealings with police and court systems (Lamb & Weinberger, 2005).

Despite concerns over high arrest rates of the mentally ill, research suggests that those with mental illness are arrested less often than the mentally well and that the manner of response favoured in such circumstances is informal resolution (Cotton, 2004; Rowe, 2001; Teplin, 2000; Wells & Schafer, 2006). Teplin (2000) reported that while 16% of interactions resulted in arrest and 12% resulted in hospitalisation, 72% were resolved by informal

means. The most common practices for police involvement with those in the community, whether mentally ill or not, can be described as “order maintenance” (Morabito, 2007, p. 1582), with arrest not often utilised as a response to the situation. Furthermore, the arrest rate for those with mental illness is even lower than that of the mentally well, despite those with mental illness reacting to police interaction with more antisocial and aggressive behaviour in comparison (Novak & Engel, 2005). Influences that produce this lower arrest rate are not well researched (Morabito, 2007), however Watson et al. (2004) suggest that attribution theory may explain why mentally ill individuals are arrested less often than the mentally well. Those without mental illness may be constructed as in control of their behaviour, therefore responsible for their actions, and commit such behaviour knowingly and purposefully. This may produce a desire to hold such individuals accountable and punishable for their actions. Those with mental illness, however, may be constructed as having little control over their behaviour, therefore not responsible for, or aware of, their actions. This may elicit sympathy from police officers and the desire to help instead of punish, encouraging police to defer arrest for more informal methods of resolution.

Morabito (2007) draws attention to environmental factors that may also contribute to the way in which police handle encounters with those with mental illness. In particular, the neighbourhood in which the police are called to can impact the choices they make when deciding how best to respond to the situation. If the police are called to a neighbourhood that they know to have good social support structures, familiarity between residents, and can offer assistance and safety they might more inclined to utilise informal resolution as the appropriate option. Conversely, if the neighbourhood has a problem with crime and neighbours are transient or do not know each other, police may feel less confident about leaving an individual with mental illness in that environment for fear for their safety or the risk of offending.

Another factor that may influence police discretionary processes is the power and authority to protect the safety and well-being of the general public. Public expectations of how police should handle particular incidents may place pressure on how the police react to such interactions despite whether a crime has been committed or whether the matter could best be resolved informally (Schwarzfeld et al., 2008). Lamb et al. (2002) acknowledge that this pressure may affect police discretion and encourage them to take action to 'protect public safety' where they may not normally be inclined to do so. Indeed, Patch and Arrigo (1999) note that the more public the event, the more likely the person will be hospitalised and that public involvement proved to be a stronger variable in the decision to hospitalise than psychiatric symptoms. The current research is interested in police officers' understanding of their use of discretion in relation to policing the mentally ill.

Policy and legal considerations

To examine the tension between desired outcomes and potential boundaries of police involvement with those with mental illness, it is important to discuss how the powers and limitations of police officers as members of an organisation produce possibilities for action or conversely prevent certain behaviours from occurring. As members of a governmental organisation dedicated to the maintenance of law and order, there are certain allowances and restrictions involved when interacting with the mentally ill that enable or constrain police involvement.

Police power and duties when interacting with those with mental illness can be separated into two categories: police officers as agents in the community and police officers as alliance partners with other service providers. As agents in the community, police are able

to arrest for criminal offences; on suspicion of an offence; and disturbing the peace (Bell & Brookbanks, 2005). The police can also take into custody an individual who is constructed as 'wandering at large', someone appearing to be mentally disordered in public, for the purposes of transporting to a safe place in order to organise a mental health assessment. Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, if once in custody the individual is deemed to not be mentally disordered they must be released immediately. If retained in custody, police are only legally allowed to hold a person for a maximum of 6 hours. However, if any of the previous situations do not apply, police have no authority to detain anybody solely because of a mental disorder and must therefore find an informal means of resolution to the situation (Bell & Brookbanks, 2005).

As alliance partners with other service providers, police duties can be constructed as more peripheral in nature. As outlined in the 1992 Mental Health (Compulsory Assessment and Treatment) Act, police can respond to a call from a medical practitioner requiring assistance to enter a person's property in order to detain or transport them for the purpose of an urgent assessment. In addition, they can enforce a judge's order for a warrant for arrest if someone has failed to present at a court-ordered assessment or treatment. From this position of police as an alliance partner, duties are constructed as a response (as opposed to 'active' in the community agent position) to the Duly Appointed Officer (DAO) or medical practitioner. Here, police act in a supporting role and can only initiate interactions with the mentally ill when requested (Bell & Brookbanks, 2005).

Contributing to this construction, the Memorandum of Understanding between the police force and mental health services in New Zealand (New Zealand Police and the Ministry of Health, 2000) emphasises police are only required to participate in inter-agency relations if their skills and expertise is essential.

These constructions of the 'role' of police are imperative to material practice because of the threat of negative consequences that can follow if police act beyond their authority. Vermette, Pinals and Appelbaum (2005) found that potential accountability for any negative outcomes was an important concern for police, and the Memorandum of Understanding (New Zealand Police and the Ministry of Health, 2000) encourages officers to constantly monitor their behaviour to ensure they do not overstep their boundaries of authority. If a police officer does not adhere to policy and legislation, law suits and bad publicity can result and so it is imperative that police are knowledgeable in current legislation. However, Fry, O'Riordan and Geanellos (2002) found that this is an area that police are not fully comfortable regarding their level of knowledge in.

The question can be asked then, how do the different positionings of police when interacting with those with mental illness and mental health services produce understandings of the police officers' responsibility in these relationships? How do they influence the way in which police approach the area of 'policing the mentally ill' and what are the implications? The legally defined obligations and duties of both police as a community agent and an alliance partner would appear to suggest that the police 'role' and involvement with the mentally ill should be limited and peripheral. How is this locatedness experienced by police in their interactions involving the mentally ill? Furthermore, how can police obtain 'resolutions' to crises, normally constructed in police culture through the prevention and control of crime (Watson et al., 2008), without criminalising the behaviour of the person in question?

Police as mental health workers

One of the fundamental 'ideals' of forming relationships between police and mental health services is to deflect those with mental illness in the community away from involvement with the criminal justice system and towards agencies that can provide the appropriate care (Lamberti & Weisman, 2004). As Lamberti and Weisman (2004) note, the operational and functional ideals of each individual organisation are not cohesive, police are concerned with law, order and public safety whereas the mental health system is concerned with assessment, treatment and wellbeing, therefore while they are well suited to integrating effort towards service provision they still retain distinct 'roles' in the service of the mentally ill in the community. Diversion from the criminal justice system can only occur if mental health services are available and accessible, not only for crisis situations but for community mental health services as well, which often appear to be lacking (Watson et al., 2008).

The concern has been raised that police often have to bear the burden of adopting a pseudo-mental health worker position as a result of inadequate mental health service provision within the community (Cooper et al., 2004). Police are an easily accessed, 24 / 7 emergency service provider, therefore they are a service that is available to the public when other agencies are unavailable or inaccessible. As Rowe (2001) states, the police are "the only free, 24 hour service with unique mobility and a legal obligation to respond" (p.16). In fact, they may be the *only* service available in situations where the individual poses no immediate danger to themselves or others, yet is still in need of assistance. Wylie and Wilson (1990) found that most of police calls involving those with mental illness were placed between 7pm and 2am, suggesting police are utilised as an after hours emergency care provider for mental health crises. Furthermore, many of those with mental illness in the community may not be able to access, or be eligible for help until they become

problematic, dangerous or seriously ill and require police assistance (Griffin, 2007; Plowman, 2006). Here, the police are required to act as both mental health crisis workers and the gatekeepers to mental health services. Indeed, Vermette et al. (2005) report that police were responsible for a third of referrals to emergency mental health services, and their interaction levels with the mentally ill are second only to mental health workers. This may produce tensions or complications as the control of crime and protection of public safety must increasingly incorporate more therapeutic methods when interacting with those with mental illness (Watson et al., 2008).

The term transinstitutionalisation has been used to describe the effects of deinstitutionalisation on the structure and location of mental health service provision, whereby one undesirable care provider (the mental asylum) has been replaced with several inadequate providers (Lurigio & Swartz, 2000). Indeed, a chain of events has been produced post –deinstitutionalisation in which long-term facilities were replaced with a small number of intermediate care facilities, which were then unable to meet the demand for such services directing the pressure onto acute care facilities who have therefore had to set stringent admission criteria to ease it's burden, which has finally impacted the police on the frontline (Lamb & Weinberger, 2005). The issue of contention here is not that 'institutions' are no longer available to provide service, but that those who previously would have been placed in such institutions are not being supported by community mental health practices and find accessing adequate and timely assistance difficult, therefore are often left until their illness becomes so pronounced that crime or crisis develops that could have been prevented (Human Rights Watch, 2003).

Griffin (2007) suggests a direct link between failings in the mental health system to the increase in the number of those with mental illness interacting with the criminal justice system through the process of untreated psychological problems developing into criminal behaviour. Plowman (2006) notes that early discharge from strained services may fail to adequately resolve the presenting mental health issue, resulting in further crisis and police intervention. Indeed, as discussed at the very beginning of this study, police have been referred to as “the ambulance at the bottom of a cliff” (Plowman, 2006, p.114). Wylie and Wilson (1990) found some officers feel disgruntled towards the deinstitutionalisation movement, viewing it as a cost-cutting venture of which they are positioned at the losing end of. One officer in an American study commented that police have “inherited the problem without the resources to deal with it” (Cooper et al., 2004, p. 307). Although a Ministry of Health survey (Ministry of Health, 2001) found that police in New Zealand are positive about the current level of mental health services, they expressed concern over having to arrest people as a ‘last resort’ and having to take responsibility for caring for those who are acutely ill in police custody.

One important question raised by requiring police to act as pseudo-mental health workers is *should* they be expected to adopt such a role given that police and mental health workers have different duties, priorities and training that may at times conflict with each other (Fry et al., 2002)? Although most police agree that it is in their responsibility as a police officer to interact with the mentally ill (Cotton, 2004), it is questionable whether the best results for any party are being reached by dispatching police officers who know little about mental health or mental health services to respond to, and provide for, the needs of those with mental illness. Most police units do not have specialised services or teams established specifically to deal with calls involving the mentally ill, despite the amount of contact police have with the mentally ill indicating that this would be a useful, if not necessary measure

(Cotton, 2004). Therefore most responding officers are entering situations that they may not be comfortable or confident with due to limited training and knowledge in the area of mental health. This research is interested in whether limits to knowledge about mental health impacts on police practices.

Training and skills for working with the mentally ill

Given that police have frequent contact with those with mental illness, it would seem logical that this is an area they receive concentrated training in. Unfortunately, the amount of training dedicated to policing the mentally ill does not correspond with the amount of contact, the complexity of the challenges such contact produces, or the potential for serious consequences of mishandled situations (Hails & Borum, 2003). As an example, the United States 1997 Police Executive Research Forum recommended that 16 hours of training be devoted to the topic of mental illness, yet the average number of hours spent training recruits in the field of mental health was 6.5 hours (Hails & Borum, 2003).

New Zealand recruitment processes also appear to provide minimal training in the area of mental illness (Hancock, personal communication, March 2008). Generally, new recruits are provided with knowledge of the 1992 Mental Health (Compulsory Assessment and Treatment) Act, their responsibilities when dealing with the mentally ill (in particular in regards to DAOs and medical practitioners), and a 2 hour package on mental health delivered by a guest speaker. Additional information relevant to mental illness is dispersed throughout training where appropriate, for example the concept of 'vulnerable considerations' when conducting investigative procedures (Hancock, personal communication, March 2008). Hails and Borum (2003) note that including training on

mental illness within other 'blocks' limits the time needed to cover such areas successfully and also may give a generalised introduction to an area that actually requires diverse and divergent considerations for differing conditions and disorders. While there appears to be some follow-up or specialist training in New Zealand for particular roles, such as for communications personnel that receive calls from and about those with mental illness, any additional training, if present, is not a standard practice for up-skilling or curriculum (Hancock, personal communication, March 2008). In fact, Plowman (2006) notes that New Zealand has *no national standard* of training on policing the mentally ill. Furthermore, the nature of the majority of police training on mental illness is legally defined (their rights and powers under the Mental Health Act and when interacting with medical or mental health professionals) and while specific and relevant to their duties, how does this translate towards positive mental health outcomes for the mentally ill in the community in light of the police often being the first and sometimes only service provider to respond?

Given the limited nature of the training received on mental illness and the large amount of contact police have with the mentally ill, it is not surprising that the majority of police officers desire more training on mental illness (Cooper et al., 2004; Lamb et al., 2002; Lamb, Weinberger, & Gross, 2004; Rowe, 2001; Wells & Schafer, 2006; Wylie & Wilson, 1990). Indeed, 72.7% of New Zealand police felt that their training did not sufficiently prepare them for working with the mentally ill and 84.6% believed additional training would contribute to their ability to interact with those with mental illness (Rowe, 2001). Police are enthusiastic to learn more about how to recognise mental illness and the various disorders (Lamb et al., 2004). Although Wylie and Wilson (1990) found that most officers had a reasonable to good understanding of what 'mentally disabled' means, it is an area that many police feel needs to be further elaborated. More in-depth training on the presentation of mental illness may enable officers to identify when an individual's

presenting behaviour may be attributed as symptoms of a mental illness, such as intoxication or acts of resistance (Lamb et al., 2002; Teplin, 2000). This could facilitate more appropriate responses, such as referral to mental health services that may not be initially obvious to someone less trained in the specific details of mental health matters.

Another area that police have expressed a desire for further training in is skills and procedures for how to respond and behave in difficult situations involving mental illness, such as how to deal with a potentially violent individual and what the best course of action is when someone is suicidal (Lamb et al., 2004). Sced (2006) reported that 48% of Australian police felt they were not confident in their level of skill regarding responding to interactions with the mentally ill and another Australian study found that police often attributed a lack of education (alongside experience) as a contributing factor for feeling unprepared and lacking confidence in their competency to respond to situations involving those with mental illness (Fry et al., 2002).

As the police force is, to some degree, a paramilitary organisation, there is great importance placed upon the ability to adhere to rules, procedures and controls for behaviour (Kennedy, 1993). Given that mental illness is a complex area in which police receive limited training, they may feel uncomfortable with the lack of operational procedures and rules supplied by police force training regarding how best to interact with those with mental illness. The type of training advocated here is slightly different to the more intellectual pursuit of education in the specific details of particular 'mental illness' in that it encourages an increase in the skills base of officer behaviour that can be materially applied to police duties . Bell and Brookbanks (2005) note that it is often the junior and inexperienced staff that are delegated to frontline duties and if these inexperienced officers do not receive adequate training in college they are at a great disadvantage when

responding to complex situations such as those involving the mentally ill. Further training could help reduce the potential for criminalisation of mental illness given that inexperienced officers are more likely to arrest those with mental illness than officers who have had more experience (Watson & Angell, 2007). Training on mental illness can have other desirable effects also, such as increasing positive attitudes towards the mentally ill (Rowe, 2001). In addition, education on what services and community resources are available to those with mental illness, how to access them, and when it is appropriate to get them involved may ease frustrations with the mental health system and service providers in inter-agency interactions (Lamb et al., 2004), while helping police feel comfortable to remain within their boundaries of service provision (that is a legal response to those with mental illness) by facilitating better understandings of the care and support they can access.

One specialist form of training that is employed internationally is Crisis Team Intervention (CIT) in which officers who express interest in mental health issues are provided skills training to enhance their performance in crisis situations and act as liaisons between police and mental health services (Lamb et al., 2002). Goals are to increase efficiency of response to crises and facilitate better inter-agency relations (Watson et al., 2008). Positive outcomes of this initiative have been: better response times; increased ability to identify instances of mental health crisis; anticipating behaviour that might be displayed in crisis situations; increasing confidence in competency to resolve such situations; less need for emergency services; less injuries; and increasing their understanding of the mental health system (Parent, 2007; Wells & Schafer, 2006). Hails and Borum (2003) also note such training attracts and produces officers who are motivated and knowledgeable in the area of mental illness, and in turn this benefits the mentally ill by enabling interactions with officers who may be more inclined to respond to them with respect and dignity. Kennedy

(1993) warns that specialised units, through their exclusive control of the area at hand, can often prevent other officers from the experience of developing skills in such areas and can decrease the ability for local police stations to utilise creative problem-solving initiatives. Also, Watson et al. (2008) note that such initiatives may be resisted by police officers because they are seen to remove focus and resources away from 'real' police duties. This research is interested in how issues of specialisation may be understood as necessary to policing the mentally ill.

Time management and resources

It has been noted that while demand for police services has risen over the years, their budgets and resources have remained static, or even declined, requiring police to focus attention on smooth and efficient systems of operation in order to problem-solve the demand versus ability-to-supply issue (Kennedy, 1993). Kennedy (1993) notes that the utilisation of partner agencies can help alleviate resource constrictions by drawing on their assistance and potential resource-pool, allowing room for any savings in police resources to be invested in other important and strained areas. While this problem-solving strategy to help save and increase valuable resources has much potential, the inter-agency relationship between police and mental health services may be more complicated and difficult to transverse than such a solution suggests.

As discussed earlier, police are increasingly coming into contact with those with mental illness (Patch & Arrigo, 1999). In the annual New Zealand police report for 2006/2007 (New Zealand Police, 2007) police provided custody and escort services to 8,438 people with a mental illness or disability. This figure does not include mentally ill who committed a crime

that resulted in arrest and prosecution, nor does it begin to comment on the number of incidents police were called to which were resolved informally. Such interactions with those with mental illness have the potential to utilise a great deal of police officers' time, with one study finding that 61.3% of New Zealand police reported the time spent with mentally ill persons was 'more' or 'a great deal longer' than time spent with the mentally well they interacted with (Rowe, 2001).

There are also unique complications to interactions with those with mental illness which may result in longer interactions and a greater use of resources than for those who are mentally well. If a person believed to have a mental illness is also under the influence of substances, mental health workers will often not respond to assess until the individual has detoxified, necessitating the use of police custody in the interim. Keeping such individuals in custody requires 'jailors', resulting in the restriction of police officers from engaging in their usual duties while they oversee the prisoner, or the hiring of temporary jailors which requires police budgets to stretch to accommodate the added expense (Plowman, 2006). Plowman (2006) further emphasises the demands that interactions with those with mental illness place upon the police by noting more officers are needed if the person acts violently and that vehicles and officers often need to stay with the individual while waiting for DAOs or other relevant mental health personnel to arrive, which can be quite a lengthy period due to the heavy workload such personnel are under. Even the transportation of those with mental illness can be problematic for resources given that the geographic nature of New Zealand will often require officers to transport people to or from rural areas which can take up several hours of valuable time (Plowman, 2006).

So how do the police feel about the resource and time demands created by responding to those with mental illness? Not surprisingly, this has been a source of frustration fuelled, in part, by having to perform duties considered 'not real police work' (Cotton, 2004; Fry et al., 2002; Rowe, 2001; Watson et al., 2005; Wells & Schafer, 2006). Fry et al. (2002) report that this can create tensions for police officers because they are aware of other competing demands in light of time consumption and what they consider their 'real job' to be. Rowe (2001) found 57% of New Zealand police surveyed felt they were not the appropriate agency to be providing services for the mentally ill, with 68.8% reporting they could not effectively address the issues such situations presented and 79.3% were frustrated with the amount of time such callouts require. Such frustrations may be exacerbated if the lengthy wait for mental health personnel to respond fails to gain the individual in question access to such services (Green, 1997). Patch and Arrigo (1999) note this can result in police failing to pursue admittance of the individual into mental health service provision due to the anticipated lengthy wait and lack of guarantee it will produce a resolution to the situation. Green (1997) suggests frustrations concerning access to mental health services may explain why the majority of calls involving those with mental illness are resolved informally. Informal resolution may be a problem-solving technique utilised to avoid handing the individual over to the criminal justice system which may not be the appropriate service provider for such individuals, or the mental health system which may not be able to accommodate the individual. Alternatively, Watson et al. (2005) note that because dealing with the mentally ill may not be regarded as 'real' police work, and that police do not get rewarded for such work, they may avoid or quickly dismiss cases involving the mentally ill to enable resuming their 'real' police duties.

Because of the limited officer training concerning mental illness combined with strained police resources and limitations of police powers in interactions with those with mental

illness, the relationship between the police force and mental health agencies is extremely important. Police must rely on mental health service providers to respond and assist where possible in order to attempt resolution for those with mental illness in the community. If cohesive and coordinated, such a relationship would weaken demands and frustrations of police officers, but if uncoordinated and fragmented such services can further contribute to the tension involved in policing the mentally ill. How is the coordinated response understood by police officers?

Relationships with mental health service providers

It has been noted that there is a growing turn in organisations and agencies to form cooperative alliances in order to advance the comprehensiveness and efficiency of various services and objectives that is not possible under a demarcated and isolated system of service provision (Provan & Milward, 1995). The relationship between police and partner service agencies, in particular mental health services, is important given that each agency has certain duties and responsibilities that, while sometimes at odds with one another, can contribute and coordinate together in the goal of providing comprehensive support and assistance for those with mental illness in the community. Uncoordinated or fragmented inter-agency relations can produce 'gaps' in service provision that can make it difficult for police to obtain the desired response or resolution to the situation at hand and ultimately result in the individual with mental illness not receiving the services they need. Fry et al. (2002) found that such gaps produced by a failure to establish a connection between police and mental health services resulted in officers feeling unsupported by their partner agencies and frustrated at not being able to access the services and assistance they believed they needed in such circumstances.

One frequently stated concern police have with the working relationship between themselves and mental health services is mental health agencies 'failure' to respond adequately and efficiently to the needs of those with mental illness (Fry et al., 2002; Green, 1997; Sellers et al., 2005; Teplin, 2000; Wells & Schafer, 2006). Institutional barriers such as admission criteria to services and a lack of available resources have been cited as preventing those with mental illness from gaining entry into mental health services (Teplin, 2000). Such institutional barriers can prevent the police from establishing connections for the individual into services beyond that which they can offer, effectively situating the individual with mental illness at the 'end of the road' in police custody. Interestingly, often mental health services will not respond if the individual does not pose a significant risk of immediate danger to themselves or others and yet will not respond if the level of 'threat' is too high (Bay of Plenty District Health Board, 2010). Here a problematic situation occurs: in order to facilitate contact and referral of the individual to mental health services, the police need to utilise their skills to deescalate the 'threat', but by doing so can often calm the individual to the point that mental health services will decide their assistance and intervention is not needed (Sellers et al., 2005) despite the fact that follow-up care and treatment should be provided to prevent crisis from occurring again. Here there appears to be a tension in an understanding between 'threat' to safety in the legal system and that of the mental health system.

Lurigio and Swartz (2000) state that the police desire to deal with a presenting crisis or situation to the point of resolution and with confidence that the current problem will not occur again in the future. If a connection is blocked to a mental health service provider, how can the police ensure that the matter at hand will be resolved? In these cases police may find themselves pursuing a criminal justice method of problem-resolution to a mental health issue (Teplin, 2000). When alternative options are not possible, police may have to

utilise what power and agency they have at hand in an attempt to adequately resolve the issue by arresting and charging the individual. In essence, the police force becomes the safety net to catch those falling through the cracks in the mental health system.

Unfortunately, the implication of such actions is that the core problem, that of mental illness, is not addressed and instead the response forms a temporary 'band-aid' which then has a strong possibility of reoccurring again in the community once this 'band-aid' is removed (Green, 1997). Furthermore, it can lead to the police constructing mental health services as 'impenetrable' which may discourage future attempts at establishing a working relationship. Indeed, Fisher et al. (2006) reported a phenomena where, on subsequent investigation many of those 'mercy bookings' that eventuated in evaluation actually met the criteria for immediate involuntary hospitalisation, but the responding officers' did not pursue an evaluation at the time due to a distrust of the health system. Similarly, Wells and Shafer (2006) found that police believed it was easier to place people into jail than to organise an assessment in mental health care facilities.

In Rotorua, New Zealand, an initiative has been adopted in an attempt to resolve issues surrounding accessing expert mental health care through the employment of an on-site mental health nurse to assist in the assessment of those with mental illness and to provide education to officers about the mental health system and techniques for positive interactions with the mentally ill (Plowman, 2006). The Rotorua initiative has been reported to: reduce the time taken by police officers to deal with the mentally ill; facilitate more desirable avenues of action when meeting the mentally ill's needs; provide the police with greater access to the knowledge, training and support of professionals in the mental health system; reduce repeat problems through identification, in particular early identification; enhance both police and mentally ill citizens safety; and help improve co-ordination between the police force and the mental health system (Carswell & Paulin,

2008). However, such a model is costly to run, with Plowman (2006) estimating 80-100 mental health employees would be required and would cost 7-10 million dollars to implement nationwide.

The current research

Reflecting on questions that emerge in the literature regarding policing the mentally ill, it becomes clear that traditional empirical research cannot easily understand the intricacies of such a complex relationship. Research on attitudes can tell us *what* officers may feel and believe, but they are limited in their ability to increase our understandings of how such meanings and associations are produced. Furthermore, it is difficult to utilise quantitative methods to provide accounts of the variations, conflicts and contradictions that are sometimes apparent in the research findings. For instance, the research indicates that police accept responsibility for providing services for those with mental illness, yet they also feel they are an inappropriate agency to respond to such situations (Rowe, 2001). What are the understandings and processes that produce such discrepancies and how do such understandings interact and combine to form a coherent system of meaning making? How are such understandings produced? How do they combine, interact and re-produce each other? How does this affect the way in which the various subjects relate to and interact with each other?

Furthermore, attention needs to be paid to the various subject positions produced in interactions with the mentally ill. It is possible to make sense of instances or experiences that are important to the police, but often analysis and interpretation is restricted to description only. Instead, what needs to be explored is how the positioning of police is

constituted and what it means to navigate and negotiate those positions. For instance, how does the legally orientated police officer interact and negotiate with the increasing need for police to adopt a more therapeutic role in the service provision of those with mental illness post-deinstitutionalisation? How are those with mental illness constructed by police and how does this affect their interactions, enabling certain practices while constraining others?

Provan and Milward (1995) argue a focus on individual organisations involved with service provision for those with mental illness in the community may not always be appropriate because the 'success' or 'failure' of such service cannot be attributable to the actions of any singular organisation. Therefore, examining the inadequacies that have emerged following deinstitutionalisation should not focus on which service agencies are responsible for what problems. Instead a focus on the integration and coordination of a network of systems, the structure of those systems, and how the relationships are produced and reproduced is of great value to examining the area at hand. This requires a shift of focus from examining outcomes of service provision to a study of the relationships and networks constructed in the area of policing the mentally ill and how they relate and interact with one another.

Furthermore, while there are many instances of research examining the organisations and institutions as they 'practice', that is how they materially operate and coordinate together, what is often left unexamined is the 'network' itself and what that means (Provan & Milward, 1995). What is needed to advance the literature on policing the mentally ill is to examine how relationships are established and practiced and what meanings and material effects such constructions of these relationships produce. What such an examination would

enable is a shift from a focus on individual agencies or service providers to an exploration of the relationships and the locations of connection and fragmentation that are produced through these relationships in order to gain a deeper appreciation of the significance of partnerships and interactions involved with policing the mentally ill. This could avoid limiting discussion to the instance at which police officers can no longer provide further service and would enable an examination of how each agency in the network can contribute to achieving positive results for those with mental illness.

In order to gain a deeper appreciation and understanding of the collaborative and problem-solving relationships involved with policing the mentally ill, the current research asks:

In the movement from deinstitutionalisation to community collaboration in the care of the mentally ill, how are the police constructed in relationship to policing the mentally ill? What are the institutional power relationships that enable or constrain police in their practices? How do they understand their position in the often complex network of relationships that provide community care? How do they understand the material effects that their practices have on the mentally ill?

It is hoped that through such questions, successful collaborative and problem-solving relationships between police, mental health services and the mentally ill will be identified in order to support and strengthen such services, as well as the identification of particular 'gaps' that may lead to potential benefit for better outcomes.

METHODOLOGY AND METHOD

As noted by Coombes and Te Hiwi (2007) it is imperative that we in the field of psychology challenge areas of potential oppression and discrimination and promote and strengthen community practices that can contribute to the wellbeing of its members. Indeed, they argue it is our ethical duty to do so as explicated in the Code of Ethics for Psychologists Working in Aotearoa / New Zealand. The New Zealand Police Force is one of many community service providers in an interagency collaboration that play a major role in the potential improvement to, and benefit in the lives of those with mental illness in the community. However, as concluded in the previous chapter, existing literature on policing the mentally ill appears to neglect a sense of exploration into the relationships between agencies involved when providing comprehensive and quality service to those with mental illness and the networks these relationships form. What a more qualitative study, like the present research, can contribute to the growing body of work in this area is an attempt to not only include, but examine, trace and discuss the institutional relations of, and influences on police officers and how these relations affect the understandings and experiences of interactions with the mentally ill.

While the dominant quantitative research techniques previously used to explore policing the mentally ill have provided an 'indicator' of salient concerns or attitudes surrounding specific instances or examples of interactions, the analysis has been limited to the statistical manipulation of, and inference from, static scores from measures such as surveys and questionnaires. Such traditional methods constrain the ability to explore the multiple meanings, subtle differences in assumptions and the complexity of understandings

inherent in how we navigate our experiences, which can constrain the ability to locate the analysis and interpretation within the social, historical and cultural contexts they are both relevant to and have material effects upon. Qualitative research approaches offer a method that can accommodate multiple realities, complexities in knowledge and understandings and contradictions in the meaning making processes, and provide a vehicle through which to represent these complexities of how we experience and make sense of the world around us (Coombes & Te Hiwi, 2007). In the current study, what was needed was an approach to researching the area of policing the mentally ill that can accommodate, explore and analyse social relations and connections as a system or network and represent the contradictions and ambiguities inherent in the meaning making processes of such relationships. In order to facilitate this, a method was needed that could generate a rich and detailed body of data to enable this analysis. The methodology chosen to meet these aims was a form of discourse analysis.

Discourse analysis enabled an exploration of the way in which experiences were constructed and made sense to the officers interviewed and what this could mean not only to our understandings of the relationships involved with policing the mentally ill, but also how it is possible for police officers to act, interact and relate to those with mental illness and the mental health system. For example, we 'know' that police often will not utilise mental health personnel if they believe they are 'inadequate' (Morabito, 2007), however how is this understanding constructed? How do the statements that produce this understanding communicate the power relations and subject positions realised in their experience? What are the broader understandings that inform police officer understandings of mental health services in relation to police work and how do they combine to produce such statements? What material effects do such understandings have

and how do they enable certain identities and behaviours to be adopted while constraining others? Here, one is moving beyond a description of an idea or attitude to a deeper understanding and appreciation for the complex relationships and knowledge structures that collaboratively produce ways of thinking, knowing and being. As Coombes and Te Hiwi note (2007) more qualitative methods can enable an exploration of the processes of knowledge and understanding formation through a participant-led production of meaning rather than relying on the researcher to define what it is that can be 'known' through subscribed forms of data generation such as static questionnaires and surveys.

To more meaningfully discuss the implications of what a discourse analysis can contribute to the area of policing the mentally ill, it is necessary to begin by discussing social constructionism, as it is through this theory of knowledge that the current research is defined and produced.

Social Constructionism

Social constructionism is an approach to knowledge that examines how culture and social processes influence how we understand and experience ourselves and the world around us (Parker & Burman, 1993). It is concerned with how our sense of reality is produced through these processes, conceptualising reality as a construction built through the language, resources, understandings and concerns of a particular culture at a particular historical location (Willig, 1999). This produces important implications for how psychologists regard and research the individual embedded within the social structure.

Firstly, taking a social constructionist approach implies that there is no one fixed 'truth', but instead there are multiple systems of knowledge that are specific to various cultures across different historical periods (Parker & Burman, 1993; Willig, 1999). Examining cultural differences, trajectories and transformations can inform the researcher as to how 'knowledge' is produced, why some particular conceptions of 'truth' are privileged over others and what effect this has on how we relate to others in the present day (Parker, 2002). This approach is useful to the current research given that we now occupy a historical period that is concerned with community care provision for the mentally ill, but understandings surrounding both the nature and treatment of mental illness may still be influenced by the not-so-distant past of institutional-based service provision. How are constructions of mental illness different now? How are they similar? Are there constructions from pre-deinstitutionalisation that have remained as dominant systems of meaning and if so how does this enable or constrain certain understandings and practices for the police as they engage with those with mental illness and mental health service providers in the community? For instance, as discussed in the previous chapter, Rock (2001) argues institutions may have served to alleviate the fear or threat that those with mental illness posed to the community through social control and surveillance. How has this construction of the 'dangerous other' changed through the process of deinstitutionalisation, if at all, and how does it produce positions to adopt within the social and power relationships of the police and the mentally ill? How are residual constructions of 'threat' now addressed through the operations and practices of current institutions such as the criminal justice system?

Furthermore, social constructionism encourages the researcher to explore 'knowledge' as something that is produced through social processes specific to the population of interest,

rather than the traditional approach to knowledge as something that exists 'waiting to be discovered' and explicated by academics (Gergen, 1994). The traditional, individualistic understanding of thought processes resulting from a rational appraisal of conflict and ideas that are 'present' in the world ignores the influence that social interaction and processes play in the construction of 'reality' (Parker, 2007). Social constructionism restores the location of the individual to their social environment in order to understand the processes of knowledge construction and production through interactional power relationships. In the present study, this allows the focus and exploration of relationships that was felt to be missing from previous research through the analysis of officers' everyday speech concerning their experiences with the mentally ill. The analysis and interpretation of data gathered will be explored for the ways in which social relationships are constructed within police officers' own language and how these constructions enable certain meanings and practices to become dominant systems of knowing and being.

Social constructionism places importance in language, as language is one way in which we convey, share and organise how we make sense of our world (Gergen, 1994; Willig, 1999). Within this approach, no longer does the researcher seek to extract and isolate the individual from the world around them, but rather embraces that world as an inherent component of the individual, seeking to make sense of the symbiotic relationship between both the personal and the social. It is an examination of social interaction and relationships. By investigating discourses, the critical psychologist is examining exchanges between members of society that have, at their foundations, cultural and historical significance (Gergen, 1994). Attitudes and beliefs in the current study are conceptualised as social exchanges of dominant understandings and productions of power relationships. They are

important, but not definitive, stable or intrinsic to the individual being studied. They are shared constructions that shape how we understand and experience the world around us.

Taking a qualitative approach to research does not necessarily entail a rebellious overthrowing of traditional empirical methods of study in psychology. Rather, it can be seen as an approach that can contribute greatly to the field of psychology through its focus and acknowledgement of the social elements of psychological life (Gergen, 1994). There is a definite conflict in the empirical method between the desire to make research applicable outside the psychological laboratory and the need to keep methods and conditions objective. Social constructionist methods can to some extent discard this conflict by embracing the unavoidability of the social and cultural, and by acknowledging the importance of them in the design, conclusions and applicability of the study in regards to the population for which the research was produced to benefit.

In relation to the present study, the researcher has identified what is lacking in the field of investigation concerning policing the mentally ill is a body of knowledge from the vantage point of the police officers themselves: that is, how they understand their experiences of policing the mentally ill. In this regard, the creation or utilisation of a survey or questionnaire to collect data was avoided to limit as much as possible my role in the production of paths and boundaries as to what was able to be said, which might have overlooked concerns, meanings and understandings that are unique to police officers dealing with the mentally ill in the community. If we want to understand what experiences and knowledges exist in a particular culture, is it not better to ask them to define it themselves rather than request they agree or disagree with knowledge an 'outsider'

produces for them? Qualitative interviewing offers the production of a much greater and richer set of data that can be explored and analysed to enable a more detailed understanding of the complexities and intricacies of the subject at hand.

An emphasis on social relatedness allows an examination of how the police interact with other relevant groups and populations and what effects and implications such interactions have on how their world is understood and experienced. The qualitative research method of discourse analysis has been used in the current study to facilitate a richer exploration of the social relationships and systems involved in policing the mentally ill than has previously been enabled in order to contribute to, and advance, the gathering body of research in this area.

Discourse Analysis

Discourse analysis centres on exploring how discourses are produced by people to achieve desired outcomes and goals (Potter, 2003). It moves away from traditional explorations of attributes residing within the individual to focus more on performance and interactions between people (Potter, 2003). Discourse analysis can be employed by researchers from varying orientations for varying purposes and as such it is impossible to describe it in a manner that is congruent to all that utilise its methodology (Burman & Parker, 1993). However, most conceptualisations share certain theoretical principles from which they draw upon. The method utilised in the current study is influenced by the work of Foucault, but it is useful to examine some of the basic tenets of discourse analysis before a more in-depth discussion of the present study's focus and orientation is detailed.

The object of study in discourse analysis is language and linguistic resources (Burman & Parker, 1993; Willig, 1999). Instead of endeavouring to capture unobservable mental processes, discourse analysis places focus on language, whether spoken or written, as the place in which meaning and understanding is produced or constructed outward into the social world (Parker & Burman, 1993). This view of language as the process through which meaning is socially produced and actualised is in contrast to the traditional view of language as an exact reproduction or reflection of unobservable processes of understanding and the site at which they can be accessed (Gergen, 1994). Therefore, language is not simply a vehicle for the 'truth' that 'exists' in some form within our minds, but instead language creates certain 'truths' through social interaction, it is productive and within it we create our world, our understandings and how we define both ourselves and those around us (Burman & Parker, 1993).

If knowledge is socially constructed then it follows that in order to study it we need to examine the point at which it is created through discourse in order to understand its meanings and implications. Furthermore, construction implies tools, materials and processes through which some 'thing' is produced. In order to make sense and understand each other, we have discourses that we share, that mean something and do something to each member of a collective and community (Burman & Parker, 1993). Therefore discourse analysis looks at the resources that enable or constrain what can and cannot be said. These resources are culturally situated in that they are developed from cultural understandings and knowledge and must, therefore, in some way reflect the concerns and understandings of the social milieu in question (Willig, 1999). As Burman and Parker (1993) note "discourse analysis offers a social account of subjectivity by attending to the linguistic resources by which the socio-political realm is produced and reproduced" (p. 3). In the present research,

discourse analysis can enable the dominant understandings and concerns of not only those geographically located for the purposes of this study, but of the police 'culture' to guide the data generation process, enabling a more genuine representation of police knowledge than an approach which seeks to eliminate as much as possible the situational and cultural influences on the data collected.

Discourse analysis is able to, and actively encourages, variation and contradiction in meaning (Burman & Parker, 1993; Parker, 2002). Instead of finding comfort in the security and certainty of one universal truth, discourse analysis accepts that variability and contradiction is not only possible, but almost inevitable as people draw from various different discourses available to them in order to form a coherent construction of their world. These inconsistencies can be explored in relation to the way in which they combine to form a coherent text, what they achieve, what they enable, what they constrain or have been constrained, and how they shape and influence the social world in which they relate to (Parker, 2002).

The present study has adopted a certain orientation to 'doing' discourse analysis informed from the body of work of Michel Foucault. The following discussion will explore in more detail the influence and effect this has had on the focus and method of discourse analysis and will also explore relevant understandings and systems of meaning making that Foucault examined from which the present research was informed.

Foucaultian Discourse Analysis

Because the present study aims to examine the interaction and relationship between the police, mental health services and the mentally ill, an approach was needed that enabled an exploration of how these parties relate, what power relations such interactions produce, how particular discourses construct and locate certain individuals and to what effect.

Foucaultian discourse analysis is well suited to meet these goals because it enables an understanding of social power relationships that produce such relationships.

Foucaultian discourse analysis distinguishes itself from other applications of discourse analysis in the manner that it approaches the examination of text or discourse. In a Foucaultian approach, the researcher does not narrow their examination to the language used by focussing their analysis to the structural elements of language production (Hook, 2007). Approaches that grasp too strongly on to the examination of the specific content and structure of the text itself are in danger of producing work that has little significance or relevance beyond that particular text. This can serve to mute or even destroy any productive conclusions developed from the research while at the same time falling into the same trap of more traditional methods where the analysis and conclusions have extracted the data from its social context (Burman & Parker, 1993). Furthermore, methods that focus too closely on the text run the danger of divorcing the data of meaning and interpretive qualities (Burman, 1991). Rather than examining the content of discourse, a Foucaultian approach broadens its reach to examine beyond the text itself into the social contextual realm (Hook, 2007). This is an important distinction, especially when considering the individualistic internal locus of 'reality' privileged through traditional research methodologies. A Foucaultian approach considers discourse as more than a representation

of thoughts and attitudes, instead the process of thought is in itself a discursive production and therefore discourse is the very place at which ideas, knowledge and understandings are produced, which have in turn been developed through social, cultural and historical processes (Kendall & Wickham, 1999).

Hook (2001) suggests that focus be placed not on what the text reveals about the speaker, but on what it reveals regarding how certain constructions and 'subjects' are made possible through the discourse. Therefore, the focus of examination in the present study will concern questions regarding the processes of how the officers construct discourses surrounding policing the mentally ill instead of limiting explorations to simply what discourses were available for them to draw from. Every location and situational context of police officers will have, to some degree, varying dominant cultural and social discourses to draw from and by broadening the research to questions of 'how' not only 'what' as a means of interpretation I will be able to extend the relevance of the study beyond the specific location of the participants to some degree.

The Foucaultian analyst is aware of, and explores the discursive resources available for such thought production supplied by the cultural and social context of the individual. This places the text, and therefore the analysis and conclusions, at the point at which the individual intersects with culture and society. The Foucaultian approach encourages a genealogical examination of discourse to explore how certain understandings have come to dominant our knowledge systems and also how they affect and produce current meanings and understandings (Hook, 2007). Through this approach, meaning and knowledge are problematised, studied in their own right, to explore how previous historical and cultural

elements have informed and constructed what represents truth and knowledge, and the power relationships that have been produced and perpetuated by these influences.

This makes it possible for the researcher to ask questions such as: How are discourses and discursive objects constructed? How have these discursive practices evolved into their present usage? What are the processes in which this has been enabled and how do these discourses enable or constrain particular knowledges? How do they produce and then locate various subject positions? By asking such questions in the present study, I will be able to gain a greater understanding of the taken-for-granted systems of knowledge operating through the police officers' language and the implications and consequences for police relationships that may have been obscured or ignored previous to examination of the broader systems of meaning (Parker, 2002).

This is particularly salient to the current research given that it is located in a historical era that embraces the concept of community care but has until recently utilised institutional-based treatment provision for those with mental illness. Previous research has tended to compare and contrast pre and post-deinstitutionalisation as if they are two distinct and separate locations in history. What this fails to address is the evolution, as moments in history, of modes of service operation for those with mental illness. One evolved from another, was informed by it, distanced itself yet sprung forth from it. In order to understand how we conceptualise quality service provision for those with mental illness in today's cultural milieu there must be an examination of how our understanding of mental health care has changed, especially to address why it seems to be failing. How has the

transition between modes of service operation produced certain positions for individuals to adopt, and how have these positions been negotiated, reproduced or resisted?

Furthermore, an aim of this study is to produce a piece of work that has relevance, which can act as a tool for further developments and procedures that enable a more productive policing of the mentally ill. By utilising a method that connects discourse to broader societal systems, I enable the promotion of practical implications of the research findings. Rather than discussing the individual participants, I am able to discuss action and practice, both of discourses themselves and the proceeding effects of such discursive practices.

Foucaultian discourse analysis pays attention to the discourses that exist within particular institutions and how they relate to and produce ways in which people are able to interact and position each other and themselves (Willig, 1999). Foucault emphasised that how institutions seek out and 'confirm' knowledge is governed through particular rules and procedures. The discourses that relate to these systems of power are not only applicable to the present, but have their foundations in discourses of the past (Hook, 2007). This encourages the researcher to look back historically, beyond the current statements the participants produce, to examine what common or taught meanings and understandings are utilised, distorted or in some way wielded and for what purpose. By tracing the genealogy of particular discourses through institutional practices we are able to understand and articulate more substantially how our view of the world has come to bear and how such discourses effect us still today (Parker, 2002). Institutional practices in the current study will concern both 'policing', discourses of control and discipline, at the very site that may be understood as 'psychological': the policing of the mentally ill in the community.

Furthermore, this approach emphasises the idea that such discourses are not stagnant or stable. As they have changed in the evolution of our cultures, navigating through different social movements, so too will they change in our future. This opens up the possibility and ability to legitimise and promote alternative discourses that may be able to offer the area of policing the mentally ill a better or more healthy way of operating (Hook, 2001).

Another focus in a Foucaultian approach is attention to subject positions (Parker, 2002). Through language, subject positions are produced that carry with them certain rights, expectations and allowances – *power* – in relation to those involved in discursive practices (Parker, 2002). Such subject positions have a purpose and an effect, of which the speaker may or may not be aware of. Never-the-less they construct certain possibilities, ways of interacting, benefits and sacrifices, but overall they *do* something, *produce* something. Identification of the various subject positions and therefore the different power relations that are produced through discourse can inform the researcher as to the processes, affects and implications those discourses enable, or constrain. In the current study, particular attention will be paid to how the ‘police’, ‘mentally ill’, and ‘mental health service provider’ are positioned in relation to each other and what effects such positions enable and constrain.

Dominant discourses serve to create, affirm and maintain current systems of power that usually serve a particular purpose (Parker, 2002). They situate certain ‘knowledges’ in a privileged position at the expense of other systems of meaning that challenge those ways of understanding ourselves and our experiences, as well as systems and institutions that have a stake in this matter (Willig, 1999). Within this conceptualisation, power is seen as a

verb not a noun (Hook, 2007). It is not a 'thing' that is able to be acquired, possessed, yielded and opposed. Instead it is a process, a production, the method through which we relate to one another. As Hook (2001) argues discourse is both an instrument of power, as it produces power relations, and an effect of power, the dominant understandings evolve through privileging certain discourses over others. As a consequence, certain subject positions are created that enable or constrain particular forms of knowledge and material practices. The implication for the current study is that power will be examined in relation to how police 'do' it and how this practice effects the relationships involved in policing the mentally ill, instead of what or where this power 'is', who possesses it and what different forms it takes (Hook, 2007). This is because the list of forms power can take is as inexhaustible as the instances of human relational behaviour. In every instance of interaction, power relations are being constructed in some form for some purpose (Parker, 2002).

There are criticisms that this conceptualisation of power as insidious and inescapable can lead to a certain fatalism in regards to the importance and impact research regarding such relations can offer (Burman & Parker, 1993). However, by examining the way in which power is constructed through relational interactions, discussions of the broader systems and networks of power that inform those interactions are enabled. As Hook (2007) notes "the attempt to comprehend the relationality of power should result in an understanding of a dynamic functioning which is greater than the sum total of its parts" (p. 81). Police officers adopt varying positions of power as they negotiate different relationships with others: their work peers, their relationships with mental health agencies and mentally ill citizens, therefore taking a Foucaultian approach can help explore how each of these positions either privilege or prevent certain understandings and practices and how they

combine together to produce complicated or inventive new discourses and subject positions. Furthermore, by conceptualising power as a relational process it is no longer something that is 'done' to people and therefore each individual has the opportunity to contribute to the direction of the power-relationship (Hook, 2007). This creates the opportunity to explore instances and examples of resistance and alternative discourses to those dominant. How do the differing discourses police officers utilise combine and co-exist, and are there areas in which the combination and co-existence of certain discourses can provide healthier, more productive ways of conceptualising policing the mentally ill?

Hook (2001) also notes that the danger in examining social and cultural discourses of power is that, whether intentionally or not, these discourses may then be further strengthened and legitimised. By concentrating effort, examination and focus on the dominant discourses concerning policing and the mentally ill that may produce boundaries and limits to relational interactions, they may be reaffirmed and perpetuated. However, through my work I will distinguish between discourse as an effect of power (reflected in the dominant discursive practices and the resources they offer) and discourse as an instrument of power (the production of both dominant and alternative systems of meaning). By keeping in mind that discourse is both a power effect and an instrument, the danger of perpetuating current understandings that may limit how police interact with others and the concerns that may arise from the production of these discourses can be addressed. Furthermore, Burman and Parker (1993) note that discourse analysis can be used as a tool to illuminate dominant discourses that may have gone unchallenged in the past and identify the processes, purposes and consequences by which they operate in the act of the maintenance of power.

A Foucaultian approach also emphasises the material aspect of discourse (Willig, 1999). The implications of discourse are not limited to the text, instead the consequences extend out into the material world in the form of actions and behaviours. How one comprehends the world and themselves must manifest itself both in the construction and understanding of their identity and in the way in which they relate to others. Discourse produces the understandings and boundaries within which this identification, action and experience can take place and be made sense of. Furthermore, discourses are material in that they promote and support particular social institutions, systems and practices, and the way in which these regulatory systems engage with particular versions and views of what can be considered 'truth' (Hook, 2001). Analysis at the discursive level is able to accommodate variation and diversity in text through an identification of how discursive practices unite and combine to produce various purposes and effects (Hook, 2001). The police force and mental health system are examples of such institutions that both produce and support particular systems and practices. An exploration of the material conditions and possibilities these structures and systems of meaning produce can illuminate the different power relations inherent within them and therefore the effects on individuals living under the influence of such structures.

Reflexivity

Reflexivity is an important element of discourse analysis in that by adopting the position of the researcher, one is also accepting that they themselves become part of the research (Burman & Parker, 1993). Whether it is through the co-construction of the data itself through interviewing or analysis and interpretation, the researcher is a vital element in the process. As such, I as a researcher must maintain awareness of the contribution and effect I

have on what data has been gathered and how that data has been interpreted. It is essential to relay this to the reader so that an evaluation can be made as to how the research findings were constructed. This serves to acknowledge the power relationship implicit between the researcher and the 'researched' and whose version of events is privileged as a result of the research process: namely that of my own (Burman & Parker, 1993).

Discourses relating to police

Discourses employed by police are privileged in many societies given that they represent what can be seen as the 'truth', the governing law under which all citizens must abide by, and therefore such discourses are granted a certain power and privilege in those cultures (Foucault, 2003). As such, one must be alert to the practical effect such discourses have on how we view and experience our lives and the ways that it can exert power, and limit or enable certain practices, conduct and ways of relating to the world around us (Hook, 2007).

In order to examine discourses that relate to policing the mentally ill, a discussion is needed concerning the trajectory of dominant historical discursive practices that have constructed the ways in which 'policing' has been understood. This is because, as mentioned previously, the discourses of earlier historical and cultural eras produce and inform current meaning making systems. It is both informative and enlightening to delve backwards in order to fully comprehend how our existing understandings have been formed and for what purposes certain meanings and knowledges have been utilised.

Discourses concerning policing and law and order began to take solid formation in the 13th century, but it wasn't until the 17th and 18th century that discourses concerning the role of police and what those systems of meaning enabled surfaced as dominant societal regulatory systems (Dean, 1999; Foucault, 2003; Hook, 2007; N. Rose, 1996). The need for discursive understandings that concerned the regulation and control of society coincided with the historical political concerns of sovereignty and how best to govern the people under the control of the sovereign ruler (Dean, 1999; Hook, 2007). The external nature of power and control under sovereign leadership has been described as one that was inherently incomplete in application (Hook, 2007). Laws and decrees were 'administered' from the sovereign downwards to the population in order to amass wealth and territory, therefore gaps were present in the instances where individuals evaded detection and punishment (N. Rose, 1996). In this era, territory and wealth were under surveillance, not the inhabitants themselves, and although many found themselves under the scrutiny and punishment of the state, many others were able to disobey the governing laws and escape punishment without detection. From the middle of the 16th century there began a political shift towards the governing of people instead of material objects in order to build a strong, productive state and to limit the gaps in surveillance and control produced under sovereign rule. This required a technology of state power that could promote developing 'good' subjects instead of simply 'punishing the bad ones' (N. Rose, 1996).

As a result of this political shift, discourses of policing began to extend beyond matters of discipline and punishment alone to encompass the promotion of moral and social concerns. Police practices began to combine social control with a moral trajectory, regulating areas of social life such as good parenting, developing morality, church-going and how to behave decently in public (Dean, 1999). Here one can see that 'policing' as an external system of

control (the enforcement of laws as set by the head of state) began to shift towards more internal matters (the way in which individual subjects of the state thought and behaved). This enabled the exercise of power to extend beyond the walls of the legal system and into the individuals' very own homes. The concept of 'government' was introduced as the focus of control, and concern began to shift from the protection of the state and sovereign towards the regulation of subjects in order to promote economy and discipline (Rabinow, 1991). The purpose of this was to increase political power over the subject and produce a state that contained a collective strength (N. Rose, 1996).

This amalgamation of preventing disorder or disruption to the state and facilitating the promotion of values and productivity was coined in the 18th century as the 'science of police' (N. Rose, 1996). N. Rose (1996) notes that this science was comprised of three components: Objectives, procedures and the invention of techniques. The objectives of this science were to maintain order and enforce discipline, reduce harm to subjects, increase economy and productivity, and to facilitate peaceful localities and subjects. The procedures concerned systems of surveillance that involved the collection of statistics concerning the population in order to appraise what resources were available to the state. Invention of techniques concerned developing systems of governance that promoted and enforced state values and offered protection to the population.

An illustration of the political shift focussed on the governance of people given by Foucault (2003) is the treatment of plague victims in the 17th and 18th centuries. A previous health concern had been leprosy, which was addressed through a process of purification. Lepers were removed from society, excluded and contained to designated areas with the purpose

of ridding the population of the 'diseased'. However, the plague was dealt with differently. Instead of removing plague victims from society, they were quarantined and placed under heightened surveillance and control. Whilst segregated into particular communities within the territory, they were still considered 'part of the state' and as such were vigilantly monitored. Foucault (2003) notes that this produced an individualising element to the subjects of a given population. People were compared to the 'norm' (healthy, productive citizens) and although they were not excluded, they were assigned a certain position in society. This position needed to be observed and controlled, both for public safety and for the development of knowledge. Individuals in society were now subject to 'policing' in accordance to their personal attributes and capacities, in comparison to earlier models of policing that simply concerned the adherence to sovereign state regulations. We can see here that 'policing' changed and adapted to meet political and social concerns in order to increase state power and control exponentially. 'Crime' and 'law' were no longer concerned solely with acts of defiance or disorder, but instead also become concerned with the very nature of the individual (Foucault, 2003).

The humanist reforms at the end of the 18th century linked law and psychology in a meaningful way through this focus on individualisation (Hook, 2007). By turning focus towards the individuals that occupied the state, it was revealed that these individuals made up a collective community with its own rules and regulations: society. Because 'society' could be seen as a government in its own right, independent of the law, the police were no longer automatically granted complete authority and access. Instead the need arose to understand this form of governance (N. Rose, 1996). As our knowledge of the individual increased through closer surveillance, so did the need to classify and quantify, to explore such concepts as the 'criminal mind' (Hook, 2007). Danger and madness became linked

through this fervour for understanding the 'criminal mind' and "every criminal offense came to carry with it the legitimate suspicion of insanity" (Hook, 2007, p. 15). This produced constructions of fear and 'threat' by focusing on the 'nature' of the individual instead of their behaviour, constructing the latent 'threat' for potential future disorder or deviance daunting and almost inevitable. As a result, the government's power to control the individual increased. Not only could they react to a crime that had been committed, but they could also project future uncommitted crime onto the individual and act in a preventative fashion (Hook, 2007). Such a construction legitimises and increases the ability to exercise power and control over the individual.

N. Rose (1996) notes that as a result of the focus on 'society' a second major political shift began, liberalism, that was concerned with the limits of government and how best to negotiate the control and regulation of a 'society' that possessed its own mores and rules and therefore is not wholly dependent on the state for guidance. N. Rose (1996) stresses the governmental dilemma between attempting to enforce too much or too little control over this society. As a result, psychological discourses began to contribute to governmental systems as there was a need to develop and utilise a language in which it was possible to describe, discuss and propose recommended 'ways of being' that could guide the subjects towards behaving in a way that adhered to the wishes of the state, but also appeared to coincide with their own wishes, desires and fears. This psychological discourse gave society the language and means through which they could reflect upon, and interpret, their own actions and behaviours. It created standards and norms that individuals could strive for and methods in which they could, if needed, correct and modify their behaviour to best situate themselves within those norms. The political then became the personal, and the values and

ideals of the state became internalised into morals which each subject of the state either 'possessed' or 'lacked'.

The historical examination of sovereignty, governance and discipline above contributes to a discourse of power referred to as subjectification (Foucault, 1988). Through subjectification, a relationship between the state and the individual is created wherein the ideals, norms and 'rules' as set out by the state are intimately connected to our understandings, desires and conduct of our own lives. They become ethical activities (Foucault, 1988). As such, each individual performs this ethical activity by subjecting themselves to the dominant discourses of morality in order to locate themselves in a particular position in society. Police officers may experience this two-fold: not only are they subject to social mores and values, but they also adhere to and enforce those of the legal system. These systems of knowledge and understanding interact, inform and transform each other, giving rise to complexities, contradictions and conflicts for police officers in their interactions with other agencies and systems (such as the mental health system) and also individuals within the community (persons with mental illness). This is even more poignant given the more therapeutic approach police may need to take when providing service to those with mental illness in the wake of deinstitutionalisation.

Another discourse of power that is highly relevant to policing is that of pastoral power (Foucault, 1988). This discourse has its roots in religious discourse and is concerned with the concept of the shepherd caring for and guarding their flock from illness and danger (Hook, 2007). The shepherd is an authority figure who's 'law' cannot be questioned as it arises from a power, or an ideal, that is greater than humanity (traditionally God). The

shepherd adopts responsibility for the protection and well-being of their flock and ensures this by absolute knowledge and surveillance of those under his care. Not a single member of the flock is permitted to 'wander' or be lost and 'salvation' is offered through the flock's adherence to the shepherd's supervision, guidance and control (Foucault, 1988; Hook, 2007). Again, an individualisation process has been established whereby the 'flock' develop means in which they self-examine and regulate their own behaviour through the teachings of the shepherd. Hook (2007) notes that pastoral power has served as the "predominant form of the individualising power of modernity" (p. 239). This discourse is relevant to the police as they can be constructed as a modern 'pastor' monitoring and protecting the community and guiding them towards 'salvation' through the institutional practices of the governing laws and rules of the dominant culture.

Discourses concerning the mentally ill

Another set of discourses relevant to the present study are those concerning mental illness. Policing the mentally ill operates at the nexus between, at a very minimum, discourses concerning both policing and the mentally ill.

The concept of 'madness' was introduced in the 15th century as an emerging fear and threat to society (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995). Madness was a lurking danger, potentially hidden within any individual and capable of being released and unleashed upon the 'good' subjects of society. 'Houses of correction' were established in late 16th century England to contain and confine those who were mad – a matter for the police – but over time, with the emergent understandings of 'society' and 'government', 'madness' also became a concern for the community. Institutions were

established to abstract 'madness' from social deviancy in general, which enabled a more concentrated exploration and intervention of mental illness : how it was understood, how it was positioned within society, and ultimately how it was treated and controlled (Parker et al., 1995).

Foucault (2003) discussed, through a collection of lectures, historical discourses of abnormality: how discursive practices created certain subject positions in which an individual can occupy and what those positions enabled or constrained. As noted earlier, discourses of a 'norm', a standard of human behaviour to which either people 'achieve' or 'fail', were adopted in order to correct, modify and control the population. In the 18th century, with the focus shifting towards the individual, systems and processes were constructed wherein the character and conduct of the individual became open to intervention, regulation and control, enabling a more comprehensive and thorough enacting of power upon the individual than under sovereign-led power mechanisms. Alongside the system of policing to regulate public health and protection, psychiatry emerged as a dominant meaning making system that could confront and attempt to 'solve' the dilemma of the disordered and therefore dangerous subjects (N. Rose, 1996).

Previously, mental 'disorder' had been constructed as something that was separate to the human condition. The mad were not the same as 'us', they were monsters, animals, completely different from the rest of society. Towards the end of the 19th century the concept of instinct emerged, transforming the notion of 'monster' into the understanding that any person had the capacity to possess 'monster-like' capabilities or instincts. A discourse of abnormality was introduced wherein psychiatry had an important role to play

as a science that could discuss, define and perhaps correct the 'little monster' that potentially lurked in any of us threatening to infect others in the population if not treated with caution and intervention (Parker et al., 1995). Discursive understandings of madness as something external to the concept of humanity (that we were either human or 'mad') were discarded in favour of discourses that concerned moral issues regarding the humane treatment of the insane.

Through returning the humanity to the construction of those previously considered animal-like, the concerns, weaknesses and problems of 'madness' were transferred from outside the human condition to inside the individual. Because the responsibility for insanity lay within the individual, logic follows that so did the cure. Although the insane were returned to a position within society, through internalising the problem and responsibility of 'madness' society in general was relieved of the responsibility for the problem. Responsibility for cure was instead given to the conscience of the insane. No longer would state-run facilities be held accountable for the regulation and control of madness - it was now the domain of the subject to correct their own abnormal behaviour (Parker et al., 1995).

Furthermore, madness became a crucial concern for society as in returning insanity back to the community, the strength and resources of the state were threatened (Parker et al., 1995). This 'threat' opened the door for psychological discourses to hold a dominant position in the maintenance and protection of society because the science of psychology was in a position to address such threat. Psychological discourses enabled discussions of a 'norm' from which to measure others, producing subject positions of power or

powerlessness, and enabled discussions concerning the conduct of the individual to facilitate this placement. They made possible the identification, and therefore intervention, of the danger of 'madness' and set up positions of normality and abnormality to adopt alongside the responsibilities and consequences of such positions (Foucault, 2003). These discourses also exponentially increased the ability for surveillance and control of the state upon individuals by pushing the boundaries of investigation deeper within the individual, into their family history, their upbringing, their experiences, their thoughts and feelings and their conduct in order to identify and address the moral and social threat of madness (N. Rose, 1996). Here again we see the personal and political combining in a parallel fashion to discourses concerning policing and governance. The act of regulation and control is combined, and therefore extended and strengthened, with the desire of the individual to obtain 'normalcy' (Parker et al., 1995).

This history is important to reflect upon as it traces the emergence of discourses concerning regulation, governance, 'policing' and mental illness which have informed present day discursive practices and the ways in which we can understand 'policing the mentally ill'. The question Hook (2007) encourages us to explore is 'how' rather than 'why': How have such discourses come to represent the dominant ways in which police understand their interactions with the mentally ill? How have they created certain subject positions? How have they enabled or constrained what has been possible to know and do? By examining present day systems of meaning and tracing them back to historical discursive understandings, a picture emerges of the processes and consequences of particular discourses. The aim of this process is not to 'discover' new forms of knowledge, but to open up discussion and critique of the dominant forms of understanding policing the mentally ill, while at the same time strengthening discourses that may have been subverted

or subjugated through power relations of dominance and suppression and can offer resistance to the taken-for-granted forms of 'knowledge' that police operate under daily.

Discourses for both policing and mental illness followed similar trajectories, working parallel with one another in response to the dominant concerns and events throughout different historical periods. Although the domains of police and psychology may be considered separate and discrete, police officers occupy a position in which they are influenced by and produce systems of meaning that combine these two domains when policing the mentally ill. Furthermore, with the advent of the deinstitutionalisation movement such clashes of discourse are bound to be increasingly combined, contrasted and amalgamated due to the increasing intimacy between the interface of police officers and the mentally ill population. How do these two sets of discourses combine to create a system of meaning concerning policing the mentally ill? How does the genealogy of those discourses produce the ways in which we can understand and discuss these concepts and how do they limit what can be said? With the recent historical change of deinstitutionalisation are there new discourses emerging? How does that affect the relationship between mental health agencies and law enforcement? How do police make sense of their experiences of 'policing the mentally ill'?

Sampling and recruitment

Qualitative studies approach the concept of sampling differently to that of more traditional, quantitative orientated research methodologies. In quantitative research, the desire is to obtain a sample that is representative of the population of interest to allow

generalisations from the research findings to similar populations. Because qualitative research is more focussed on the depth and richness of information produced by the research participants rather than the ability to generalise conclusions to other populations, sampling is guided more by concerns surrounding the ability to obtain a sample that is most appropriate given the research aims and can supply sufficient data to allow the research question to be adequately explored (Fossey, Harvey, Mcdermott, & Davidson, 2002).

Before commencement of sampling and recruitment, I attended a meeting with the local police Area Commander and District Intelligence Manager. The purpose of this meeting was to explain my proposed study and gain their written consent to interview police officers in the local district. A research proposal outlining all pertinent information regarding the proposed study was presented and discussed. After obtaining written consent to interview officers in the district, I was provided with a list of potential police officers considered to be relevant for participation in light of the issues discussed during the meeting.

On first conception, the intended sample for this study was limited exclusively to front-line police officers. It was believed that police officers involved in front-line duties would have the most specific and detailed experience with negotiating situations and relationships involved in policing the mentally ill in a practical, material manner. However, as Fossey et al. (2002) note, sampling in qualitative research is often a process that can be influenced and re-evaluated as a result of engaging in the research procedure itself. As such, sample population definitions can be subject to change in order to better address the research aims. The list of potential participants provided by senior police management was not limited to front-line duty officers: some were involved in community and youth projects

and other various job-roles not exclusively 'front-line' in nature. I respected the senior officers' knowledge and understanding of the research area and reflected upon the previous assumption that exclusively front-line officers would be relevant to the study at hand. I began to appreciate that by utilising various police officer positions of duty I would gain access to varied experiences, knowledge and understandings of interactions with the mentally ill and therefore decided to broaden my sample population to include any officer position that had knowledge of, and interaction with, those with mental illness in the community. Furthermore, after conducting early interviews I was able to identify particular areas of policing and the relevant job titles that I believed would provide informative and comprehensive data, utilising purposive sampling through consultation with the local police station manager to recruit participants involved in the identified areas of policing. This extending of the sample population served to ensure a wide, detailed and informative body of data was collected that was best able to explore the various practices and issues present in the field of policing the mentally ill.

Police officers on the provided list were contacted via email and supplied an information sheet detailing the study (Appendix A). Of the 6 officers contacted, 3 consented to participate in the study. The local district police station manager assisted the recruitment process by locating 8 further officers to participate, resulting in a total of 11 participants recruited.

Although this sample may appear small by traditional research standards, therefore inviting criticism of the research's power of generalisability, Wood and Kroger (2000) note that small samples in discourse analysis do not necessarily prevent generalisability of the

research. They note that while traditional, quantitative research strives for generalisability through large samples in order to examine relationships between variables of interest, discourse analysis has as its central goal the exploration of the production and function of those 'variables' (i.e. discourses). By adopting a Foucaultian approach to discourse analysis, the emphasis is not on discovering 'truth' as conceptualised as discovery of fact within the data collected, but instead explores the processes behind knowledge and knowledge production (Hook, 2001). As Wood and Kroger (2000) note "...the interest in discourse analysis is in language use rather than language users: the units of analysis are texts...rather than participants" (p. 78). Because the focus of examination is on language and language processes instead of the individual participants and the population they are reported to represent, the sample size needs to be adequate enough to provide a comprehensive and detailed sample of discursive processes concerning the research subject and this does not automatically require a large sample population. In fact, Coyle (1995) notes that large samples can be cumbersome to discourse analysis in consideration of the large amount of data collected that is needed to be transcribed, analysed and interpreted.

Furthermore, the number of participants recruited in qualitative research is often guided by the concept of data saturation (Fossey et al., 2002). This entails that the data collection process is continued until the point at which no new systems of meaning are emergent and the researcher is confident that continued data collection would contribute no further relevant information. It was hypothesised that between 10 and 12 participants would be required to reach data saturation in the present study. On completion of the 11th interview it was noted that no further variation or range of discourses and experiences were

emerging, therefore I was confident that no further interviews were needed in order to conduct my analysis.

3 of the 11 participants were women and officers ranged in number of years working in the police force from just under two years to over twenty years in service. Although gender did not appear to have an effect on the nature of data collected, it should be noted here that those with shorter lengths of working experience within the police force expressed greater frustrations with the mental health system than the more experienced officers. The participants ranged in title and duties within the police force. While some officers had more direct interactions with those with mental illness, others had more indirect relationships, such as senior management officers. Whilst participants involved more specifically with front-line duties were able to comment on and discuss current interactions and concerns involved at the 'coal-face' - the immediate experience when attending call-outs - those who were somewhat removed from front-line duties were able to discuss more systemic and interagency relation-based systems and considerations. Positions and duties represented were: front-line officers; community constables; armed offenders squad members; youth service officers; domestic violence team members; and senior management officers. Some officers held more than one position and others had been involved in a range of positions over their career. Because of the small and local nature of the potential participant pool, I have chosen not to provide descriptions of titles and duties in further detail for fear of inadvertently identifying those who chose to take part in the study. No further demographic data was to be included in the analysis and was therefore not collected.

Data collection

One-to-one semi-structured interviews were conducted to produce oral accounts of police officers' experiences of policing the mentally ill. After obtaining written consent (Appendix B) and answering any questions presented, the interviews commenced.

Given my outsider status and subsequent limited knowledge-base regarding police work involving the mentally ill, employing a semi-structured interview format allowed me to direct conversations towards relevant topics through the utilisation of open-ended interview questions (Appendix C) whilst remaining open to exploring conversational directions pertinent to the study that may not have been anticipated in the original research outline. It must be acknowledged that this style of interviewing requires the researcher to engage in interpretative methods during the data collection process itself due to the immediate and consistent assessment of whether certain paths of conversation are related to the study and whether or not to pursue particular avenues of thought (Wood & Kroger, 2000). Therefore, it is possible that potentially important directions of conversation may have been overseen or ignored that could have proved insightful and informative.

Awareness of this limitation is important to bear in mind when interpreting the results and highlights the role of the researcher in the co-construction of the research data. As a consequence, my own discourse was included in the transcription and analysis.

10 interviews were conducted over a series of three non-consecutive days during work hours in private meeting rooms at the local police station organised in collaboration with, and approved by, the police station manager. One interview was conducted in the participant's own home outside of work hours.

The interviews ranged in length from thirty minutes to one hour, producing between 13 and 29 pages of text per transcript. This variability of interview duration depended on the individual officer. Interviews were terminated when the participant indicated that they had nothing further to discuss on the subject matter.

The open-ended interview questions were formulated as starting points for discussion and were designed to act as 'prompts' to be utilised only when conversation was not naturally forthcoming. However, early in the interview process some participants communicated discomfort with this interview style, either through direct comments or non-verbal cues, and it was found a more structured approach was preferred. I believed a more structured interview format was preferable for the officers because it enabled the conversation to stay structured within safe boundaries and better suited the constraints of the police role and position. Because the police are in a highly public position in New Zealand society and often liaise with the media, they may have a heightened awareness of the risk of being misquoted or misunderstood if conversation is free to diverge into areas not anticipated. Therefore, as the interviews progressed I found myself utilising most to all of the pre-prepared questions in order to stimulate discussion and endeavoured, where the situation allowed, to follow divergent conversational paths produced naturally through conversation.

I was also required to re-examine the question list itself as it became apparent that particular questions were difficult for the officers to answer and may have produced some discomfort. These questions related to the officers' personal feelings regarding policing the mentally ill. In my opinion, it appeared such questions were at odds with what the

participants' believed was their 'role' and responsibility to comment on, both as a contributor to the research project and as a police officer, and subsequent to this observation I avoided asking such questions directly.

On completion of the interviews, some officers conveyed they would have preferred to have been supplied the list of questions prior to interview commencement in order to formulate answers and think about issues ahead of time. As mentioned previously, police officers are in a highly public position and this concern may have stemmed from prior experiences dealing with media and the desire to represent the police force adequately and comprehensively to others. Whilst I was seeking a more informal and conversational body of data than this would allow, I have to acknowledge that preparation and thoroughness was valued by many, if not all, of the participants and a more structured approach to interviewing may have allowed them to feel more comfortable and willing or able to share information with me. Whether these concerns were related to the subject of policing the mentally ill or to a tension produced by the constraints on what police officers are able to discuss with someone outside of the police force is unclear.

It is also important to note my subject position within the interview process – that of a student of psychology. At all times I encouraged participants to share their understandings and knowledge free from psychological 'language' and its limitations to meaning, however there were certain moments when officers would ask me for my understandings or knowledge on a subject matter and I replied honestly in kind. Although I endeavoured at all times to stay within the parameters of the officers' experiences and knowledge, there were many instances where I was asked to comment on, explain and discuss certain

psychological issues such as the definition of mental illness. Therefore, I was not removed from the data creation process, but instead was an active contributor and co-constructor of the data gathered.

Furthermore, due to my position as a younger student of psychology there were times I sensed this caused a degree of caution for the participants. Given the public and influential nature of the police role in the community, and that they as officers are representative not only of the police force in general but also as employees of the Crown, it can be posited that the participants may have been concerned that information discussed would be misunderstood or taken out of context. It may be the case that some officers censored themselves to some degree during the interview process in order to prevent circumstances in which they could be misinterpreted or misrepresented. I believe that the most pressing issues emerged during the interviews due to the participants' desire to advance and improve current practices and so feel confident that this censorship did not result in the omission of any crucial information regarding policing the mentally ill.

The interviews were digitally recorded and then later transcribed by myself as close to the completion of the interview as possible.

Transcribing

Lapadat and Lindsey (1999) note that transcription should never be viewed as an exact mirror or replication of the interpersonal exchange that took place in the interview room, even when the researcher employs highly sophisticated and detailed methods of

transcription. All transcriptions are translations of experience and as such are as much of a construction as the discourses produced in the interview. As Lapadat and Lindsey (1999) note “the process of transcription is both interpretive and constructive” (p. 72) and they urge the researcher to consider the ‘usefulness’ of the transcription, that is: how best can one construct a transcription that will allow the researcher to meet the aims of the research?

To meet the goals of the present study, my transcription technique focussed on creating as accurate a translation of the interview-exchange as possible, while also allowing for clarity of reading. By taking a Foucaultian approach to discourse analysis, I am analysing and interpreting discursive resources and constructions of meaning and knowledge, therefore the transcription style adopted needed to facilitate this focus and orientation.

Transcription of the recorded interviews focussed on conveying content and meaning rather than the specific in-text dimensions of talk, so basic documentation of aspects of intonation, inflection and non-verbal communication were included if they appeared contribute to understanding. Quotation marks were utilised to indicate when a participant paraphrased or mimicked another’s speech. Instances where participants laughed was indicated by (laughs) following the relevant text. Pauses in speech were indicated by the use of a triple-dot punctuation mark (...). In order to enhance readability of content there were instances where I opted to complete incomplete words or conversational lapses in grammar. These corrections were indicated by use of parentheses: []. Stuttered speech and repetition of words that did not contribute to meaning were removed. If sentences were incomplete or abandoned, I retained their presence in the transcription and utilised

hyphens (-) to indicate where such sentences were interrupted, followed by a comma and the new sentence, for example:

So if there was somewhere-, Like the guy that we had yesterday, he needed to be in hospital (Jane, 145-146).

Instances where speech was unable to be understood were communicated by: [unclear].

Any identifying material was removed and replaced with generic statements in parentheses, for example:

You can't get mental health services 24 / 7, especially so here in [Town Name] (Matthew, 41-42).

The approach to transcription adopted in the present study introduces issues of fidelity and highlights the concern that even in the process of transcription there is a level of interpretation needed which can introduce error to the data (Wood & Kroger, 2000). However, Sherrard (1997) believes that this element of error also adheres to the natural conventions of conversation, whereby those involved normally help the flow of interaction by offering 'repairs' for each other and searching the surrounding talk for clues in which to make a best 'guess' as to what missing sections of speech may have been. By signposting instances of repair in the transcription instead of removing them, I was able to avoid discarding various elements of the text – something that can be considered a further distortion of the data in its own right (Sherrard, 1997).

All participants were offered the opportunity to review the transcripts and make corrections or remove information as desired, after which they signed a transcript release

form (Appendix D). Only 4 participants chose to do so. Subsequent changes to transcripts included changing words or terms that did not appear to convey what the participant intended, instances where the participants desired to correct grammatical errors, and the further removal of material that may have identified the participant and /or others discussed within the transcript. One participant requested that no direct quotes be used from their interview, however this did not hinder the analysis or discussion as the systems of meaning and understandings produced echoed those of other research participants. The raw data contained in this transcript was marked for identification to prevent it from being quoted, but was useful in the analysis process to augment and explore various constructs and understandings contained in the collective texts of the police officers.

In accordance with Massey University research protocol to ensure safe and ethical practices, I was the only person who had access to the digital recordings. Once the recordings were transcribed and release of transcripts were authorised all digital recordings were destroyed. Only the researcher and the research supervisor had access to the transcripts.

Ethical considerations

This study was formulated to adhere with the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants and was approved by the Massey University Human Ethics Committee: Southern B, application 9/11.

- Respect for privacy and confidentiality

Participants were given fictitious names and any identifying information embedded within the data was removed, however this study posed some unique issues regarding anonymity and confidentiality, both in character and design.

Due to the small and local nature of the research sample absolute anonymity was impossible to guarantee. This was communicated to the participants prior to giving consent via the information sheet. Holding 10 of the 11 interviews in the police station further compounded the issue of anonymity. Although interview rooms were private, other officers present in the station at the time of the interviews may have been able to identify those taking part in the study. Although this could not be avoided due to resource and organisational demands on the police force, and the officers involved did not appear to be concerned by this, this threat to anonymity was undesirable. It must be noted here that police officers often interact with the media and are highly visible as representatives of the police force, so this may explain why the participants seemed comfortable with this threat to anonymity.

Because of the nature of police duties, embedded within the data gathered were descriptions of external identities (for example, clients the officers had interacted with and mental health personnel). Every effort was taken to either remove or obscure identifying material concerning any person that was discussed within the interview.

- Informed and voluntary consent

All participants were provided an information sheet detailing the study, the opportunity to ask questions or decline to participate, and signed a written consent form. However, 8 participants were approached for recruitment by the manager of the police station and it is possible these participants may have found it difficult to decline to participate when asked by their superior. Although I endeavoured to ensure as much as possible that the officers were participating of their own free will and that they felt comfortable to ask questions or withdraw from the study, I do not know the extent to which this recruitment process influenced their consent to participate.

- Minimisation of harm to participants, researchers, institutions and groups

The research explored various individuals and agencies that hold a very public and scrutinised position in New Zealand society. For this reason it was imperative that I paid particular attention to how I presented my findings in order to avoid any harm or distress falling upon those who were discussed in the research. The intention of this study was to identify and support successful relationships involved in policing the mentally ill alongside any possible issues present. It was not my objective to criticise, blame or find failing in any service provider or population discussed in the interviews. As a result I was mindful to present my findings in such a way that conveyed respect and avoided criticism. It would not only be irresponsible to present conclusions that located blame or failure within certain institutions, but it would also contradict the goals of this study – that being to explore *relationships* involved in policing the mentally ill. The reader is directed to approach the resultant study with awareness that this is a comment on interlinking webs of discourses, power and knowledge which are common and are constructed on a daily basis through our

social relationships, not just particular to the police force or any other agency discussed in this publication. As such, any issues or conflicts revealed are ones we share, reproduce and take for granted ourselves as they are woven into the fabric of the society in which we live. Furthermore, any issues or conflicts discussed should be viewed as points at which action and development can take place, that through exploring these points of contention not only is our understanding of the issue at hand increased, but also our ability to reflect on possible ways forward to improving those issues.

Analysis

The analysis stage began during the transcription process. While transcribing, I made notes on ideas, understandings and concerns that appeared salient and how I responded to them. After transcription, the transcripts were re-read and examined for constructions and systems of meaning and understanding regarding the relationships involved with interactions concerning policing the mentally ill.

For the purpose of this study, 'discourses' were defined as statements or sets of statements that shared a common meaning and produced various constructions of relationships involved in policing the mentally ill. It was important to focus on discourses that described relationships, rather than exploring police officer attitudes and beliefs in light of the plethora of previous research discussed in the introduction already examining this subject in some detail. The focus of my analysis was not in uncovering the working mind of the individual, but in the language they produce, which is always situated in relation to others.

My personal style of analysing and interpreting the various discursive constructions and practices was through the identification of metaphor to enable access to varying systems of meanings produced in the text as well as providing a vehicle through which to express my interpretations. Firstly, I examined the ways in which discourses of 'policing the mentally ill' were constructed within the data. I identified the dominant and recurrent meanings produced discursively that commented on the different relationships involved. The salient relationships discussed in the text tended to be between the police and those with mental illness, the mental health crisis team, community mental health services, the mental health 'system' in general, as well as the criminal justice and governmental systems. Although relationships with alternative service providers were discussed, for example Non-Government Organisations, medical practitioners and ambulatory care, they did not appear to consistently engage with these systems of meaning as with the other relationships. I also identified 'missing' relationships and the significance of these. To illustrate, one recurrent construction produced was a 'no man's land': a category of 'being' for those with mental illness that did not fall under any agency's responsibility or control. Although this is an example of 'no relationship' it is also significant given that it indicated an awareness of a relationship between police services and those of another agency that was needed, yet not present.

I then examined the productivity of the various discourses: what do they achieve? How are meanings and knowledges produced through the discursive practices and how do they vary over the course of the transcripts? How do the discourses enable or constrain particular meanings and action? How do they affect those involved and the ways in which they are able to relate and interact? Attention was paid to how the various discourses interacted

with each other, either in contradiction or amalgamation, and the significance of such interaction.

Attention was paid to what subject positions were produced through discursive constructions: where does the discourse situate the speaker and those who are spoken about? How does it achieve this and what are the effects? I also sought to identify instances where officers may have attempted to resist these positions and the effects that this resistance may have. This required me to search for points in the transcript where there appeared to be gaps or 'blocks' in the discourses. Often these locations of resistance were signalled by sentences that were abruptly halted, unable to be continued, or where the speaker was unable to utilise one particular discourse consistently and needed to draw upon others (often in contradiction) in order to express themselves comprehensively. For example, when discussing perceived inadequacies in the mental health system, often officers would stop mid-sentence and qualify their criticisms with expressions of a lack of willingness or ability to cast judgement on another agency's service provision, or alternatively continued to produce contradictory statements that praised such service providers. These instances signposted the emergence of meanings or understandings constrained or discouraged by dominant discursive practices, or alternatively areas in which police officers had difficulty discussing topics due to the lack of a 'speakable' discourse that conveyed their desired intention for meaning.

I then examined how these various discourses were constructed with reference to broader systems of meaning and knowledge that have enabled these variations to emerge. As Hook (2007) notes "there can be no objects of knowledge in the absence of methods for their

production” (p. 175). Importance was placed upon the rules, systems and structures through which knowledge / discourse is produced and legitimised (Hook, 2001). I sought to identify the historical and cultural systems of knowledge and understanding that have shaped and informed the current way in which the participants were able to speak about the topic of policing the mentally ill, or what Kendall and Wickham (1999) call the “conditions of possibility” (p. 37). This required me to regard discourses produced in the interview to be more than a specific and situated production between the researcher and participant. Systems of meaning in the text are connected to dominant discourses of the society in which we are embedded. As a result, the origins of discourses produced and utilised within the interview process were explored: How have the discourses in the transcripts evolved? How do they affect, and in turn are affected by, what one can say, think or ‘do’ regarding the subject matter. One such example in the current research was the utilisation of a ‘pastoral power’ discourse, a system of meaning where the ‘pastor’ delivers the flock, through guidance and surveillance, towards salvation at the hands of a higher power (Foucault, 1988). The understandings in this discourse were employed to construct the different duties and responsibilities of the police (the pastors) and mental health service providers (higher power) in order to facilitate the ‘cure’ for mental illness (as discussed in ‘the cure’ analysis). This example shows how historical discourses can continue to inform current understandings and produce various subject positions and conditions for action.

Since our discourses are also a part of larger power systems, it follows that the researcher can explore larger societal constructions and networks of knowledge, meaning and power from the location of the everyday speech of those who utilise them (Parker, 2002). The term ‘trans-individual’ has been used to describe the way discourses extend beyond the

individual producing such discourses into broader political power relationships situated in various systems and structures (Hook, 2001). Therefore, it was important in the analysis process to remain aware that the discourses identified acted not only as individual 'bodies' of knowledge or understandings, but also as a part of, and contributing to, larger more broader systems of knowledge and power production. I sought to identify those systems, the assumptions behind them and the effects they have on relationships involved in policing the mentally ill. This required the examination of 'discourse' in the present study to not just encapsulate closed categories of statements which contain common meanings or understandings, but also the intertwining and interlocking of different discourses that combine to inform or produce particular meanings and possibilities for positioning and action in the world beyond the interview room (Hook, 2001). For example, the '(un) identifiable other' discourse produced the need for the 'categorisation' of a 'mentally ill subject' to enable police to respond to the 'threat' of mental illness in the community, and yet 'categorisation' also produced barriers to service delivery in the 'no-man's land' discourse through admission criteria and so often by re-constructing 'mental illness' as 'criminal' (as was seen in every discourse), and therefore locating the individual within the criminal justice system, police were enabled to respond to the situation in a manner that provided resolution through constructions of control as the 'cure'.

I examined the practical applications of the discourse: what opportunities are created for material, practical action and as such have influence and consequences that extend beyond language into conditions for behaviour. Questions asked included: how do discursive practices influence the way police officers act and interact with other agencies and the mentally ill? How do the discourses structure behaviour involved in policing the mentally ill? How is this behaviour supported or discouraged?

During the analysis and interpretation process I was mindful of my own contribution in the construction of data that situated myself and the participants in various subject positions (Hook, 2001). Due to my position as researcher, it is my voice that is privileged and legitimised through the disciplinary institutions of Education and Psychology. Just as my participants cannot remove themselves or their discourses from the various institutions to which they belong, I cannot fail to acknowledge that my analysis, interpretations and conclusions are informed by the discourses that I draw from constructed from the institutions I belong to.

The final published conclusions of this report do not constitute 'fact' or 'truth' that I have discovered, but instead are an exploration and discussion on systems of discursive practices, power, understanding and relationships that have material effects, meaning and significance for the populations involved. It is not my intention to 'discover' the truth of policing the mentally ill, or expose the 'great unsaid' lying hidden behind the surface. Instead I seek to give permission and authority to police officers experiences and knowledge, to produce a document that examines accounts of this experience and infers consequences and positive directions to support and advance material practices.

Through my analysis I was able to identify five dominant discursive constructions that concerned the relationships involved in policing the mentally ill. 'Links in the chain' constructed the police as the first, middle and last link in a chain of service provision for those with mental illness and served as an anchor and influence throughout most of the other text. Each position in the chain produced different benefits and frustrations and all links were heavily influenced by police relationships with those with mental illness and the

mental health system. 'The (un)identifiable other' explored what being mentally ill might mean or signify alongside what effects this has for the police and their ability to perform their job. 'No-man's land' was a location constructed in the text produced through barriers to the provision of adequate and effective mental health services to the mentally ill. The 'Underdogs' commented predominantly on the interactional relationships between police and mental health services and the effects on power and materiality such relationships have, and 'the cure' explored different conceptualisations of how best to provide community services for the mentally ill. These dominant discursive practices combined together to form a comprehensive, sometimes contradictory, but always meaningful construction of how the police understand themselves and those they interact with when policing the mentally ill.

In order to make sense of the understandings produced through the text of the experiences of 'policing the mentally ill', I utilised the concept of the metaphor to organise the discourses into separate systems of meaning. The identification of discourses by metaphor allowed an exploration of the contingences and implications produced through the meaning making processes of the police officers. The metaphors emerged either directly from the officers' words, such as 'links in the chain' or as a reflection of my own interpretative understandings, such as 'underdogs'. What the use of metaphor enabled was a meaningful examination of the assumptions underlying the various discourses, how particular discursive constructions were linked and related to each other, and what the effects of various understandings were for material practices. Once identifying the dominant metaphor, I then organised the discussion under different subheadings in order to convey the subtle differences in focus and construction the various systems of meaning running through each metaphor produced. The metaphors provided my interpretations with a 'language' through which I could understand, make sense of and communicate my interpretational processes of analysis.

Links in the chain

The dominant metaphor for police involvement with those with mental illness in the community and their relationships with other service providers in the text was that of 'links in a chain'. The 'chain' in this discourse was the integrated and coordinated community response by partner agencies to supply adequate and quality service provision for those

with mental illness. A chain is a construction that has a beginning and an end. The beginning in this instance would be entry into services provided for those with mental illness and it can be presumed that the end link provides satisfactory resolution of the presenting mental health problem.

The chain metaphor suggests there are separate 'links' or positions in the chain of service provision for those with mental illness to adopt, each with its own responsibilities, duties and expertise. While these links by nature overlap with the next in the chain they still retain a separateness. Once a link is adequately 'joined' with the next it can release the 'weight' it was supporting. Such a construction produces points at which police service provision for the mentally ill may be more appropriate than others. For instance, the 'first link – handing them on' was constructed as the most appropriate link or position to adopt for police. It was a position they felt their responsibilities and skills were most suited for. The 'second link – babysitting' and 'last link – the buck stops here' were constructed as the least appropriate positions to occupy, locations where their skills and resources were 'wasted' on fulfilling a position best suited to another agency.

A chain is normally an object of strength. Each link contributes power and support to keep the chain intact. However, it is only strong if its links are able to hold the 'weight' allocated at the corresponding position and will break at the weakest link. In this sense, the metaphor of links in a chain enabled police to express frustration at different aspects of community service provision for those with mental illness through the description of the locations at which this chain was broken. It gave the police a language in which to express their experiences of the inadequacies in current service provision while at the same

time advocating their understandings of how strong, efficient and adequate relationships between various partner agencies could function optimally to benefit those with mental illness in the community.

The first link – handing them on

We just want to take the person off the street and we want to hand them on to the right agency (Dylan, 624-625).

Determine their safety initially I guess and then to get other agencies involved that are designed to help mentally affected people. Ah...the police-, Probably-, It's not our role to deal with them, is it? Like, we can't offer them the support that they need or the help that they need, so I guess we're just one way of initiating that chain of events that takes place in terms of getting them some help (Tony, 15-20).

Often police duties when interacting with those with mental illness were constructed as the first link in a chain of events for service provision, in particular an entry point from which to access the services of partner agencies in the community. In this link, the duties of the police consisted of responding to crisis in the community, assessing the situation's needs and demands, ensuring safety and then problem solving as to the next course of action or the appropriate service provider to connect with.

So, it's our role-, Is to basically get rid of any threat and any harm. Basically put them into custody and bring them back and try and kick in or get them connected to the people that can help them. Get them in the mental health sort of circuit or loop

and, you know, hopefully get them back on track as far as, you know, living a normal life or, as best you can, a normal life that they can. So, I think that's basically our goal or our aim is to basically help them get through this-, Their-, The crisis that they're in at the moment and get the people trained involved to help them really (Thomas, 278-286).

So we turn up type thing and it might be a mental health issue, but that's-, I mean, and that's what we're for too, I mean, that's what we're trained to do. So we might turn up and we're problem-solvers and we turn up there and there's a person with, say, a mental health issue, then we take them into custody and we take them to get them crisis-, To assess them and that sort of thing (Dylan, 236-241).

Many of the statements that constructed the duties of police were produced through military discourse. Given that the police are to some degree a paramilitary organisation, the manner in which their duties were constructed within the data was often expressed using tactical or military terms such as ensuring security, establishing and maintaining control and conceptualising actions and responsibilities according to territories assigned to different agencies.

*The **first line of defence** is us (Nathan, 177-178).*

*We're...ruled by our...obligations and / or our powers to deal with people so we have a fair bit of training on that and I think if we were starting to do more training towards mental health people then **we've probably encroached then on someone else's territory** (Nathan, 253-257).*

*They are there to...attend and basically **hold the fort** if-, And until other people can do their job at least more than anything and that's really all they're really trained to do (Nathan, 315-317).*

*We sort of just go there and try and **keep the peace** really and settle them down (Jane, 102-103).*

One of the effects of constructing police duties through military terms is to produce a boundary between policing and mental health work, which enables a separation between the two different specialised service sectors and produces distinct positions, or in this case 'links', to adopt according to their particular orientation towards service provision in the community. Once control of the crisis situation is established by the police, mental health agencies are then able to enter the (now safe) location and perform their specialist duties. Through emphasising this separation, the understanding produced is that police officers are there to do a specific job and once that job is completed the individual is then 'handed over' to another organisation to assume responsibility for forward action.

The construction of 'handing over' the individual to the appropriate agencies was dominant in this first link and suggests the physical act of passing something over to another party, essentially the removal of a possession or responsibility.

So we want them to take this person off our hands so we can get on with our core business (Dylan, 208-209).

We can do our assessments which are questions and stuff like that and we can basically hand it over to them to deal with it (Thomas, 143-145).

It would be nice to attend the job for patients and then whilst we're there is to hand it over to mental health at the time in a timely fashion (Nathan, 404-406).

This physical 'passing' of the individual suggests that the limits of police skills and resources have been reached in this first link and the 'receiving' agency is better equipped to take the matter further in regards to service provision. It is an action imbued with finality, once the police have performed their duty or service the individual is no longer their responsibility because they have 'given' them to another agency to 'hold'. In the initial crisis location, police officers have the most appropriate skills, resources, time and motivation to respond to that particular situation. Once their duties are performed to the fullest extent that they can be, then the individual is handed over to the next link in the chain of events that is most suited to meet the needs of the next phase of service provision. The implication of constructing police duties as specific and limited within the first link is to establish boundaries in the understanding as to what police involvement *should* be when interacting with those with mental illness in the community. Police duties should be confined to what their job description and training allows and any situation that requires expertise beyond this parameter of knowledge and experience should be the responsibility of the more appropriate agencies.

It's brilliant to have an organisation like that for a start because, you know, they're trained and they're on-call and we can ring them 24 hours a day. They can come down. We can do our assessments which are questions and stuff like that and we

can basically hand it over to them to deal with it. So, like I say, they're trained in that sort of stuff and we're not. So, that's the really good thing. It's the fact that they don't have a problem. They come down, you know it's their job and, you know, it's what they want to do (Thomas, 414-148).

The systemic practices constituted through quotes such as the previous produce the understanding that the 'chain' operates successfully when each service provider performs the duties of their 'link', while the following quote affirms that each 'link' is distinct and the boundaries of the expectations and duties of the police have been reached once the next 'link in the chain' has been established and connected:

They shouldn't be here. We should be able to get rid of them (Christine, 228-229).

In this sense, by constructing specific and limited expectations of police officers in the first link, it is then possible for police to achieve a satisfactory and conclusive result in the presenting situation. A result, or resolution, was a common concern throughout the first link discourse. Once 'handed over', police obligations and duties are completed. They have connected the individual to the next link in the chain and are enabled to continue forward to other policing duties with the understanding that they have positively contributed to the presenting situation.

We get involved and then that will be the last we see of them, you know. They'll get dealt with through the crisis and then that's it (Tony, 69-71).

As such, the first link is constructed as a clean, organised job when all goes smoothly and one in which steps and procedures can be followed in order to accomplish set goals.

We bring them in, we call them, they come down, they go, we get rid of them and that's how we deal with them a lot of the time (Tony, 130-132).

We've got our procedures for dealing with people and I think they work pretty well (Craig, 430-431).

Cops tend to take a fairly simplistic view of the world, you know. Here's a problem. It's a frequent problem. All we need to fix it is 'this'. Why don't you do that? (Laughs) (Matthew, 468-470).

This produces a sense of simplicity towards situations to be resolved and also suggests it is possible to resolve all situations if they are conceptualised as such. This simplification enables the police to understand what their duties and expectations entail and also how it is possible to achieve them. However, interactions involving those with mental illness are not as prone to such simplification given the complexities involved, both regarding the nature of the mental illness itself and the organisation of service provision for the mentally ill in the community.

Often the jobs involving the mentally ill are so untidy that it's hard to get a good result (Craig, 336-338).

Interactions with the mentally ill often do not sit comfortably within the construction of police duties as simple and procedural given the complex needs and demands of the situation. Through an emphasis on procedures and objectives, an attempt is made to bring structure, order and clarity to a complex and difficult area. The understanding of a clear, definable position for police as the first link provides a vehicle in which to avoid those situations which do not follow or respond to such logical, tactical manoeuvres through the emphasis on what police duties involve and exactly where their duties end. Therefore, police duties when interacting with those with mental illness may be produced in more a comfortable manner, eliminating the grey area of how to deal with those with mental illness in the community by organising such interactions into a systematic process with clearly defined limits and end-points for engagement.

All we can do is get them assessed and if they're assessed as not being at risk is to release them with some instructions to go to the doctor (Craig, 42-44).

I personally think that we do our bit right, but, yeah, it's not up to us to give them the medication or fix their problems and that. So it's really, really hard. That's what I mean, we just deal with it at our level and then you've just got to kick it out (Tony, 220-223).

The 'handing over' of those with mental illness was not exclusively constituted as a connection between police and mental health 'links' in the text. Statements within the text discussing police preferences to pursue criminal charges with the mentally ill, and therefore retaining constructions of 'appropriate police duties' associated with enforcement of law

and order, also produced a 'handing over' effect through utilisation of the criminal justice system.

If they've committed a crime, we will charge them no matter whether they're mentally ill or not because it's not for the police to decide whether they were sane or insane at the time, that's the decision of the court, or whether they know what they were doing at the time they were doing it was wrong. So that is for the court to decide and they have their procedures that they follow there, but we're not qualified to make that decision, so if an offence is committed it's our responsibility to investigate that and if there's sufficient [evidence] to charge, we charge that person (Christine, 25-31).

And basically anything that happens we will use the police, or our powers and charge them accordingly and if they-, At the time, it comes back mental health don't believe they're up to-, At the time they were not knowing what they were doing or they believe the charge wouldn't be beneficial then we will withdraw that for mental health care (Nathan, 126-230).

Although the 'handing over' of the individual through criminal justice procedures is more of an indirect action compared to referral directly to a mental health agency at the 'scene' of the crisis, it enabled police officers to stay within their boundaries of expertise and to ensure that, through the institutional processes of criminal proceedings, the individual in question will eventually be 'located' within the appropriate service provider with which to best address their needs. Furthermore, there was a sense that by pursuing a criminal justice path until such point as the mental health professionals assume responsibility for

the situation, the police can avoid wasting valuable police force resources by ‘babysitting’ (discussed in detail in the ‘middle link’ analysis) through the construction of their behaviour as active and productive in the duration of time until mental health service providers enter the ‘chain’.

Although this first link would appear to portray the police as the ‘weaker’ link in the chain due to their limitations for service provision, it actually constructs police in quite a powerful position where they are enabled to remove responsibility for the welfare and the treatment of those with mental illness from themselves through the understanding that mental illness is not within their boundaries of expertise and therefore they should not be expected to have further involvement in such situations. Here, the police have the power to place responsibility for those with mental illness in their partner agency’s service provision and logically require those agencies to ‘take over’. The position of ‘first link’ enables police to say they supplied the service required of them, reached the boundaries of their service provision and any further action taken (or not taken) falls under the responsibility and accountability of the more appropriately skilled and able agencies.

We deal with them to a certain extent. We’ll hold people until they’re assessed correctly and then it’s up to the mental health people to deal with them from there. And that’s-, You get a few people that just, I suppose, don’t know the processes that place blame on other areas (Nathan, 151-155).

I think it’s a big call sometimes that they make when they do just release them. I’m like “phew, glad I’m not making that decision” (laughs) because it’s huge. You just don’t know what they could go out and do (Jane, 450-453).

This produces a sense of freedom from responsibility in that police officers should not be asked or expected to do more than their skills and experience has prepared them for. By constructing their location in the chain of events as the first link, it is possible to be accountable for their initial response, but shift that accountability for services police cannot provide and also gain satisfaction through the ability to provide adequate and efficient service where they can.

The doctor will sign a form basically putting them into [local hospital mental health ward], into care. But if not, they're signed out and they're free to leave, but that's on the DAO's approval not the police. So if they did go out and something else, another incident, happened, and maybe they did kill themselves or do something-, And the fact is the DAO says "look, once they walk out the door we can't control what they do". But, you know, at the end of the day we can't bring someone in and then decide "Oh no, they're fine" and let them out before mental health get the chance to come and see them because if we did that then, rightly so, we'd be criticised (Thomas, 155-164).

They all feel failed by the mental health. That they haven't had enough support or they haven't done the right things for them. But yeah...they don't-, None of them have had a beef with us, yeah, with what we've done. But, like I said to you, I just explain to them that it's not our job to sit down with them and prescribe medication and, you know, and get them into the right facilities or whatever. That's someone else's job. And all the people that I've dealt with, the client's that I've told [you about], have understood that. Yeah it hasn't been a problem (Tony, 259-266).

Problems are produced for police in this first link when the connection to the next link in the chain becomes blocked or broken. This can occur because of an initial failure to 'hand over' the individual or the partner agency's inability to continue to 'hold' the individual once connected. In this construction, an attempt has been made by the police to establish a working relationship between the individual with mental illness and mental health services, but that relationship has failed to either establish or continue because of the individual not meeting entry criteria into that agency's services (entry criteria as a barrier to service provision will be discussed in the '(un)identifiable other' analysis).

We deal with a lot of attempted suicides and then you call in the DAO's and [they say] "Oh no, there's nothing wrong with the person", but he's just tried to commit suicide. And it's just like then "Well, what do we do?" We haven't got any powers to hold him so we have to release him. Because we've had the DAO down, they're saying he's fine and we release him or her and then we hope for the best and it's really quite scary (Christine, 61-66).

The construction of this broken link, in effect, halts the chain of service provision for those with mental illness at the location of the first link (essentially establishing the first and last links in the chain as the same location, which will be examined further in the 'last link' discussion) and constrains the ability of police to refer or defer responsibility onto another agency. The inability to avoid responsibility in this situation is compounded by understandings of the police force's duties to serve and protect the community. Such expectations, either by the public or the officers themselves, produce pressure on the police to act upon any situation they become involved in. It would conflict with the general

ethos of the police force to discard or ignore community members who are in need or a potential danger to themselves or others. Therefore, once this first link has been initiated there is an understanding produced that police must continue to 'battle' for service provision, especially service provision police cannot provide themselves, in order to meet the expectations of their job and the needs of the community members. This places responsibility on the police to be the driving force of service provision for mental health services.

We have to be the lead agency, when it's a social, it's a health problem or that's what it should be, but because we're the ones who keep getting called when she gets violent, you know, we become the lead agency (Dylan, 574-577).

One of the ways the officers attempted to establish more control over this undesirable position was to appeal to contractual relationships established through the Memorandum of Understanding between mental health services and the police. This served to 'officialiate' the importance of mental health services' refusal to respond through the appeal to a legally binding official document and produced the need for partner agencies to fulfil their accepted obligations.

The excuse that was given actually isn't a valid excuse. I know that drug use and intoxication can mask certain symptoms or can make things appear that perhaps wouldn't normally be there, but the Memorandum of Understanding between police and health is that they will be assessed and that they will attend within

twenty minutes I think, but I don't think they actually achieve that (Matthew, 185-190).

Statements such as this draw upon legal, contractual relationships to re-establish the broken link. By referring to an official document that describes the expectations and requirements of each agency in relation to each other, mental health care agencies are constructed as falling short of their contractual obligations and needing to correct their practises by reconnecting into the chain of events as required by the Memorandum of Understanding.

The construction of this 'broken link' in the chain of service provision was supported through statements that discussed a possible 'place' or 'system' that is not currently present and available, but that could enable the police to connect the individual to the next link in the service provision chain and ensure adequate help for those with mental illness.

But there just seems to be a bit of a gap missing. The link to help for them (Jane, 108-109).

If they could actually go in, drop them off, follow through those other procedures, drop them off and disappear it would have positive [effects for the person] because you have someone following up on it. And positive for the police because they'll be out there being proactive or dealing with incidents that are coming in. So I think it would be a huge benefit to society as a whole in many different ways (Christine, 366-371).

As will be discussed in the 'no-man's land' analysis, the 'missing link' in currently available services for those with mental illness was often constructed as a spatial location. This 'absent facility' produced distance between possible causes for 'breaks in the chain' and the current service providers involved in the chain of events, thereby avoiding locating blame or criticism in presently operating service providers. The spatial constitution of this 'missing link' usually took the form of a facility, such as a drop-in centre, where the police could, once having assessed the situation as a mental health issue, provide transportation and physically relieve themselves of the individual to return to their general policing duties.

The middle link – babysitting

From a police point of view you want a quick response and it's really frustrating when you have to basically babysit someone until the professionals then come down and that's always been a thing with police, that time factor between someone coming to see the adult or the young person. I know we live in a busy world, but that is a frustrating factor as far as police are concerned. We seem to be the holding place for a lot of people (Chris, 175-181).

Statements positioning the police as the middle link in the chain of service provision for those with mental illness constructed their duties as that of mediatory in function, wherein those with mental illness were held in police custody until the point that mental health services attended the situation and offered assistance in the form of assessment and / or service provision. The majority of statements that produced this middle link contained expressions of frustration stemming from an inability to 'hand over' those with mental illness to the appropriate agencies in a timely and smooth manner. The understanding this

produces is that once the crisis situation has been resolved and the appropriate agencies contacted, police involvement should cease due to constraints in the ability to offer the individual any further relevant and constructive assistance towards resolution for the presenting situation.

We don't have the facilities or the resources. We're not trained – I mean we do have some mental health training, but not to diagnose. Obviously [mental health service is] a career, it's a job, but we're expected to try and deal with these people. So we're probably the most unqualified to deal with them and we're dealing with them the majority of the time (Christine, 97-101).

The middle link was almost exclusively constructed through negative statements, with the dominant metaphor of 'babysitting' utilised to communicate what responsibilities and 'burden' were produced by police occupying this position. This metaphor of 'babysitting' produces several important ways of constructing how the police position in the middle link can be understood. Firstly, it constructs those with mental illness as 'childlike' in their needs and behaviour. They need to be protected, provided for and sheltered from harm. They are understood as compromised in their ability to take care of themselves and need constant attention from the police.

That's the good thing about us and for our guys is we initially deal with it, but, you know, once they go up to hospital they've got to continue on and deal with it and it would be like teaching for me, you know (laughs), dealing with kids all the time would be the same as mental health people. There's just something about-, It's not

for me (laughs). I've got my own bloody [kids] I wouldn't want everyone else's
(Nathan, 419-424).

Through constructing those with mental illness as children, or childlike, an implicit comparison is made between those with mental illness and the mentally well in police custody. This comparison produces a difference in the needs and demands 'housing' those with mental illness require and suggest that the mentally ill subject is not the population police are expected, or motivated, to interact with in the manner the position of the middle link requires. As Nathan suggested in the previous quote, police may not be motivated to look after 'children' at work.

Secondly, through the combination of the construction of those with mental illness as children and the middle link as 'babysitting' there is an emphasis on the disparity between the duties of the police and the skills involved in caring for the mentally ill in police custody. It implies that police must spend their time while housing those with mental illness performing 'childcare duties' and are constrained from practising their responsibilities as skilled police officers in the community.

We've got an officer sitting with them all that time when there's other victims of crime out there that need our assistance or we should be doing a public relation type of job or whatever. There's people missing out on our services because mental health aren't providing-, Aren't getting down there fast enough and the guys on section will tell you the waits that they have. So it's not like you ring them up and

they arrive 10 minutes later. It doesn't work like that at all and that's a big concern (Christine, 242-247).

...Sit around waiting, twiddling your thumbs at the police station (Matthew, 180-181).

Usually you might have a couple of hours that you have to sit-, And if they're in our cells then they've got to be constantly monitored. So they're there, someone's watching them basically outside the cell all the time until they're assessed (Nathan, 87-90).

This produces the understanding that by having to adopt the middle link position, police are wasting their skills, abilities and resources that are better spent undertaking more appropriate tasks involved in policing. Police are often criticised by the media for perceived inadequacies to provide comprehensive, timely and quality service and through emphasising how police resources are being 'wasted' babysitting those with mental illness, especially through descriptions of 'twiddling thumbs' and 'sitting around', these statements persuasively produce disapproval of the strain on the already strained police resources the middle link position produces and encourages motivation to correct this misuse of resources and relieve police of their 'babysitting' duties.

The construction of 'babysitting' also communicates the understanding that mental health agencies utilise police services to look after their 'children' for them instead of undertaking the task themselves.

Sometimes we might be waiting, at least, sometimes 2 hours for them to come to the station here. It's a huge time where just-, It takes a police member off the street for a start and we've got to pretty much babysit them because we've got to make sure that they're safe. We can't just leave them in a cell and so it's sort of a huge time waster for both the police and the prisoner (Jane, 38-43).

It should come under their umbrella rather than us having to look after them (Jane, 372-737).

Mental health services should be responsible for the service provision for those with mental illness because that is their area of specialisation, but in practice this is often not occurring in a timely fashion and the middle link position allocates the responsibility for the intermediate welfare of such individuals to the police.

It's sort of like "Oh well, they're at the police station, they're off the street, we'll get there when we can" and it's-, I find that quite slack. Like, they might be busy, but so are we (laughs) and they just expect us to hold them and they'll get here when they're ready and I just think there's not enough police as it is let alone having to pretty much babysit them because it's out of our control. It's not up to us what happens next (Jane, 139-145).

The understanding that responsibility for the welfare of those with mental illness was inappropriately situated with the police was strengthened by statements that expressed how distressing the police station could be for those with mental illness.

The worst place that anyone could be in that condition is in a police station
(Christine, 178).

We're putting unwell people into an unhealthy environment and they're being left
there because no one will take them (Christine, 184-185).

It's a big sort of timewaster for police, but also distressing on the people that we
have to bring here because they don't need to be in a cell, well in a police cell, they
need to be with people that know what's going on (Jane, 415-418).

Such statements serve to produce the understanding of a 'vulnerable' population needing protection from distress by a service provider that is designed and equipped to meet the requirements for their mental wellbeing, but through various systemic processes are 'leaving' them in an inappropriate and sometimes harmful situation. Through describing the police station as an 'unhealthy environment', parallels are drawn to previous 'uncaring' mental asylums and the associated human rights concerns. The suggestion that those with mental illness may need to be in a 'cell', but not the 'police cell' produces a need for the provision of more suitable locations in the field of mental health services with which to 'house' the mentally ill. The construction of the police station as a location undesirable and perhaps inhumane for those with mental illness advocates for the removal of the police in the position of the middle link due to the police environment being one that is ill-equipped to ensure the wellbeing of those with mental illness.

Another construction that contributed to the sense of frustration regarding the position of the 'middle link' was the use of variations of the term 'nutter' to make sense of those with mental illness.

It's just another job that we didn't really need to be doing, well thinking that we didn't need to do. You know, as I said 'it's just another 1M' or a 'nutter' so you deal with it the best you can at the time (Nathan, 361-365).

Although variations of the term of 'nutter' were used to refer to the individual with mental illness, there was a sense that the term actually spoke more about the *situation* than the person. It was almost shorthand for a link to understandings and meanings related to the kinds of experiences and frustrations associated with interactions involving those with mental illness, such as the time consuming nature of callouts and frustrations regarding not being able to deal with the situation appropriately and efficiently due to constraints on police authority and the relationship with the mental health system.

There is an attitude by some in the police that, you know, it's just another 1M job, mentally ill person job, and so it's sort of "Oh yip, just another one"...To some people, I mean it's not everyone, "It's a waste of time", you know, "Why do we bother" (Jarrod, 493-499).

This 'wastefulness' is further emphasised by statements describing instances where mental health services eventually responded to the presenting situation, but then declined to admit the individual with mental illness into their care and suggesting their release.

Sometimes you think "What's the point?" We waste 2 hours bringing them back here. Have to wait for them for 2 hours to come down and say "Oh nah, they're

fine” and then we’re left with them again to kick them out back to where they were or home to where they were depressed or whatever (Tony, 85-89).

Here the ‘babysitting’ is constructed as serving no purpose whatsoever in the provision of either police or mental health services. Not only is it a waste of policing resources, but it also fails in some instances to produce any resolution or service provision at the conclusion of this middle link. This produces the understanding that police as the ‘middle link’ is not only an inappropriate position to occupy, but also positions the police as having to take the action to release the mentally ill back into the situation that produced the crisis in the first place. It is utilising police resources without achieving any satisfactory results.

Often this ‘babysitting’ was constructed as a public disservice in that the police are employed to ensure community safety and wellbeing and are prevented from doing so because their resources are engaged in holding and monitoring those with mental illness.

That’s one person off the street that we could have out there dealing with it, especially on a Saturday night, you know, closing time, the more staff you’ve got around the better for everyone really and that’s generally when things happen (laughs) (Nathan, 522-525).

It shouldn’t be our job to be looking after them when there’s so many other things going on, either in town or-, Like, there could be fights happening and stuff like on a busy Friday / Saturday night and we’re stuck dealing with someone that has got,

clearly, a mental illness who needs to be in the care of someone in that field, but yet we're stuck doing [that job] for a couple of hours until they turn up (Jane, 283-289).

Statements producing the understanding that by 'babysitting' those with mental illness police officers cannot perform the duties the public expect of them appeals to common concerns regarding the spending of tax-payers money and the adequate provision of government agency services to the community. Detailing the strain on police services in the 'middle link' in regards to budgeting and resource allocation within the police force reinforced how occupying this position financially upsets and disrupts the ability of the police to meet the expectations for their services accordingly.

They might, because they're busy, might be 4 / 6 hours or something before they come down. Well, in that whole time we've got someone sitting with these people. So yeah...I know it might not sound like much, but, say, on a night shift covering [City name] [We] would have, early in the week, probably 6 cops ok? So 6 / 7 cops outside the front counter here and [we've] kept one back in the cell block and then [we've] got 4 or 5 on the street type thing to deal with any incident that comes in. So if [we've] got a prisoner in the cell block, which means [we] need somebody else there type thing, then we have to hire a jailor to do it because [we] can't use one of the cops. Yeah, so and there's a significant cost in doing that, which we obviously then have to pay it out of our 10% casuals budget, which means we can't hire typists when our typists go down sick or hire other- (Dylan, 166-177).

it's really resource draining because obviously they need lots of care and often you end up getting a civilian jailor in, which is another drain on police resources because

we're not budgeted to get those people, but what else can you do? It's better to have a uniformed police officer out on the street than looking after- (Jarrod, 538-542).

The effect of statements that detail such budgeting restrictions and juggling of resources emphasises again what the human and social costs of occupying the 'middle link' produces for the police. It constructs the police as constrained in their ability to provide their highly skilled services to the community due to the demand of having to perform a job that does not utilise their expert skills base and is not conceptualised as 'policing'.

Alternatively, the middle link was constructed as a waste of resources through statements communicating the willingness of police to occupy this position *if* appropriate with regard to the demands of the situation.

If there's somebody that we can treat, that we can make a difference with, yes we'll have them, but no anybody else (laughs) (Matthew, 84-85).

If the social worker thinks, or the DAO thinks, that there is some kind of effect on their presentation then surely it's "Well, keep them under obs[ervation] and we'll send somebody back in two or three hours" (Matthew, 195-198).

I think the guys do a fairly good job with what they're doing, but then, you know, the main thing is that they're not mental health case workers or-, They're there to be intermediary, or a mediator until professionals get in and deal with it from

there. And by all accounts the guys on the street do a fairly good job (Nathan, 593-597).

Through communicating acceptance that at times police *are* the most qualified and appropriate agency to perform ‘middle link’ duties, the understanding is produced that the most pertinent concern should be the utilisation of appropriate skills and allocation of the appropriate agencies for the situation at hand. This construction of willingness to assist when appropriate alongside the inappropriateness of the middle link position for police services produces a logical and persuasive argument that police services should be utilised only when absolutely necessary. On any other occasion it is a wasteful and unneeded drain on an already stretched service provider and should be dealt with by the more appropriate agencies, such as mental health services.

Although the middle link was constructed through critical statements suggesting that mental health agencies are at times not fulfilling their obligations while police are filling the ‘space’ created by a lack of service provision, the greater understanding produced here is that police officers and the police force in general is not equipped, skill or resource-wise, to adopt this position in the chain of events and therefore there needs to be a system put in place that has focussed skills-base and funding to alleviate the strain on police resources this middle link position produces. A related discourse that combines with, and contributes to, this understanding is the ‘Underdog’ discourse (discussed later in subsequent analysis), which constructs both the police and their partner agencies as trying to ‘do the best they can’, but yet are constrained from doing so through the system of institutional practices they are positioned within. Through the construction of the middle link as an inappropriate

position for police to occupy, with the emphasis on the waste of resources and specialist abilities, and by supporting such statements with discussions of a more appropriate 'location' for the service provision in this 'middle link', the understanding is produced that there could be, and should be, a better system put in action that is appropriately staffed and funded that can better serve those with mental illness and at the same time put to better use tax-payer funded government agency resources. As will be discussed in the 'no-man's land' discourse, the responsibility lies beyond the individual service providers and can be located in a 'system' which has not yet organised the various agencies and services providers efficiently enough to maximise skills and minimise wastage of resources.

It may be possible that the middle link was associated with the greatest amount of expressed frustration and criticism because of the lack of power enabled in this position in comparison to other links in the chain. From the first link especially, and to a lesser amount the last link, there is a certain amount of power associated with the police's position of responsibility to take action and ability to obtain control over the responding situation. From the first and last link locations it is possible, although sometimes undesirable, to act with momentum towards the situation and be an active contributor to the service provision process. However, the way in which the middle link is constructed, as stagnant and unproductive, it produces little-to-no room for momentum and action.

The issue of responsibility is important when considering the power relations each link produces. In the first and last links there is a sense of responsibility on the police to actively resolve the problematic situation. The middle link, in contrast, is constructed as a 'waiting room' where police have no ability to act upon the underlying issue and instead must

merely 'hold the fort' for more appropriate service providers. This produces tension between the need for 'holding the fort' in light of few alternatives and the desire to protect the community and be an active presence on the streets, therefore constructing the 'middle link' as the most frustrating position for the interviewed officers.

The last link – the buck stops here

At the end of the day the buck stops right in this building here. Everything that happens that's bigger than anybody else can deal with (Dylan, 246-248).

It would be fair to assume that the last link in the chain of service provision for those with mental illness in the community would be constructed as the resolution link, one where the individual was able to access and benefit from the chain of service provision. However, when police officers are positioned as the 'last link', the understanding produced was that community mental health agencies were unable to provide services and resolution to the presenting problem, and instead the police had to take up this position. Here, the police are constructed as the 'last resort' in a number of (more appropriate) service providers that could have adopted this 'last link' position, but were constrained from doing so by systemic and institutional practices.

The first and last links are intimately connected because the first link can often become the last link when the chain is broken. This happens when mental health crisis services do not respond to the officer's request for assistance or are unable to take responsibility for the individual through their services.

This exactly how police work, if there's a problem out there that nobody else can solve it's the police that step in and deal with the crisis. But often what I'm left feeling is that we've dealt with the crisis, so we've stopped someone being hurt or getting, you know, or hurting someone or whatever and then-, But there's no-, That's it. That seems to be the end of, you know, everyone goes "Err, it's not our problem" (laughs). Yip and so police are left to try and deal with it and whatever. Well, we don't really have the facility to deal with it and that's the problem (Jarrod, 25-33).

Through the understanding that there are often no further alternatives to police practices in situations of mental health crisis, the first link *becomes* the last link and the police are isolated as the only available and accessible responding service provider for those with mental illness in the community. The police respond to the crisis and once the crisis situation is, to some degree, resolved there is no further action or service provision offered and the entire chain of service provision for those with mental illness in the community dissolves, positioning the attending police officers as acting pseudo-mental health workers as they are the only service provider offering assistance to a situation that involves mental illness.

It makes me think that police are the last stop. We are, pretty much, the only 24 hour emergency service now (Matthew, 35-36).

The skills and duties expected from police in mental health crisis situations often conflict with police officers' understandings of the duties associated with their domain of expertise

(as discussed in the 'first link') and also raises questions related to the adequacy and efficiency of mental health service provision in the community. In the previous quote, 'last stop' suggests a chain of events that should be present prior to crisis point, but is absent. One can only be situated at this 'last stop' if there were steps or links beforehand that should have been travelled through that are either missing or were unable to efficiently address the problem. By conceptualising police as this 'last stop', the understanding produced is that previous links (agencies) have been unable to provide efficient service to circumvent mental health crisis and suggests a lack of proactive or pre-emptive effort on the part of the mental health system to prevent such occurrences. In effect, in this construction police are the last link in a chain of events that does not exist, but has the potential and the need to be present.

I mean, we're dealing them the week after that and then, you know, the fact that we keep dealing with them and nobody's got their medication right and nobody's got-, They don't seem to be getting any help (Dylan, 557-560).

Police as the 'last link' produces criticism of existing services that have potential to provide specialist assistance for those with mental illness, but where those services fail to do so the police are required to fill the mental health service gap.

But they leave it to us to deal with and it's their problem (Christine, 239).

But the actual dealing with the problem of the mentally ill-, You can't get mental health services 24 / 7, especially here so in [Town Name], so the police are pretty

much the last line of defence and we're the ones called out. We're not trained in it, we know very little about it other than what your experience teaches you and it's kind of a-, It's not a very satisfactory situation. We're dealing with problems that we really have no expertise in. Yes, I could deal with incidents but the thing that strikes me most of all is, you know, we're used as the stop-gap (Matthew, 40-48).

Statements such as 'they leave it to us' and 'we're used as the stop-gap' suggest mental health service agencies *could* provide assistance, but instead often utilise police services to provide institutional support and control. The understanding produced by the police response to this utilisation is that the police are more dedicated to attempt to resolve any situation the community requires them to, despite their limited knowledge and training in such areas, in comparison to other service provision agencies. This actually locates police in a powerful position of service provision for those with mental illness because in this last link, where perhaps no other agency has been motivated to intervene, police have the position and obligation to be the service provider. The mental health agency's inability to accept the individual into their services leaves the police with no other option than to proceed forward with that person, regardless of whether they believe mental illness is an issue, and although it is an undesirable position in regards to what services it appears those with mental illness require, it is none-the-less a position of strength, agency, motivation and active service provision.

Where this motivation and responsibility becomes problematic is when the police are unable to provide a service that would appear to address the concern at hand. Constructing police as a link in a chain produces several distinct 'points' of service provision that have

demarcated demands and skills required. When this chain breaks, creating a singular point for service provision, it becomes problematic for police to assist in a manner that addresses the specific requirements of the situation. While motivated to provide assistance, it then becomes impossible to provide the kind of assistance that is required at the corresponding link to resolve the core issue. As discussed earlier, the construction of police duties locate the most appropriate position in the chain of service provision at the first link. In the middle link, while not desirable, the police are still able to offer services that fit into constructions of police duties of control and safety. In this last link the situation becomes more complicated and difficult because of the understanding that they lack the skills and options required to provide a satisfactory resolution to the presenting problem. Unlike the middle link, where duties are constructed as waiting for eventual service provision, in this last link there is an understanding that if the individual receives no mental health assistance at this location, they will receive no help at all, except where criminal charges can be laid.

The police are getting called, you know, "Take him away!"..."We can't!" (Laughs)
"Why can't you?" "I can't. I know you're stressed. I know it's difficult. I just cannot-,
I don't have the power to take him away from you sorry" (Laughs) "But you must! I
want you to take him" (Laughs) "Well, it doesn't work like that" (Matthew, 431-
435).

But nobody's given us any other options to take it forward from there in a safe
manner (Matthew, 123-125).

Motivation to provide resolution may result from the construction of police in society as the agency that has the authority and ability to address any and all public concerns. Police are employed by the government to enforce the rules and laws of the land and also ensure public safety and wellbeing. The assumption underlying such a position is that any point of concern or issue of public safety and distress could be, and should be, a police matter regardless of the nature of the presenting situation.

Because we're seen as a-, You know, you see the uniforms and the authoritarian figures that you should be in there and you should be able to make all these decisions for everyone (Nathan, 158-161).

Just because we're in a blue uniform we're expected to be able to deal with any situation that crops up (Jane, 376-377).

It ends up it always falling back on us because we're everyone's everyman type thing. So if you don't know who else to call you always call the cops (Dylan, 232-234).

We're a fall-back role for just about everything (Christine, 225).

Statements produced during interviews addressing public constructions of police as omnipotent served to attend to these misconceptions and to offer an alternative understanding of police duties. By locating police as a link in a chain of events that involves various other government agencies, the police are able to specialise and limit their abilities and obligations, producing a specific position to adopt in which they are able to meet expectations and avoid criticism for service provision beyond that particular position.

Obviously there's a lot of people, as I said before, believe that we're there and we should be solving everything which is, you know, that's not entirely true. Although they do solve a lot of stuff, it's there to put measures in place until someone gets to speak to them properly (Nathan, 328-331).

The construction of police occupying various links in the chain of service provision produces knowledge regarding what police duties should consist of and also where police resources and services are inappropriate. It communicates to the listener the locations of assuming responsibility other agencies and service providers should enter, alongside justification of why police should not be expected to perform certain 'roles'. The first link, that of crisis resolution and handing over to mental health services, is the appropriate link for police to occupy. The middle link is a position that the police can provide service for, despite it constructed as a 'waste' of police resources. The last link is only occupied by police when other service providers 'break the chain'. This removes responsibility for perceived failings in service provision for those with mental illness from the police and indicates that the middle and last link locations are where mental health services need to be improved in order to provide adequate and coordinated successful mental health care in the community.

If the 'first link' is the most appropriate link for police to occupy and the point at which the individual's involvement with the criminal justice system should cease, it can then be asked: what barriers are present in the current system of service provision for those with mental illness that constrain the ability for coordination between the various agencies

active in the community? What institutional practices produce these barriers and how are they understood and experienced by police officers?

The (un) identifiable other

The '(un)identifiable other' is a metaphor for how those with mental illness were constructed within the text and the meanings this produced for relationships between those affected by mental illness in the community, the police and mental health services. The 'label' of (un) identifiable *other* implies one who is living amongst 'us', yet is different to the 'norm'. One who is able to appear just like any member of the public yet is 'other' in some way fundamental to their identity. The difference in this case between the general public and the constructed 'other' is 'mental illness' and the assumption behind the need for identification of those with mental illness is to prevent the 'threat' their illness poses to the individual in question, the community they live in and the service providers they interact with. Under this understanding, identification becomes essential because while those with mental illness are able to avoid detection due to a lack of obvious difference, if not identified as 'other' they avoid service provision that may help benefit their personal mental health and the ability of the community to be strengthened through the promotion of wellbeing for its members.

The '(un)identifiable other' subject position assumes that in order to receive services aimed at the particular 'other', one must be identified and categorised first. Once detected, they can be protected and subjected to treatment in order to improve their mental health. This subject position carries important meanings and understandings as to what this 'other' means, what effects it has both on the individual and on those interacting with them. In

this case, the ‘otherness’, echoing understandings of mental illness discussed both in the introduction and the methodology, was constructed as a threat. Unpredictable and sometimes dangerous in nature, this threat lay hidden within the individual and indeed within the community. Police are constrained in their ability to provide safety from this ‘threat’ unless they can first identify the individuals who pose such danger and then address the threat appropriately.

The ‘(un) identifiable other’ was constructed through three dominant systems of statements in the text. While all very similar, each had a subtle, yet important, difference in focus. ‘Raising the flag’ constructs those with mental illness as in need of quality service provision which may be prevented by a lack of identification of their illness. ‘The hidden danger’ explores potential barriers to identification and ‘sitting up and taking notice’ examines the position of the police and partner agencies in the identification process.

Raising the flag

But generally, as I said, if they’re flagged then the guys know they’re unpredictable so it’s just to be wary, more wary of things happening. So as long as everything’s documented and we’ve got our systems flagged and so forth that helps us (Nathan, 573-576).

Practices of identification were constructed within the text through the notion of a ‘flag’, a marker or signpost raised that identified the risk, needs and demands of a particular

situation. This 'flag' predominantly took two forms. Firstly, through a system of computer alerts:

Our technology has been updated somewhat over the years as well so now we know if something's happened, that person comes up on our system and it's flagged or alerts to say if they're a mental health patient or they carry weapons and stuff (Nathan, 229-232).

And secondly through police officers own informed knowledge of what mental illness may appear like, developed through personal experience gathered on the job:

I think if you're aware that they are [mentally ill], and there are signs that [help you] become aware through talking to them that the person may have problems, the warning bells go up and you would be more cautious certainly (Chris, 241-244).

'Marking' knowledge of mental illness is valuable because it enables officers to prepare for the specific situation presented. Every situation police respond to is different and officers must make constant and immediate judgements as to what approach the particular situation requires, evaluating and responding to the cues and demands of the specific incident. By being able to utilise a 'flag', officers are enabled to respond to a situation with advance preparation for possible action. In a job where the safety of others, as well as themselves, is a constant concern any system that enables advanced preparation in order to ensure safety is important.

It's for more of an alert that we get put into our system. So it's a screen that will come up with who they are and it will tell us if there's any alerts and that definitely comes down to our risk analysis of what we are doing , day-to-day work. So we're going to this. This person's got this, this, this and this. Ok. We can change our tack or we might even not go there straight away. We might wait for other people to come and help and it's just a staff safety thing (Nathan, 238-244).

The 'flag' enables a system of advanced warning for possible risk located in the presenting situation which allows the attending officers to accommodate their approach and behaviour according to the perceived level of danger present. As Parker et al. (1995) note, mental illness has long been associated with 'threat' to the safety of the community, and this 'threat' produces danger and risk for police officers, the public and those with mental illness themselves. The 'mentally ill subject' was constructed in the current text as one that was unpredictable, sometimes dangerous and different from the mentally well individuals that officers came into contact with, and where the illness itself can mean that more usual practices can be provocative.

They can be unpredictable so they can be potentially quite dangerous. Sometimes they've got no regard for their own safety or anyone else's or yours in particular so we certainly approach them...you know, with quite a lot of caution just because you don't know what they're going to do next. So, yeah, the thing that sort of springs to mind is the unpredictability of what's going to happen. The situation you're dealing with them in often is quite strange (Thomas, 58-64).

I think it's probably more unpredictable. It's probably more of a-, Because at some stage-, You know, you can be talking to them on a even keel then all of a sudden something will just snap and they'll go and I think that's probably the biggest danger. But generally, as I said, if they're flagged then the guys know they're unpredictable so it's just to be wary, more wary of things happening (Nathan, 570-575).

You have to remember what words can flare some of them up because that's just a [general statement] "Oh ok, I understand" and they're like "No you don't!" and they'll nut out (Jane, 173-175).

The risk here is constructed as a latent threat, something beyond the surface of how the individual presents, *undetected* and *unobvious* but that threatens to erupt and cause danger for the individual and police officer at little notice or provocation. The shift to the internalisation and subjectification of 'madness' from the behaviour to the *nature* of the individual made it possible for this latent understanding of the 'threat' of mental illness (Hook, 2007), and through constructing mental illness in this way, the need for detection and identification is strengthened by emphasising how police officers need to be aware of such latent danger in order to navigate and prevent the unpredictability and potential threat it poses. Here, police officers are positioned in a potentially powerless location in opposition to the unpredictability and sometimes dangerousness of mental illness and a 'flag' would help provide the police with knowledge concerning the potential for harm and enable the responding officer to approach the situation with a certain 'wariness' if applicable.

One contradiction to the construction of those with mental illness as unpredictable was through officers' statements that described those with depression or suicidal behaviour. In these cases, the 'mentally ill' identity was different to the 'dangerous other' in that they were 'sad' not 'bad'. Those constructed as depressed or suicidal were often more amenable to productive conversation, intervention and calm negotiation in interactions and were understood as more worthy of help. In contrast, other categories of mental illness, such as substance abuse and those with behavioural symptoms such as aggression were separated from the subject of 'mentally ill' and constructed as a different category, one that was more inherently dangerous and prone to difficult interactions, one more associated with a 'criminal' subject position.

If they're violent people and aggressive and that, I don't-, That's not a mental-, Well, I don't know, it might be a mental illness, but it's not to me. They're the sort of people that get my back up, but these poor people that are getting depressed and that-, No I actually feel sorry for them (Tony, 145-149).

These people are aggressive, yeah. And whether that means we've got less time for them, you know, and not prepared to listen to their problems because they are aggressive or they do flip. Whereas these one's sort of take on board what you're saying, the depressed people, yeah. Well they're not trying to shout you down or whatever, you know. They listen to what you're saying, whereas these ones are actually causing a problem. Well, that's the way we see it, they're causing a problem. But with these one's we're just giving them some help so, like, I guess we've got more time for those ones (Tony, 332-352).

If they're more [a] drug-abuser type, that side of mental illness because they've kind of done it to themselves and got issues like that, then sometimes that can be a bit different because it's sort of different offending rather than just sort of flipping out and needing help (Jane, 195-199).

This creates a division in the constructive 'category' of the mentally ill subject, with some mentally ill 'classed' as a higher threat or more dangerous than others. Those that have symptoms that more traditionally fit the profile of 'criminal' (such as exhibiting aggressive or substance related behaviour) are constructed less favourably and with less sympathy or empathy, and as a result were positioned in a separate category than those who are more typical of the 'sad' mentally ill: depressed and suicidal, but not 'bad'. As Coombes and Te Hiwi (2007) note, the production of the distinctly more criminal 'class' for subjectification enables more 'institutional' style behaviour (for instance, prosecution, segregation, institutionalisation) due to its inherent undesirable 'lower class' standing. They give the example that society is somewhat vigilant towards social justice for those with disabilities in the community, but that the 'criminal' category does not often invoke the same response. Therefore, by separating the 'good' mentally ill from the 'bad' in criminal terms, it is possible that there might be an allowance for greater freedom for action, not just concerning privacy issues (as discussed shortly), but also for material practice of policing to attempt to resolve the situation to the police officer's satisfaction.

As discussed in the methodology, one mechanism the police have historically employed to address the threat of mental illness in society is through surveillance, vigilance and therefore control (N. Rose, 1996). In the instances where police reach the limits of their

surveillance through a lack of awareness and identification of the 'threat' present, they are no longer able to effectively fulfil their obligations in response to this threat and therefore become powerless to meet expectations of both the public and the police force to resolve the situation in a satisfactory manner.

In my view, people who are mentally ill or unstable are often transient and therefore it's difficult to maintain contact with them...We all know who they are and it's not the ones that are nuisance value that are the-, I mean they're probably fine in the community if they're being properly monitored. It's the ones who are not being properly monitored and are seriously ill that I think present a huge risk to the community (Chris, 140-146).

The previous quote combines the construction of an 'other' that poses a risk to community safety (as distinct from a 'nuisance other') and the understanding that such 'dangerous others' are not being 'properly monitored', in other words under the surveillance of the mental health system, to produce a sense of threat to public safety. In order to address this threat and protect the public, the police need to extend their knowledge regarding those in the community that are currently receiving (or should be receiving but are 'noncompliant') treatment from mental health services.

It would really good for us, for me at street level, to be able to know that there's somewhere I can call to find out whether a person is receiving treatment or has recently received treatment...um, whether that could be set up, who knows. It would be tied up with privacy I'd imagine (Craig, 64-68).

The desire for identification of interagency information is limited through privacy issues, but here the argument is made that in this instance, and due to its intimate connection with public and personal safety, it would be useful for better monitoring of those who present a high risk of danger. Although rights to privacy were acknowledged, officers often communicated that in order for them to deal effectively with situations and reach satisfactory outcomes for all involved such privacy issues needed to be abandoned in certain circumstances. By acknowledging privacy issues and embedding this acknowledgment within discussions regarding the ability to perform police duties efficiently and to ensure client and public wellbeing, a logical argument is produced that the right to privacy should be waived for those who in particular are likely to be understood as 'criminal'.

Often the officers constructed their personal identity and their police officer identity as separate in order to further enable this privacy conflict to be addressed with respect. It was often emphasised that police do not seek personal information out of social curiosity, but from a job position that requires information in order to function effectively.

I'm not saying that we need to know because we want to know... (Craig, 377-378).

The 'flag' becomes problematic when it fails to be raised. Although officers communicated that they are familiar with signs indicating possible mental illness, they also emphasised they are not trained mental health professionals, therefore requiring experts in the field of mental health to raise that flag in order to advance in a safe and effective manner.

We may pick them up and [he] clearly hasn't committed an offence, but until he's seen or looked at, and even with young people displaying suicidal tendencies, because we're not professionals in mental health and trained in that area, well we are to a little extent, but you rely on the professionals to come down and make the call (Chris, 182-186).

As was discussed in the 'middle link – babysitting' analysis, the police are constructed as ready, willing and waiting to manage a situation, but are constrained from preparing and performing as thoroughly as could be possible by systems that do not allow the provision of appropriate services in the timely fashion required by urgent police practices. This produces a possible stagnation of police service provision in situations such as these where police have the motivation, authority, power and control to act on the situation if required, but are not trained mental health professionals and so rely on the collaborative relationship with mental health agencies to enable them to problem-solve together and provide timely and efficient service provision for those with mental illness.

This became especially salient when discussing issues of client safety in police custody. Through discussions of the risk of danger to the client and / or others, the issue of identification becomes a more serious and pressing matter. If an individual is not identified as mentally ill when taken into police custody it can prevent the activation of appropriate and necessary safeguards to ensure client safety, which could possibly result in undesirable consequences such as client suicide. By producing statements concerning the threat of serious harm or death due to a lack of 'flag raising', the argument becomes more urgent

requiring improved and more comprehensive information sharing systems to enable the immediate identification of those with mental illness.

If we're dealing with somebody who's not well and we think they're not going to hurt themselves so we don't involve the emergency team and then they do it looks bad it, even though we're not qualified to make that sort of assessment (Craig, 78-82).

I suppose the benefit for us-, If we know they're mental health patients then the level of supervision is already heightened for us. So, we know that they've got some issues. The ones that are bad for us are the ones that come in and have got no flags or anything like that and do not say anything they shouldn't do and then they'll try and do something (Nathan, 560-565).

Client safety was a dominant concern throughout the text and one that holds great significance to police given the highly public nature of tragic events while in police custody and the potential harm to police and their reputation. Because tragic events such as client suicide create a great deal of criticism from the New Zealand media and public, discussions concerning such instances often coincided with an emphasis on officers' limited training and knowledge concerning the ability to identify mental illness. This discourse, to some degree, attempts to remove responsibility of such occurrences from the police through the understanding that police officers are not the appropriate service providers to identify the presence of mental illness and directs the listener to locate the responsibility in the collaborative relationships with partner agencies whose duties and service provision focus on the identification and treatment of mental disorder. It is logically unreasonable to place

responsibility for tragic occurrences on police if the situation requires an expert skills base the police do not possess.

One of the striking things I've noticed is that people who I think are mentally ill and need to be looked after are often turned away by the emergency team, and others who appear to be maybe just a little bit depressed are often taken away and I think that's an indication of my level of experience in determining who needs help rather than anything else...Yeah, like I said, the vocal ones are often just looking for some sort of human contact I guess, you know...and it's hard to determine the old saying 'mad, bad or sad'...who knows? (Chris, 82-90).

So the DAO's are called down to the station when we arrest someone that's acting like, what we would think, is irrational. I mean, we're not trained in mental health, you know diagnosing mental health patients, but [we] just [go on] what information we pick up from the people that are surrounded [by] or are associated with the mentally ill person. We bring them down here and they're just released back and it could be that we deal with the same person 2 or 3 times in a day and all we get is that they 'don't fit the criteria' or 'they're just angry with police' or 'they're just angry'. But they might have tried to commit suicide, they may have harmed other people, they may have assaulted officers, it's just an ongoing daily occurrence (Christine, 15-24).

Here, the police officers own informed knowledge of what mental illness appears like is in conflict with the mental health service providers' identification of instances of mental disorder, therefore the individual is sometimes left 'unidentified' and unaided, despite

behaviour that would suggest that mental health problems are present. Potential barriers to this identification produced through the text were often constructed as an obscuring, or 'hiding', mental illness in communities by different parties that prevented adequate identification and therefore service provision for those with mental illness.

The hidden danger

But that's a scary thing when they're leaving people in the community and not letting us know that this persons out there. And I know there's good reason for that, but it can be scary for us too, especially the young constables who don't know that maybe they're getting someone who is completely insane, you know, or who can be, you know, have episodes like that which are potentially very dangerous to police officers (Dylan, 345-351).

The obstacles towards the identification of those with mental illness in the community were often constructed through statements in the text that conveyed keeping secret, or hiding, information regarding the presence of mental illness. The understanding here was that such obscuring of identification of mental illness was at times purposeful, but not necessarily malevolent. The act of hiding information concerning the presence of mental illness served various purposes for the various populations involved, but the net result was to restrict the ability of the police to perform their duties of ensuring public and personal safety.

In various statements the 'hidden danger' was constructed as resulting from the individual with mental illness neglecting to share relevant or accurate information regarding their mental health with police officers. This hiding of mental illness could take the form of providing police with false information:

He was the one that says "Oh, I know you, don't I?" and the guy would say "Nup", [Client name] would say "Nup. No, I don't think so. No, no". And [the sergeant] said "No I know your face. I know your face" and so I showed him the name tag and he said "No that's not your name" and he said "What's your name. I know your name. I know that face" and then he said, after a few minutes he said, "You're [Client name]!" and he [said] "Oh ok, [Client name]. How have you been and when did you get out" and had time to chat with him properly. "Rightio, put him in the cells", so I put him in the cells and meanwhile I [asked] "Who's he?" He said "That's [Client name]" and then, you know, told us the story about what he'd done many years prior. Not that many years prior, but, you know, and how incredibly insane he was at the time (laughs) (Dylan, 313-325).

We can be just pretty forthright and say "Hey look. This is what we've been told you've been doing" and get their story, you know, what's going on and if we've got enough people that-, If we know that this person's being doing such-and-such and they're telling us something totally, sort of, different and we're quite confident to say "No. We're going to take you back and get it looked at. Get you sane" (Thomas, 303-308).

Or withholding various elements of relevant information:

Somebody won't tell us that they're schizophrenic, but they will tell us that they're on, for instance, clonazepam, ok? Or somebody won't tell us that they're on clonazepam, but they are schizophrenic and they're taking medication, so if we, you know, have some sort of cross reference either way to say what we might be looking at (Craig, 366-371).

It is important to note that there was a sense in such statements that this hiding of information by the individual was often not constructed as malevolent in the understanding that those with mental illness were intentionally attempting to deceive police. Here I am drawing from extra-textual cues such as tone of voice, as well as the construction of the mentally ill subject lacking control over their illness and behaviour (as will be discussed in detail in 'the cure' analysis later) to interpret the underlying understanding of such statements as communicating that this 'deception' was attributable to the nature of the individual's illness and their ability to comprehend what was required of them during interactions with police. If those with mental illness are constructed as constrained in their ability to be forthcoming with important information regarding their disorder, the implication of this is that other parties not affected by mental illness, such as mental health professionals or the police officers themselves, have the responsibility to activate open communications regarding the identification of such individuals in order to evaluate and respond to the particular situation in an appropriate manner. Echoing the discussions regarding the possibility of waiving rights to privacy in 'raising the flag', this revealing of hidden information is presented as for the 'greater good' despite the attempt by those concerned to conceal information about their mental illness.

This 'hidden danger' was also constructed through statements concerning the denial of the presence of mental illness from responding mental health agencies.

We take them down and say "Oh sorry, there's nothing wrong with them" and [The family will] say "There is something wrong with them" and we say "We think there's something wrong with them too. They're telling us there's not and we can't hold them" (Christine, 268-270).

Here, mental health service providers were constructed as denying the identification of mental illness through the absence of 'criteria' despite behaviour present that indicated otherwise. This 'hiding' was further emphasised by statements which described mental health agencies declining to identify an individual as mentally ill and this assessment proving to be incorrect through future events.

And so it's that sort of thing that really frustrates, can be the frustrating thing, when you're told over and over again it's behavioural, but in the end it turns out not to be (Jarrod, 77-79).

Turned out-, He was described by the social worker who saw him the following morning after his arrest with the firearm as actively psychotic and you think "Well" (laughs) "If we'd done this three days ago we wouldn't be in this situation" (Matthew, 166-169).

Where mental health services require a person to meet specific criteria, they can exclude those with mental illness from service provision. This can produce frustrations for the police when their understanding of a 'mentally ill individual' does not correspond to the understandings of 'mental illness' produced through the criteria of mental health services. The lack of identification and subsequent intervention can lead to more serious offending.

But when they go through an assessment and they say "No, he's not. We haven't got a bed for him. No, he's fine" type thing or "We're happy to sign off" type thing and the cops are standing there thinking "How can this be? This guys nuts" type thing and, again it's from a lay persons point of view, but sometimes it's pretty obvious, I tend to think you know that this person isn't well and cops are pretty good general, you know-, At, you know...assessing peoples characters and their characteristics and so forth and their personalities and when the cops sort of sit there and think "Hang on, I'm pretty sure this persons mad. They need to be taken away and given some help" and the crisis team are saying "Well no, they're not mad enough or they're not bad enough" type thing, then it's a bit-, Yeah jeez, you lose a little bit of faith in them sometimes (Dylan, 105-117).

The emphasis on the 'obviousness' of presenting mental illness symptoms suggests that mental health professionals were declining to identify such individuals as mentally ill due to specific bounded criteria rather than the presence of mental illness. Such statements were often placed in context with others describing how the individual in question was then left in the responsibility and care of the police, suggesting that the purpose of this obscuring of identification could be to avoid responsibility for those with mental illness. This

construction of an ongoing suspicion of mental health agencies willingness to assume responsibility for those with mental illness suggests the responsibility for care and treatment of those with mental illness is a difficult burden, one that they, and other agencies, are hesitant to adopt (this last understanding will be discussed in detail in the 'no-man's land' analysis).

You could understand their frustration, but sometimes you also felt that they might have been shoving it off to you because they couldn't do anything, but then they wouldn't go that step further, like "what do we do?" (Christine, 110-112).

While tensions between 'knowing' a person has mental illness and the criteria for diagnosis is apparent, the 'hiding of information' by the mental health agencies was highlighted through comparisons to information sharing systems within the criminal justice sector. The criminal justice system was constructed as motivated to share relevant information that would be of benefit to those interacting with the mentally ill in the community.

If they're going through the prison, generally we're aware that what their release dates [are] and that's on our computer, but under mental health it's a bit more dodgy as to what sort of information we're getting (Dylan, 356-359).

Police are, to me, one of the leaders in sharing of information compared to a lot of other government departments (Christine, 268-269).

Statements that position the police and the criminal justice system as motivated to problem-solve and coordinate for better outcomes through information sharing systems encourages other agencies to respond in like in order to facilitate integrated community service provision that benefits those with mental illness.

Sitting up and taking notice

All we can do when she comes up is just take her out of it again and put her through the court process again, but how many times do you put somebody through a court process before somebody sits up and takes any notice? And even if they have taken notice and they decided there's nothing they can do, where to from there? (Craig, 247-252).

Identification of those with mental illness was constructed through the text as allowing a series of events to unfold that work towards positive results for the individual with mental illness, the community and the police. If police are able to identify someone as affected by mental illness, then they are enabled to take control of the situation and attempt to resolve the presenting problem. If no identification is made, no action can be taken other than what can be allowed under the limits and authority of criminal justice system procedures, which could be understood to ignore the core problem present – that of mental illness. Following this trajectory, the presenting problem will continue to re-occur, and police services will continue to be required, until such time as the individual is identified as mentally ill and adopted under the care of mental health services.

Similar to the 'last link – the buck stops here' system of meaning, the police in this construction are positioned at the last link in the chain and simultaneously the lead agency in mental health service provision due to having identified the individual in question as a responsibility of mental health service provision, but not meeting the criteria for intervention. As is common in all three systems of statements that construct the '(un)identifiable other', this 'sitting up and taking notice' discourse can be associated with motivation on behalf of the police to act on the problems present in comparison to other partner agencies who may be understood to lack motivation or 'proactivity' in their service provision, which in turn places the burden of responsibility on the police to address as best they can the presenting issue.

That would show me that they're actually being proactive and I don't think they are proactive. I think they're sort of more reactive. They wait for the problem to be identified (Craig, 278-280).

One way of attempting to address this problem of lack of (access to) identification produced in the text was to demarcate and disassociate mental illness from 'the criminal act', thereby avoiding the need to rely on alternative agencies. If one can focus on any event of criminal activity, despite indications of mental illness, then one is enabled to take an active position in dealing with the situation and resolution of the issue is possible through legal means. This mechanism of problem-solving involved producing limitations and boundaries regarding where mental illness was applicable to the resolution of the situation and when it was not. For instance, identification and classification of mental illness is useful in situations involving suicidal behaviour because such crisis situations are

most likely to be responded and reacted to by mental health crisis services. However, if a person's behaviour is predominantly marked by impulsivity or aggression, then it may prove beneficial to ignore the presence of mental illness due to the high probability of such individuals being denied access to mental health services. Therefore, in such circumstances it is more favourable to construct the 'mentally ill' identity as 'criminal' to enable a subscribed and reliable course of action to proceed with that more than likely will result in resolution of the incident (despite the lack of address to the core problem of mental illness). Interactions then become a legitimised criminal police matter and accordingly police have the power to respond, such as in arrest.

...People who perhaps didn't fit in the system as being mentally ill, but obviously had some reasonably major mental issues that perhaps were big enough to affect their lives, but perhaps not categorise them as being mentally ill and to take them into the system I suppose and I think we'd probably classify a lot of our recidivist criminals as that. And I think perhaps at that time, and the fact probably is still, you know, a lot of the alcohol and drug abuse type things we were talking about, or were experiencing and the problems we were having with those sort of guys, you know, we tend to categorise them simply as criminals, but many of them as criminals also had obviously addiction problems and had mental illnesses (Dylan, 11-21).

An important aspect of this 'criminalisation' mechanism is the production of a 'categorisation' process of identification. The officer is enabled through the category of 'criminal' to place the individual into a subject position that denotes a certain type of action

– prosecution or containment. If classed under the ‘criminal’ category, following action on behalf of the officer is permitted and required. Officers communicated that they were often aware that someone might be affected by mental illness, but by constructing their actions as ‘criminal’ rather than ‘mentally ill’ they were able to take what they believe is appropriate action in order to provide resolution to the situation, where the mentally ill are accountable for their behaviour.

Just wandering, you know, around the place, but-, And he may not be causing a huge amount of problems, but it's enough for 3 members of the public to ring us and you can't-, Not-, Every time we go there we can't just let him keep walking away because otherwise we're not serving the public are we? Yeah, so if he does commit offences he needs to be locked up. If it is that he's just walking and he's in the wrong part of town and he's, you know, he's just sniffing out of his bag or whatever, well then, you know, try and get the bag off him, you know, check his kit for any other drugs or anything like that, you know, or cans and then let him go, you know. But if he commits offences he's still gotta be-, Even if-, Even because of his state he's mentally affected, he's still gotta be held to account, yeah, I think...hmm... (Tony, 409-421).

It is important to note here the difference between this construction of those with mental illness as ‘criminal’ as opposed to that discussed in ‘raising the flag’. Here, it is understood that the act of ‘categorisation’ is purposeful in that it was constructed in order to serve the purpose of resolving a situation that may not have been resolved otherwise, in essence it is a problem-solving response. In ‘raising the flag’ there is a sense that the shift in

categorisation was more unconscious, one that was constructed in order to make sense of the differing needs and demands various forms of mental illness can present for police officers. Although the outcome is similar, if not identical, for both mechanisms of subjectification, it is important to note that the current 'criminal' construction is motivated by the desire to help, while the former was an unconscious reflection of the presence of oppressive practices that occur in our culture which need to be addressed.

The issue that police *need* to produce and manipulate various constructions of the mentally ill subject for various purposes points to the usefulness of such actions in the aid of service provision for those with mental illness. This raises questions regarding how the current system and networks operate that necessitate this activity, and why the police feel that the production of such constructions are required in order to facilitate service provision for those with mental illness in the community.

No-man's land

No-man's land is a metaphor that produces some provocative imagery and understandings of location. It suggests a metaphorical location that is not under the power or jurisdiction of any particular governance. It is a vacant and uninhabitable space due to the lack of security it provides as well as the conflict it is under. Common understandings of 'no-man's land' conceptualise it as a piece of territory that is under conflict – no governing body wishes to encroach on this territory for fear of the damage and destruction that may await in the fight to 'possess' the 'land'. It is associated with feelings of fear, ambiguity and hesitancy, for to attempt to take control of this space is to engage in a battle that may not be 'won' and in which many casualties may occur. It also suggests a 'dumping ground' as,

when associated with war discourses, it was strewn with dead bodies and land mines that were unrecoverable on account of no party taking responsibility or ownership, or indeed taking up the fight to possess this piece of territory.

In relation to the present study, 'no-man's land' is the 'space' produced when differing service provision agencies fail to accommodate those with mental illness into their services. This occurs when boundaries and limits produced by entry criteria and the institutional and legislative practices established by the government effectively 'block off' avenues and abilities for comprehensive and accessible service delivery. In these spaces where individuals fail to meet criteria or fall under an agency's umbrella of service provision, those with mental illness are essentially left in 'no-man's land' where no service provider will claim responsibility and / or care for that individual. The fear and uncertainty generated by this 'no-man's land' may be attributable to the complicated nature of treating mental illness and the hesitancy to inflict 'casualties' to agencies through a lack of observable goal and outcome standards achievement. Therefore, in order to avoid criticism of 'failed services' this 'no-man's land' is left ungoverned and inhabited by the 'fallen soldiers' of mental illness. The police, however, are one service provider that has authority, and indeed the expectation, to encroach and govern this 'no-man's land' and yet are unable to 'retrieve the bodies' for treatment into a governed 'space' through the transportation of the 'wounded' into agencies and service providers that can coordinate and collaborate together to help assist successful community living.

The two systems of statements that constructed the 'no-man's land' discourse were that of the 'unticked box' and 'cracks in the system'. The 'unticked box' was a metaphor for the

constraints in gaining access to services through an inability to meet entry criteria and the resulting subject position of 'unserviceable' that is produced. It is heavily influenced by cultural constructions of mental illness that require the process of categorisation in order to identify and therefore treat the individual. 'Cracks in the system' moves beyond a focus on the individual to examine structural and systemic contributions to the production of 'no-man's land' and is more concentrated on exploring relationships between service providers in efforts to provide effective and adequate service delivery for those with mental illness in the community.

The unticked box

There seems to be a bit of a grey area or a hole in the system where you can't just tick a box and he's placed somewhere (Chris, 112-113).

One of the systems of statements that constructed barriers to service provision resulting in the production of a 'no-man's land' was that of the 'unticked box', in other words the individual failing to meet entry criteria established by the various agencies and mental health policies of the New Zealand government required to access services. In order to gain entry into services, the individual has to 'tick all the right boxes' and fit into a standard category of the eligible 'mentally ill subject'. As noted in the introduction, many or most agencies, such as crisis services, drug and alcohol services and hospital based treatment providers require the individual to fit a certain 'profile' of who their client-base is and often this is a 'pure category' that cannot accommodate those who have multiple presenting treatment issues, which is a common complication for those with mental illness (Lurigio & Fallon, 2007). If the boxes cannot be ticked, the individual cannot gain entry to services,

despite the need for treatment, and therefore they take up residence in the 'no-man's land' of community service provision.

It's quite sad out there for these people that actually need help but don't fit into any category (Christine, 88-89).

We get certain people come in, they'll assess them and they go "Oh, nah. He's just got a personality problem", you know, or "He's got- "...It doesn't fall within the mental health, sort of, what would you say, criteria. So, then we sort of go "Well, where do they fit?" and then they kind of say "Well, they just need to go away and sort themselves out" (Thomas, 187-192).

This 'no-man's land' was often constructed in spatial terms as a 'place' which lies between the various agencies and is inhabited by those who fail to fit into a particular subject position of mental illness or 'being' that falls under a particular agency's responsibility.

That's where we get to this point where we don't have anywhere to go. And I don't know whether that's-, Whether we're not heading in the right place or whether there isn't a right place or whether there is a right place and they don't want to know (Craig, 243-246).

Statements that indicate a missing 'location' for mental illness may be informed from the era of institutionalisation when there was previously the *option* of a spatial location where those with complex mental health needs could go in order to receive mental health

services. This is not to say that the officers were advocating institutional-based treatment, instead it suggests that under the old system and practices there were options and alternatives available to accommodate particular individuals who had difficulty receiving adequate services in the community and now that this 'place' has been removed, there are a lack of options regarding where to go in order to access treatment and care.

Furthermore, constructions of care residual from the institutional era may encourage an 'institutionalised' understanding of how mental health services should operate (which will be discussed in further detail in 'the cure' analysis). The physical institution has been replaced with an 'invisible institution' of community care that cannot provide for those with mental illness who need multiple service agencies in order for the promotion of good mental health in the community.

The construction in the text of those with mental illness needing to reside in clearly defined 'categories' of disorder in order to gain access to services may result from the need of various government agencies to have clearly defined and bordered areas of responsibility and service provision. Although discussing primarily medical care in the community, Welton, Kanter and Katz (1997) note that government funded agencies and services utilise market-based discourses to construct their service provision, and focus on assessment, assurance, evaluation and policy development to guide their practices of service delivery. If areas of responsibility are clearly defined and boundaries are established as to who may reside under the service provision umbrella and who is excluded, easier and more definable measurements and achievements of economic and evaluation goals are able to be produced. A defined problem area enables those reviewing such agencies to produce standards of accountability in order to facilitate evaluation of success or failure of adequate service provision. One starts to see a picture of how the vague definition of 'mental illness'

differs from other specific mental health states such as 'crisis' and 'drug addiction'. 'Mental illness' can potentially be chronic, in comparison to crisis which is a short-lived transient state, so any measure that looks at change over time will either not be relevant or will produce extremely unfavourable results in evaluation. When considering 'drug addiction', a successful outcome would be the cessation of drug using activities, but when considering 'mental illness', what would be a comparable benchmark? Getting up in the morning? Gaining employment even if that means introducing extreme stress into someone's life? It becomes clear that 'mental illness' is a complex 'category of being', one that clear boundaries and categories cannot be produced for.

They've sort of got the problem and you know that crisis can't just fix them. There's no magic injection or pill that's going to fix these people. So, I mean, some of them just take so much work and you can put so much time into them and I think honestly you can get nowhere (Thomas, 177-181).

The institutional practices of our current culture in today's society produce the methods in which we can understand and 'know' ourselves and our world, which in the current discussion relies on 'ticking boxes' or listing attributes that denote where something or someone is to be placed. If a 'subject' cannot be well defined and categorised, then it seems logical and inevitable that there will be no particular agency or place for them to be referred to. Therefore they are either positioned in 'no-man's land' or they bounce between various agencies at different stages of their illness, lacking a firm ground upon which to stand and an integrated, coordinated effort to improving mental health.

One example of such institutional practices that was clearly salient to the police in the text was of those with mental illness who had co-existing drug or alcohol problems. As discussed in the introduction, if someone is under the influence of drugs or alcohol, the crisis team will most likely decline to assess (Bay of Plenty District Health Board, 2010; Rock, 2001). In these instances the police must assume responsibility over the individual until such point that they are considered no longer under the influence of substances.

Some of the other issues are mental health won't deal with people when they're taking drugs or alcohol. It's really frustrating for us... they won't come and assess them at all. I can understand their point of view is that it masks or whatever or something (laughs). But yeah, "That's it", you know, "Sorry" hang up [the phone]. "That's it. We're not going to do anything". So you just have to detox them. You just have to leave them in the cell (527-535).

And there's the other side too of whether somebody's mentally ill or an alcohol or drug problem. There seem to be quite clear demarcations as to how they're dealt with. But for me, I think they're quite linked...Yeah, and then you get the, like I say, the Friday night drug or alcohol problem that you can't direct anywhere because there is nowhere to direct them to. You know, like with mental health people you've got the emergency team, but there's nowhere for drug and alcohol abuse (Craig, 152-160).

Once detoxified, the individual can then be assessed, but this will most likely lead to release due to the primary manifestation of the problem (for example mental health problems compounded by substance use) no longer present. In effect this bouncing of an individual

from care agency to care agency fails to locate a 'solvable problem' due to the presenting issue dissipating over time and an inability to provide dual-diagnosis and assistance.

It is possible that agencies are structured to avoid taking responsibility for the 'mentally ill' because of the difficulty in achieving what a medicalised model of understanding illness constructs as a 'cure' (discussed in detail in 'the cure' analysis). Each agency, in order to sustain job allocations, funding and usefulness in society must be seen to be effective, especially cost-effective, and taking responsibility for the complex area of mental health could be seen as potentially harmful for the continuation of service provision. Indeed, S.M. Rose (1979) tracked changes in government led mental health policies that coincided with historical political, economic and social concerns, each new mode of service delivery being 'replaced' once having outlived its perceived 'usefulness' and relevance to the various concurrent cultural and historical locations. If an agency cannot prescribe and administer a cure then they may be constructed as not having met their obligations as expected and demanded by those who authorise funding and resources for such services. Therefore it is possible there may be a tendency to avoid taking responsibility for the complex area of community living for those with mental illness in order to avoid the unfavourable result of having being labelled as 'ineffective' in terms of meeting service provision outcome goals.

So they're kind of, to use the word bailing, they're bailing people out from a full-time care hospital to a community care and a community care that either doesn't exist or cannot cope with what's presented to it. I've found that you tend to find (laughs) the mental health 'excuses', if you like-, I use 'excuses' just to put a label on it...they're either not mad enough or they're too mad and if they're too mad "Well,

hang on a minute, why am I getting them?" (Laughs). I don't want to know, you know, I really can't cope with that. That should be somebody who's cared for in either a hospital environment or a secure environment and (laughs) to use that reason for why somebody's not cared for is beyond belief, from a layman's point of view (Matthew, 72-82).

And the ones that have had contact with the crisis department before always say "They do nothing for me, you know, they just keep fobbing me off, fobbing me off" and so that's a trend that I've picked up from the people (Tony, 185-188).

The consequences of such a refusal of responsibility produce extra burden on other agencies involved with those with mental illness in the community such as the police force. If left with little-to-no care in the community as a result of defying categorisation, the individual's mental health can deteriorate to the stage where crisis point is reached and the safety of the individual, the police and the community is compromised.

One department's unwillingness to deal with a problem creates problems for two other agencies and then three days later, because he wasn't assessed then, he ends up crashing through the door armed and with a rifle that turned out to be loaded to two unarmed police officers (Matthew, 129-132).

To understand another agency in the collaboration as 'unwilling' assumes that 'willingness' was a reason why those with mental illness defied categorisation and therefore placement under a certain agency's jurisdiction was compromised. As discussed in the '(un)

identifiable other' analysis, there is a sense that other organisations *could* admit these individuals into their service, but chose not to. In comparison, the officers interviewed often expressed their own willingness to address the situation and attempt to resolve it successfully, despite the presenting mental health problem residing beyond their specialist expertise. Here, there is no situation the police will turn their back on and even if it is an area they are uncomfortable with, and to some degree unskilled in, they are still motivated to problem-solve to attempt resolution.

It's a case of "Hey. No one else is going to do anything", you know...there's no one else after us really (Thomas, 275-277).

The motivation for police to 'breach' this 'no-man's land' may be produced by the public's expectation and pressure on police officers to respond to and navigate any and all situations despite their limited powers and training concerning incidents involving the mentally ill (echoed in the 'last link – the buck stop here' analysis). As noted in the discussion of the construction of the '(un)identifiable other', there is a tendency for the actions, or indeed inaction, of the police force in the community to produce comment and criticism from the media and public opinion, which may result in the police feeling pressure to act upon situations in an attempt to avoid such criticism, despite the nature of the incident relating more to mental health service provision than criminal justice matters and therefore residing beyond the boundaries of their specific skills and duties.

You're a police officer and no matter what the situation you're expected to take control of whatever's happening (Chris, 215-216).

This seemed to produce frustration regarding the level of responsibility placed on police officers in such situations. There was a sense that criticism of police action is often unjustified and / or misplaced, resulting from a public misconception of what the police 'role' entails.

I tried to explain to her "So well, you know, he was arrested for this reason, but we don't make the decision. At the end of the day it's someone else's" and so they see us as the...bad guys, I suppose. We've gone in and dealt with the issue and taken someone away, but then, you know, it's for a reason (Nathan, 339-343).

Such statements implicitly indicate the absence of a needed collaboration between partner agencies that enables each specialist service provider to contribute their unique skills and abilities where appropriate. In isolation, no *one* agency can transverse this 'no-man's land' because of its lack of definition or categorisation. Therefore, partner agencies need to problem-solve in a collaborative and coordinated manner in order to communicate and provide services where applicable. It is possible that through the process of collaborative problem-solving the need for a consistent category or criteria in order to receive services may be dissipated and instead the gaps in service provision can be filled by inter-agency coordination. Here, it is not a case of producing more encompassing 'categories' within which to 'fit' the individual, instead what is being advocated is a net-effect of service provision wherein the overlapping, connected 'space' between service providers is great enough to ensure no 'gaps' are present.

It's a complex area with lots of different organisations involved and there's probably not the coordination that you need perhaps (Jarrod, 640-641).

I think that's the only way that a lot of these social problems can be dealt with now because, yeah, you have to bring all the agencies together. That's the smartest way to work (Jarrod, 650-652).

Without the needed coordination and collaboration between partner agencies, police stations and the community in general in effect *become* the 'no-man's land'. Whether it's the police cells, the streets or the family home, the officers interviewed often communicated that at the end of the day they were sometimes the only agency left to interact and respond to those with mental illness and often could not provide any further assistance, leaving them to reside in the community unaided.

At the moment, they're brought in and then the DAO says "no they don't fit under our criteria" and then they walk out the door and we're left with them. They're not our issue. What do we as police do with those people? We release them [and] there's no aftercare (Christine, 167-170).

The absence of a well-defined category, and therefore an agency, under which to assign those with mental illness, in a society where the need to categorise guides service provision, produces a revolving door effect in which individuals cycle through various stages of illness, coming to the repetitive attention of various service agencies due to needs not being met by a coordinated movement or system of service provision.

It seems that they fall into a grey area where they're committing offences, but they're not deemed bad enough to be placed somewhere. So where do those kids go? [There] doesn't seem to be anywhere. And then they'll commit more offences and end up back in court [where] a psychologist says he isn't at risk or hasn't got a mental illness though he is bad, but he's not bad enough and they're the ones that may come back time and time [again] for offending (Chris, 122-128).

But you know it's not fixed, it's only displacement. It's only moving them somewhere else and then you're going to get a phone call again (Tony, 329-331).

As present in every analysis in the current study, one mechanism police officers employ to attempt to address this issue is to redefine what they believe to be primarily mental illness as 'criminal behaviour'. This 'creative policing' positions the individual within an 'actionable' category, that of the 'criminal', on the understanding that once placed within this category criminal justice processes are enabled that can address the situation and work towards resolution of the problem.

When they do, you know, constantly come to our attention, constantly sort of reoffending, then basically we have to arrest them under a different Act like a criminal nuisance type thing and actually get the courts to put them away or take them away for a while (Thomas, 102-105).

What we did with her is we basically ran a project on her and so the thing was there was to be no leeway in our policing of her. So any phone calls or complaints about her behaviour were to always be dealt with by prosecution. Whereas in the past, we might have explained it away to people, you know, "She's not well, so, you know,

put up with it”, but we absolutely-, Everything we could find on her we prosecuted for until we got to the stage where the court agreed to remand her in custody for an assessment and then as a result of that assessment she was, this is my understanding, she was a compulsory patient at [Local hospital mental health ward] (Jarrod, 82-91).

This process, in effect, locates the individual with mental illness in a governable and controlled ‘territory’. The criminal justice system becomes the modern day mental asylum. Once located in this territory the individual is enabled access to service provision, despite that service being inadequate and inappropriate to meet the needs of the individual. This rearranging of constructions and categories indicates a possible flaw in the system of service provision for those with mental illness in the community. That police have to manipulate constructions of presenting situations in order to ensure that they can be resolved indicates that perhaps the broader system of service provision, and the understandings their practices enable, are producing barriers to effective community service for those with mental illness.

Cracks in the system

So there’s a lot of people, in my mind, that are falling through the cracks of the system. There’s nowhere for them. They don’t fit under mental health anymore since the criteria changed, but probably would of in the past (Christine, 51-53).

A related set of statements to the 'unticked box' that constructed 'no-man's land' was that of 'cracks in the system'. The legislative practices of governing policy produce a system of institutional processes that locate various government employed agencies in a position where possibilities for intervention are limited or constrained. Following from the 'unticked box', legislation and government Health Acts produce boundaries to service provision through the separation and demarcating of categorical constructions (such as mental illness and intellectual disability) to which people can be assigned. This constrains the ability of various organisations and agencies to assume responsibility for those with mental illness in the community through the establishment of criteria for admittance to service provision and the forced separation between partner agencies.

We get people who have intellectual and mental health problems. They really fall between the gaps as well. We have real problems getting them dealt with. They sort of fall between the two Acts and, you know, the Intellectual Disability Act or whatever it's called and the Mental Health Act and so there's sort of a tension between-, Well, nobody really wants to deal with them (Jarrod, 611-616).

And I do understand that there are limits to what the Mental Health Act allows the hospital to do and I don't like it, but I accept it (Craig, 470-472).

Statements concerning government funding and the allocation of resources was heavily emphasised in the production of the understandings in 'cracks in the system'. There was a sense of government funded agencies having to work under conditions and boundaries they were powerless to change and had an obligation to uphold. This also conveys an understanding that servants of the crown are willing to, and would provide if they could,

better services, but their hands are tied when it comes to increasing the resources they have been allocated (a major construction that results from this understanding is that of the 'underdogs' which will subsequently be discussed in the next analysis).

*I know you've got to prioritise, I know you've got to spend your money properly,
but...if there is a problem and nobody acts on it, it just becomes a bigger problem
(Craig, 264-266).*

As noted in the 'unticked box', the gaps in community service provision were often constructed in spatial terms: 'no-man's land' was a spatial location produced through the 'cracks in the system'. The transition from the one specific physical location that had a clear organisational and hierarchical structure in the institutional era, to a myriad of relatively unstructured locations within the community has produced a model of service provision for those with mental illness which has dispersed responsibilities and accountabilities that are unable to be located or positioned in any one agency or service provider. The dramatic change and contradiction between operational modes of mental health service delivery may have caused confusion and difficulty when attempting to re-construct the focus of how one understands the delivery of mental health care. The need to produce physical locations for service provision may be a relic from previous institutional meanings of mental health care and this could be seen in officer statements that discussed 'no-man's land' as resulting from the removal of previously available facilities to house those with mental illness.

And I think it's getting more prevalent. There's more people out there because there's no institutions, there's no homes that they may have gone to in the past where they lived in communal kind of settings (Christine, 71-73).

Have facilities been closed down over the years that would've been open where these kids [could] go? (Chris, 139-140).

So, they've [closed] [Name of mental health care facility], closing all these places and just putting them on the street and who else is there to deal with them? So nobody-, There's cops (Dylan, 228-231).

The effect of institutional understandings of mental health service provision is to obscure the core problem of fragmented and uncoordinated problem-solving relationships between partner agencies and instead concentrates on historical constructions of mental health services as operating through physical institutional settings. This historical system needs to be examined and challenged in order to highlight how the modern provision of community health care is struggling: are we still holding on to the construction of service provision that radiates outwards from a definable, specific location towards the individual with mental illness to the detriment of a focus on producing networks of systems that instead co-exist, co-contribute and coordinate in a dispersed, yet organised fashion to provide comprehensive and efficient services for those with mental illness in the community.

What the focus on specific locations and services with which to allocate responsibility produces is the positioning of individuals with mental illness in various 'pockets' of the system where they 'best fit', but yet is not the appropriate place to receive adequate service provision given their specific issues and circumstances. For instance, many of those

with mental illness 'fit' into the criminal justice system, specifically correctional institutions, because they were unable to meet entry criteria for other services and despite prison being an unsuitable institution to meet their service needs.

Yeah, all that is masked. It's all masked. Because a prison costs x-amount to run a day. Ok, we know that breaks down to 70 dollars a day per inmate...but, how many of those inmates are mental health? How many of them shouldn't be in prison and should be in a mental health care facility? (Matthew, 476-479).

As mentioned in the previous quote, this phenomenon was constructed as a sort of 'masking' in that the lack of an appropriate agency creates undesirable results that are not obviously present, but are underlying the various system structures. To illustrate by expanding upon the previous example of the prison, the individual would have engaged in criminal behaviour and therefore would appear to 'fit' into the prison system, but on closer examination the core issue that needs to be addressed and yet has been ignored is a lack of mental health service provision in the community.

Much like the 'no-man's land' itself, the 'system' is a nameless, faceless force that defies location and substance, but yet has powerful effects on how police and partner agencies conduct their core business and action. The construction of 'cracks in the system' in the production of 'no-man's land' serves to locate a certain amount of blame on this network of systems involved in mental health care while at the same time avoids placing blame in any one agency or individual and, as such, this system of statements may provide a vehicle with which to identify and express frustration of service provision that takes into account

the contradictions and variations in quality of service delivery that occurs in different agencies and organisations. Every partner agency is 'blameless' through the 'cracks in the system' discourse because they can only work within the confines of their allowances and abilities. Even the government can escape 'blame' to some degree because of the production of, and changes to, mental health and associated legislation having been dispersed over an extended period of time and through socio-political movements. Perhaps 'cracks in the system' produces a *removal* of blame, rather than a construction of it, by the lifting of responsibility for the production of the current 'no-man's land' from the various partner agencies involved in policing the mentally ill through an emphasis on the helplessness service providers face when it comes to adherence to institutional practices. As an agent of the crown themselves, police are all too familiar with the tendency of the media and public to blame particular agencies for failings in service provision and 'cracks in the system' may provide a safe way for them to communicate where they think service provision might be lacking and also advocate positive development areas without needing to locate blame in any organisation or person.

Furthermore, by locating 'no-man's land' within the 'system's' responsibility, or alternatively a network of service providers, police are enabled to materially manipulate this system where possible in order to work with its strengths and weaknesses so that the individual with mental illness can eventually be located within a particular agencies jurisdiction or provided services by jumping through various 'systemic hoops'.

*[We] put them before the courts and we have our prosecutor talk to the judge
beforehand, make it pretty clear to the judge that this person actually is mad and*

needs some help and then the court orders a psychiatric assessment [unclear]. So we sort of get around the system by then getting the judge to actually make mental health do it. It's one way we get around things sometimes (Dylan, 138-143).

The ability to 'manipulate' systemic practices to obtain mental health assistance produces the understanding that, despite appearing immovable, the 'faults' in the system are actually able to be overcome through creative and persistent effort on behalf of the various partner agencies. This manipulation or 'fighting' of the current system of mental health service practices through the production and management of inter-agency relationships will be discussed further in the following 'underdog' analysis.

Underdogs

The 'underdog' is a metaphor that describes a subject engaged in some manifestation of competition who is not favoured to win and is located in a low power position in the hierarchy of 'competitors' due to disadvantage. However, when utilising the underdog metaphor this disadvantage is usually constructed in terms of unfairness or injustice against the individual in question, producing the understanding that the underdogs are the 'good guys', that they are subjected to oppression or unfair conditions that force limitations and weakness upon them instead of 'possessing' these limitations as an inherent part of their nature (Vandello, Goldschmied, & Richards, 2007). Underdogs are motivated and determined to continue to 'fight' regardless of their social position and, as such, can be seen as a subject to be admired and respected. Despite battling with the injustice and unfairness of the competition, the underdog continues to fight to the best of their abilities. The effect of this metaphor is to challenge the 'spectators' assumptions of

justice and fairness within the competition at hand and to motivate support and sympathy alongside admiration of the 'fighting spirit' the underdog shows in the face of overpowering adversity.

Within the text, police and their partner agencies were often constructed as the 'underdogs' in the 'battle' to provide efficient, quality service for those with mental illness in the community. Although the term was never explicitly used within the text, systems of statements were employed that constructed the abilities of, and conditions faced by the police and other service providers as unfairly positioned with respect to what was expected from them and what resources were allocated to them. The two identified systems of statements that constructed the police position of the 'underdog' were 'making do' and 'underdogs stick together'. 'Making do' was a system of meanings that constructed police as a government agency suffering from disadvantage in the form of resources and training and yet 'battling' determinedly to still obtain successful outcomes in the provision of care for those with mental illness in the community. 'Underdogs stick together' positioned the police and partner agencies in 'battle' with the 'top dogs' for successful service provision for the mentally ill and makes sense of how that battle is realised in practice.

Making do

It's just a matter of working with what you've got (Nathan, 590).

We're not psychologists and we're not forensics nurses and so forth. So we're still just cops who are dealing with situations as we can (Dylan, 72-74).

The metaphor of the 'underdog' was constructed in the text through statements that emphasised how their expertise as police is limited when providing service to those with mental illness. It produced the understanding that despite such limitations police still strive to provide the best service they can, 'making do' with their limited resources and knowledge concerning mental illness to obtain satisfactory results for the mentally ill in the community.

The 'underdog' communicates the understanding of the experience of a competitor that is not favoured to win. The disadvantage is in comparison to its opponents, and therefore the underdog must struggle and battle more than others in hopes to achieve victory. In 'making do', the police understand this disadvantage through a lack of resources, funding, and specialisation. Essentially, the skills and strengths police 'possess' are not specific to the area of mental health service provision and yet they are 'engaged in battle' with mental illness in the community, trying to provide efficient and effective service for a particular event, but disadvantaged in this 'battle' because they lack the appropriate expert skills required when not supported in the collaboration with other services.

We go in there and try to deal with people [whose] problems are so complex. It might be financial, it might be gambling, it might be alcohol, it could be just they don't get on anymore and here we are coming for a 2 second window and are trying to deal with things that could have been accumulating over years (Christine, 309-312).

I think we as police are in a changing environment all of the time and we learn to cope with those changes and we just, we put different processes in place and we

just, we keep on working. We're rolling with the punches because at the end of the day the work's always going to be there for us (Dylan, 411-415).

So I think that's the biggest problem for us is-, It's probably not so much the workload, it's probably lack of knowledge or expertise in that area for us because we don't know how to deal with these people professionally in the mental health side of things (Nathan, 179-182).

Through statements such as 'not so much the workload' and 'rolling with the punches' the construction of a 'battling spirit' is produced where police officers are motivated and dedicated despite their limitations and respond to the 'fight' with a determination to succeed. In this way, the 'spectator' might admire, rather than criticise, the efforts of the police in the provision of service to the mentally ill regardless of the outcome.

Furthermore, although language such as 'cope' and 'keep on working' implies a sense of 'making do', the construction of a 'battling spirit' begins to suggest a more dynamic practice at work. 'Put different processes in place' assumes that the 'underdog' can learn to adapt and overcome certain limitations in the determination to succeed. In this case, the 'underdog' with a 'battling spirit' may perhaps be underestimated by opponents in regards to their position of power and likelihood for success.

The construction of police as the 'underdog' in the text is augmented through statements that position individual police officers as 'ordinary' citizens.

Police are really just very normal people from a variety of backgrounds. A lot more these days are varsity qualified, but you've got people that were builders, you've

got people that were lawyers, you've got people that might have been plumbers or engineers or worked for MAF. It's just a huge range of people (Christine, 298-301).

Here, police officers are constructed as meeting the standard of 'normal' members of the community pooled from the general public. However, unlike their peers in the general public, they are faced with the complex and difficult task of providing adequate service to those with mental illness without specialist training. In essence, they are 'average people doing an un-average job' or 'normal' people attempting to battle an abnormal opponent.

An implication for constructing the police as an 'underdog' is the production of understanding for their plight, encouraging the listener to feel compassion for the officers' struggle to provide adequate and efficient service to those with mental illness. In this way, support for the underdog increases, both to dissuade criticism of police actions in interactions with the mentally ill, and also on an action level where the campaign for more resources, funding or improvement of other service agencies involved with the mentally ill is advocated. Furthermore, the production of a 'battling spirit' inherent in the actions of police when interacting with the mentally ill inspires support and appreciation for the job that they do. Police do as best a job they can under unfavourable and difficult conditions against a formidable 'enemy' (that of mental illness in the community) and although they may not always come out on the winning side, they continue to find ways to succeed.

Police were not the only 'underdogs' constructed within the text. Partner agencies that are involved with providing service to those with mental illness in the community were also

constructed as occupying an underdog position in the battle for mental health service provision.

The crisis or mental health [workers] have got a huge job and there's not enough of them basically as well, but, I guess it's like the police, like any government agency, they're all stretched, you know, at certain times (Thomas, 378-381).

Unlike the police, mental health service providers have the skills and expertise appropriate to 'fight', but similar to the police they are limited, or 'weakened', by the lack of resources and funding needed to effectively provide those services in the community.

I know that they're doing a good job and they come along and do what they can, but I know that they're also overworked and so forth and that they struggle like the rest of us do to deal with crisis, you know, with crisis intervention, you know what I mean? So, you know, that's-, I mean, quite a lot of the frustrations is the lack of, perhaps lack of funding, lack of training, lack of funding for them (Dylan, 617-623).

In order for the police and mental health service providers to be constructed as 'underdogs', there needs to be a 'top dog' that is imbued with power and influence and which poses a threat to the ability of the police and their partner agencies to 'win'. Statements that constructed the 'top dog' in the text produced two dominant subjects: mental illness itself and the 'system'.

Firstly, mental illness itself was often constructed as a powerful and overwhelming ‘top dog’ that police and their partner agencies were engaged in battle with. In this sense, mental illness was no longer constructed as a state or a facet of an individual, but was a free-floating force that was dangerous, strong and often ‘overcame’ both those affected by mental illness and those who endeavoured to provide services to such individuals.

And you can see parents really getting to the end of their tether and they’re not getting the respite care that they need and CYFS don’t have the specially trained caregivers to look after them. Mental health don’t have the recourses to actually give them the support they need. Even school counsellors can only do so much with a kid with that problem. (Laughs) you really do feel for the parents and the kids as well. I mean, with a condition like that, they know it’s happening, but they don’t know why, they don’t know what they can do about it (Matthew, 435-443).

Mental illness as a ‘top dog’ positions the police as extremely limited in their ability to ‘win’ the fight for service provision not only because mental illness as a construction is invariably complex and powerful, but also because they are not specifically trained to battle this precise opponent. Furthermore, the police understand the commonality of the limitations through the range of service providers. The problem of mental illness in the community is ‘bigger than they are’ and therefore is a difficult problem to address, especially when services are fragmented and uncoordinated.

Secondly, the ‘top dog’ was often constructed through statements that suggested the ‘system’ was the more powerful opponent.

The relationship with the people is quite, you know, is good with the team that comes out. It just seems to be a frustration with the system more than anything (Jarrod, 143-145).

Although this construction of the 'top dog' often avoided a direct naming of the 'system', or even which 'system' was being referred to, the context surrounding the statements suggested the governmental system as a more likely candidate than the mental health system in and of itself. Statements that more directly concerned partner agencies as 'underdogs' supported this interpretation of the governmental system as the 'top dog' through discussions relating to legislation and resource allocation.

So it's not always the mental health people that are at fault and in fact I feel quite sorry for them because they're tied when it comes to their criteria, like whether they can be involved or not (Christine, 49-51).

The NGO's out there do an absolutely fantastic job in my mind and do everything they possibly can, but they're very under-resourced as well (Christine, 93-95).

That one social worker can look after twenty clients. It simply doesn't work (laughs) because they can't be there all the time (Matthew, 255-256).

Because police are employees of the crown and are charged with upholding the laws and legislation of the government, it is logical that the police were hesitant to explicitly name this institution and system as an opponent of sorts or direct any criticism towards it. What was realised in the text were the effects of the boundaries that emerge from the 'top dog's

response to community based mental health care. The gaps generated through the policies, resources and funding for services providers located responsibility at the site of the legislation and their practices, and can be positioned as the 'top dog' relevant to the current text.

Through constructing the 'system' as 'top dog', a questioning of the way in which the system currently operates is enabled. The 'top dog / underdog' dynamic is one that has inherent injustices and unfairness located within the power relationships and as such this unfairness can be examined for how it is both produced and perpetuated. Statements regarding resources and funding question the success of community care through their limited allocation, namely the cost-cutting motive of service provision. This is particularly relevant given that one of the motivations of the deinstitutionalisation movement was the desire to reduce expenditure on mental health service provision by the government (Bennie, 1993). When combined with the 'top dog' construction, this raises the issue of whether the post-deinstitutionalisation service providers have been treated 'unfairly' as a result of the concern to decrease costs, and encourages a questioning of whether such methods of cost-cutting should be acceptable to the public given the size of the problem created for service providers, and indeed those living with mental illness in the community, in its wake. Has a focus on economic concerns produced undesirable and harmful effects for those who suffer from, and respond to, mental illness? How much does the strengthening of the health of the community cost?

One consequence of constructing police and partner agencies in the position of 'underdog' in the text was the production of a sense of resignation to the limits placed upon them.

Here, no matter how hard police and their partner agencies attempt to provide adequate services, they will never be 'strong' enough to obtain resolution or to achieve their goals in a comprehensive and satisfactory manner. Understanding this position, many statements within the text produced the impression of service provision that inevitably would fall short of meeting expectations and that police and their collaborators can only 'make do' to the best of their abilities.

We've got to be realistic that the resources are not there and or the safety or risk side of things for them is going to be higher so they've got to have that backup from us and that's what we get paid for. So, it would be nice to attend the job for patients and then whilst we're there is to hand it over to mental health at the time in a timely fashion, but, as I said, we're pretty realistic about things now so-, And it's not just mental health, it's a whole lot of issues. You'd like this, that and the next thing at any job you attend to, but it just can't be done, [it's] just got to be prioritised (Nathan, 401-409).

I still think the biggest gap is in, you know, just the lack of support for people. But I have to imagine that's going to be a huge problem to solve because it would take a huge resource to look after people better or more, you know, have more contact and more structure for people. It must be a huge job (Jarrod, 522-526).

So I would just like to see that we actually have those gaps filled and in today's economic climate I cannot see that that is going to be a possibility. I would say that, more likely, resources are going to diminish rather than increase (Christine, 221-224).

Given the inherent weaknesses and disadvantages associated with occupying an 'underdog' position, the question could be asked "why would police construct themselves as the underdogs?" Perhaps the attraction of the underdog position lies in how it produces ways of 'being' and talking about the weaknesses and limitations of police services for those with mental illness. A dominant understanding inherent to the underdog metaphor is that the *underdog itself* does not question its position. The underdog is the party that courageously battles on, puts its head down and gets the job done. While this position encourages spectators to explore the unfairness and injustice of the power relations that produce it, the underdog is removed from that philosophical debate and instead merely 'fights' to achieve as best an outcome it can, continuing to compete and work hard towards goals. This may offer an extremely important mode of operating and thinking about issues within the police organisation with specific goals that require an adherence to legal authority to enable a safe, efficient and productive technique of policing.

It's that generation X or Y or whatever that are coming through now that don't-, That are much, much harder to manage because they don't just accept doing what they're told to do (laughs), you know, and that's caused some real problems for us as well because we are a paramilitary organisation so if [we] want to send a big team out to take down all the bikies then there needs-, There's probably gonna be some bloodshed and [we] need the guys there that [we] know will go in and do that and do the business for us. That [could] cause a few issues (Dylan, 503-510).

The position of the underdog is cohesive with the attributes needed to be a productive member of the police force. Through constructing themselves as underdogs police are

enabled to raise issues in regards to fairness and justice regarding the limitations of their position.

Underdogs stick together

We're all very much aware of the fact that the mental health system and the crisis team are under an incredible amount of pressure. Same sort of pressure that we're under type thing. They get criticised in the media often, we get criticised in the media, we know what it's like type thing so we have a bit of affinity for them (Dylan, 117-121).

The construction of the 'underdog' indicates a competition that has not yet played out. In this sense, at this specific location the 'winner' is yet to be decided thereby enabling the underdog to develop strategies and skills in which to increase their potential for success. 'Underdogs stick together' produces a vehicle through which the police can collaborate with other 'underdogs', most often mental health agencies, in order to increase the chances that quality, effective service provision can be provided to the mentally ill. Therefore, the underdogs need to band together to win, providing successful help and treatment to those with mental illness in the community.

Within the text, various statements produced the understanding that agencies involved in the provision of service to those with mental illness needed to combine efforts in order to counter-act their individual weaknesses and limitations. In this sense the police rely on

their relationships with partner agencies in order to achieve their objectives and expectations of service provision for the mentally ill.

At times when it's working well it works very well and we have to rely on each other (Nathan, 134-135).

We're not professionals in that area and we leave that up to the professionals in that area and you rely on referring or getting the right people or getting them assessed (Chris, 148-150).

However, as discussed in the previous analyses, relationships between the police and partner agencies often suffer from difficulties due to institutional gaps in service provision. Such frustrations and difficulties produce a need to construct a way in which these issues can be overcome in order to establish an alliance, or bond, that enables cohesive service delivery and positive problem-solving relationships between the various service providers. Through constructing the various agencies as 'underdogs' an alliance is formed through connecting and uniting the service providers in a similar struggle, against a similar 'opponent' and directed towards similar goals or objectives.

I know they're probably feeling the pressure pretty much like we are or like everyone is at the moment [when concerning] mental health (Nathan, 413-415).

I guess they get to see similar situations to us because if someone's not ringing us because they've got a crisis, they'll be ringing them. Yup, so I guess they get to see some situations like us (Jarrod, 376-379).

And I do understand that there are limits to what the Mental Health Act allows the hospital to do and I don't like it, but I accept it. And it's no different from my job, there are limits to what I can do and I don't like that, but I understand it (Craig, 470-473).

One way this alliance of the 'underdogs' was constructed in the text was through the establishment of personal relationships with individuals in partner agencies. The personal nature of these relationships is of paramount importance because the 'underdogs' are fighting a nameless, faceless 'enemy' (both that of mental illness and the system). Connecting through a shared understanding of that 'enemy' enables a relationship between service providers that understands the constraints shared between agencies and the invisible 'top dogs'. This unites the different service providers on a 'human' level and strengthens the productive relationship between agencies.

Generally we do have a fairly good partnership and the guys pretty much know the crisis team on a first name basis most of the time (Nathan, 533-534).

You build up quite a good relationship with the people that come out because you get to know them because it's a small team and you get to see them all the time (Jarrod, 124-126).

They were absolutely brilliant in [former city] and we could discuss [things with them]. They really went out of their way to do whatever they could...Like in any organisations, it depends on the relationship-building capacity of each person I think. Like, I have a good relationship with CAFS here and you just have your certain people that you deal with on a regular basis (Christine, 105-116).

A striking example in the text of the power of constructing relationships between agencies as personal was through statements that tracked changes in the nature of relationships between service providers over time. Through the building of personal relationships, the more effective and efficiently the agencies cooperated together to provide services for those with mental illness.

The mental health emergency team has definitely got better and they're a little bit more relaxed in that we can telephone them and say "We've got this guy. We know you've dealt with him before. What's his current situation?" and often that's good enough for us to know that they've been dealt with and they're not at risk (Craig, 125-130).

Sometimes they won't come and see somebody we think needs to be seen and it's-, Less now than in the past. And we pretty much have to threaten to get them down here-, No, we used to have to threaten to get them down here. It's very good at the moment. I don't think we have any major issues. They explain to us very clearly what the problem is and I don't know whether that's us in general or me personally. I have a pretty good relationship with them all. [Unclear] the time they've been around and I've been around (Craig, 197-204).

So if I've got a problem-, And in this case I didn't know anybody in mental [health]. I had to address it to 'director of mental health services [district] DHB' because I don't know who I'm dealing with. So I sent the letter off and I got the reply back from a person and then rang them up and said "Look, thanks for taking the time. I appreciate your reply. I've passed it on to the two guys involved. They're delighted with your response. Thanks very much". Now, that's just a building block really to

the future possibly... But at least if I find somebody who I've got a concern, we take it over to [nearest major city], they get assessed, they get booted out and now there's nothing we can do for them, I've at least got now somebody I can go to and say "How can I-, How can you help me to get somebody to look after this person". So, there's a start of a relationship there (Matthew, 377-389).

Connections between agencies enabled stronger relationships where it was possible to understand each other's limitations and to share information about ongoing concerns. Relationships with each other, enabled through finding common ground and similarities in struggles, were valued. No momentum can be gained from understanding partner agencies as working against each other or at cross-purposes, and through statements constructing the nature of relationships as personal, the production of a working-relationship was enabled to overcome the various issues and problems that present in the course of duty.

I think they've probably got a better understanding of our position as much as we've got a better understanding of their role. I don't think they have enough staff on, particularly over the arrest periods of Friday / Saturday night, but then that's their budget, their rostering (Craig, 207-211).

But when you talk to them and you get to know them you understand that they're working from a set of criteria that they have to work to (Jarrod, 320-322).

They just see hundreds of blue uniforms. I suppose they just-, Until they get to know who you are they probably don't really listen (Jarrod, 387-389).

One effect constructing relationships as personal produces is the separation between the individuals who work within the agencies and the agencies themselves. This separation helps to weaken frustrations concerning the procedures and limitations inherent in the organisational system of the agency, positioning each other as fellow 'underdogs' that struggle with similar procedural constraints. If this separation does not occur, and the individual worker remains a representative of the 'agency', then it becomes harder to 'excuse' or understand perceived inadequacies of the various service providers.

Relationships served to create space for collaboration between the agencies in service provision for those with mental illness despite the difficulties, criticisms and limitations faced by the fellow 'underdogs'. However, tensions did arise where shared understanding of the limits were not always present.

We've have a couple of dust ups I suppose and that would be...primarily around how busy they are and how busy we are. When we're busy and they're busy I think we sort of clash and get a little bit short tempered (Craig, 186-189).

Because I'd have to say that some other police would have not as good a relationship with mental health (laughs). Some get very upset with them, with the crisis team, yeah...I think that it's just that frustration thing and they're probably a lot more willing to take it out on someone (Jarrod, 367-373).

I mean it's all about individuals. Sometimes I guess you have personality clashes, but generally we work pretty well with most of our partner agencies and...I think they understand our point of view and we understand their point of view.

Sometimes there might be some words exchanged between-, At lower level, but I think that that's all between personalities type thing (Dylan, 199-204).

Through an understanding of individual differences, the interagency relationships are maintained and sustained by those with a shared understanding of the frustration that police themselves face when the system does not always work.

Furthermore, through the establishment of personal relationships inside agency-to-agency connections, the police are enabled to bypass the 'top dog' system and deal directly with the fellow 'underdogs', thereby increasing the likelihood of producing positive outcomes of collaborative service provision. Agencies are organised and disciplined through legislation and procedures that, as discussed in 'no-man's land', can make it difficult for the police to provide satisfactory service to those with mental illness. Personal relationships, or networks, are experienced differently as they are not as strictly governed and therefore are more amenable to accommodate other's needs.

It's probably a network establishment rather than anything. It was-, Instead of dealing with things formally that takes a long time we could deal with it informally and get things done and resolve it a lot quicker and put measures in place to make things run more smoothly (Nathan, 291-295).

What I've always suggested to sergeants is that what we really need is to sit down with people like the crisis team for example in an environment that's not-, Where we were not just taking their referral or referring someone to them, so that where

we actually speak to each other round a coffee or something so we can better understand (Jarrod, 358-362).

Another advantage of the separation between the individual and the agency is the power relationship this produces. A police officer in isolation has little power when engaged in a relationship between itself and the 'system', however through separating others from their agencies and locating the relationship between people, the power relationship is not as static and is open to the possibility of better outcomes. An illustration in the text of the benefits this separation of the individual from the agency produces is the enabling of information sharing. Through access to 'insider' knowledge of other agency's systems and procedures, a power relationship is produced whereby it is possible for police to utilise this knowledge to inform their practice.

And the other thing is that as you (laughs) as you develop your experience you get to know what to say on the telephone to get them there. Isn't that a terrible thing to say? But, you honestly do. When you first join you say-, You just tell them what's happened, but once you get to know how they work you need to tell them stuff that will get them to come down (Jarrod, 405-410).

The 'underdog' needs to produce and maximise any advantage or strength they can 'acquire' in order to make success more likely. While the network of relationships with the 'other' underdog enables a body of knowledge through sharing information and experiences, the shared knowledge also enables police access to a 'combative' form of power over the territory.

The combat was produced through tension where meaning was not shared, in the disciplinary difference in understanding safety. Here, instead of emphasising the unity of working towards a common goal, statements were produced that constructed the agencies as working towards differing objectives that clashed with one another.

Like from a personal view, I think they're good people trying hard, but they also have to-, I mean, you can see the tension: We're the police, we want to get rid of these people to somewhere safe and they're mental health and they're wanting to keep them out of an institution as much as possible. So, you know, there's always going to be that sort of conflict I guess (Jarrod, 126-131).

[We] appreciate what they do and they appreciate what we do, but sometimes our goals aren't the same and they clash a little bit type thing (Dylan, 206-207).

By establishing this tension, consistent with the competitive nature of the underdog metaphor, an organisational structure is produced that subjects even the 'underdogs' to differing power positions within the hierarchy. There were instances where police were constructed as 'less of an underdog' than others, especially where in their 'making do' they were positioned as being more active in the 'fight' against the boundaries.

I think they're sort of more reactive. They wait for the problem to be identified. Maybe they have to, just thinking about it (Craig, 279-281).

I think sometimes even the mental health workers aren't even up with the play enough because it's such a complex field (Christine, 306-307).

Because they're frustrated in their environment it passes on to us (Christine, 134-135).

And I know people are helping them and I know that it's easy for a policeman to sit back and criticise and say "Get the medication right and you'll be right". I mean, I know it's not as easy as that, but that's a really frustrating thing (Dylan, 560-563).

Through such statements, the understanding produced is that other agencies are 'weaker' than police at 'battling' to provide effective and efficient services in the face of disadvantages and limitations shared by all underdogs. The construction of other partner agencies in a 'weaker' position deflects criticism from the police, and at the same time, they were reluctant to criticise the 'weaker' agencies.

It's very hard for me to comment on their agencies. All I can say is how it really affects us. So I feel a bit uncomfortable about actually [commenting on that]. I'm not trying to pass the buck (Christine, 142-144).

Um...well, I can't bag them at all because, you know, I don't know a whole lot about what goes on (Nathan, 412-413).

Such comments were often produced alongside an awareness that any criticisms expressed could easily be returned to the speaker by others.

It's easy for me to sit here and say that, everybody says that about us (Craig, 273-274).

It appears that the location of blame was of concern for the police. As was discussed in 'no-man's land', as a culture we are motivated to assign responsibility and accountability to various institutions or populations in order to measure effectiveness and achievement of outcome standards. In order to be able to discuss constructions of blame, weakness and limitations, there must logically exist a 'correct' way of practising in current society, a method of service provision to aspire to, a 'cure'. It is to dominant understandings of what constitutes this best practice, or 'cure', that attention will now turn to.

The cure

Understanding of the constitution of a 'cure' can be conceptualised in two dominant ways. Firstly a 'cure' can be constructed as a verb, wherein it takes the form of a process of treatment that has as its goals and foundations healing or restoring the individual back to good health. Here the 'cure' is a process where 'experts' in the specific area of interest provide assistance and guidance in order to help the individual to overcome their illness. Secondly a 'cure' can be constructed as a noun, an end point at which after delivery of treatment the 'illness' in question is 'cured' or removed from the individual. Both constructions require 'experts' who facilitate the gathering of knowledge in the area of interest, processes in which the 'curing' can best take form and who can then administer the 'cure' efficiently.

In the current text, understandings of a 'cure' are complicated and problematic, especially when examining the two conceptualisations previously mentioned through which 'cure' can be understood. As a process, or verb, the understanding of 'cure' was constructed in the text through two dominant systems of meanings, firstly, as 'taking control' over the individual and secondly, as 'medicating the sickness'. 'Taking control' constructs the process of 'cure' as the provision of a structured, secure administration of guidance over, and management of, the individual with mental illness' daily life due to the mentally ill subject's inability to control their own illness and behaviour in the community. 'Medicating the sickness' constructs mental illness as a 'failing' of the physiology of the body which requires treatment through control, but the emphasis is on 'inside' control through medication-taking behaviour. The subtle difference between the two systems of statements is the position of the 'mentally ill subject'. In 'taking control', the 'cure' means the person with mental illness is subjected to treatment, whereas in 'medicating the sickness' the 'cure' can be understood as more of an internal process – those with mental illness should subject *themselves* to control and treatment.

When making sense of the 'cure' as a process, these discourses emerge seemingly unproblematic. 'Taking control' denotes surveillance, supervision and management as the process of 'curing' and in 'medicating the sickness' it is the delivery of medication to control the symptoms of mental illness. However, difficulty arises when the construction of the 'cure' is understood as an end-point at which the 'illness' is removed from the individual. While 'taking control' may 'cure' the community of mental illness and 'medicating the sickness' may 'cure' the individual of many symptoms of mental illness, neither of them can be understood to have 'cured' the actual individual that is the focus of

intervention. It appears the chronic and stigmatising effects of being diagnosed with mental illness are still dominant.

Taking control

I think that the quality of their life would benefit from being somewhere more structured and that they-, You know, somewhere that there's some guidance to what they do every day and somewhere-, Someone to help them solve their problems. Yeah, oh definitely there's need for that (Jarrod, 163-137).

One understanding of 'the cure' produced in the text was that of a controlled, restricted environment in which those with mental illness were contained, monitored and administered treatment in a particular location, reminiscent of facilities dissolved during the deinstitutionalisation movement. Statements that constructed the 'taking control' discourse focussed on processes of securing the mentally ill subject in a controlled environment better suited to meet their needs and the issues of safety their 'threat' may pose to themselves and the community.

There's some that you just think "Oh my God, you need to be in a secure unit somewhere" (Jane, 55-56).

The construction of this institutional meaning of a 'cure' combines with the underlying assumption in the 'first link' analysis of the 'handing over' of individuals with mental illness

to a more appropriate 'place' and positions those with mental illness needing to be physically moved or placed somewhere due to an inability of police to provide further services at that point in time in the community location. As discussed previously, there is a sense of finality produced through statements requiring the 'placement' of those with mental illness to a more appropriate location. When the 'end of the link' is reached, a 'place' is required where those with mental illness can be transferred to receive the specialist services they need, services which may be understood as lying outside the domain of policing.

This need for the 'removal' of the individual to a 'secure' and appropriate location is enabled by the construction of those with mental illness in the text as different to the 'normal' population and therefore not able to adequately function in 'normal' environments. The community is constructed as an undesirable location for the mentally ill due to their limited ability to respond to life events and situations present in community living that pose no issue or difficulty for 'normal people'. Here, those with mental illness are positioned as limited in their ability to navigate the socially complex and demanding locale of the community whilst maintaining good mental health.

Some sort of a life-, Adverse life event can trigger it which, you know, effects normal people, but effects them worse I guess (Thomas, 232-233).

I think people need structure and to help dealing with their problems because it's often a small thing that blows people right out of the water and causes them do to stuff to themselves and to other people (Jarrod, 563-566).

Drawing from how mental illness is constructed within the 'underdogs' discourses, mental illness can be understood as a 'top dog' who easily overpowers those affected. This construction of the 'top dog' nature of mental illness enables the production of a 'taking control' discourse by appealing to the understanding that an institutional construction of a 'cure' is for the mentally ill subject's own good because they cannot function healthily in the community on their own accord. Their 'disorder' is beyond their control.

Sometimes they might lash out, but they don't actually mean to hurt someone, things like that, I don't think that's fair really just to charge them for the hell of it because it's sort of beyond their control (Jane, 183-186).

Here, the mentally ill subject is 'out of control' and positioned as 'mentally ill' rather than 'criminal'. This understanding shifts the material practices that are enabled from such subjectification. From the vantage point of the police, their behaviours may be in need of control, but it is beyond the criminal justice system.

If it's a name that keeps coming up it's frustrating because something should've been done, hasn't been done and half the time it's the person's fault themselves because they won't go and get the help and there are no laws in place to force them to get the help (Craig, 109-113).

I still think a mentally ill person can help themselves and often they don't and I find that frustrating, but I understand the reasons for that. Don't like it, but understand it (Craig, 467-470).

That some behaviours are counter-productive or even harmful to their own wellbeing, there is an understanding produced that their illness or 'weakness' means they are unable to make choices that will enable an improvement of their mental health. By constructing the mentally ill individual as essentially a 'good' person, but one who is unable to control their 'disorder' and their potentially harmful behaviour, it is logically necessary, then, for them to be placed in a structured environment in which their behaviour is monitored and controlled for them.

You know that this person is nuts and this person needs some help. They need to go to hospital and they need a bed, then someone needs to be looking after them because they're gonna do themselves some injury type thing (Dylan, 84-87).

If somebody's got that kind of issue where they're needing that type of medication they-, A lot of them seem to get to a point where they think "Right, I've felt good for so long, I don't need this anymore" and they stop taking it. Well, you know, if that's going to be an issue then they need to be under more...not really 'more', closer supervision (Matthew, 235-240).

Control is the key element of discourses constructing the 'cure'. At the heart of the matter, the mentally ill individual is positioned as someone who lacks control. In this sense, the 'cure' for police is to ensure they are either in a facility or, at the very least, are placed under close supervision. For the police, it is when control turns to chaos that a call for the implementation of 'order' is required.

Someone needs to take control of this (Dylan, 601).

Drawing on an understanding that those with mental illness were 'seeking help' reinforces the notion that it is mental health expertise, not police intervention that is required.

I don't think it's fair on themselves because half the time they're crying out for help (Jane, 74-75).

The argument for the 'removal' of the mentally ill subject to a controlled environment was further enabled by statements that described those with mental illness 'wandering' around the community, apparently without purpose or regard for their own or others safety, due to a lack of controlled supervised environments in which to 'contain' them.

So it's like "God" (laughs) "These people are just driving around or walking around and you just don't know" and you don't know what could happen (Jane, 267-269).

I think now, at the moment, he's walking around the streets trying to-, He's offering people sex and stuff like that, you know, around alleyways and stuff like that, so. He's just got no-, I mean, you know, he just wanders off and there's no sort of-, Nothing there for him and he's always going to have problems. That's because he's had to move out of home I think. He's got no support at all now (Jarrod, 586-591).

Combining the various constructions of mental illness and those affected by mental illness within the 'taking control' discourse, a sense of threat and danger is produced. The mentally ill individual is constructed as at the mercy of their illness, unable to be trusted to engage in health-seeking behaviour and prone to inappropriate overreaction to normal environmental stimuli. Furthermore, combined with the construction of their behaviour in the community as undirected, irrational 'wandering', those with mental illness pose a risk to themselves, the public and service providers. This threat can be eliminated by removing the 'wandering mentally ill' from the community and placing them in a secure environment where mental health specialists can prevent this threat from endangering the safety of those with mental illness and the community.

In 'taking control', mental health service providers were constructed as 'experts' and possessors of the 'cure'. They were they most qualified to know what was needed and required, and were trained, capable and motivated to provide the 'cure'.

*Mental health is a very specialised area and it should be dealt with by specialised-,
And there should be specialists there to deal with it (laughs) (Matthew, 334-336).*

The key understanding produced here is that mental health workers are positioned within a particular expertise different to that of the police –mental health – and therefore they are the more appropriate institutional system in which to locate the mentally ill subject. However, due to the lack of institutional style mental health facilities present in the community, police were often left to deal with incidents, placing a burden upon police

services and duties which are understood to be an inappropriate form of service provision to provide a 'cure' for the underlying problem.

We're stuck dealing with someone that has got, clearly, a mental illness who needs to be in the care of someone in that field (Jane, 286-288).

That's probably the most frustrating, and just dealing with them over and over again, if you know that they should be in either a psychiatric hospital or at least under someone's care (Jane, 289-291).

This appeal to a different field of expertise resonates strongly with Foucault's discussions on pastoral power as discussed in the methodology, in which the police are positioned as modern 'pastors' who guide those under their care to safety and wellbeing through appeals to the knowledge and teachings of a 'higher power' (Foucault, 1988; Hook, 2007). Police are constructed within the current text as the 'pastors', working on the streets and in the communities, becoming familiar with and looking after the members of their locales. They are the enablers of healing, but not the healers themselves. Much like the pastor guiding the flock towards salvation, police facilitate the 'cure' of mental illness by identifying and then directing those with mental illness in the community to the appropriate service providers. In this way, the construction of an 'identifiable other' is a dominant concern for police. Until the individual is firstly located or identified and then secondly 'diagnosed' as having mental illness, police are powerless to guide that individual towards a safer place in the community. They can only occupy a 'pastoral' position once the individual in their community has been located and identified as mentally ill.

Because of a lack of available institutional-style settings in which to 'place' those with mental illness in the community, as has been discussed in almost every analysis in the current study, without 'identification' the only institution the police have access to and the power to 'place' an individual within is the criminal justice system. However, this was constructed within the text as an undesirable location because from a police position, those with mental illness are not best served by placing them in such facilities in their understanding of what constitutes a 'cure'.

Something not right, yeah. And she's just a nightmare and I don't know why, but she's not-, She went down to [Regional mental health care facility], got released so then she was in prison because they don't know what to do with her. So she's stuck in [Name of prison] prison down in [City name] and it's just because she's got mental issues (Jane, 307-311).

Because if you don't charge her with anything, nothing happens. At least if she's charged the court starts getting sort of like a picture, you know, there's a bigger picture built up, that there is issues and sometimes it's for their own good because then it keeps them off the street. It keeps them out of the community because they're just causing too many problems (Jane, 318-323).

This echoes the understandings produced in the 'last link – the buck stops here' discourse where the police are constructed as needing to resolve situations involving those with mental illness, but are limited in options other than the criminal justice system in instances where other service providers are unable to offer assistance. Here, the police are attempting to offer a 'cure' which is in fact recognised by them as not an appropriate or

adequate response to the intricacies of the current situation, even though it might lead to potential access to a cure.

This focus on a controlled, supervised institutional 'cure' is informed both by how mental illness and the criminal justice system are understood, and the institutional constraints that police are bounded by. Through these power relationships the mentally ill are 'subjected' to 'care' that those systems produce. Police are, traditionally, the enforcers and promoters of the 'norms' and values of society. If those with mental illness are constructed as 'subjects' that are incapable of locating themselves within those 'norms' then they need to be removed and transferred to a location where they can gain the skills to do so, or at least are 'contained' in order to prevent further 'harm' in the community. The institutional practice of surveillance enables an understanding of the control and removal of those subjects who cannot position themselves within the 'norm'. It seems the process of subjectification of the mentally ill, like the criminal, reproduces institutionalism as sometimes necessary for the 'cure'.

We're then between a rock and a hard place where we need to find a place for them so we often end up charging those people with offenses that they've committed when clearly they've-, When they've committed [the crime] they've actually [haven't] been in their right mind (Dylan, 134-138).

'Finding a place' implies a physical location that has a discrete boundary. The 'community' was constructed as an inappropriate place to locate the 'cure' through statements that understood the community as a place where those with mental illness received little help

and often deteriorated in their ability to maintain good mental health. The predominant understanding constructed through such statements was that the 'streets' were a location where those with mental illness were 'kicked out' to through a lack of available institutional-style care. Consequently, those with mental illness are 'abandoned' by limitations in service provision and in effect are left to 'fend for themselves' without the skills, support or control mechanisms necessary to achieve successful living in the community. Therefore, they take up residence in 'no-man's land'.

I think, [we're] nowhere near like America, but you know it's sort of-, It seems to be just going that way a little bit type thing where, you know, that the people who are ill in our community aren't perhaps being looked after in an institution and getting the help that they need. They're just cut loose and out on the street (Dylan, 395-400).

I don't know whether there's any way they can be rehabilitated and kind of...being-, Start functioning normally. I mean, I guess that's the aim, but I think being back in the community's not really...benefiting them or everyone else (Thomas, 110-113).

Without access to a controlled institutional form of care, 'the cure' was understood as being an 'unobtainable ideal' because the 'top dog' mental illness is too powerful and the number of mentally ill on the streets is simply too great. Therefore, police are constrained in their ability to provide effective service and achieve satisfactory results for those with mental illness in comparison to their ability to do so when there were 'places' to go.

You see obviously a lot more homeless people type thing than we used to. We never used to have homeless people back in the early 90s because if somebody was, like, homeless we'd sort something out for them. So we'd tell them, you come with them straight "That's it" you know "You have to go and live somewhere" and we'd take them and someone would find somewhere, it would be one of the welfare agencies, and they'd put them somewhere and they'd have a home (Dylan, 362-368).

There was also an understanding produced in the text that the 'wandering mentally ill' are becoming more prevalent in current society because an increase in the number of psychiatric 'beds' needed by those with mental illness in the community outweighs the number of 'beds' available. As a result, there is an acceptance that many more mentally ill are living in communal spaces, but acceptance is limited to ignoring the particular behaviours that might be 'weird and wonderful'.

Anybody that was like going through rubbish bins in the old days we'd, you know, we'd be picking them up and taking them somewhere and getting them assessed and getting them sorted out. You know, we just didn't really allow that sort of thing to happen. Nowadays, there's so many people out there doing all sorts of weird and wonderful things that really, just, I mean, I think we have, and the public have, learned to just ignore it and just keep going and think that person's, you know, mentally ill, but that's fine that they're on the street (Dylan, 376-383).

The understanding that the 'cure' requires some form of control was also constructed through a sense of 'before' where the 'wanderers' were a social responsibility. With less

access to appropriate facilities, it seems the return to a more institutional-style care is reproduced. However, the desire for a return to controlled, institutional forms of providing a 'cure' does not mean a return to inhumane conditions of the past.

It's a hard one to talk about because I know all of the issues that were with those institutions that we had type thing and I remember taking people on several occasions out to [Name of mental health facility] doing transports out there and I put them in and thought "Fuck, this is a horrible place. I wouldn't want my worst enemy to be here. This is a really, really horrible place" and, you know, but at least it was a place for them and, you know, you relied on the people that were out there looking after them to be doing a good job (Dylan, 402-409).

I'm all for reducing the contact we have, but by the same token I don't believe that shutting mental patients away is maybe the best way to deal with it (Craig, 385-388).

The reproduction of institutional care is located differently, a place where there is control, supervision and expert guidance. When reflecting on the 'taking control' discourse, it seemingly constructs a new location for the provision of a 'cure' for mental illness which may be coined the 'community quasi-institution'. This discursive object was constructed through knowledge of the criticisms of the past and a need for contemporary treatment services now that are subjected to stringent and encompassing control through constant and concentrated surveillance and supervision. In this way, an understanding was produced that was both time in 'care' and control, achieved in the community through medication

Medicating the sickness

Because that's, I think, how some of us, or how I see them as, as being sick people who really just need some help, you know what I mean? It's pretty straight forward and they need someone to, they need, might need, to stay in [hospital mental health ward name] for a while. Might need to get their medication right before they can go out. But that's just an illness pretty much like the flu, but lasts a bit longer and you need some medication (Dylan, 543-549).

It seems to be just the best way to deal with it is with medication (Thomas, 85-86).

Mental illness was often constructed in the text as a medical sickness or disease. Indeed, Parker (2004) draws attention to the way in which the very term mental *illness* encourages understanding the deviation from mental 'normality' as a sickness that has specific symptoms and therefore, through a medical discourse, would logically have a 'cure'. This 'sickness' produces a separate, defined category for those with mental illness in which to occupy and, as discussed in the '(un)identifiable other' discourses, this production and consequent insertion of the individual into an identifiable 'category' of 'illness' enables action and resolution on the part of service providers.

As in the 'taking control' discourse, this 'sickness' is beyond the individuals control. It is something they are subjected to through a 'failing' of their physical body. This 'failing' of their body overpowers their ability to conduct their behaviour within established 'norms' and separates those with mental illness from the 'normal' healthy population.

They understand that this person's sick and they're, for want of a better term, mad not bad (Dylan, 52-54).

Through constructing the mentally ill as 'mad not bad' in light of their 'sickness', responsibility for their actions and behaviour is removed from the individual (and consequently the criminal justice system) and located instead as a product of their illness, they are not in control of their behaviour. Control over the illness is achieved through the medicalisation of the problem

A shift from institutionalisation to medical discourse shifts the location of the cure, however the problem is still regarded as complex.

I used to think it was people who are incapable of looking after themselves, of making decisions around their own lives, but I now view it more as a medical problem...and probably a difficult medical problem because the mind is such a difficult thing and I always remember saying actually that if our brains were so simple we could understand them, we'd be so simple we couldn't and, to me, that's what it's like (Craig, 292-298).

They are complex people with complex problems I suppose (Jarrod, 551-552).

A common understanding echoing through most of the analyses in the current study is that negotiating the boundaries between their own limits and those of the mental health system is sometimes problematic for the police, especially where there is a clear need for

specialist knowledge to produce the cure. What was identified was the idea that police might benefit from how to interact with those suffering from mental illness rather than learning more about the illness itself on their side of the boundary.

I don't believe in putting [people] into a silo. There's already enough specialised areas in police. I think by having these silo type positions then you reduce the skill-base of the police force, not increase it. I think it's very unlikely that 2 people or 4 people are going to be able to respond on a 24 hour basis, so I think your best bet and your best service would come from police officers having that bit of training that's required to think a bit outside the square. Like, it's how you should deal with mental health rather than trying to look at what they've got. Like, if they're presenting with symptoms, they're probably suffering from a mental illness or depression or such-and-such [and we should] be more open-minded in the way we approach things – that kind of training rather than a silo thing (Christine, 277-286).

However, the dominance of medical discourse in how mental disorder is implicated in understanding possible service provision for those with mental illness appeals to constructions of 'expert knowledge' and the division of 'domains' through which to guide the provision of service by various agencies.

Because the medical model for constructing how one thinks about illness, health and disorder focuses and emphasises the individual's physiology, it necessarily follows that the 'cure' must lie in treating the physical body, in particular through medication.

There's heaps of them that can be on medication and be fine and everyone might have their moment where they do have a flip out or whatever (Jane, 83-85).

In the 'medicating the sickness' discourse, those with mental illness are constructed as returned to a 'normal' state of functioning through medication. It is important to note, though, that this return to 'normality' was not constructed as being a 'cure' for mental illness itself, but rather a 'cure' for mentally ill *behaviour*. The dominant understanding in this discourse is that mental illness is part of the physical body and although the effects of it may be 'removed' through medication, the mental illness itself endures. In effect, it lays dormant and can resurface if the individual stops taking their medication.

Medication [is] just a band-aid effect. It's just covering (Thomas, 258).

Therefore, what is produced is a mistrust of the medicalisation of mental illness to effectively provide a 'cure' for the problem of mental illness in the community. While medical institutions can offer a temporary relief of the symptomatic presentations of mentally ill behaviour, here there is the assumption that it does not address the core underlying issue of the 'origin' of mental illness itself.

The effect of constructing mental illness as enduring and therefore requiring constant control, here through medication, is to position psychological medicine as a modern institution. Where traditional institutions operated upon the individual externally, through service providers practising control and supervision from a specific spatial location, the

'medical institution' operates at the site of the individual through medicine-taking behaviour controlled in a large part by the individual themselves. Both are technologies of control and operate in a similar manner – the changing of behaviour through enforced management over the individual – however the 'invisible' and self-directed nature of the 'medical institution' encourages the understanding that it is a significantly more socially acceptable form of control than that of traditional institutions. It appears to offer freedom and power to the individual with mental illness, but its underlying assumptions of enforced management, control and modification of the 'self' remain the same.

Despite constructions of control through the medication of the individual's 'mental illness', and that those with mental illness 'lack control', many statements also positioned the mentally ill as 'in control' of their medicine-taking behaviour. Here those with mental illness are responsible for complying with medication.

Sometimes they've just simply come off their medication. It generally doesn't seem to be too hard to find out what's caused it. Sometimes they'll be up-front telling you, like, you know, "I've stopped taking medication. Don't need it anymore" (Thomas, 51-54).

While they're medicated and basically looked after they're fine, but when they're unsupervised and they decide that they're well again and they don't need any medication that's when we get involved (Thomas, 77-80).

This contradiction of the 'possession' of control by those with mental illness offers a competing discourse to the control and subject positions produced elsewhere in the text because in these statements the individual with mental illness is very much 'in control' of their actions. As Parker et al. (1995) note, the internalisation of mental illness enabled the removal of the responsibility for the treatment of mental illness from others to the location of the individual. This makes it possible for faults or failings in the provision of mental health treatment to be placed upon the individual instead of examining the systems of service provision and the role of the community that may have prevented good mental health outcomes. So while at odds with other statements regarding 'control', they produce and support the dominant assumption in the construction of the 'cure' that those with mental illness need to be controlled, supervised and monitored in some form because left to their own devices they can potentially make unhealthy decisions and reactivate the threat of mental illness in the community.

The dormant threat of mental illness was further emphasised through statements describing what possible events can happen when one decides to discontinue taking their medication. Here, the mental illness can quickly 'spring back to life' and cause the individual to behave in an inappropriate manner, sometimes dangerously.

If people are medicated, who have issues, and they're medicated properly then you don't know. It's only when either the medication fails or something tips them over the edge that they come to our attention (Nathan, 213-216).

If he's not properly medicated then he just becomes violent (Jarrod, 255-256).

Mostly it's people that their medications gone-, It's no longer working or their not taking it and they're having episodes at that time and that might be anything from just wandering the streets to actually making threats to people or verbalising whatever thoughts they may be having (Craig, 7-11).

Therefore, control as constructed within 'medicating the sickness' is insidious and encompassing because it needs to be long-term or even permanent in order to adequately address the threat posed to the community. Ironically, 'medicating the sickness' as a 'cure' for the symptoms of mental illness actually produces the understanding that there is no cure at all. It constructs mental illness as incurable, that one must always take medication, even as a band-aid, to prevent the illness from its inevitable resurgence and disruption on the lives of those with mental illness and those around them. This construction, in effect, necessitates compliance to the institutional practices of medicine in order to live successfully in the community. Here, the ability to refuse medication and choose one's own treatment is constrained through the understanding that to take such action would mean the inevitable resurgence of the 'danger' of mental illness and the necessity of policing.

Although medication was constructed as a 'cure' for the symptoms of mental illness in order to enable healthy living in the community, where the continuous uptake of medication was breached, and the effects required policing, then institutional care outside the community was understood as the solution.

If somebody requires that daily supervision to make sure they stay on medication, then being in the community isn't the place for them (Matthew, 226-228).

Here, medication is a symbol for 'out of control' mental illness, which positions the mentally ill as 'too sick' to be living in the community and instead requires the supervision and control offered in secure mental health care facilities. This understanding, where those with mental illness can only live successfully in the community when medicated, relocates medication as a new form of institutional control. In this way, the mentally ill 'other' is positioned as either 'compliant' or 'dangerous'.

Where the police understand mental illness as a medical problem, locations are produced at which they can make sense of the 'developmental' sites of intervention where both environmental and physiological conditions merge.

They can overdose on drugs or take a lot of drugs at a young age, alcohol and, you know, those things to-, Obviously does affect the brain and probably when they're younger too if they're abused or whatever, then they're growing up-, Solvents and stuff like that can lead them down the track of suicides and, you know, depression, mental health issues (Thomas, 88-83).

This understanding enables police to identify points in a pattern of behaviour where they can be proactive in the provision of services for the mentally ill. However, despite the 'medicating the sickness' discourse enabling increased points of access for police to intervene in the development of mental illness, it also produced barriers for delivering the 'cure' in a practical, present-day manner. A medicalised construction of mental illness has the 'side-effect' of producing categories, criteria for diagnoses and lists of symptoms that in effect limit the ability of service providers to deliver treatment and assistance. As discussed

in the '(un)identifiable other' and 'no-man's land' discourses, the understanding that individuals must meet certain criteria and benchmarks of 'illness' produces the power to deny access to services based on 'unticked boxes' and in turn a reliance on a medical system that does not have the resources to accommodate all those who need their services.

We've been informed in the past that how mad you need to be not to go to hospital depends on how many beds are available at the time so if there's no beds available at the time.... (Dylan, 122-125).

A difference in the understanding of diagnostic categories between police and crisis services was produced in the text through a split between 'disorder' and 'behaviour', that located responsibility for 'behaviour' in the criminal justice sector. From a police vantage point, the distinction was not necessarily clear.

The crisis team come down and said "No, he's ok as far as we're concerned. We're not going to take him away" that type of thing. "It's a behavioural issue or-", you know. We honestly don't understand behavioural issues compared with being mad because to us it's just a big problem (Dylan, 128-132).

When we've got them calm and sitting in a police cell it's quite different to when we arrived and they were, you know, ripping up their home or hurting their family or whatever, you know. So, when we've had the experience of seeing them acting out all these problems and then we come back here and we're told "No they're fine" or

"It's a behavioural problem"-, We often get told it's a behavioural thing rather than a mental illness thing (Jarrod, 44-50).

Such a 'separation' of the boundaries between 'disorder' and 'behaviour' reproduces the mental asylum in a new form. If the individual is able to be identified and positioned in a 'pure' category of 'disorder', control and management of the subject can be enforced through mental health services. If the individual cannot be categorised in a 'disordered' position, then their 'behaviour' is located within the responsibility of the police and the institutional practices of the criminal justice system are utilised for control over the mentally ill subject. This split between 'disorder' and 'behaviour' produces a significant position in the service provision for those with mental illness in the community that is best suited to police practices, the enforcement of control and 'order' over community members. It *assumes* a shared understanding that police are an appropriate and effective agency to provide assistance and 'control' for those with mental illness without questioning whether such a re-institutionalisation of the mentally ill is acceptable in light of best practice outcomes. As has been seen throughout the analyses, such assumptions produce tension and frustration for police officers who *do* understand how they can best serve those with mental illness, are confident in the quality of the services they do provide where deemed appropriate, and are aware of the gaps produced in service provision through the fragmented and uncoordinated network of relationships involved in the community care for those with mental illness.

DISCUSSION

The collaborative relationships involved in the service provision for those with mental illness in the community produce a complex network of systemic and institutional practices that are at times integrative and problem-solving and at others complicated and constraining. These relationships are formed through multiple systems of meanings and structural practices that affect the way in which the various service providers can interact and react with each other and those who suffer the effects of mental illness in their daily lives. The shift in focus from institutional-based mental health care to a collaborative community model of service provision has produced relationships between various agencies and populations that reflect the complexity and multifaceted nature of community living itself. Although not commonly understood as a 'mental health service provider', with New Zealand's focus on community policing there is no doubt that the position of police in this network of agencies dedicated to providing support and assistance to the mentally ill is firmly established. This position in a system of service providers requires police to consider how their duties to protect the safety of the community, establish and maintain law and order and enforce control can also incorporate the more therapeutic elements that interactions with the mentally ill require (Watson et al., 2008). Policing the mentally ill locates police officers at the intersection between two distinct, yet related institutions – mental health and the criminal justice system – and the current research sought to explore this junction in light of the recent deinstitutionalisation movement for how relationships were experienced and understood and how they both enabled and constrained police practices with the mentally ill in the community.

The police are often the first service provider to respond to crisis situations in the community and therefore would have material knowledge of the systems and practices of relationships involved in the service provision for those with mental illness (Vermette et al., 2005; Wylie & Wilson, 1990). Indeed, it was clear from the data generated during interviews that officers understood the significance of the proposed research, engaged with this study and had extensive knowledge to share. Interviewing police officers enabled access to a particular vantage point to make sense of the relationships involved in policing the mentally ill, one that previous literature suggested was often burdened with a difficult and frustrating 'role' to play in the provision of services to those with mental illness in the community (Cotton, 2004; Fry et al., 2002; Rowe, 2001; Sellers et al., 2005; Watson et al., 2005; Wells & Schafer, 2006) and also one that, by nature of the institutional practices that dominate current culture, had a 'frontline' position in the aftermath of the deinstitutionalisation movement (Plowman, 2006; Wylie & Wilson, 1990).

As mentioned when discussing data collection in the current research, there were concerns that at times 'access' to police officer knowledge may have been constrained by institutional understandings of a 'police officer role'. Participants may have censored themselves through awareness of the institutional constraints on what could be said due to the highly public and scrutinised position of the police force in New Zealand culture, but it is this precise position that this research seeks to understand. The strength of employing the methodology of discourse analysis is the embracing of multiple meanings and vantage points from which to understand and make sense of experiences (Coombes & Te Hiwi, 2007; Parker & Burman, 1993; Willig, 1999). It was never the intention of the researcher to 'reveal' how police officers personally 'think' and 'feel' about policing the mentally ill – this approach can limit an exploration of the deeper processes and understandings of the

system of service provision for those with mental illness. Instead, what discourse analysis facilitated in the current study was an examination of experiences and understandings of 'police officers' in their 'role' in the practice of the relationships involved in interactions with the mentally ill. Far from being 'constrained' by the limits of what officers can say, the research was *informed by them* because that is the 'reality' of policing –police officers 'do' policing through particular institutional constraints, techniques and procedures which both produce and re-produce understandings of their experiences and practices.

The legitimising of the police voice in research concerning community service provision for those with mental illness was noted by Police News Editor Steve Plowman (2006) when he argued that "if the systemic failures of the past are not to be repeated, perhaps an acknowledgement of the work that police do in providing that much needed 'ambulance at the bottom of the cliff' would be a good place to start" (p. 117). Inspired by this statement, the current research sought to explore police officer understandings of the network of relationships involved in policing the mentally ill, paying attention to the ways in which police were positioned in these relationships, how police practices were enabled or constrained within these power relationships and how this affected their everyday practices. In an attempt to address these questions, the various discourses and subsequent analyses were separated into five distinct metaphorical systems of meaning making: links in the chain; the (un) identifiable other; no-man's land; underdogs; and the cure. However, *together* they co-articulate a movement of understanding for the police officers experiences and the following discussion utilises the various discourses to produce a coherent system of understanding 'policing the mentally ill'.

From the vantage point of the police, the 'ideal' construction of relationships involved in policing the mentally ill is a 'chain' of service provision through which various positions to adopt were produced. The requirements of each position in this chain corresponded to various agencies domains of expertise and the interconnections among the links prevented 'gaps' between service providers from occurring. Each service provider in the community joins the chain of service provision at the appropriate location and relieves the previous 'link' from their position in the chain.

The police understood the most appropriate position for their services to be located in the 'first link'. In this position, understandings of 'policing the mentally ill' were the initial response to crisis, assessment of the particular requirements of the situation and then referral to mental health agencies if appropriate. Given that the domain of expertise of the police is understood through criminal justice practices, the 'first link' position enabled the officers to stay within the boundaries of their training, which was noted in the introduction as being guided by legal discourses concerning the enforcement of government policy and legislation (Hancock, personal communication, March 2008), whilst also adhering to understandings of the relationship between the police force and mental health services as guided by the Memorandum of Understanding (New Zealand Police and the Ministry of Health, 2000) that locates police at the boundaries of specialised mental health care in New Zealand. However, as is realised in the text, the boundaries are not always that clear and police practices often relocate them in the centre of mental health service provision as the "ambulance at the bottom of the cliff" (Plowman, 2006, p. 114)

Constructing 'policing the mentally ill' through legal discourse produced boundaries between criminal justice practices and those of psychological services and therefore emphasised the contrasting specialist skills required by the differing domains.

Constructions of mental illness produced through 'the cure' discourse implied it was a complex area of expertise, often depending on the medicalisation of categories and 'disorder', and requiring extensive training, which serves to reinforce the understanding that a 'chain' of service provision is the logical and necessary manner in which to maximise specialised skill sets and minimise resource wastage through the collaboration and integration of services for the mentally ill in the community.

Understanding the 'appropriate' position of police as the 'first link' had material effects on how police experienced interactions with the mentally ill in the community. Given that 'first link' duties were understood through the institutional practices of the criminal justice system, any response from this position will predominantly be constituted through practices of maintenance and enforcement of control. This remains unproblematic when working relationships between partner agencies reinforce the construction of the 'chain'. However, tensions are produced when police are positioned in alternative locations in the 'chain' that require more therapeutic delivery of services, such as the mediatory responsibility of holding the mentally ill in police cells or having to resolve the presenting situation if access to other services is constrained. Here, the conceptualisation of various 'appropriate positions' serves to produce frustrations when police are required to perform duties in conflict with their understandings of 'policing'. Public pressure on the police to adopt any position in the chain of service provision regardless of their domain of expertise combines with police's own understandings of their 'police identity', to locate the police in a position where they have a 'duty' to provide service, but understand their specialist

expertise to be inadequate to best address the problem and serve the interest of those with mental illness and the community in which they live.

Although the constructing of positions to adopt relevant to appropriate specialist skills is useful for the police to make sense of how best they can serve those with mental illness in the community, it also places them in a position of reliance on their partner agencies. If 'experts' in the domain are unavailable to assist, police are unsupported in the delivery of service, the 'chain' breaks and 'gaps' in the provision of community care form. As noted in the introduction, the large workload of those in mental health services often result in lengthy delays or refusal to respond (Plowman, 2006). Until police can connect with mental health personnel, they are constrained in their ability to proceed further towards resolution of the mental health situation whilst remaining within their specialisation. Furthermore, the issues in information sharing systems can hinder police abilities to identify and therefore connect the mentally ill subject to appropriate agencies. As noted in previous research (Lamb et al., 2002; Teplin, 2000), in situations where the presence of mental illness may be ambiguous, the label of 'dangerous' becomes attached to the mentally ill subject and the proceeding possibilities of action revolve around criminal justice procedures, reproducing the mentally ill as dangerous. Furthermore, if mental illness is not identified, and therefore intervention is not supplied, a 'revolving door' effect situates the police as the repeated response to a mental health problem that is beyond their expertise to resolve satisfactorily and it is in this position that the two binaries of 'criminal' and 'disordered' are reproduced in an attempt to address the tension this 'revolving door' creates.

The construction of collaborative relationships between service providers as a chain introduces the potential for this chain to become 'blocked' or 'broken'. Here, the distinct domains and need for specialisation that enabled the police to adopt an 'ideal' and appropriate position in the delivery of services for the mentally ill now produces barriers for effective service provision through the gaps formed by fragmented and uncoordinated relationships between community agencies. The legislation and policy that constitute police practices prevents the successful delivery of services by serving to demarcate the service providers and produce locations at which the chain is able to be broken. As in previous research (Lamb & Weinberger, 2005; Lurigio & Fallon, 2007; Rock, 2001; Teplin, 2000) barriers to access for coordinated services are produced through policies relating to admission criteria, as well as legislative practices that constrain open information sharing systems through a forced separation between service providers that emerged from the current text. The legislative demarcation and specialisation between community agencies constrains the ability of the various service providers to be flexible enough to incorporate dual-diagnostic constructions of practices that have been noted to be vital for community care (Mental Health Commission, 2005) and therefore police remain at the bottom of the cliff as they continue to fill the gaps created when individuals are in crisis, but cannot be accommodated by an appropriate specialisation.

The understandings produced in 'the cure' regarding the complex, chronic and to some degree 'incurable' nature of mental illness may have contributed to the legislative and policy barriers in service provision through a tension between the need for government agencies to demonstrate accountability and effectiveness in order to secure government support and funding and the difficulty that 'classification' of mental illness poses to achieving such outcomes. The dominance of market-based discourses in guiding the

organisation of governmental resources and services (Welton et al., 1997) may place pressure on agencies to employ a 'separateness' and 'narrow' field of service in order to retain access to funding and resources. However, this may not serve in the interests of best practice outcomes for the mentally ill in the community or for the police who are an agency who cannot refuse to 'admit' individuals into their services and therefore whose resources become strained as a product of responding to those who cannot gain access to other service providers.

Although a focus on funding and resources was a dominant concern within the text, echoing common criticisms of deinstitutionalisation and police resources in previous literature (Bennie, 1993; Cotton, 2004; Fry et al., 2002; Kearns & Joseph, 2000; Mason, 1988; Mental Health Commission, 2005; Plowman, 2006; Rowe, 2001; Watson et al., 2005; Wells & Schafer, 2006), understandings of strained resources also enabled the emergence of the 'underdog' discourse, which was essential in the establishment of productive working relationships between partner agencies in the community. Ironically, the 'underdog' discourse was produced through the lack of support in the collaborative inter-agency effort to address mental health service provision in the community, constituting police as constrained in their ability to 'police the mentally ill', yet the construction of 'underdogs' produced a valuable tool for connecting with various agencies through shared understandings of frustrations, concerns, limitations and goals in the practice of the delivery of services to those with mental illness. The 'underdog' discourse served to demarcate the boundaries between agencies to some degree, thereby enabling a negotiation of legislative barriers and information sharing processes not otherwise available. The method of 're-joining' working relationships between service providers through the development of personal relationships enabled 'breaks in the chain' to be

mended and reconnected, and re-introduced other agencies into the 'chain' of service provision that had 'dissolved' previously.

The shift in resources, power and the ability to problem-solve produced through the 'underdogs stick together' discourse could have potential implications for current service provision. Focussing energy towards developing personal, interactional relationships between service providers may serve to ease personal frustrations and reduce the burden upon bureaucratic practices through the strengthening of problem-solving relationships not constrained by the need to navigate legislative boundaries and barriers. The involvement of alternative community resources such as NGOs and consumer-led support groups could further enable a strong, productive and collaborative network to be established that reduces or fills the gaps between service providers.

The locations where gaps between service provision may occur were able to be identified through the 'links in the chain' discourse by examining the 'broken or blocked links', therefore indicating where services could be improved to address the concerns police understood as present within current practices. Connections between the first and second link (availability of, and access to mental health services) and the last link (the provision of supportive, managed community care) were identified as areas that may need to be strengthened in order to improve the policing of the mentally ill. From a police vantage point, if an individual defies 'categorisation' and is positioned as 'unserviceable', they are forced to occupy 'no-man's land' with the only available responding service provider being the criminal justice system. Therefore, strengthening the integrative coordination between agencies and the availability of alternative services to a police response can reduce gaps in

service provision while maximising the various specialist skills of each service provider. If service provision is conceptualised more as a 'net' than several distinct points of service, then the police may find it less problematic to contribute their services without needing to extend far beyond their confidence or domain of expertise due to the understanding there are options and support present in the community that they can collaborate with to assist their efforts.

However, a retention of particular 'specialised' understandings of service provision may perpetuate dominant systems of meaning within the differing institutions that can serve to constrain the material practices of service provision for those with mental illness in the community. Police understandings of how best they can meet the needs of community members are constituted through legal definitions and technologies of control dominant in criminal justice system practices. Police are trained to attend to issues of risk, threat and danger present in the situations they attend to (Bell & Brookbanks, 2005; Pinfold et al., 2003). With historical discourses producing a relationship between 'madness' and 'danger' (Hook, 2007; Parker et al., 1995) and discursive constructions of mental illness in the text as 'out of control', it makes sense that police would construct the 'mentally ill subject' as a risk to safety on initial encounter. The '(un) identifiable other' discourses reinforced such meanings of mental illness through the understanding that the 'disordered' subject must be identified in order aid risk-analysis due to the perceived unpredictability and dangerousness associated with incidents involving the mentally ill. 'Threat' requires a police response of order maintenance in the community through control, and therefore the construction of the 'dangerous other' necessitates the police to utilise the institutional practices of the criminal justice system to best respond to this 'threat' in the community. Furthermore, through medical discourses the mentally ill subject was understood to either

be too sick to function without medication and therefore was positioned as 'compliant' to the institution of medicine, or 'dangerous' if demonstrating freedom of choice over treatment options. Neither position offers understandings of community 'care' that is not associated with a level of risk or threat present and therefore requires an institutional response.

However, as noted in the analyses, constructions of the 'mentally ill subject' do not exclusively position those with mental illness as 'dangerous'. The 'sad' and 'bad' mentally ill subject positions produced in 'the cure' discourse combine with understandings in the text of the nature of barriers to accessing services to enable the police variation in how they position the individual with mental illness depending on the intricacies of the presenting situation. The position of 'sad' was useful when the police understood the individual could be accommodated by the legislative and policy requirements for entry into mental health services. The position of 'bad' enabled the police to remain within their domain of expertise to resolve a situation if they believed mental health services would not respond and where the 'problem' was understood as 'behavioural' (Fisher et al., 2006).

Criminalisation of mental illness was further supported by the split between 'disorder' (a psychological concern) and 'behaviour' (a criminal justice concern), as produced in 'the cure' discourse. While the ability to position the individual within different domains of expertise was a useful problem-solving tool for the police, the officers were very aware of this process and understood that it had the potential to produce distress for those with mental illness. However, due to institutional and legislative constraints, it became necessary for the police to either follow criminal justice practices or leave the individual in the situation that caused the crisis in the first place with no support, therefore reproducing the potential for a 'revolving door'.

Furthermore, institutional responses are encouraged through the construction of the community as an unhealthy and undesirable location for those with mental illness. 'The cure' discourse constituted the community as a detrimental location for those with mental illness because they were often unable to navigate and negotiate 'normal' daily living unproblematically. The 'mentally ill subject', as noted in historical discourses (N. Rose, 1996), are constrained in their ability to situate themselves within the norms of society and police are the agency responsible for upholding and enforcing society's norms, suggesting a police response to the mentally ill in the community is necessary and appropriate.

The emphasis on institutional responses to the problem of mental health service provision within the text may be a 'hangover' effect from the institutional era. This was suggested through understandings concerning causes of 'breaks' in the chain of service provision often resulting from a lack of secure and controlled mental health care facilities present in the community within which to 'house' the 'disordered mentally ill subject'. Inadequacies in current service provision were often attributable to a 'missing location' that lay beyond the current service providers and agencies, reproducing institutional understandings of the 'cure' for mental illness in the community. The police station and prison were understood as inhumane and unhealthy institutions to 'place' the mentally ill in, yet the community was too unstructured and unsecure to meet the safety needs of both those with mental illness and the community. Furthermore, the medical institution was understood as inadequate to provide the 'cure' for mental illness. Medication was often referred to as a 'band-aid' and one that could easily be removed by the individual due to the 'lack of control' they possessed over their own illness and behaviour. The centrality of 'control' as the response to mental illness therefore produced the need for this 'missing location' for the mentally ill that can provide control, structure and management for the benefit of both

the individual and the public. Deinstitutionalisation removed such 'concrete' mechanisms of service provision, but it did not change the desire for such control.

Given that police are positioned at the interface between psychology and the criminal justice system when policing the mentally ill, respect must be given to the fluidity they demonstrate when confronting the challenges produced by a care system that is struggling to provide coordinated services for those with mental illness in the community.

Institutional understandings dominate how police make sense of community care, both through the criminal justice practices of control and the institution of mental health medicalising the 'mentally ill subject'. These two institutions combine at the location of 'policing the mentally ill' to produce a re-institutionalisation of those with mental illness through technologies of power and control. The police can offer a culturally sanctioned response to services that are institutionally understood without a solid 'institution' within which to address the problem, but in doing so they necessarily adopt the position of the ambulance at the bottom of the cliff.

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Appendix A: Information Sheet

Policing the mentally ill: A discourse analysis

INFORMATION SHEET

The Researcher

My name is Stephanie Denne. I am a part-time student at the Palmerston North campus of Massey University and am in my final year for my Master of Arts degree in Psychology. I am undertaking this research project for my master's thesis, which is being supervised by Dr Leigh Coombes from the school of psychology at Massey University.

The Research

The research aims to explore the collaborative and problem-solving relationships involving policing the mentally ill. It will seek to identify and support successful practices as well as identifying any issues officers may have surrounding interactions with the mentally ill, alongside any ideas or beliefs as to how those issues may be addressed.

Officers involved in frontline duties in the Manawatu/ Central Districts region are invited to volunteer to participate in this study. It is estimated that 6 to 10 officers will be required for this study. All efforts will be made to include a larger number if more officers volunteer than needed. However, if the number is too large the sample will be selected from those who volunteered first.

It will involve individual face-to-face interviews lasting approximately one to two hours. Full consideration will be given to your time and resources, and every step will be taken to ensure being part of this research causes as little disruption to your time as possible. Interviews will take place outside of work hours, with possible interview venues being Massey University Campus or your own home. During the interview you will be asked questions about your experiences, beliefs and ideas involving interactions with the mentally ill.

I will then transcribe the interviews into written form for an analysis of common themes and ideas. You will be able to examine these transcriptions for comment or correction. This research will be conducted and reported with the goal of advancing psychological knowledge surrounding the area of policing the mentally ill. On completion of the study you will be given a summary of the results.

It is not anticipated that any discomfort or harm will result from your participation. However, if you should have concerns prior or during the research process they will be handled with urgency and respect.

All efforts will be made to keep your participation in this research confidential. Fictitious names will be given and identifying material collected during the process of the interviews will be removed or altered in the transcription process. I will be the only person who has access to the interview transcripts and when writing the final report I will not include any identifying material. However, it is impossible to guarantee absolute confidentiality given the small and local nature of this research and this must be taken into consideration before

agreeing to participate. All data collected will be stored in a secure location, accessible only to me and the research supervisor. After 5 years, all data collected for this research will be securely destroyed.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any point during the research process;
- ask questions concerning the study at any time during participation;
- provide information on the understanding that your name will not be used, that no-one but the supervisor and myself will have access to this information and that the information gathered will not be used for any other purposes other than the research outlined above;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

If you are willing to participate, or have any questions or queries regarding this research please contact me via phone or email.

Contact details

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Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 09/11. If you have any concerns about the conduct of this research, please contact Dr Karl Pajo, Chair, Massey University Human Ethics Committee: Southern B, telephone 04 801 5799 x 6929, email humanethicsouthb@massey.ac.nz

Appendix B: Participant Consent Form

Policing the mentally ill: A discourse analysis

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: Date:

Full Name - printed

Appendix C: Interview Questions

Policing the mentally ill: A discourse analysis

INTERVIEW QUESTIONS

Please note, not all questions will necessarily be asked as the interviews will be semi-structured. These questions will be utilised if the naturally flow of conversation does not cover the topics raised by the following questions.

- Describe your experiences with the mentally ill in the community.
- How does responding to callouts involving the mentally ill make you feel?
- What are your thoughts regarding deinstitutionalisation?
- What kind of pressure/s do you feel when responding to callouts involving the mentally ill?
- What do you believe the ideal course of action would be regarding callouts with the mentally ill, and how does this relate to what actually happens on a routine basis?
- Describe your experiences with the mental health/crisis system when dealing with the mentally ill.
- Discuss the parens patriae/protect and serve interaction when dealing with callouts regarding the mentally ill.
- What do you believe is your role in the service of the mentally ill and what do you believe should be your role (if different)?
- What are your views on the mental health system as it currently operates?
- What are your thoughts regarding mental illness?
- How would you describe your knowledge and training on mental health issues?
- What issues are raised regarding interactions with the mentally ill in the context of your work?
- How have your work experiences affected your attitudes and thoughts regarding mental illness?
- Describe the impact you believe interactions with the mentally ill have on job-satisfaction and you personally.
- How do you believe services could be improved in regards to responding to callouts involving the mentally ill?

Appendix D: Authority for the Release of Transcripts

Policing the mentally ill: A discourse analysis

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

This form will be held for a period of five (5) years

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me.

I agree that the edited transcript and extracts from this may be used by the researcher, Stephanie Denne, in reports and publications arising from the research.

Signature:

Date:

Full Name - printed