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Governing through care: A qualitative assessment of team play between police and nurses for people with mental illness

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ABSTRACT

The nexus between law enforcement and public health represents a new and emerging policy field. Yet, most scholarly work has been devoted to police attitudes and interventions involving people affected by mental illness. This paper draws attention to a law enforcement – public health partnership in Amsterdam, the capital city of the Netherlands. We present a qualitative study based on interviews and some observations. Three major themes emerged from our fieldwork that involved policy makers, community police officers, and district nurses: how these officers and nurses perceive the problem of disorderly and confused people, how they work together in practice, and how they relate to a wider network of many other players. We argue that community police officers and district nurses have developed a kind of informal 'team play' consisting of three steps: receiving and analysing a signal, undertaking action, and providing aftercare. These steps offer a preventative approach aimed at avoiding and forestalling crisis situations. Difficulties arise in terms of tracing so-called 'care avoiders' (people who do not present a 'readiness for treatment'), hampered information exchange, and the governance of partners beyond our respondents' own organisations. In particular, we argue that today's society is not only governed through crime, but also through care. There is no such thing as a robust 'punitive complex' in which policing and criminal justice logics prevail. Rather, we witness a multi-agency network of police, public health, mental health, youth care housing associations and other nodal actors, each with their own bureaucratic logics and working methods tending to clash with, or even undermine, informal team play on the streets.

1. Introduction

As is the case with homeless and intoxicated people, much police attention has been directed to persons affected by mental illness who increasingly drain street patrols away from other priorities. Although psychiatric disorder does not usually involve major crime or (gun) violence (see Swanson, McGinty, Fazel, & Mays, 2015 for a study in the US), the Dutch police claim that what they code as 'E-33 incidents' – disorder arising from 'confused', 'disturbing', or 'erratic' behaviour – went up, nationwide, from 40,000 to more than 65,000 between 2011 and 2015 (Politie, 2018). Translated in terms of police time, patrol officers in the Netherlands now spend around 20% of their working hours on, for example, elderly people with dementia, disorderly youth, multi-problem families and so-called 'care avoiders', "who do not engage in services, but are perceived by social workers as in 'need' of some kind of intervention" (Maesseele, Bouverne-De Bie, & Roose, 2013, p. 621). Problems may vary widely, but all centre around the label of mental illness or, at least, mental instability.

The Dutch police are especially concerned about the problem of emergency apprehension: the need to take a person into custody when he or she is likely to harm them self or poses an immediate threat to their direct social environment. As Bittner had already observed by the late 1960s, patrol officers are quite reluctant to apprehend persons with mental illness, transport them to hospital, or even put them in police detention when other options have failed. They generally disavow competence in dealing with psychiatric problems and think that restraining disoriented people is not their task, because taking such people from the street is a "civil rather than a criminal matter" (Bittner, 1967, p. 281). In other words: the police strongly believe that people suffering from mental disorders and causing trouble to their fellow-citizens should first and foremost be dealt with by social workers and psychiatrists.

Similar to the US and the UK, police concerns in the Netherlands arise from 'an age of austerity' (Innes, 2010), specifically budget cuts on welfare arrangements, including plans to downsize the numbers of psychiatric hospital beds (Knispel, Hulsbosch, & Van Hoof, 2015), and the 'responsibilisation' of citizens (Ilcan & Basok, 2004) more generally. This political rhetoric has gained momentum in the Netherlands since the Dutch King announced a shift from the welfare state to a 'participatory society' (Hameleers & Vliegenthart, 2018) in which everybody

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who is able to should actively contribute to the 'common good' and take responsibility for their own life. In practice, psychiatric patients, elderly people with dementia and juveniles with mental health concerns should remain at home and in their neighbourhoods as long as possible, which increases the risk of serious disorder and public safety issues. In addition, Dutch housing associations, being private organisations with a social duty, have economised "on 'soft' goals such as tenants' quality of life or well-being" (Elsinga & Wassenberg, 2014, p. 37). The steady decline of, for example, residential caretakers and janitors may contribute to greater anonymity among neighbours, as a consequence of which problems with mentally confused people could remain unnoticed for longer.

Working in close collaboration with the public health service, the Dutch police "seek to move 'upstream' and bolster early intervention and re-intervention in furtherance of long-term stabilisation and recovery" (Wood & Beierschmitt, 2014, p. 440). The basic idea here is to implement a preventive approach to identify mental illness and confusion at an early stage, anticipate potential tragedies and assist 'problematic' people who fall outside a shrinking public safety net. Notwithstanding that policing and public health have highly divergent institutional roots, goals, perspectives, working-methods and cultures, both are engaged in discouraging risky and disturbing conduct on the part of people affected by mental illness, and this is where the two sectors connect: "it is often around the dangerous, injurious, unequal, traumatised, excluded social world that public health and policing find their intersection" (van Dijk & Crofts, 2017, p. 266). In 2015, therefore, the Amsterdam police force and public health service (*Geneeskundige Gezondheidsdienst*; GGD) initiated a joint pilot project with the goal of getting a better grip on the growing problem with people engaged in behaviour that leads to citizen calls for assistance. Recommendations were to reduce the number of repeating patients and repetitive crises, improve working agreements between police officers and health care professionals, and safeguard the continuation of public service provision through law enforcement, public health and mixes thereof.

This paper presents the findings of a follow-up study that looks in greater depth at the day-to-day collaboration between the police and district nurses in terms of 'team play' as both are typically involved in a street-level collaborative approach towards individuals with mental health issues. It is important here to distinguish between two types of police officers in the Netherlands: 'patrol officers' and 'community police officers'. The first are traditional beat officers who patrol in their cars and respond quickly to emergency calls, whereas the latter engage more closely with local inhabitants (they usually patrol on foot or by bike), have longer-term agendas and adopt a more socially-oriented stance towards citizens (cf. Lamin & Teboh, 2016; van Steden and Broekhuizen, 2015). We are primarily interested in the work of the second type of community police officers as they stay in direct contact with district nurses employed by the Amsterdam public health service. Consequently, our central research question focuses on how community police officers and district nurses practise team play within the context of a complex system where many other organisations deal with patients engaged in behaviour that people perceive as problematic. This line of inquiry is structured around the following sections: section 2 theorises on team play as an informal, improvisational way of working through bureaucratic systems and procedures. Section 3 further elaborates on the particularities of our research project, after which we present the empirical findings in section 4. Section 5 closes with conclusions and reflections on the results.

2. Team play

Not unlike other countries, the Netherlands has a multifaceted landscape of public health care, which often hampers coordination and collaboration between different professionals treating patients suffering from mental disorders. Patients may get lost in a fragmented system built around a variety of actors responsible for different parts of their treatment (cf. Elhauge, 2010). In response, researchers and practitioners have developed 'unified' or 'integrated' public health frameworks such as the 'cascade of care' models in the behavioural health and drug treatment worlds designed to guide patients across a series of steps ranging from preventing the harms associated with substance abuse to diagnoses, intervention, retention and, if possible, remission and recovery. These steps, in sequence, should "enhance outcomes through improved treatment program accreditation standards, data collection and reporting, and monitoring of key clinical targets" (Williams, Nunes, Bisaga, Levin, & Olfson, 2019, p. 7). Yet, low levels of information sharing between professionals, legal constraints, a lack of proper training for healthcare and police workforces, and the often-criminalised nature of mental health problems all form major challenges to an effective implementation of tailor-made interventions and to achieving better quality of life for patients (Socias, Volkow, & Wood, 2016). One promising solution to such challenges is the innovation of so-called care 'navigators' (Tierney, Wong, & Mahtani, 2019) who should, as central points of contact, informally guide persons with mental diseases and their families through patchworked health care systems.

Community police officers and district nurses resemble care 'navigators' specifically devoted to strengthening the interface between law enforcement and public health. Both types of professionals are examples of what is theoretically known as 'street-level' or 'frontline' workers vested with the task of solving local disorder problems and offering solutions before things escalate. According to Lipsky (1980), street-level workers have regular contact with sometimes unwilling citizens and possess discretionary power to make choices about when and how to act over the course of their public service delivery. Police officers and district nurses, in other words, enjoy a high degree of freedom in dealing with complex situations that cannot be fully scripted beforehand. Although they need to follow certain protocols, police officers still have room to manoeuvre in deciding whether to issue a warning or a sanction. And nurses, too, use discretion when performing (emergency) assessments of mentally confused persons.

In addition, street-level workers may try to develop certain routines in order to keep their 'clients' under control and be as efficient and effective as possible in the face of inadequate resources, an ever-expanding workload, ambiguous organisational goals and the pressure of performance measurement. However, as Tummers, Bekkers, Vink, and Musheno (2015) argue, it would be too cynical to conclude that street-level workers, such as community police officers and district nurses, primarily use their discretion to make their job easier and less demanding. They also sincerely try to discount their own interests, move towards (vulnerable) individuals, and offer them meaningful assistance, even under difficult, stressful and dangerous circumstances. Either way, street-level professionals play a major role in implementing policy, which makes it important to look at what they do. It is ultimately at this street level that decisions regarding patients affected by mental disturbances are taken.

Another, even less recognised, dimension of street-level work is the acquaintance of community police officers and district nurses with a large number of other agencies involved in local safety programs. When reflecting on the problem of mentally confused people, we may think, for example, of janitors employed by housing associations, general practitioners, psychiatrists, youth workers, and neighbourhood managers all of whom are on the front line. These 'nodal' actors ideally make up a larger network if they feel they share a common goal in terms of preventing disorder and helping vulnerable people. However, it is a major challenge to establish exactly how multifarious professionals can establish beneficial cooperation in volatile and agile network settings (Burris, 2006; van Steden, 2018; Wood & Shearing, 2007). Depending on the problem at hand, community police officers and district nurses constantly negotiate with others about who should take which position and be responsible for what. It is thus important not to study street-level workers in splendid isolation, but to place their

activities within the larger context of interorganisational collaboration.

Where organisations constitute network intersects, the actors involved can be said to display a type of 'team play' (Boutellier & van Steden, 2011), defined as an informal and improvisational way of influencing the agile and creative delivery of public services – i.e. policing and (mental) health care – within the context of bureaucratic systems. As (Nix, Huber, Shapiro, & Pfeifle, 2016, p. 134) argue, "in the navigation team approach, each individual brings a unique set of skills to the table, while enabling a cost-efficient distribution of responsibilities". Since organisational networks do not automatically flourish, team play stresses the highly dynamic environment in which multi-agency collaboration takes place. This metaphor recognises the importance of cross-sectional assemblages on the streets, while acknowledging system-factor dynamics that may obstruct or run counter-productive to law enforcement-public health partnerships. The key query for all kinds of players, including community police officers and district nurses, is to determine who should take which positions within a 'nodal' or 'networked' governance field (van Steden, Wood, Shearing, & Boutellier, 2016). As such, team play, much similar to the improvisations of a jazz ensemble, derives particularly "from the force of the context, one that challenges players, listeners and all those caught up in its social field, to reevaluate the 'space' in which the conjoined activities of making music and community happen" (Fischlin cited in Cobussen, 2008, p. 54). Community police officers and district nurses have begun to consider this insight, but to date have done so in a rather unstructured fashion whereby the enrollment and alignment of third parties are central features of their approach.

3. The research project

3.1. Background

As touched upon above, in 2015, the Amsterdam police force and public health service (GGD) set up a pilot project to improve collaboration between community police officers and district nurses. Both types of professionals have a longer working relationship under auspices of the Care, Housing and Nuisance Hotline (*Meldpunt Zorg en Woonoverlast*; MZWO), charged with the task of managing cases of serious and continuous nuisance whether arising from complaints about noise or stench or concern expressed about (disorderly) residents who might need help. Our research project does not, therefore, introduce a new working method, but aims to better document an already existing cooperation between community police officers and district nurses within a bureaucratised nodal environment. The project's objective is twofold.

Firstly, the police and GGD seek to 'move upstream' – that is: they pursue early interventions before people affected by mental disturbances slip into downward spirals and start to cause problems at home and on the streets. The underlying policy logic is that the implementation of preventive measures decreases the influx of psychiatric patients into police and health care chains and lowers the numbers of crises interventions. The prevention and control of recidivism and the establishment of long-term recovery programs also fits this objective as 'repeaters' – or 'care avoiders' (people who do not present a 'readiness for treatment'; McMurran & Ward, 2010) – tend to swamp the system. Together with their network partners, including metal health and addiction care, youth care, social work, housing associations and others, community police officers and district nurses play an important role here.

Secondly, the police and GGD aspire to improve and intensify their joint cooperation, because not all community police officers and district nurses necessarily work together. Both types of professionals enjoy a high degree of autonomy when carrying out their work. Laws, standards and protocols remain important, but dealing with vulnerable and confused people often requires discretionary space and improvisation. As a result, the attention paid to psycho-social problems and the ways community police officers and district nurses deal with the mentally ill and disturbed may differ per city, borough and police district. Community police officers and district nurses also exchange a lot of information informally, which can potentially lead to a lack of transparency and insufficient feedback loops. Their informal, even personal, way of working is sometimes at odds with the more bureaucratic approach that MWZO, which is officially in charge of the case management process, adopts. Thus, there seems need for some standardisation and professionalisation, as too much informality can be harmful in terms of an equal distribution of public services and accountability.

3.2. Definition of 'people affected by mental illness'

The concept of 'people affected by mental illness' is an ambiguous one. In order to provide some clarification, the Dutch police and public health service use the following description: "a person affected by mental illness refers to someone of whom there is reasonable suspicion of a psychological disorder affecting his or her judgements and behaviour". Broadly speaking, this definition involves psychological instability, mentally impaired persons, dementia and other behavioural disorders occurring from psychiatric causes. We may think of psychiatric patients, confused older persons, people manifesting social anxiety, homeless people, people who use drugs, people in care institutions, people who do not initiate treatment, and people suffering from a somatic disorder (such as diabetes) that causes confusion and distress. Mentally ill or unstable persons usually fit into multiple categories at the same time, which makes it impossible to understand exactly what the problem is. Therefore, a national working group on people affected by mental illness restricts the definition of the problem to "persons who are at risk of losing control over their lives and, as a result, may cause harm to themselves or to others" (Aanjaagteam Verwarde Personen, 2016). Our research project is restricted to the aforementioned vulnerable people who combine mental confusion with behaviours like screaming, littering, hoarding, and other nuisance. Where the public order is at stake because of mental health issues, collaboration between law enforcement and public health practitioners is deemed necessary.

3.3. Qualitative research and analysis

We deployed an action research methodology for providing a better understanding and advancement of the everyday work that community police officers and district nurses carry out in jointly bolstering (preventive) interventions with people affected by mental-illness. Because Participation Action Research (PAR) is an umbrella concept for many types of studies grounded in 'co-creation' between academic scholars and the populations involved in their investigations (Coghlan & Brannick, 2014), our approach deserves some explanation. In its most purist form, PAR blurs the traditional division between scholars and their objects of study: "the distinction between the knower and the known, between the researcher and the researched tends to be suspended" (Eikeland, 2007, p. 354). Haverkate, Meyers, Telep, and Wright (2019), for example, encouraged a group of incarcerated men to fully participate in their research project on life in an Arizona prison by turning them into 'indigenous interviewers' who played a central role in obtaining and interpreting the data. However, for reasons of rigour and neutrality, we decided not to completely blur the boundaries between the researcher and the researched. Instead, we kept a little more distance from law enforcement and public health practitioners, but at the same time immersed ourselves in local situations and practices. By actively engaging policy makers in the process of shaping and reflecting on our study, and by closely participating with street-level workers, the ambition was to comprehensively map out the actions and activities of community police officers and district nurses, learn from obstacles, and stimulate evaluation and improvement.

Our qualitative research took place in four phases from December 2015 until April 2016, and resulted in a policy-oriented report. We

triangulated interviews and observations with the aim of checking "interferences drawn from one set of data sources by collecting data from others" (Hammersley & Atkinson, 1995, p. 230). This must, in turn, strengthen the reliability and validity of all findings in terms of accurately describing, explaining, and theorising the phenomenon under study (Long & Johnson, 2000). The first research phase covered informal conversations with five policy-makers working for the police, the city of Amsterdam, and the public health service (GGD) and was designed to sharpen the contours of our project. The respondents informed us about the initial goals and intentions behind the collaborative efforts between community police officers and district nurses and provided us with some relevant documentation. For example, they recommended looking specifically at issues of personal contacts between police and public health and (hampering) information exchange within larger bureaucratic settings.

Secondly, we conducted in-depth interviews with all 17 community police officers and the three district nurses involved in the pilot project aimed at early intervention in the lives of disorderly and confused persons. Each interview lasted for about an hour. The reason for the imbalance between community police officers and district nurses interviewed can be simply explained by the fact that the police officers involved outnumbered the existing group of district nurses by far. Questions and probes that guided the interviews revolved around our respondents' perceptions of what 'confused behaviour' means and entails, how they perceived their own small 'police-health care nexus', and how they would express their needs concerning the governance of a broader 'multi-agency approach' to people engaged in behaviours that others perceive as problematic.

Thirdly, we attended two group meetings with community police officers, discussed their experiences with the Dutch public and mental health services, and matched the stories with our interview data. Fourthly, we spent two days on the streets with community police officers observing joint actions with district nurses. During these days, we participated in various home visits to assess the situations of people affected by mental disturbances in a non-crisis context. Our objective was to get a fuller impression of what partnerships between law enforcement and public health looked like in everyday reality by looking at incidents, the handling of such incidents, and possible follow-ups.

The final stage of our project covered the coding of our findings with the help of Atlas.ti, a qualitative research and analysis software package, to let important issues emerge from our data in a process of discovery (cf. Charmaz, 2014). The coding process encompassed two steps. The first was 'initial coding' to get a systematic overview of our data. From this analytical process, we identified twenty-five themes (Table 1). Among other things, community police officers and district nurses noted that the concept of 'individuals with mental health issues' encompasses a whole range of problems, stressed their 'professional freedom' in solving these problems, put emphasis on the importance of building 'trust relations' in neighbourhoods, distinguished between 'informal' contacts and 'formal' government structures, and pointed at 'multi-agency' working within larger organisational networks.

During the second step towards a 'higher-level interpretation' of our data, we searched for overarching codes and patterns emerging from the interviews. We grouped the initial twenty-five themes around three general clusters: (1) the community police officers' and district nurses' own perception of the nature and size of the problems caused by individuals who suffer from mental instability, (2) their mutual collaboration, and (3) their 'linking capital' with surrounding organisational networks. This additional process of labelling text fragments, ordering information, highlighting patterns, and shaping categories iterated a better understanding of 'team play' in which a logic of care was manifest in the thinking of our street-level actors. Community police officers and district nurses repeatedly framed their work as 'taking care of vulnerable people', were frustrated about 'care avoiders', and found difficulty adjusting to 'wider networks' of (non-)cooperative partners.

Table 1
Three clusters of qualitative data

Problem perception
1. The term 'people affected by mental illness' can mean anything
2. Substantive groups of vulnerable people cannot be 'responsiblised'
3. Signalling 'confused behaviour' in an early stage is a challenge
4. 'Care avoiders' represent a serious problem
5. Treating 'people affected by mental illness' takes a long breath
Mutual collaboration
6. Substantive personal involvement of community police officers and district nurses
7. Police officers and nurses enjoy much autonomy
8. Police officers and nurses must create and experience trust in neighbourhoods
9. Informal contacts with residents are important
10. Police officers and nurses must be visible in neighbourhoods
11. Police officers and nurses experience increasing distance to neighbourhoods
12. Accessibility of police and health care for populations
13. Use of telephone, e-mail or social media by police officers and nurses
14. Police officers and nurses can be overburdened
15. Police officers' and nurses' knowledge of neighbourhood problems
16. Day-to-day contacts between police officers and nurses
17. Registration of signals
18. Care, Housing and Nuisance Hotline (*Meldpunt Zorg en Woonoverlast*; MZWO)
19. Consultancy of other partners
20. Preparing and undertaking home visits
21. Feeding back information to professionals and residents is important
Wider network
22. Conflicting interests of other partners
23. Fragmented organisational landscape of public and mental health care
24. Collaboration in wider networks is often troublesome
25. Unclear laws, regulations and covenants about information exchange and privacy

4. Results

4.1. Problem perception

As indicated earlier, the Dutch police have reported a major increase in 'E-33 incidents': a bureaucratic code for disorder arising from 'confused', 'disturbing', or 'erratic' behaviour. Community police officers recognised this trend, but also added that it is 'difficult to discern what is really happening' (police officer #2), because the target group is 'highly diverse' (police officer #10) and the whole concept of people affected by mental illness is open to 'various interpretations' (police officer #1). They spoke of a 'mixed group' ranging from hallucinating tourists on a bad 'mushroom trip' to demented elderly getting lost in town. Put differently, the E-33 code appeared to be a generic term for indeterminate incidents and accidents, an insight with which district nurses were in agreement. There was consensus among our respondents that psychiatric diseases, frequently in combination with drug and/or alcohol abuse, psychoses and compulsive hoarding, form the core problems in Amsterdam.

This ambiguity, in turn, made it challenging to indicate 'how big' the problem actually is. Quite surprisingly, our respondents arrived at fairly low numbers of people in relation to the population size of neighbourhoods. Estimations ranged from five to a maximum of twenty notorious troublemakers in densely inhabited urban areas, signalling that intensity and durability of problems rather than the quantity of troublemakers was of main concern to our respondents. Both community police officers and district nurses underlined that, in their view, the framing of these problems should not be biased towards 'disorder' and 'nuisance', but should instead acknowledge the 'vulnerability' of people (cf. Bartkowiak-Théron & Asquith, 2017) in times of financial cutbacks on public welfare systems:

> There are many people who struggle to survive. They have no income, no unemployment benefits. We can speak of the socially weak in need of help and tranquillity (police officer #12).

Indeed, district nurses too accepted 'that there are many vulnerable people' reaching out for professional assistance (nurse #3) and therefore thought that the commonly used terms 'mentally ill' or 'mentally confused' persons bear undesirable negative connotations. They were vocal in pointing out that those people are losing their grip on their lives, can't help themselves and run the risk of being left alone. Despite a political discourse of 'individual responsibility' and 'citizen participation', there remains a relatively small, but permanent group which is unable to live up to such ideals. Family members, neighbours and other relatives can do a lot 'by keeping an eye on people in need', but this is not self-evident in an anonymous city like Amsterdam (police officer #16). It is thus important to reinforce the insight that 'troubled' people do not only pose risks to others, but are 'at risk' themselves (cf. Crawford, 2009). Their grave vulnerability, (self-chosen) isolation and social stigma also make persons affected by mental instability apt to cause nuisance in their local communities and generate police attention.

It is against this backdrop that the Dutch police are greatly concerned about current budget cuts in public welfare, "because services essential to the quality of life for many in society are perilously on the verge of 'running on empty'. […] For the police there is an added burden that, in the absence of provision elsewhere, people will increasingly turn to the police if they need assistance" (van Dijk, Hoogewoning, & Punch, 2018, p. 187). Therefore, there is firm political pressure from police leaders to avoid a situation as described in Chicago where "the police […] serve as the front line of mental health service delivery" (Watson and Wood, Watson, & Fulambarker, 2017, p. 454) in crisis situation, due to continuously understaffed and under-resourced mental health services. The police, in fact, try to slow down public demand for interventions in the Netherlands and urge the introduction of preventive measures that should forestall mental health-related disturbances. The latter means that there is need for a type of 'early-warning system' to be implemented by both community police officers and district nurses who hold a strong vigilant position in their neighbourhoods.

However, this ambition for proactive and preventative public health and safety delivery is easier articulated than realised, because of "*care avoiders* […] who *do not want to participate*, who *cannot participate* or who *cannot enter* regular […] care" (Maesseele et al., 2013, p. 631; italics in the original). As our respondents confirmed,

> I still encounter new people struggling with mental health problems around this neighbourhood. Gosh, the persistence of such problems is actually quite amazing! (district nurse #1).

> Curiously enough, I sometimes enter homes I haven't seen before, thinking: 'how on earth is this possible?!' […] In particular, people suffering from delusional disorder keep on insisting that they are not mad and refuse proper treatment or medicine. We can't do anything to help them (district nurse #3).

> There is a high 'dark number' of care avoiders […]. It can take a while before we spot them since those people don't allow anybody in their private lives (police officer #3).

From their own experiences, both district nurses and community police officers voiced frustration about prevention policies as core democratic principles of 'individual autonomy' and 'self-determination' keep wearisome situations intact, make crises perpetual and limit 'carrot and stick' options for influencing behaviour (cf. Wood & Beierschmitt, 2014). It rather takes a very long breath to reach people who do not present readiness for treatment and change their attitude – if it is at all possible. Not unexpectedly, therefore, a recurrent – often implicit – theme during the research was our respondents' fight against a "defeatist mind-set" (Noga, Walsh, Shaw, & Senior, 2016, p. 141) in the face of unimaginable caseloads, serious stress and recurrent financial cutbacks as insurmountable barriers. Participation in the pilot project might have had the positive side effect of improved self-esteem and professional pride as community police officers and district nurses were genuinely listened to when expressing their doubts and concerns.

4.2. Mutual collaboration

A central feature of our study was to explicate mutual routines that community police officers and district nurses have spontaneously developed over the years. We will discuss the following stages in turn: (1) receiving and analysing a signal, (2) undertaking action, and (3) providing aftercare. This section closes with a critical reflection on the mutual collaboration between community police officers and district nurses.

4.2.1. Receiving and analysing a signal

"Many justice–mental health problems exist", Steadman (1992, p. 85) notes, "because there are no boundary spanners at key nexuses of the two systems". This is certainly not the case in Amsterdam, the Netherlands. Being far from a perfect model, community police officers and district nurses nevertheless try to arrive at 'joined up' solutions after they have received a signal, email or telephone call. Formally, the Care, Housing and Nuisance Hotline (*Meldpunt Zorg en Woonoverlast*; MZWO) monitors such signals and passes them on to the Dutch police and the public health service (GGD). Signals may come from anxious neighbours, worried family members, neighbourhood managers and general practitioners. Informally, citizens also approach community police officers and district nurses directly about 'people who are not doing well' (police officer #3): local inhabitants just 'phone our office number' (district nurse #1) if they are experiencing an emergency. Uniformed community police officers are highly visible when walking or cycling the streets and some of them have formed tight alliances with so-called 'neighbourhood burgomasters': inquisitive citizens who know everything about what happens in their local community. After receiving a signal, district nurses and, if necessary, community police officers run a background check on the troublesome person concerned. It is important to identify whether they have a history of violence or hold a criminal record in order to reduce avoidable harms within the city.

4.2.2. Undertaking action

Home visits are the core activity of community police officers and district nurses exercising 'collective guardianship': a form of law enforcement/public health collaboration which includes "elements of both deterrence and prevention while moving beyond a focus on criminal behaviour to health risk behaviour more generally" (Wood, Taylor, Groff, & Ratcliffe, 2015, p. 212). As a community police officer reported:

> I want to make contact with a person and do so with the help of a district nurse. It very much differs whether the nurse or I feel a 'click' with someone. That is the power of collaboration: having two complementary views on observing, listening and explaining. I carry a stick; the nurse uses a carrot. […] We play the 'good cop' and the 'bad cop', so to speak (police officer #3).

Once they enter a house, community police officers and district nurses start to analyse the situation at hand by filling in a screening questionnaire that should trigger an urgent or routine referral to one or another (mental) health service (cf. Noga, Foreman, Walsh, Shaw, & Senior, 2014). It is not easy to convince the chronically overburdened municipal 'care office' (*zorgloket*) about 'how bad' a situation really is, which makes the presence of a district nurse speaking the right 'caring jargon' invaluable (police officer #17). The district nurses themselves do not offer any treatment, but act as gateways for people in need of

treatment by youth care, a psychiatric institution or other health centres. This can be a demanding and exhausting effort because patients are either unwilling to cooperate or get stuck in the byzantine Dutch welfare system. District nurses and community police officers complained that processes can be so slow that they sometimes fail to hospitalise people adequately.

4.2.3. Providing aftercare

A last step in the common endeavour of community police officers and district nurses is providing aftercare to patients and to the neighbourhood they live in. Depending on the diagnosis, they did so more or less intensively. In particular, chronic patients and care avoiders deserved much attention, even after cases were formally closed, but our respondents were also very open about the limited time they had due to 'mega work pressure' (police officer #2), 'a lack of capacity' (police officer #12) and a notorious 'understaffing' of the public health service (district nurse #1). Community police officers and district nurses continuously tried to find a balance between monitoring identified patients before things went out of hand and following vulnerable people after an intervention had taken place. However, the latter duty of providing aftercare seemed to receive relatively less priority, not least in times of congestion and being busy. Subsequently, a properly functioning monitoring system assumes basic information sharing and a detailed registration of important occurrences such as home visits, acute crises, and nuisance alerts. A central concern of community police officers was that they 'are not very good at this' (police officer #16) and sometimes fail to organise sufficient feedback to district nurses. From their side, nurses felt uncomfortable about 'red tape': MZWO is formally the lead in operations and interventions, but this adds an extra and potentially conflicting 'bureaucratic layer' (district nurse #1) to the nurses' rather informal collaboration with community police officers and increases the already fierce demands experienced on the shop floor. District nurses sometimes (deliberately) fail to exchange information with MZWO, which hampers the correct recording of information. Their idea of building a shared digital database containing the specific details of their target group runs up against legal barriers of privacy and civil rights. Although system-wide information sharing turns out to be crucial for monitoring psychiatric patients, it is one of the weakest links in law enforcement/public health partnerships.

4.2.4. Critical reflection

Community police officers and district nurses alike showed considerable pleasure in going about their daily work. Respondents praised their 'professional freedom' (police officer #17; district nurse #1) and 'independence' (police officer #5), underlined the development of 'personal working styles' (police officer #1; district nurse #2), wanted to 'serve society' (police officer #8), and 'enjoyed moments of success' (district nurse #3). However, as a downside, several community police officers were notorious for creating their own 'silos' or 'kingdoms' (district nurse #1), which resulted in an unequal distribution of mutual collaboration with district nurses. Professional relationships appeared to be fragile if people didn't get along very well or partnerships split up for reasons of job change or long-term sick leave. In short, building, strengthening, and maintaining partnerships was an ongoing challenge during the community police officers' and district nurses' tours of duty.

Furthermore, in theory, community police officers and district nurses should be fully integrated in the "micro-places of vulnerability" (Wood & Beierschmitt, 2014, p. 443) that they bear responsibility for, whilst reality demonstrates that neighbourhood geographies can be fairly large, making it hard to 'know and be known' in all of such places. Other difficulties that occurred in law enforcement/public health relationships originated from our respondents' inability to spend all of their time, 24/7, on the streets. They juggled with many priorities, suffered from massive work pressure and bureaucracy, had divergent working hours, and were unable to 'look behind every front door' (police officer #2). As touched upon above, the monitoring of vulnerable people returning from hospital, for example, seemed especially cumbersome. Even though proper personal linkages between community police officers and district nurses mostly stayed intact, they failed to preserve a solid information cycle about the outcome of medical treatments. Our respondents admitted that patients sometimes went out of sight, after which problems may start all over again.

Finally, the regulation of mental health problems regularly takes place in amorphous 'grey zones' in which provisional solutions are preferred over legalistic interventions (Wood et al., 2017). This assumes enduring co-operation between patrol officers and community officers, and their respective modes of action, to uphold and restore public order. Yet, ever since the introduction of community police officers during the 1990s and 2000s, they have been typified as 'loners' within the force, and have been accused of not being 'real police', busy as they are with 'soft' and 'caring' approaches (Punch, van der Vijver, & Zoomer, 2002). In particular, the social mandate of community officers to intermingle in a friendly fashion with (vulnerable) inhabitants of local neighbourhoods is likely to conflict with patrol officers' appetite for 'quick fixes'. One rude action on the part of a patrol officer may spoil months of investment in trust building with care avoiders and other hard-to-reach people.

4.3. Wider network

Our research project was confined to the partnership between community police officers and district nurses, but we also became aware of their 'nodal' positioning within a wider organisational network. Indeed, since the 1990s, there has been an "increasing convergence of the social sector and of the judicial criminal law enforcement", which has gradually stimulated "collaboration between different actors" in Dutch public safety and public health policies (Boutellier, 2001, p. 374). In addition to monthly consultations between the police, the GGD, and the MZWO, therefore, a larger consortium of municipal boroughs, housing associations, debt settlement services, youth and child care, mental health care, and addiction care comes into play after long-lasting nuisance and extreme crises. Community police officers, and more specifically district nurses, act as gatekeepers to this larger welfare state apparatus, but do not have any mandate to solve 'conflicting interests' or create 'vital alliances' (police officer #7). This omission may result in 'time consuming efforts to get professionals round the table' (police officer #14), difficulties 'in getting something done' (police officer #14), an 'unnecessary duplication of work' (police officer #17) and an even greater 'lack of information exchange' (district nurse #3). Respondents referred to a fragmented interorganisational system that obscures the bigger picture of 'who is responsible for what'. One cynical community police officer was suspicious of bureau–-political turf wars and a Kafkaesque 'pumping around of troublemakers' (police officer #13).

Whether this allegation is justified or not, the governance of vulnerable people is indeed a 'wicked problem' in the sense that there are no definitive formulations of the problem and no ultimate solutions to unique cases. This dilemma requires learning by 'trial and error' and the realisation that problems can be considered as a longer chain of more fundamental symptoms (Rittel & Webber, 1973). In other words: community police officer and district nurses face a 'double challenge', because there is 'normative conflict' about what to do and because of the 'factual complexity' of the issue itself (Bannink & Trommel, 2019). For example, our respondents felt that housing associations had saved too much on the janitors who exercised informal social control in local estates. The net result is a decrease in preventative surveillance and insufficient evidence-building that is necessary for the out-of-home-placement of repeated disorderly and confused persons. A second complaint alluded to the ongoing mismatch of information between public health and mental health services: 'we are not always informed about patients being released from hospital' (district nurse #1) and 'they do not necessarily involve us in the management of dangerous

psychiatric patients who go about waving knives' (district nurse #2). Again, the information flows within the network were portrayed as suboptimal. Owing to limited resources, it was impossible to validate these observations and carry out a full-blown investigation into the frictions and tensions described by our respondents. Nevertheless, we can cautiously conclude that problems caused by vulnerable people affected by mental illness are very difficult to solve because of contradictory requirements, enduring disagreement about the nature of the problem itself, and multifaceted interdependencies between the actors involved. Networks spanning the policy domains of public health, mental health, social support and law enforcement do not automatically flourish.

5. Conclusion

5.1. General findings

This paper has sought to offer empirical grounding for the insight that law enforcement and public health are increasingly intertwined 'nodes' (cf. Boutellier, 2001; Burris, 2006; van Dijk & Crofts, 2017) that do not necessarily cooperate in daily practice. Earlier significant publications by Wood and colleagues (Wood & Beierschmitt, 2014; Wood et al., 2015; Wood & Watson, 2017) reported on qualitative research to determine how patrol officers interact specifically with people affected by mental illness in the US. We have broadened this scope to a partnership between community police officers and district nurses in Amsterdam, the capital city of the Netherlands. Compared to traditional patrol officers, community officers engage quite closely with local inhabitants, are responsible for the policing of confined neighbourhoods, act as players in local community safety networks, and combine a law enforcement mandate with a social work approach. Our research questions involved both their and district nurses' practice of informal team play within the context of wider interventionist nodes.

Interestingly, the respondents under study were sceptical about the current alarmist political discourse that evolves around an 'explosion' of people suffering from mental illness. They rather perceived the core problem in terms of a relatively small, but potentially disturbing, group of vulnerable care avoiders who are hard to trace until crises erupts. Together, community police officers and district nurses have developed a kind of team play consisting of three steps: receiving and analysing a signal, undertaking action in the form of a home visit and referrals to public health and mental health institutions, and the monitoring of situations afterwards. Walking through these steps should prevent things going wrong.

Collaboration between community police officers and district nurses, in general, runs fairly smoothly, but is sometimes hampered by several factors: informal team play is vulnerable to personal working styles, professional knowledge about 'micro-places of vulnerability' is limited, substantial amounts of work undermine the essential engagement in aftercare after incidents have occurred, and the alignment of the missions of multifarious network partners is not self-evident. With regard to the latter, a key insight of our research is that informal team play efforts clash with, or are even undermined by, formal bureaucratic systems that do not support the ways in which governing through care is promoted on the streets. In particular, since nodal actors hold divergent factual and normative positions *vis-à-vis* the problem, community police officers and district nurses have difficulty influencing a wider landscape of housing associations, mental health care, and psychiatric hospitals. "Nodal actors", Wood and Shearing (2007, p. 27) observe soberly, "may not come together to form 'networks' at all".

5.2. Discussion

Against this background, over the past two decades, criminologists have analysed how crime and disorder in North America have transformed into a tool that governs society. Fischer and Poland (1998) and, most famously, Garland (2001) examine how the combination of fear of crime, populist 'law-and-order' policies, and neoliberal ideology that holds people responsible for their own misery have led to harsh punishment of individual offenders. The latter analysis inspired Simon (2007) to argue that Anglophone societies are increasingly 'governed through crime' in the name of avoiding victimisation. From his viewpoint, crime has become a defining policy framework for legitimising tough and exclusionary actions towards risky populations and restricting civil liberties in order to minimise future harm. A similar point has been made for the Netherlands:

> Most community safety plans were embedded in a politics of social welfare and inclusion, but the dominant trend from the mid-1990s on clearly echoes a mere exclusive discourse […] The widening of the scope to so-called 'pre-crime' – problematic behaviour that is not yet punishable as such, but which, according to life-course criminological risk assessments will eventually lead to crime – […] is yet another major policy change with respect to preventative programmes. […] Multi-disciplinary intervention teams are installed to offer 'help' in latently criminogenic situations (Boone & van Swaaningen, 2013, p. 25).

Indeed, the argument that 'multidisciplinary intervention teams', such as our community police officers and district nurses, draw people affected by mental disturbances into the hard-nosed realm of security and law enforcement holds some truth. Following Pakes (2005), the Netherlands have undergone a 'punitive shift' which targets deviants and lawbreakers with uncommon lifestyles and life-courses, including people struggling with mental instability. However, at the same time, our case study suggests that this punitive shift occurs alongside the regulation of neighbourhoods and communities by ideals of social work, welfare and well-being – a governance through care. There is, in fact, no such thing as a robust 'punitive complex' in which policing and criminal justice logics prevail.

Firstly, our findings show that community police officers together with district nurses take a caring, not a punitive, stance towards vulnerable individuals with mental health issues. Their prevention scheme aspires to offer help and solace in an early stage of incidents and crises, which should increase the chance of successful treatment. Secondly, both community police officers and district nurses operate in a setting of wider nodal actors, each inhabiting a unique mentality or *raison d'être*, which is rooted in potentially conflicting law enforcement, public health, mental health, and other social welfare logics. Put differently, their team play efforts take place within a highly volatile networked reality, not within some unidimensional, punishment-oriented organisational culture. Sensitivity to this theme is key to more nuanced thinking about how the enrolment and alignment of assorted nodal law enforcement and public health actors plays out in practice.

5.3. Policy recommendations and future research

The widening web of 'integrated' law enforcement and public health programs in Amsterdam, the Netherlands, has stimulated a form of public craftsmanship, in the sense that finding team play solutions for local problems has created a whole raft of improvising initiatives developed by community police officers and district nurses. "Spontaneity and creative freedom", Boutellier (2013, p. 158) notes, "are distinguishing characteristics of improvisation, yet at the same time improvisation is bound by the principles within which it occurs". The institutional context matters too. Our paper highlights some areas for improvement which, we hope, intensify multi-agency collaboration over supporting individuals with mental illness.

For sure, community police officers and district nurses deserve reinforcement because, as in Britain and elsewhere, they suffer from "stress and burnout […] as a result of increasing workloads, increasing administration, and a lack of resources" (Lamp & Tarpey, 2019, p. 288–289). For example, a small number of community police officers

may become designated 'care officers' who have expertise in the field of public and mental health and have received extra training in treating persons affected by mental instability. Policy makers should also set clearer goals, since it is impossible and undesirable to look behind every front door, track down all care avoiders, and create a watertight preventive system. Rather, it seems appropriate to place the police and public health call for enhanced support from others nodal agencies higher on the political agenda.

A final and connected recommendation is to augment the position of the Care, Housing, and Nuisance Hotline (MZWO) as the formal coordinator of receiving and distributing signals about incessant nuisance posed by mental health disorders. On the one hand, MZWO must facilitate standardisation and professionalisation of joined-up policing and nursing practices arising from informal contacts. Too personal working methods might be detrimental, for example, to the necessity of sustaining long-term partnerships. On the other hand, MZWO has a pivotal task in strengthening sustainable relationships with the wider network. Without proper coordination multi-agency partnerships fall apart easily.

Future research is needed to advance our understanding of how to manage the police–health nexus beyond that between individual community police officers and district nurses. The success of such management efforts might be measured according the following metrics: the 'need' to build a network or partnership, the 'realism' of its purpose, the building of 'trust' and 'commitment' among participants, the reach of (written) 'agreements', and the 'monitoring' of results (see, for example, Hardy, Hudson, & Waddington, 2003 for an inspiring assessment tool). Participatory Action Research methodology (Coghlan & Brannick, 2014) can be used to construct an ongoing learning cycle of diagnosing, planning, acting, evaluating, and reflecting – so as to generate practical knowledge, make necessary changes, and arrive at satisfying results.

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References

Aanjaagteam Verwarde Personen (2016). *Doorpakken! Eindrapportage aanjaagteam Verwarde Personen [Keep going! Final report policy team mentally ill persons].* The Hague: VNG. Retrieved 17 march, 2019 from https://vng.nl/files/vng/publicaties/2016/20160930-eindrapportage-aanjaagteam-verwarde-personen-sep2016_0.pdf.

Bannink, D., & Trommel, W. (2019). Intelligent modes of imperfect governance. *Policy and Society, 38*(2), 198–217.

Bartkowiak-Théron, I., & Asquith, N. (2017). Conceptual divides and practice synergies in law enforcement and public health: some lessons from policing vulnerability in Australia. *Policing and Society, 27*(3), 276–288.

Bittner, E. (1967). Police discretion in emergency apprehension of mentally ill persons. *Social Problems, 14*(3), 278–292.

Boone, M., & van Swaaningen, R. (2013). Regression to the mean: punishment in the Netherlands. In V. Ruggiero, & M. Ryan (Eds.). *Punishment in Europe: A critical anatomy of penal systems* (pp. 9–32). Basingstoke: Palgrave MacMillan.

Boutellier, H. (2001). The convergence of social policy and criminal justice. *European Journal on Criminal Policy and Research, 9*(4), 361–380.

Boutellier, H. (2013). *The improvising society: Social order in a boundless world.* The Hague: Eleven.

Boutellier, H., & van Steden, R. (2011). Governing nodal governance: the "anchoring" of local security networks. In A. Crawford (Ed.). *International and comparative criminal justice and urban governance: Convergences and divergences in global, national and local settings* (pp. 461–482). Cambridge: Cambridge University Press.

Burris, S. (2006). From security to health. In J. Wood, & B. Dupont (Eds.). *Democracy, society and the governance of security* (pp. 196–216). Cambridge: Cambridge University Press.

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). London: Sage.

Cobussen, M. (2008). Improvisation: between the musical and the social. *Dutch Journal of Music Theory, 13*(1), 48–55.

Coghlan, D., & Brannick, T. (2014). *Doing action research in your own organization* (4th ed.). London: Sage.

Crawford, A. (2009). Criminalizing sociability through anti-social behaviour legislation: dispersal powers, young people and the police. *Youth Justice, 9*(1), 5–26.

van Dijk, A., & Crofts, N. (2017). Law enforcement and public health as an emerging field. *Policing and Society, 27*(3), 261–275.

van Dijk, A., Hoogewoning, F., & Punch, M. (2018). Running on empty: reinvigorating policing through "what matters". *Cahiers Politiestudies, 48*(3), 179–194.

Eikeland, O. (2007). From epistemology to gnoseology – understanding the knowledge claims of action research. *Management Research News, 30*(5), 344–358.

Elhauge, E. (Ed.). (2010). *The fragmentation of U.S. health care: Causes and solutions.* Oxford: Oxford University Press.

Elsinga, M., & Wassenberg, F. (2014). Social housing in the Netherlands. In K. Scalon, C. Whitehead, & M. F. Arrigoita (Eds.). *Social housing in Europe* (pp. 25–42). Chichester: Wiley Blackwell.

Fischer, B., & Poland, B. (1998). Exclusion, "risk" and social control – reflections on community policing and public health. *Geoforum, 29*(2), 187–197.

Garland, D. (2001). *The culture of control: Crime and social order in contemporary society.* Chicago: The University of Chicago Press.

Hameleers, M., & Vliegenthart, R. (2018). Framing the participatory society: measuring discrepancies between interpretation frames and media frames. *International Journal of Public Opinion Research, 30*(2), 257–281.

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.). London: Routledge.

Hardy, B., Hudson, B., & Waddington, E. (2003). *Assessing strategic partnership: The partnership assessment tool.* London: Strategic Partnering Taskforce/Nuffield Institute for Health.

Haverkate, D., Meyers, T., Telep, C., & Wright, K. (2019). On PAR with the yard: participatory action research to advance knowledge in corrections. *Corrections* online first.

Ilcan, S., & Basok, T. (2004). Community government: voluntary agencies, social justice and the responsibilization of citizens. *Citizenship Studies, 8*(2), 129–144.

Innes, M. (2010). A "mirror" and a "motor": researching and reforming policing in an age of austerity. *Policing, 4*(2), 127–134.

Knispel, A., Hulsbosch, L., & Van Hoof, F. (2015). *Landelijke monitor intramurale GGZ, tweede meting 2013 [national monitor intramural mental health].* Utrecht: Trimbos-instituut.

Lamin, S., & Teboh, C. (2016). Police social work and community policing. *Cogent Social Sciences, 2*(1), 1–13.

Lamp, V., & Tarpey, E. (2019). "It"s not getting them the support they need': exploratory research of police officers' experiences of community mental health. *The Police Journal, 92*(4), 277–295.

Lipsky, M. (1980). *Street-level bureaucracy: dilemmas of the individual in public services.* New York: Russell Sage Foundation.

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing, 4*, 30–37.

Maesseele, T., Bouverne-De Bie, M., & Roose, R. (2013). On the frontline or on the sideline? Homelessness care and care avoiders. *European Journal of Social Work, 16*(5), 620–634.

McMurran, M., & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health, 20*(2), 75–85.

Nix, A., Huber, J., Shapiro, R., & Pfeifle, A. (2016). Examining care navigation: Librarian participation in a team-based approach? *Journal of the Medical Library Association, 104*(2), 131–137.

Noga, H., Foreman, E., Walsh, A., Shaw, J., & Senior, J. (2014). The development of a mental health screening tool and referral pathway for police custody. *European Journal of Public Health, 25*(2), 237–242.

Noga, H., Walsh, A., Shaw, J., & Senior, J. (2016). Multi-agency action learning: challenging institutional barriers in policing and mental health services. *Action Research, 14*(2), 132–150.

Pakes, F. (2005). Penalization and retreat: the changing face of Dutch criminal justice. *Criminal Justice, 5*(2), 145–161.

Politie (2018). *Personen met verward gedrag 2017 [(Mentally) disturbed and confused people 2017].* Retrieved 17 March, 2014 from https://www.politie.nl/wob/korpsstaf/2018-personen-met-verward-gedrag-2017.html.

Punch, M., van der Vijver, K., & Zoomer, O. (2002). Dutch 'COP': developing community-policing in the Netherlands. *Policing, 25*(1), 60–79.

Rittel, H., & Webber, M. (1973). Dilemmas in a general theory of planning. *Policy Sciences, 4*, 155–169.

Simon, J. (2007). *Governing through crime: How the war on crime transformed American democracy and created a culture of fear.* Oxford: Oxford University Press.

Socias, M., Volkow, N., & Wood, E. (2016). Adopting the "Cascade of care" framework: an opportunity to close the implementation gap in addiction care? *Addiction, 111*(12), 2079–2081.

Steadman, H. (1992). Boundary spanners: a key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior, 16*(1), 75–87.

van Steden, R. (2018). Building a nexus between policing and care: The case of flying squads in Amsterdam. In H. Boutellier, & W. Trommel (Eds.). *Emerging governance: crafting communities in an improvising society* (pp. 51–65). The Hague: Eleven.

van Steden, R., & Broekhuizen, J. (2015). Many disorderly youth, few serious incidents: patrol officers, community officers, and their interactions with ethnic minorities in Amsterdam. *The Police Journal, 88*(2), 106–122.

van Steden, R., Wood, J., Shearing, C., & Boutellier, H. (2016). The many faces of nodal policing: team play and improvisation in Dutch community safety. *Security Journal, 29*(3), 327–339.

Swanson, W., McGinty, E., Fazel, S., & Mays, V. (2015). Mental illness and reduction of gun violence and suicide: bringing epidemiologic research to policy. *Annals of Epidemiology, 25*(5), 366–376.

Tierney, S., Wong, G., & Mahtani, K. (2019). Current understanding and implementation of "care navigation" across England: a cross-sectional study of NHS clinical commissioning groups. *British Journal of General Practice, 69*(687), 675–681.

Tummers, L., Bekkers, V., Vink, E., & Musheno, M. (2015). Coping during public service delivery: a conceptualization and systematic review of the literature. *Journal of Public Administration Research and Theory, 25*(4), 1099–1126.

Williams, A., Nunes, E., Bisaga, A., Levin, F., & Olfson, M. (2019). Development of a Cascade of care for responding to the opioid epidemic. *The American Journal of Drug and Alcohol Abuse, 45*(1), 1–10.

Wood, J., & Beierschmitt, L. (2014). Beyond police crisis interventions: moving "upstream" to manage cases and places of behavioural health vulnerability. *International Journal of Law and Psychiatry, 37*(5), 439–447.

Wood, J., & Shearing, C. (2007). *Imagining security*. Cullompton: Willan.

Wood, J., Taylor, C., Groff, E., & Ratcliffe, J. (2015). Aligning policing and public health promotion: insights from the world of foot patrol. *Police Practice and Research, 16*(3), 211–223.

Wood, J., & Watson, A. (2017). Improving police interventions during mental health-related encounters: past, present and future. *Policing and Society, 27*(3), 289–299.

Wood, J., Watson, A., & Fulambarker, A. (2017). The "gray zone" of police work during mental health encounters: Findings from an observational study in Chicago. *Police Quarterly, 20*(1), 81–105.