Changing policing for communities

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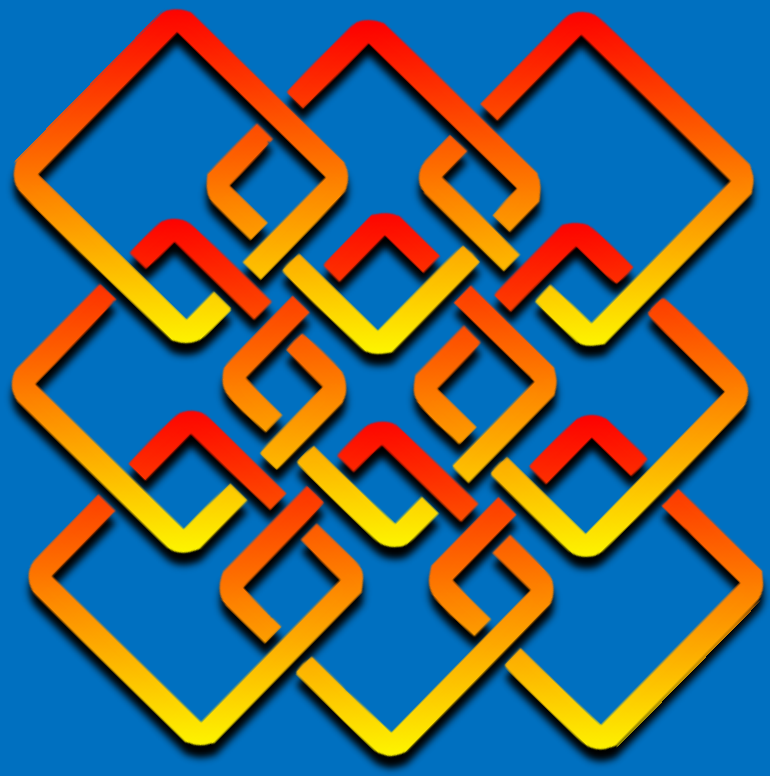
CHANGING POLICING FOR COMMUNITIES

Law enforcement and public health as an emerging field of practices, concepts and research



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CHANGING POLICING FOR COMMUNITIES

Law enforcement and public health as an emerging field of practices, concepts and research

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Chapter 1. Introduction

The role of police in public health

There is growing academic and societal attention being paid to police interventions that are unrelated to their traditional 'core business' of fighting crime and maintaining public order. As we know from the literature, much police work has nothing to do with crime at all but relates to solving all sorts of human problems and caring for vulnerable people (Banton 1964; Bittner 1970, 1974; Bayley 1994). Many of these activities are in accordance with the – more or less implicit – function of policing in the public health domain. Public health can be broadly defined as 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life among populations through the organised and informed efforts of society' (Marks et al. 2011). The role of the police in public health is increasingly acknowledged and seems to be growing at the same time. Issues at the intersection of policing and public health are the subject of the emerging field of Law Enforcement and Public Health (LEHP).

The core of this doctoral thesis is the meaning and possible impact of LEPH on police work from a policing perspective. Specifically, the focus is on the development of policing in the context of communities, where policing engages in many tasks, 'including responding to the range of problems that citizens approach the police with in search of aid and solutions' (van Dijk et al. 2015: 2). An important dimension of LEPH is the observation that large amounts of police time are spent on issues having an important (public) health component. The increase in police dealings with people experiencing mental health crises – from a police perspective generally referred to as incidents involving 'Emotionally Disturbed Persons' (EDPs) – is a clear example of this in many Western societies as diverse as the US, the UK and the Netherlands (McDaniel et al. 2020; van Dijk et al. 2020). Changes in the nature and volume of this kind of crisis – and of other public health crises in which the police are involved – obviously have a variety of causes. In particular, growing demand for police intervention in the field of public (mental) health is related to political choices made about public service delivery.

Firstly, in the case of mental health, the changing police role stems from the political choice made to de-institutionalise care in the Netherlands and in the other aforementioned societies. Care in institutions has been replaced by community-based services such as community health centres, supported housing and community psychiatric nurses. However, particularly in the US, these community-based services have never been adequately funded (Lamb et al. 2002; Druss et al. 2006). This, in turn, has led to an increase in the number of mental health crises (Lancaster 2016), which, in the absence of alternative emergency services, have been left to the police to deal with (Baker and Pillinger 2020: 107-108). The police, after all, are on the street 24/7. Drawing on the work of Robert Reiner (1992), Punter and Bronitt go as far as to argue that policies favouring de-institutionalisation of care for persons with

mental illness mean that 'modern policing is increasingly conscripted into "mental health street-sweeping"' (2020: 59).

Secondly, and more broadly, since the 1980s and at least until the Covid-19 pandemic in 2020, there has been a strong momentum in favour of market forces in the public sector under the heading of neoliberalism. What the long-term effects of the Covid-19 pandemic on neoliberalism will be remains to be seen. Tooze (2021), for example, sees the year 2020 as a comprehensive crisis of the neoliberal era and describes how the lockdowns in response to Covid-19 basically led to a shutdown of the world's economy. Regardless of future development, it was the preceding decades of neoliberalism that largely defined public sector conditions when hit by the pandemic. In the case of public services, neoliberalism translated into New Public Management (NPM): the idea that governments should be 'run like a businesses' (van Dijk et al. 2015: 10-16). NPM has affected public services such as health care and policing in various degrees and ways, among other things by the introduction of performance measures, financial controls and managerial efforts to deliver 'value for money'. As an unintended net result, in many cases NPM has led to a decline in the quality and availability of public services, including policing and public health (van Dijk et al. 2019b). Vulnerable people now run a higher risk of not receiving adequate treatment, which leads to an increase in incidents and crises the police are expected to deal with.

In this context, Wood et al. (2020) point to an inverse relation between the quality and resources of community health systems on the one hand and the content and appreciation of police work on the other. Deficiencies in the delivery of mental health care increase citizens' reliance on police officers in crisis situations that in many cases – although not all – could have been prevented. This is a clear example of what Loader (2020: 12) calls the tragic quality of policing: 'the fact that the police are routinely called upon to deal with problems the causes of which lie beyond their control'.

Dealing with mental health crises, however, is just one example of police involvement in issues that have a clear public health component. Other obvious examples are substance abuse – including drug- and alcohol-related incidents – and (domestic) violence. The police regularly encounter all sorts of vulnerable groups (Ratcliffe 2021). The heavy involvement of police officers in a wide variety of public health issues can be seen as problematic, especially if they perform poorly or even cause serious harm to vulnerable people. This worry and criticism are prominently part of the debate in the US (*Vox* July 31, 2020). Indeed, the police are increasingly involved in solving many incidents with a social and public health component (*New York Times* June 19, 2020), but perhaps they should not be? Conversely, there is an argument in favour of better training and education for police officers as they are regularly confronted with public and mental health issues. As Friedman (2020: 1) writes in a well-grounded research paper on US policing:

> "Crimefighting actually is a very small part of what the police do every day, and their actual work requires an entirely different range of skills, among them: mediation skills to address conflict, social work skills to get people the long-term solutions they need, interviewing and investigating skills to really solve crimes, and victim-assistance. Yet, the police are barely trained in any of this, so, it is no surprise harm is the result".

The author continues to argue that, in order to […] 'reduce the harms of policing, we need to reimagine public safety from the ground up'. One of his suggestions is to introduce a set of highly trained 'first responders', who 'have the capacity to use force (or law) when necessary to stabilize a scene, but have sufficient training to respond in a variety of very different ways' (2020: 63). Learning basic medical care for physical and mental illness should be an explicit part of such training. Although many police officers do not consider public health interventions as their core business, they are probably mistaken. As Bartkowiak-Théron and Asquith (2017: 280) put it:

> "While police and health practitioners have their own disciplinary and occupational goals, in contemporary policing, the practical reality is that police now accept their place and role as 'public health interventionists' (Wood et al. 2015) or 'public health facilitators' (via their role in referrals and diversion)".

A key question in the debate around the current state and future of policing is whether the turn to public health 'intervention' and 'facilitation' is a desirable development. Not everybody agrees on the need to fundamentally reimagine public safety and public policing, more specifically, 'from the ground up'. There is a growing consensus, however, that the increased – and increasingly varied – demand for policing has grown to the extent that policing is 'spread thin', as it were. This is regarded as unsustainable and, for some, gives rise to the argument that the police should *return* to their '*core business*', which is associated with their classical crime fighting role in the criminal justice system and public order maintenance. Yet, a possible alternative would be to argue that the police should *transform* in accordance with the social service and public health role which they are expected to perform and, indeed, do often perform in practice. These viewpoints are obviously mirrored in divergent ideas surrounding the relationships between law enforcement and public health. Should the police refrain from public health tasks or – accepting that public health issues are 'inseparable' from policing (Wood 2020, as cited in Ratcliffe 2021) – incorporate public health in the function of the police?

The need for 'joined up' solutions

In some respects, the idea of better aligning and even integrating law enforcement and public health is nothing new. Both from a historical and an empirical perspective, it even makes perfect sense. Historically speaking, law enforcement and public health are clearly connected in the sense that public health issues have always re-

quired some degree of law enforcement. Carroll (2002; cited in Punch 2019: 4) gives a vivid description of this, referring to the eighteenth century and well before:

> "Historically there is a long association between certain enforcement officials in cities and societies – religious, civil, lay – who took some form of responsibility for maintaining order and control in diverse law enforcement roles and also for a range of health, safety, medical and inspection tasks (as on human and animal waste) and during epidemics and plagues as well as regarding prostitution, the poor, indigent and mentally ill".

It was not until the 19th century that policing and public health became separate domains and institutions, a process particularly fuelled by technological innovation and urbanisation (van Dijk et al. 2019a: 289). The complexities of the city required explicit forms of public policing, be it primarily as an instrument of state control – the Continental model – or be it ideologically based on public consent – the British and wider Anglo-Saxon policing model (van Dijk et al. 2015: 29-68). Nevertheless, in the British policing model, too, there was a clear tendency towards the specialisation that invariably comes with abstract processes of modernisation and institutionalisation. As the first of the famous Peel Principles – the classical 1829 foundation of the policing model – states: 'The basic mission for which the police exist is to prevent crime and disorder'. Thereafter, principle seven reads: the police are the 'only members of the public who are paid to give full-time attention to duties which are incumbent on every citizen in the interests of community welfare and existence'.

In practice, many of the tasks the police perform are what could be called social tasks, which are largely carried out in response to requests from the general public. In recent times – the end of the 1960s and onwards – the police have been mainly driven by (emergency) phone calls about all sorts of incidents and accidents (Punch and Naylor 1973). This makes the police a 'secret social service' (Punch 1979), while publicly still being framed as the institution dealing with crime and disorder. The empirical observation that the police perform primarily social tasks in response to public phone calls is confirmed by recent findings in the US. Analyses of 911 calls to the police show that people mostly call about a diversity of social and health issues (Neusteter et al. 2019; Ratcliffe 2021). In addition, following Loader (2020: 7) in his contribution to the strategic review of policing in England and Wales:

> "Police research has, Brodeur reminds us, demonstrated that most demand for policing doesn't concern crime and that police time is mostly spent on non-crime matters. Brodeur reviewed 51 studies based on public calls to the police, officer time-use and ethnographies of police work. Of these studies, 46 showed that the proportion of police time devoted to crime was 50 per cent or less, two-thirds of them concluded that the percentage was 33 per cent or less (Brodeur 2010: 158-59). A recent report by the College of Policing (2015) found that non-crime incidents accounted for 84 per cent of all command and control calls across England and Wales".

These findings confirm that the police are involved in many social and public health-related issues. For some scholars, critical of how police officers deal with incidents and accidents, these insights lead to a plea for 'the end of policing' (Vitale 2017). In more nuanced ways, others stress that policing is essentially about community safety and wellbeing, and basically embodies a social service. This resonates with the debate around 'broad' or 'narrow' policing (Millie 2014). The narrow conception emphasises law enforcement and the role of the police as crime-fighters, while the broad conception of policing maintains that officers are potentially involved in what Bittner calls 'every human problem' (Bittner 1970: 44). This broader involvement is – in the end – based on the police authority to use non-negotiable force. In line with this perspective, Boutellier (2020: 10-11) defines the core function of the police organisation as the ability to enforce norms – by force if necessary – in the 'moral space' (Sztompka 2002) of society. Boutellier (2020: 12-13) explains how this presupposes that the police are both grounded in the rule of law and are based on public consent.

The broad conception of policing, although empirically valid, comes with a dilemma. With regard to, for example, mental health interventions, it does seem sensible to restrict police involvement as much as possible, especially because police officers have the authority to use non-negotiable force and are expected to intervene decisively in crisis situations. Handling mental health incidents – and especially preventing them – is in general better left to other, more suitable, agencies. There are important critical and classic publications that refer to the dangers of a too broad mandate for policing (Manning 1978; Braithwaite 1992). This is in accordance with the so-called 'minimalist position' of policing (Marks et al. 2009a: 160). Police action should be publicly initiated, should involve as little force as possible and should preferably be carried out in cooperation with others. However, in practice, given the unpredictable nature of incidents and crises, a clear division of labour between the police and public health agencies is hard to construct. Police officers are often the first to arrive on a scene.

The title of the famous Bittner publication *Florence Nightingale in Pursuit of Willie Sutton: A Theory of the Police* (1974) is probably the most compact description of the police role in this sense, Willie Sutton being an infamous American bank robber. Bittner (1974: 40) describes how the illusion of crime fighting encourages bad police work:

> "Believing that the real ground for his existence is the perennial pursuit of the likes of Willie Sutton – for which he lacks both opportunity and resources – the policeman feels compelled to minimize the significance of those instances of his performance in which he seems to follow the footsteps of Florence Nightingale. Fearing the role of the nurse or, worse yet, the role of the social worker, the policeman combines resentment against what he has to do day-in-day-out with the necessity of doing it. And in the course of it he misses his true vocation".

This indicates that it is not very fruitful to look at policing in isolation. LEPH therefore calls for more integrated or 'joined-up' solutions at the intersection of policing and public health (van Dijk et al. 2019a). These joined-up solutions can take the form of traditional cooperation between policing and public health, leaving their respective 'core businesses' and related professions unchanged. Yet, another direction to be explored is that joined-up solutions may structurally affect what is currently depicted as the core business of both professions. Van Steden (2020), for example, describes how police officers and community nurses are altering what their job looks like in trying to make cooperation work. They have designed a collective working cycle of receiving and analysing signals of mental health problems, undertaking action, and providing after care in order to prevent repeated crisis situations. Obviously, it can be difficult to translate such mainly practical joined-up solutions into more sustainable policies, but experimenting with integrated law enforcement and public health solutions can make a big difference for the future development of policing. The ever-growing importance of LEPH issues and the related increased demand for interventions is clearly putting much pressure on the police to change – although the direction of this change is subject to discussion.

Reimagining public policing

In the 21st century, the police in the Netherlands and in other Western countries have been struggling to position themselves in an increasingly complex safety and security environment, combined with calls for efficiency gains and uniform working protocols and standards (van Dijk et al. 2015: 29-68). This has resulted, for example, in a restructuring of police organisations, such as the nationalisation of the Dutch and Scottish forces (Fyfe et al. 2013). However, the police mission – the normative question of what policing is and means – remains subject of an ongoing debate. Under pressure of political and social circumstances, there is a real possibility that policing will become more narrowly defined in terms of criminal justice and public order maintenance, which will possibly lead to retreat from their social service and public health role, especially in times of austerity. That would mean law enforcement and public health are seen as clearly separated sectors and institutions performing different functions, which is not to say they will not cooperate at all.

A return to such a – distinctively modern – 19th century framing of policing would in many ways deny the societal developments that generated discussions on the policing mission to begin with. Under the conditions of 'reflexive modernity' (Beck 1992; Beck et al. 1994) it has become increasingly difficult to agree on what the broad function of policing in society is and should be. The symbolic image of a 'police monopoly' in matters of crime and public order maintenance has been called into question, in part due to growing demands for 'policing' around the world. Since this symbolic image appears to be an increasingly unsustainable fiction, there is a long-standing (Reiner 1992) and growing need for a profound reorientation on (the future of) public policing. At the same time, quite disturbingly, a recent review of policing studies in the Netherlands concluded that theoretical and conceptual thinking

about the police function has, by and large, disappeared (van Reenen 2020: 5). Although there is a deeply felt need to 'redefine' policing, it is not very clear where to start.

A possible starting point is the public health role of the police grounded in frontline practices. As an alternative to the influential crime fighting discourse, a discourse which rests on an increasingly explicitly fictional outlook of police work, the future of public policing could be thought of as being grounded in public health and safety needs. One could argue that the emerging field of Law Enforcement and Public Health (LEPH) is an attempt to do just that: redefine policing in the wider context of public health and safety by looking at the interface between law enforcement (especially policing) and public health domains. As Punch (2019) observes, the notion of LEPH as a specified field for academic attention and for professional practice is relatively new and is marked by the first International Conference on Law Enforcement and Public Health in Melbourne in 2012. LEPH explores the intersection of law enforcement and public health 'systems' not by introducing a new institutional blueprint, but by proposing multifaceted solutions that stimulate theoretical debates and support practical needs. LEPH is also about blurring organisational and academic boundaries and about trying to come up with new organisational formations between the police and public health institutions. Wood and Griffin (2021: 503-4) specifically refer to the mission of the Association related to the global LEPH movement:

> "Strengthening the policing and public health interface has been a practical goal for the Global Law Enforcement and Public Health Association (GLEPHA), whose mission is to advance 'research, understanding and practice at the intersection of law enforcement and public health' (Global Law Enforcement and Public Health Association 2021). Foundational to this agenda is working across geographic, theoretical, methodological, and institutional vantage points. In Braithwaite's terms, this agenda is concerned with fostering 'hybridity' (Braithwaite 2014) – that is, forming bridges in pursuit of 'theory and discovery' (Braithwaite 2014) that transcend our institutions and disciplines. By 'discovery' we refer both to empirical research that describes and explains phenomena as well as solutions-focused work devoted to practical, equitable and fair interventions".

Neither maintaining classical state security nor fighting crime are the focal points of policing in this context, but, instead, community safety and wellbeing. As such, dealing with vulnerable populations and harm reduction is an important aspect of the LEPH agenda, which, from a policing perspective, relates to a combination of handling crime and disorder and providing social services. Here, it is important to emphasise that LEPH also remains connected to the classical policing pillar of public order maintenance and public order management. The police role in enforcing public health measures in the context of the 2020 Covid-19 pandemic is the most current and perhaps urgent example. Infectious diseases were an important substan-

tive subject at the start of the LEPH agenda setting. What makes 'policing the pandemic' especially relevant in the context of LEPH as an emerging field is that it sheds light on the 'repressive' side of public health. The use of 'non-negotiable force' – primarily associated with policing and often seen in a negative light by public health professionals – clearly cannot be wished away in the context of LEPH.

At the same time, the LEPH perspective on Covid-19 results in new insights about the law enforcement and public health interface, and about the role of police officers during public health emergencies. For example, an early review by Laufs and Waseem (2020) of 'what works' in the Covid-19 pandemic leads to interesting findings and recommendations for the police on key dimensions of LEPH. The authors particularly point to the importance of police–community relations, the mental health and wellbeing of officers and intra-organisational challenges, as well as inter-agency collaboration and cooperation. A special issue of *Policing and Society* – 'The policing and public health interface: critical issues from the COVID-19 pandemic' (Wood and Griffin 2021) – is a further example of how the pandemic has affected our thinking about how to better align policing and public safety with public health. In their introduction, Wood and Griffin (2021) point to the law enforcement side of governing the pandemic (think of curfews, lockdowns, social distancing and other restrictions), but argue that officers can and do use other tools too. LEPH thus embodies an emerging field of practices, concepts and research arising from a partial overlap of the goals, methods and target population related to both policing and health domains (van Dijk and Crofts 2017). From a policing perspective, LEPH is compatible with a 'comprehensive paradigm' of policing based on three essential, equally important and interlinked pillars: crime and security management, social welfare and community outreach, and order maintenance (van Dijk et al. 2015: 184).

Subject of this doctoral thesis

How this all might pan out and what the possible impact is on the future of policing is the subject of this doctoral thesis. While there is ample empirical evidence that the police have an important social role, which, among other things, requires partnerships contributing to community health and safety, the appeal of a 'law and order' perspective remains rather strong. The community-oriented police function apparently does not sit well with what is often seen as the 'core businesses of policing', specifically crime fighting and public order maintenance. However, the framing of policing as fighting crime has ceased to be convincing, because of growing awareness that, in reality, the police – not just as *patrolmen* but also *as an institution* – are involved in solving 'all kinds of human problems'. The police function in the late modern society is thus in need of a thorough review, as is also evident in the many strategic initiatives related to policing in the 21st century. Clear examples are the publications by the Independent Police Commission (2013) in the UK, the Council of Canadian Academies (2014), the President's task Force on 21st Century Policing (2015) in the USA and the Commission on the Future of Policing (2018) in Ireland.

Against this background, it is highly interesting and relevant to study whether LEPH can be part of a new framework for the future of policing. To be more precise, how does the LEPH perspective (potentially) provide a viable and persuasive perspective on the policing function, and what would this perspective look like? Would it be around 'vulnerability' (Asquith et al. 2017) or around what is now called 'public health policing' (Christmas and Srivastava 2019)? Would it be a temporary frame or more permanent? Clearly, protecting vulnerable people and public health policing have both become important dimensions of policing in many forces over recent years, particularly in UK policing. This is so, even up to the point where the Assistant Chief Constable of Police Scotland, at the LEPH conference in Edinburgh (2019), stressed that, when having to choose between law enforcement and public health, the police are, in his opinion, 'definitely in the public health business'. Whether this vision will last – for UK policing and beyond – in the face of expected economic challenges and political pressure to 'fight crime' remains for further consideration.

While in the Netherlands, too, there is a growing realisation that approaching urgent societal issues at the intersection of law enforcement and public health solely from traditional institutional perspectives has turned out to be counterproductive, it is still very hard to break down institutional silos. However, not coming up with genuine joined-up solutions is not seen as acceptable and potentially erodes public trust in the public sector. LEPH provides a novel stand in this debate by emphasising the vital importance of integrated – law enforcement/public health – team play, thereby acknowledging that, from an institutional point of view, the demarcation of the police role and function will always be somewhat fuzzy. As Loader (2020: 13-14) argues:

> "The protection and safeguarding of vulnerable individuals, whether as victims or as exploited and traumatised 'offenders', clearly requires partnerships between various agencies and an over-arching ambition that is oriented not simply to order and safety, but to wellbeing more generally. But it is sometimes rather difficult when reading the literature outlining or promoting 'proactive preventive activity', a 'whole-system approach' or related variants of 'public health' policing to discern exactly why the police are involved and where the proper limits of their role are supposed to lie (e.g., Gilmour 2018; van Dijk et al. 2019). This question stands much in need of reflection and clarification".

In other words, there is a momentum for the reframing of traditional law enforcement and public health sectors and the associated roles of professionals. This is already happening in a number of countries as is illustrated by 'public health policing' in the UK and the construction of 'community health and safety' as a distinct priority within Dutch policing. Strengthening such developments – especially in a time that the public sector is 'reinvented' again after the Covid-19 crisis – is important for dealing adequately with LEPH's urgent issues, such as mental health, (domestic) violence, substance misuse and infectious deceases. Shared problems of LEPH require shared solutions among the police and their partners.

The interactions between practices, concepts and research

This perspective calls for new ways of distributing scarce resources and for organising research around experimental and innovative designs. There is an urgent need for practical and conceptual perspectives that supersede the traditional law enforcement and public health institutions and their respective professions. The LEPH approach intends to change the future development of the public health and criminal justice systems alike. It is especially important for the future of policing that a better 'fit' between law enforcement and public health creates novel pathways for how the police operate and are organised in various countries. This is not to say LEPH is exclusively a pragmatic endeavour. As Jardine and van Dijk (2022: 239) write:

> "A critique of some LEPH interventions may be that they focus too much on pragmatic, short to medium term impacts, instead of focusing on large scale reform. Yet, pathways to large scale reform often include successfully demonstrating the efficacy of alternative approaches developed and implemented as a pilot, innovation or local level concept. These smaller interventions contribute to testing hypotheses and theories of change, building an evidence base in specific contexts and exploring adaptations necessary for improvement. Small scale or pilot interventions provide opportunities to reframe the nature of a problem or concern so that alternative solutions, responses and responders can be explored".

The explicit objective of LEPH is to influence police policy and practice in the longer run by creating networks across traditional law enforcement and public health divides, which further connects academia with policy and practice, and with practitioners themselves.

As such, LEPH must be taken as an emerging field of new practices, concepts and research related to policing and public health in the wider context of social policy. The concept of an emerging field of enquiry generates multiple challenges concerning how to relate LEPH to the extant academic literature and debate. Although the picture is that of two firmly separated conceptual domains (law enforcement and public health), there are signs of an upcoming interdisciplinary area of research in which scholars search to adopt a common conceptual language and study similar social phenomena. The idea behind LEPH is to build on such developments at the fringes of traditionally dispersed domains. This trend has been fuelled in recent years by improved knowledge of the root causes of social problems, technological innovation, societal change, social movements and legislation (Punch 2019). All have led to practices that are changing what policing looks like, a trend which appears most prominent in a limited number of developed countries, with the UK, Australia, Canada, the Netherlands and Scandinavian countries as clear examples (Punch 2019; Bartkowiak-Théron and Asquith 2017).

The LEPH agenda touches on the legacy of vested interests and power relations, be it in terms of (financial) resources, knowledge or authority. Both law enforcement

and public health are – or can be defined as – part of a wider social system. The definition of what such a system entails has a substantial impact on what is happening in reality. Indeed, if policing is primarily seen as part of the criminal justice system, policies and practices translate into a focus on criminal investigations and 'catching the bad guys', instead of on public protection and community service as the police's core business (Kelling 1991). Alternatively, if policing is seen as part of a wider community health and safety system, this has very real consequences as well, first and foremost for the professionals involved. Above all, LEPH is about making things work.

The LEPH endeavour did not start as a theoretical exercise, but as a consequence of shifting sands between law enforcement and public health. What works and matters for whom in which context is clearly not of a purely academic interest. On the contrary, LEPH can be characterised by a constant negotiation between frontline professionals and agencies in multiagency settings (van Dijk et al. 2019a). This, in turn, does involve research, because it is empirically important to determine where law enforcement and public health meet, what the characteristics of the related practices are and how involved institutions try to collaborate. However, although LEPH alludes to both scholars and practitioners, cooperation between them is not always easy. Their relationship can sometimes even be described as the infamous 'dialogue of the deaf' (MacDonald 1987; Bradley and Nixon 2009).

Nevertheless, LEPH signals a growing academic appreciation of practical knowledge, which contributes to the professionalisation of policing and builds on a long tradition of scholars and practitioners making attempts to create strong connections between research, policy and practice. Wesley Skogan and his team, for example, carried out a comprehensive evaluation of the Chicago Alternative Policing Strategy (CAPS), the largest US-based community policing initiative in the 1990s (see for a summary: Skogan 2006). Apart from scholarly publications, their evaluation has resulted in various policy reports and practical advice over a ten-year period. More recently, the first decades of the 21st century have seen a shifting perspective towards partnership working with the police, which is flagged by ground-breaking projects such as Clifford Shearing and colleagues' NEXUS project in partnership with the Victoria police in Australia (Wood et al. 2008). Academics and practitioners worked together to create better linkages between the police and other public or private agencies in trying to map their professional realities and to establish a practical toolkit aimed at overcoming barriers to collaboration. In the Netherlands, the connection between academia and practice was perceived necessary for stimulating and developing further operational cooperation between the police and public (mental) health and subsequently led to further research in the LEPH domain. The so-called 'Top 600-approach' – an integrated approach combining criminal justice and public health/social interventions – for dealing with repeat offenders is a case in point (Segeren 2020).

Whether LEPH will have a structural impact on policing and public health is dependent on the police officers and public health professionals involved. The police are generally more inclined to connect with the public health profession than the other way around. A possible explanation is that the police seek further professionalisation and emancipation. The LEPH agenda is congruent with that ambition, while the world of public health fears the ethical and status risks that LEPH might bring. This sentiment varies across jurisdictions and is particularly strong in the US, as is evident from, for example, public health professionals' decision to no longer cooperate with an institutionally harmful and racist police force (Deivanayagam et al. 2021). For maximum contrast: the Finnish police are essentially seen as a problem-solving social service (Laird 2021).

Yet, differences between both types of professions are many and fundamental. The core of public health is 'knowledge' and designing possible interventions on the basis of that knowledge. This highlights the traits of a true profession. By contrast, the historical core of policing refers to 'practice and skills', which alludes more to the existence of a certain craft (Willis 2013; Fleming and Rhodes 2018). The LEPH premise is that there is much overlap at the intersection of law enforcement and public health. This overlap potentially constitutes a new profession, involving a body of knowledge, a community of practice and a code of ethics. Or, less ambitiously, but still vitally, LEPH aspires to the practicalities of 'joined up' solutions becoming an indispensable part of the police curriculum and craft. It should provide frontline professionals with an extended and evidence-informed toolbox to better respond to complex public and mental health issues. Knowledge should also be translated in education and training, shared education and training between police and public health workers if possible. This is already taking place, for example in relation to dealing with vulnerable people in crisis situations (Krider et al. 2020). Such a positive development would benefit from becoming more firmly embedded within the global LEPH development providing knowledge, inspiration and best practices.

Research questions

Taken together, the aim of this doctoral thesis is to capture LEPH as an emerging field of new practices, concepts and research, and to describe its actual and potential impact on (the future of) policing. Research questions are:

1) What characterises the intersection of law enforcement and public health (LEPH) as an emerging field of practices, concepts and research?
2) What is the actual and potential impact of LEPH on (the future of) policing?

The LEPH agenda is global in nature and sees the so-called Global South (low- and middle-income countries) as crucial to include (Jardine and van Dijk 2022). However, this doctoral thesis is for the most part restricted to developed Western democracies, mainly concentrating on the UK and the Netherlands, with the USA as both a

contrast and a source of thinking on policing. These countries are, in many ways, good examples of the current state of policing at the intersection of law enforcement and public health in democratic societies. Nonetheless, trends in LEPH research and practice, and their impact on policing, are vital for all kinds of political regimes and police systems (van Dijk and Hoogewoning 2016). LEPH, as a larger global endeavour, is not restricted to Western and developed democracies alone.

Research approach

The doctoral thesis itself is a product of 'joined up' interactions between advisors, policymakers and professionals in both policing and public (mental) health domains on the one hand, and an inspiring group of international scholars and LEPH advocates on the other hand. The articles that form the body of this thesis are a result of working with them, and the idea of combining these articles into a book came later and was raised by Ronald van Steden, Associate Professor in Public Administration and Political Science at VU Amsterdam and Senior Researcher at NSCR.

This doctoral thesis lacks the directness between research and practice that is associated, for example, with Participatory Action Research (Marks et al. 2009b) since it is of a more descriptive and conceptual nature. The project embodies an aim to bring together academic and policy work by combining two strands of 'thinking' and 'doing'. The first strand relates to the development of a comprehensive vision of – and strategy for – policing, stressing the importance of the social welfare and community outreach dimension of policing. The second strand refers to the creation of genuine 'joined-up' solutions between the police and public health, with regard to practices, concepts and research. Both form a combined attempt to reimagine policing in a broader public health and safety context which reaches beyond the police's alleged 'core business' of fighting crime and maintaining public order. Such a narrow focus on policing would clearly no longer be sufficient to make sense of the broader social landscape in which the police operate.

An analogy with the discipline of criminology at the beginning of the 21st century might be helpful in this respect (Squires 2016). Garland and Sparks write that in the advent of late modernity 'social changes have produced a situation in which criminology's grip upon the form and content of our thinking about crime is becoming less rather than more monopolistic' (2000: 200) The same is true for policing and the study of policing. As the very existence of LEPH shows, the conceptualisation of what the police are and do has increasingly become an interdisciplinary endeavour. This occurs by amalgamating elements from existing academic disciplines, as indeed happed with the introduction of epidemiological criminology (Akers and Lanier 2009; Waltermaurer and Akers 2013) – a field of enquiry which was explicitly introduced as a fusion of epidemiology and criminology. LEPH can, in turn, be seen as a public health approach to policing.

As touched upon above, a further way of doing justice to the interdisciplinary character of LEPH was to write with co-authors from different disciplinary backgrounds. The co-authors are also crucial in providing convincing (international) credibility to the evolvement of LEPH. Next, it is important to note that the articles are written in the context of involvement in the emerging LEPH network and activities worldwide. How to value these activities is the subject of the concluding chapter of this doctoral thesis. It is clear that a lot has happened since the proudly announced First International Conference on Law Enforcement and Public Health in Melbourne in 2012. Since then, a series of international LEPH conferences (Amsterdam 2014 and 2016, Toronto 2018, Edinburgh 2019, Philadelphia 2021), the formation of the Global Law Enforcement and Public Health Association (2017), many publications, and projects such as 'Envisaging the Future', which identify LEPH practices worldwide (Krupanski et al. 2020), have been organised and issued.

Research ethics

Trying to define the emerging field of LEPH is also a normative exercise, which aims for societal impact. Agenda-setting is part and parcel of the research itself. Ethics are a very important element of this process, because, without a human rights framework, LEPH can derail into a gross abuse of power. For example, policing the Covid-19 pandemic has led to serious concerns about human rights in a number of countries (DECAF/ISSAT, 2020). The Global Law Enforcement and Public Health Association (GLEPHA) worked together with the African Policing Civilian Oversight Forum (APCOF) to produce a paper with the telling title 'Why rights-based policing responses to pandemics are good for the police and good for policing' (Roberts et al. 2021). Police work that has been nested within the rule of law and with respect for human rights is proven to be most effective in terms of compliance, trust and success.

In an international context beyond the Netherlands and the West, it is paramount to realise that, while public health often has a very positive connotation, policing is generally seen as 'dirty business' – and bad for your health. There is, in many countries, an almost natural reaction to keep law enforcement at arm's length. However, the police are there and cannot be wished away, so working with them in a LEPH framework is probably still a good idea. In addition, there is a growing realisation that public health can be instrumental in reproducing power relations in ways that can be bad for your health too (Jeffers et al. 2020: 6-7). LEPH as a field of research and practice should be critical about the (potential) abuse of power by law enforcement agencies acting on a public health imperative, but should also be concerned about public health initiatives that produce unequal power relations and other unjust – and probably epidemiologically inferior – health outcomes.

Structure of this doctoral thesis

This introductory chapter sets the stage for the main body of the doctoral thesis. Chapters 2 to 6 consist of academic articles, which mirror police-academic cross-fertilisations, the building of an interdisciplinary field of research, the effects of the LEPH agenda on practitioners, and critical reflections on the role of police in matters of public and mental health. The chapters address the following issues:

Chapter 2: What are the foundations of the emerging field of Law Enforcement and Public Health (LEPH), which concepts are central to this field, how does LEPH interact with politics and policy and what is the nature of LEPH research? The chapter sets out the common ground of law enforcement and public health and emphasises the importance of including the police in issues of vulnerability and care. It appeared in the first special issue on LEPH in *Policing and Society* and was written together with Nick Crofts (van Dijk and Crofts 2017), the 'founding father' of LEPH and organiser of the first international conference on LEPH in Melbourne in 2012. Nick Crofts 'represents' the public health perspective to complement the part on policing.

Chapter 3: What is policing and 'what matters' in policing? It is currently quite common to stress that police work should be evidence-based. Evidence Based Policing and the related emphasis on 'what works?' has contributed to the professionalisation of policing but has limitations too. Obsessions with 'what works' may easily trigger a focus on the police 'core business' of fighting crime, which can be relatively easily measured by available quantitative data. What is more, the current social and political context of policing moves in this direction. Questions such as 'what could policing look like as a public service' and 'what is needed to accomplish this' are often less prominent. This chapter compares the UK – with special attention given to Scotland – and the Netherlands and proposes a comprehensive paradigm to reconcile divisive dichotomies, such as 'force' versus 'service, 'crime' versus 'social', 'hard' versus 'soft', in light of LEPH (van Dijk, Hoogewoning and Punch 2018). It was written together with Frank Hoogewoning and Maurice Punch. Hoogewoning is an expert on (the history of) Dutch policing. He is currently General Secretary to the Police Education Council (*Politieonderwijsraad*) in the Netherlands. Punch is an esteemed scholar of policing who has a long track record in research on policing and strong ties with both the Netherlands and the UK. The chapter comes out of many years of working together.

Chapter 4: What are substantive issues in the field of LEPH, how to relate law enforcement – especially the police – to the public health sector and what is – or could be – the role of interdisciplinary research? This chapter appeared in a medical journal rather than a policing journal and brought together a large group of authors from the worlds of public policing, health law and public health (van Dijk, A.J., Herrington, V., Crofts, N., Breunig, R.V., Burris, S., Sullivan, H., Middleton, J., Sherman, S., and Thomson, N. 2019). It is explicitly directed towards a medical audience and towards academics in the field of public health, because of the barriers to getting involved in collaborations with law enforcement agencies. The chapter sets out the need for

joined-up solutions and gives suggestions about how to organise LEPH research, training and education.

Chapter 5: What does LEPH look like at the level of frontline professionals? What are the concrete connections between the criminal justice and the public health systems? This chapter is about the possible contribution of policing and nursing to the development of LEPH (van Dijk, Zoeteman and Fassaert 2020). It appeared in a nursing journal and is about dealing with 'Emotionally Disturbed Persons' (EDPs). The article describes recent policy developments in the Netherlands and zooms in on three innovative approaches in the city of Amsterdam: the 'Top-600 approach' of high-impact crimes, procedure for EDP who are suspected of committing an offence and combined frontline nursing and policing in neighbourhoods. Reference is made to the theoretical concept of 'boundary-spanning' and what this could mean for nursing. The chapter was written with Jeroen Zoeteman (Psychiatric Emergency Service Amsterdam) and with Thijs Fassaert (Public Health Service of Amsterdam). The authors worked on different LEPH initiatives in Amsterdam for many years.

Chapter 6: How to think about the contested non-negotiable use of force in the context of public health? This chapter (van Dijk, Shearing and Cordner 2022) reflects on policing the Covid-19 pandemic and is written together with esteemed policing scholars from South Africa/Australia (Clifford Shearing) and the United States (Gary Cordner). My own perspective on policing is formed mainly on the basis of the situations in the UK and the Netherlands. In many ways, the differences between the countries are substantial, which makes the establishment of a shared vocabulary sometimes difficult. However, the seminal work of Bittner (1967, 1970, 1974) provided a common framework. The authors discuss the possibility of 'decoupling' the police from the criminal justice system and define what would be needed for such a 'decoupled' police to be a legitimate actor in LEPH.

The doctoral thesis closes with a conclusion and discussion (chapter 7), which provides a synthesis of the findings in preceding chapters and reflects on LEPH as a field of practices, concepts and research. Following from these insights, it suggests an alternative model for LEPH frontline work and what that would mean for the future of policing in the context of communities.

Chapter 2. Law enforcement and public health as an emerging field

van Dijk, A. and Crofts, N. (2017). Law enforcement and public health as an emerging field. *Policing and Society*, 27(3), 261–275. DOI: https://doi.org/10.1080/10439463.-2016.1219735

Law enforcement (especially policing) and public health share much common ground; insecurity and lack of safety, traditionally provinces of law enforcement, are iniquitous to health and to attempts to improve public health. Considering the maturity of both fields and the growing complexities of their challenges, it is urgent to more consciously 'join forces'. Public health has a strong culture of seeing the individual within their community, as active participants using social capital to build healthy communities. This is matched by the rise of 'community policing', with many of the same influences and approaches. More recently, vulnerability and holistic models of community safety and wellbeing are central to strategy in both law enforcement and public health. Public health is broad, with a huge variety of stakeholders: lists of disciplines engaged in the public health mission are long – but law enforcement officials appear rarely if ever. There is a lack of reciprocal awareness in each sector of the importance of the other in achieving its mission; we wish to raise awareness among both sectors of the importance of the collaboration in addressing the widest range of complex social issues. We argue for closer and better relationships based on mutual understanding of the inextricable entanglement of health and criminal justice perspectives in many complex social issues, and mutual respect for each other's role in addressing them. We have begun exploration of this intersectional area through establishment of an international conference series and a global network of research institutions working in the field.

Introduction: the background

Law enforcement and public health (LEPH) have long been separate domains, only sporadically cooperating and then often reluctantly. Traditionally law enforcement was tied closely to public order, intelligence on "subversives" and criminal investigations (Brodeur 2010). This indicates that *law enforcement* always has to be understood with society, politics, governance and the wider criminal justice system in mind (Manning 2010). Typically, law enforcement as public policing has not been at all geared to an explicit public health role, except perhaps in a major health crisis with a public order element, such as an epidemic or other emergency.

The public health endeavour is an intrinsic part of the societal mission to provide citizens with the conditions conducive to health – where 'health' is defined in the Constitution of the World Health Organization as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO

1946, 2014). More specifically the term public health refers to 'all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole' (WHO-WTO 2002: 23).

Indeed, a vital and highly valued freedom is freedom from the fear of ill-health, of injury, of unnatural and untimely death. It is the common province of public health and of law enforcement to protect people from these fears. On the public health side, the message of the last two centuries has been one of repeated triumphs of public health over threats of disease and preventable injury. On the law enforcement side – with the public police as the most important symbolic representative of it – significant progress has also been made. Law enforcement has evolved – depending obviously on the economic and political context – into a broad and even versatile public service contributing to social order, security and safety as necessary preconditions for individual freedom and thriving democratic institutions (Brodeur 2010; Reiner 2010).

These two distinctly separate systems can be seen to have arisen from different motives with different imperatives, leading to social distance between them, very different cultures, occasional *ad hoc* cooperation but also mutual suspicion and even hostility. As is clear from the papers in this special edition and other sources, that picture has altered considerably in recent decades due to improved knowledge, technological innovation, societal change, social movements and legislation which has aided in drawing both agencies closer together in a number of societies. Drawing on this context we shall consider here this emerging field of LEPH.

Our interest in LEPH as a field in its own right is related to our necessarily context specific professional experience with the intersection of LEPH. One of the current authors (NC), with a medical, epidemiological and public health background, began to better understand the important contribution law enforcement makes to many public health issues, initially through his work with marginalised communities in Asia (especially people who inject drugs) and elsewhere in addressing the risks of HIV transmission. With this interest came a developing understanding of the much broader relationship between the sectors across a wide range of issues, and of the relative paucity of identification of the LEPH field as one deserving of separate attention. This latter is manifest in the almost complete failure of public health training institutions to teach the role of law enforcement – specifically policing – in the attainment and maintenance of good states of public health.

This led to the organization of the first conference on LEPH in Melbourne in 2012 (LEPH2012). The first LEPH conference clearly highlighted a significant breadth of partnerships ranging across a substantial list of complex social and health issues of importance to both sectors. However, it seemed to be law enforcement in particular where the most urgent issues in LEPH were felt, as with the contribution of the Director of the US Government's Office of National Drug Control Policy with the title – *Breaking down silos: united public health and law enforcement to pioneer a 21st*

century approach to drug policy. Clearly, then, there are many experiments and innovations happening around the world in which police are defining new roles for themselves and creating new partnerships. One increasingly notable scenario has been the change in street-based drug policing in the era of HIV: the characterization of drug use and associated harms as public health issues, and the recognition of the greater urgency of curbing HIV transmission – with protocols around needle syringe programs, safe injecting facilities, non-fatal overdose attendance and so forth. But though driven by the public health imperative of HIV prevention, these approaches have in fact led to an exploration which has found more effective ways to approach drug policing, and innovative and creative ways for police to carry out their roles as, for instance, with diversion programs which broaden markedly the range of responses police can choose from (The Lancet Commissions 2016). Similar collaborative approaches involving innovative ways of police and health working together are helping redefine roles and partnerships. Such frontline programs, together with reform movements in criminal and social justice (such as diversion paradigms, restorative justice, therapeutic jurisprudence, the injection of social capital and the enhancement of collective efficacy) are providing major advances in public health, conceptually and pragmatically.

Speaking at LEPH2012 was the other current author (AvD), with an International Relations, government policy and law enforcement background, working as a civilian strategic advisor within the Dutch Police Service (Amsterdam). He obtained institutional support in the Netherlands which brought the second conference to Amsterdam in 2014 (LEPH2014); LEPH2016 will also be held in Amsterdam. The 2016 conference has the support in Amsterdam of the Police, the Public Health Service, VU University and, importantly, the Mayor. This last reflects the Dutch governance structure where the Mayor is responsible for the police and dealing with disasters and calamities, and she or he will coordinate any multi-agency response.[1]

Like Australia, but more so, the Netherlands had strongly moved to socially engaged policing in recent decades with a willingness to engage in multi-agency cooperation especially with partners in public health. Multi-agency cooperation was the cornerstone of a number of successful projects with a high political profile. An important example was the so-called *Top600* project in Amsterdam on violent crime. In the years 2010-2011, crime rates in the Amsterdam area were going down but there was an increase in crime with an especially high impact on victims: street robberies,

[1] This can be illustrated by the Amsterdam Vice Case (2010) which involved child pornography taken at three day-care centres. A suspect was arrested and confessed to abusing 83 very young children at these centres and taking photos and films of this abuse which were placed on internet sites. This caused immense concern among parents with young children in Amsterdam and it was both a major public health issue and a complex transnational criminal investigation. The Mayor launched a broad multi-agency effort for the parents concerned while continually communicating with the wider public: he mobilized key individuals from City Hall, the Police, Health Service and Public Prosecution Service along with other social welfare agencies (van Dijk, Hoogewoning and Punch 2015, pp. 102-103).

muggings, burglaries, serious abuse and public violence against persons. These crimes were often committed by young (and sometimes armed) adults. Most of them were repeat offenders and – logically but adding to the frustration – the police knew who they were. And beside the police, many other professionals had dealt with these offenders as well. Obviously, something was not working. The top 600 offenders were selected for a new approach. Together they had 15,000 police contacts in the last five years. Central to the new approach was truly horizontal collaboration between all involved professionals, leading to the integration of a diversity of possible interventions tailor-made for each specific offender on the *Top600*-list. Obviously, law enforcement and – in the broadest sense of the words – social and health services were the principal sources of interventions that could be integrated fruitfully. The political pressure to make the approach a success was very high, and *Top600* became an important buzzword with the city staff, the mayor leading the way, and within the police and public health service alike. In the perception of the parties involved, this increased considerably the chance of overcoming the usual barriers to integrating interventions from the domains of LEPH. In many ways the circumstances were 'as good as it gets'.

The 2012 LEPH conference coincided with a strategic issue on the professional agenda of the police, especially in Amsterdam, related to projects such as the *Top600*. After the financial crisis (2008) there were growing concerns that the economic downturn and the related austerity would have negative consequences for vulnerable groups. At the same time, it was seen as a real risk that austerity would be an incentive for organizations – both LEPH – to concentrate on their so-called 'core tasks' to the detriment of multi-agency approaches like the *Top600* and the broader intense collaboration with public (mental) health. The sense of urgency was heightened further by large-scale reorganisations, with a centralisation of the police and a decentralisation of social, welfare and health functions – accompanied by cutbacks. So, putting the spotlight on the intersection of LEPH was – and is – seen as an important counterbalance to the pressure on policing to increasingly focus on the more repressive dimensions of police work.

While our personal experiences are logically contingent, we argue that, considering developments in both fields and the growing complexities of the respective challenges facing them, it should be possible – and urgent – for the respective agencies to more effectively join forces.

LEPH as societal functions and professions

The fundamental basis of public health is evidence of the distributions of states of health and the causal chains involved in their production: this is the remit of the science of epidemiology. Using this evidence, loci for interventions can be identified; policies can be developed to address health issues at the population or community level; interventions can be devised and implemented; and further evidence can be

garnered to refine and improve interventions and the understanding of the causation of ill-health.

Public health is thus necessarily broadly defined, and this is reflected in the wide variety of relevant dimensions and stakeholders. Public health programs are typically cast at a range of levels, depending on the identified causal chain, possible loci of intervention(s) and the means available. These levels can range from the physical environment – removing or ameliorating harmful elements or dangerous situations; to the social environment: for example, addressing stigma and inequalities which create mental ill-health and prevent access to health care services. They can also relate to individual behaviours which occur in a community context, such as tobacco smoking, drunk driving and involvement in unprotected and unsafe sex.

Being concerned with the features of the social and physical environment in which people operate, public health is intrinsically multidisciplinary and eclectic in its approach, and the public health workforce is correspondingly most diverse. Lists of disciplines engaged in some aspect of the public health mission include medical specialists in a wide range of disciplines, epidemiologists, psychologists, biostatisticians, public health nurses, midwives, microbiologists, environmental health officers and public health inspectors, pharmacists, dentists and dental hygienists, teachers and other educationalists, dietitians and nutritionists, veterinarians, child protection officers, medical journalists and other media experts and community development workers (Joint Task Group on Public Health Human Resources 2005). Even disciplines such as surgery can become involved in public health, when they raise their gaze from the operating table – for instance with surgeons campaigning for road safety (Trinca et al. 1988). Interestingly, and to our point here, law enforcement officials (other than public health regulatory officials) do not appear in these seemingly endless lists.

As a profession, public health is linked to medicine. Modern medicine has developed into a high-status profession with personnel attending higher education, with a professional ethic of protection for the patient and a contract with the state for certification of life and death, fitness for work, mental health and so on. Public health emerged from the growing understanding of environmental and other causes of the individual pathologies medicine deals with, and recognition of the ability to intervene to prevent or ameliorate these. While the breadth of public health is enormous, it remains basically founded in medical understandings of pathological processes and resultant disease states. Public health as a separate activity from clinical medicine retains the professional, knowledge-based culture with a dominant ethic of care it has adopted from medicine, and in fact has been instrumental in the drive towards evidence-based practice.

Policing has markedly different roots. Institutionally, policing has mostly been viewed as distinctly artisan work with low entry standards and a weak knowledge base, and as conducting mundane functions compared to the professions and the

military.[2] Police patrol visibly in uniform, with an ostensible 24/7 coverage; they can intervene directly in the lives of citizens, using force where justifiable and necessary; and are asked to react to calls and encounters encompassing a bewildering range of matters (Bittner 1967). The stereotypical police culture is held to be macho, cynical, pragmatic and based on negative stereotypes with a predilection for action and 'real' police work, meaning crime fighting and arrests (Crank 1998). While policing performs positive roles – in solving crime and providing security – it also remains tainted by incidents or patterns of abuse of rights, excessive violence, discrimination and corruption (Punch 2009).

Clearly there is a gap to bridge between the two fields. At the second conference in 2014 in Amsterdam the importance of LEPH was seen to be beyond doubt, and the emphasis was on putting it firmly on the policy and research agenda. As it was phrased in the conference manual:

> "Police, in particular, are inadequately recognized as key partners in the public health enterprise, whose multi-sectorality and multi-disciplinarity are proud badges of its uniqueness. The contribution of police and other law enforcement to achieving public health goals, while recognized by individual public health practitioners in their own field, are not recognized in the broad rubric of public health. In the same vein, the importance of public health for public order and crime prevention is often underestimated".

A major difficulty with LEPH-related issues is this inadequate characterisation and legitimisation of the role of law enforcement agencies in protection or promotion of the public health. Most law enforcement agencies at most times do not construct their identity in this way, despite having this active and integral role in many aspects of public health and health protection and promotion. This and the inadequate concentration on developing effective and sustainable relationships between the LEPH programming sectors impairs the ability of the community to achieve optimum responses to a range of complex issues involving marginalization and social inequality, mental health, alcohol and other drugs, and intra-community conflict including violence. For example, in dealing with illicit drug users or sex workers (exemplifying the situation with many other marginalised communities) the interventions of police are in many cases decidedly detrimental to positive public health outcomes (Maher and Dixon 1999; Kerr et al. 2005).

A crucial case in this respect, as mentioned above, is the response to the HIV/AIDs epidemic that evolved since the beginning of the 1980s. In 'concentrated' HIV epidemics – epidemics where the spread of HIV is largely among groups of people with particular risk characteristics and behaviours, especially people who inject drugs and sex workers – the major determinant of risk behaviours and therefore risk of

[2] This was especially the case in those Anglo-Saxon countries following the early British model of low entry requirements, short training and rising through the ranks to senior officer level (van Dijk, Hoogewoning and Punch 2015).

HIV infection is the conduct of the police towards them (Marshall et al. 2009, Jardine 2013). Stop and search and confiscation of condoms or needles and syringes, and the use of these as evidence in prosecutions, clearly creates barriers to HIV prevention efforts among these populations: all of which is well documented (Marshall et al. 2009). Much less well documented is the small but growing number of interventions working to ameliorate this impact and move police to being facilitators of and partners in the HIV response (OSF 2014).

Both public health and policing are, in part, front-line organisations which intervene directly in the lives of people, with goals and missions that could sit well together but are expressed in a radically different language. Beyond the different language used to describe formal goals, the two sectors often differ fundamentally in culture and with many other matters including procedures, resources and competences. And with regard to most issues relevant to public safety, security or health, their respective interventions can complement and strengthen each other, or they can pit them against each other and thereby weaken each. However, in some respects LEPH is moving well beyond the realisation that the interventions of different fields can have a positive or negative effect on each other, as we will illustrate in the coming paragraphs.

Convergent developments?

Both law enforcement and public health also have the regulation of human behaviours as a central objective. Being concerned with people within their social and physical environments, public health is intimately engaged with human behaviours – promoting, encouraging and supporting health-concordant behaviours, and discouraging and sanctioning health-discordant behaviours. The same clearly holds true for law enforcement with regard to antisocial[3] and criminal behaviours. Both potentially involve action at many levels. For public health this includes especially building environments (both social and physical) within which healthy behaviours are encouraged and supported. The same holds true for law enforcement, as can be seen explicitly in the classical 'broken windows' concept and the related idea of 'designing out crime' (Wilson and Kelling 2003; Armitage 2007). It is immediately apparent that the degree and intensity of those interventions depend on social and political decisions about priorities and the relative undesirability of different unhealthy – or criminal – behaviours. The unwanted behaviours can attract a range of sanctions through social disapprobation and censure, to administrative and regulatory sanction and from the criminal justice system.

Through the 1970s and 1980s both policing and public health were strongly influenced by moves towards closer involvement with and greater accountability to their communities. For police, the ideas and practices of Community Oriented Policing

[3] Referring here to the UK Antisocial Behaviour Act 2003 and Police Reform and Social Responsibility Act 2011.

and Problem Oriented Policing maintained that police should engage with communities and cooperate with other agencies in dealing with those people in need who were best helped by a multi-agency response (Goldstein 1979; Tilley 2003). This was paralleled in the 'new public health' with growing awareness of the need for health care to engage with other players to address the wider range of factors involved in causation of ill-health (Awofeso 2004; Tulchinsky and Varavikova 2010).

As pointed out, much of the risk to health comes from social behaviour and the regulation of such behaviours – for the creation and maintenance of healthy physical and social environments – is the province of public health. Although public health covers an enormous field, increasingly it focuses on social risk factors such as social inequality and it is often around the dangerous, injurious, unequal, traumatized, excluded social world that public health and policing find their intersection, for the regulation of behaviours is also the province of law enforcement, and this brings the two worlds together. For example, the enforcement of health and safety regulations through food safety or occupational health and safety can link public health and policing, in that repeated or egregious breaches of health and safety regulations can move the investigation and prosecution of the offence into the remit of the police and the criminal justice system. This illustrates the spectrum of regulatory mechanisms and enforcers: from self-regulatory health activity, promoted and endorsed by public health authorities, through the administrative regulatory frameworks where enforcement is civil, to the criminal justice arena where behaviours are considered sufficiently threatening to warrant police intervention and possible criminal sanction. Viewed in this manner, public health and policing are exercising different approaches from different perspectives to a set of issues that are not simply dichotomous – health versus criminality – but have a varying mix of each, with varying emphasis in diverse contexts. Increasingly holistic models of *community safety and well-being* are at the core of strategy development in both LEPH (Russell and Taylor 2014).

The increased attention focused on communities and on community and multi-partner collaborations stimulated and was increasingly driven by the growing realisation, based on a growing body of research, that ill-health and involvement with the criminal justice system were vastly disproportionately distributed among the poor, disadvantaged, marginalized and disabled. The deinstitutionalisation movements in many countries through the 1970s and 1980s were a fundamental part of the move back to the community, but in general worsened the situation for these populations as community services were not built up to receive those deinstitutionalised (Bassuk and Gerson 1978; Dear and Wolch 1987). This was particularly the case for those with mental health problems, and led to rises in homelessness and incarceration with prisons becoming de facto mental health asylums (Priebe et al. 2005; Torrey et al. 2010).

Social movements have campaigned for attention to the previously neglected victimisation of women, children, gays, the elderly and the disabled. Human rights

legislation played a role here as well as the *UN Convention on the Rights of Persons with Disabilities* which has become increasingly implemented, and this topic has also been emphasised by the WHO and other international organizations. This has started to raise consciousness of this issue, for some countries in the context of an ageing population with multiple health needs and demands, and has led to research, legislation and coordinated efforts to tackle the problems confronting LEPH.

Furthermore, the 'discovery of the victim and the vulnerable' in law enforcement brought about a sea change in policing (Bartkowiak-Théron and Asquith 2015): the major emphasis had nearly always been on the suspect and the perpetrator with the victim being seen as merely the initiator of the criminal process. Again, it was research that revealed that many victims also came disproportionately from the same population as offenders – meaning within families, social networks and localities – and that this led sometimes to multiple victimization, all of which had been largely ignored due to a predominant focus on street crimes, crimes in public places and dubious establishments and on an assumption of 'stranger-danger' violence. Moreover, there were categories of victims requiring differential responses. This has happened especially with gender, race and age and now has started to focus on those with a disability because of their vulnerability. While other groups launched social movements which demanded rights and influenced policies and provision, those disparate groups of people with a disability were previously poorly organized and were hardly noticed by law enforcement as victims, or indeed as offenders. That has only started to change considerably in the last few years.

There clearly is increasing recognition of a range of issues in which law enforcement is a key public health actor. For instance, violence against women has for some years now been characterised as a public health issue: indeed, violence in general has fallen into this category and the intersection here of police and public health concerns is obvious (Mercy et al. 1993; WHO 2011). There are, for example, facilities in Britain known as a "MASH", for *Multi-Agency Safe Guarding Hub*, which aim to support people, mostly women and children, who have been subject to violence, at times of a sexual nature, in the home or committed by strangers. Having the diverse agencies under one roof in a victim-friendly environment would appear to be the ideal solution to an acute problem. But arriving at and establishing such agencies was a long and painful process, with domestic violence and violence against women long being a systemically neglected matter both societally and in policing, while their continuity may now even be endangered. Another such intersection concerns mental illness, in all its variety, which is an issue that confronts police very directly while it requires judgement on the boundary between illness and criminality (Taylor et al. 2014). The consequences of police getting their management of the mentally unwell wrong can be severe and have led to concerted efforts around the globe to improve the capacity of police to deal effectively with mental health issues (Wolff 1998; Wood et al. 2011; Policing 2016).

Furthermore, much of what occupies police agencies is directed at the preservation of health, often under the guise of public safety or security. The clearest example is the enforcement of compulsory seat belt and motorcycle helmet legislation by police: the *only* motive for this police role is a public health imperative. There is also prevention of road accident trauma; dealing with people with acquired brain injury, from violence and/or alcohol and other drugs; regulation of alcohol supply and consumption and dealing with those affected by alcohol and other drugs; policing of deliberate infection statutes; and the management of epidemics and pandemics; and the policing of deliberate infection statutes. The common ground of LEPH is explicitly not limited to health and safety in the (local) community, but can be related to 'high policing', and national security – as for example in dealing with bioterrorism (Butler et al. 2002; Brodeur 2007).

For all these reasons and more, it becomes very puzzling that law enforcement agencies, especially police, are so rarely numbered among the public health workforce. It is perhaps less puzzling that many law enforcement personnel and agencies rarely identify themselves as public health actors or important, often critical, in the public health endeavour. However, that is changing as well, as we will illustrate in the next section on the importance of harm and vulnerability – and the related public protection – as central concepts in the discussion on the future of UK policing.

The construction of vulnerability in policing

'There can be no greater duty placed on our police forces than to protect those in our society who are less able to look after themselves' (Speech Sir Thomas Winsor, State of Policing, 25 September 2015). This statement from Her Majesty's Chief Inspector of Constabulary (HMIC) represents the growing attention to populations facing vulnerability and experiencing harm (Carpenter et al. 2016). Hence there is a re-definitional process taking place regarding who should be dealt with in the LEPH area in the UK and elsewhere: for example, bringing abuse of those with a disability into the remit of 'hate crime' in the UK under human rights law. There is increasing attention to the needs and vulnerability of the mentally ill, disabled, asylum seekers and illegal immigrants, pupils facing bullying at school including cyber-bullying, sexual harassment and stalking, and domestic violence particularly against women and children (HMIC 2015b; Williams and Stanko 2016). This partly reflects that the categories – offender, victim and vulnerable/potential victim – are shifting and can be mixed. For instance, a street sex worker who is dependent on drugs, poses a risk for HIV transmission through not using condoms, and colludes with a partner to rob clients – and is also being exploited and abused by that partner – is a victim, an offender and a health risk. But it takes a cultural shift in police thinking to stop officers seeing sex workers as offenders and accepting them as victims.[4] An additional

[4] Following a recent pronouncement of the National Police Chiefs Council (NPCC) (England and Wales) recommending that sex workers be treated as victims and be allowed to function in zones of tolerance - common practice in the Netherlands - many comments from within

factor at the institutional level is that the social and financial costs of processing such vulnerable people as offenders through the Criminal Justice System and into incarceration – which continues to happen on a large scale especially in the USA – are high and lead to negative individual and societal consequences (Cloud and Davis 2015). Similar to the history of medicine over the last century, the dialectic within law enforcement is increasingly moving toward prevention and diversion (Waller 2014; Sparrow 2016).

The re-definition of harm to vulnerable populations is focused predominantly on the harm caused by offenders in society abusing the vulnerable. But the combined LE and PH systems themselves can become the 'offender', with the harm coming from within the systems. For when the promised multi-agency cooperation fails the consequences can be dire if not fatal for the vulnerable. We shall illustrate this with two British examples that both became major scandals. In October 2007 Fiona Pilkington drove with her daughter Francecca to a remote place, set the car on fire and both died in the blaze (Guardian, 24 May 2011):

> "Francecca had serious learning difficulties and she and her mother had been the target of more than a decade of persistent and aggressive abuse and harassment. The family and neighbours had reported on this and complained to their MP, to local authority agencies and often to the police. In a ten-year period the family had complained to the police about the intimidating situation more than 30 times including 13 times in the year of the two deaths".

This was a truly shocking case as was the equally appalling death in London of 'Baby P' (as he was referred to before his real name was released). He was a 17-month-old toddler who died of multiple injuries inflicted at his home in 2007. His mother, her partner (not the biological father) and his resident brother were subsequently arrested, prosecuted and convicted of allowing or causing the death of a child. Yet during a period of several months Baby P had been seen on home visits by local social workers and medical professionals. At ten months of age a General Practitioner noticed some injuries to him and the mother was arrested: but she was released and he was returned to her. In the following months he was twice hospitalized because of injuries and his mother was again arrested but not prosecuted. In June 2007 a social worker saw bruises on Baby P`s body and reported this to the police. However, child protection decided against taking him into care and later the mother was informed she would not be prosecuted. In August he was examined in a hospital but serious injuries – among them a broken back and ribs – were not detected. The following day he was taken by ambulance to hospital where he was pronounced dead: the post-mortem revealed the broken back and ribs but also other injuries while he had swallowed a tooth as a result of a blow to the head. All three actors in the LEPH collaboration – police, social work and health service – had failed

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the police service were derogatory, rejected the idea of sex workers as victims and continued to define them as offenders (NPCC 2015).

drastically and with awful consequences (Jones 2014). Serious system failure had exacerbated the original harm and failed to prevent a young child`s death which could have been avoided through early and effective intervention.

This is a darkly bleak picture but these cases are not isolated incidents and there is sad list of such failures leading to considerable concern (HMIC 2015a). There are multiple reasons given in successive inquiries and reports over the years but perhaps an element is simply that it remains difficult to get the required level of coordination and cooperation from the partners. Doubtless many of the people involved are motivated and committed. But in policing the bulk of the work and the dominant functions that are considered core business are patrol, investigations, public order and further specialities such as cyber-crime, counter-terrorism and firearms. In general, social tasks in the community are not ranked high in the status hierarchy and may be conducted by officers on a limited assignment who move on after a few years. There is also evidence that, while they can become closely involved and are prepared to adapt, officers tend to bring a police perspective with them and try to impose it on others (Herbert 2006). The social and health personnel may, in turn, accept something of the law enforcement perspective but they are professionals or semi-professionals with a primary orientation to the care and needs of the patient. There are some roles where law enforcement encroaches on the medical world – such as 'Sexual Assault Nurse Examiners' in US hospitals who aid the victims of sexual abuse while preserving evidence for an eventual prosecution (Stevens 2007) – but such segments are strictly defined, although they could be seen as an indicator of increasing criminal justice influence within the health profession.

It may be too much to expect that the actors in such multi-agency chains actually change their dominant occupational views. But it may well be that they become more aware and sympathetic to the diverse viewpoints and learn to cooperate in a positive manner. In particular, street-level bureaucrats in front-line response to people in trouble in their homes, on the streets or in Accident & Emergency departments have the same clientele and may develop similar views based on common experience and interests (Muir 1977; Lipsky 1980). Psychiatric social workers on a street triage team with the police may, for example, become more understanding about the dilemmas that police face in their work. But the point of their presence in policing is to define encounters as requiring a mental health response through diagnosis and, if needed, finding a place of treatment for the person apprehended: and on returning to their public health environment, they will doubtless revert to their professional identity. And police officers assigned to a multi-agency team, say for child protection or domestic violence, may adapt to the caring culture of the social tasks involved but as their role is not a permanent posting they will move on and perhaps to the 'sharp end' of policing. To a degree, then, multi-agency work with the vulnerable may be conducted by people in part-time roles in temporary alliances with a situational negotiation on principles, practices and on definitions of harm, culpability and the need to intervene.

Only recently in Britain for instance has there been a notion of protecting the vulnerable and an understanding that this requires special skills. Public Protection Units (PPUs) have now been formed to cope with the 'new volume demand' in policing – protecting the vulnerable. Rather like public health which in turning to prevention created a demand it can hardly cope with, policing is promising to respond to 'domestic abuse, child sexual exploitation, female genital mutilation, missing persons, prostitution, human trafficking, slavery, online abuse and grooming, so-called `honour' based crime and forced marriage' (Thomas 2016). And Thomas adds that this list is 'by no means exhaustive'. Within British policing there is a call from the HMIC to focus on the vulnerable and a plea from within the service to recognize the work of PPUs as a speciality requiring specific training and skills which until now were frequently absent.

Clearly, the redefinition of vulnerability is also a political process, in part driven by the exposure of incidents in the media and the related decreasing tolerance for inadequate multi-agency responses, especially if the victims are seen as extremely vulnerable in the public eye. The emerging field of LEPH has to be seen in a political context as well, as we will illustrate in the next section.

The politics of LEPH

It is immediately clear that in a modern, pluralistic society the development of LEPH policies and interventions, and their prioritisation against other health or security issues and social goods, is a potentially a deeply political process: hence negotiation between competing interests and priorities is a common feature of public health programmes. In this sense public health is intimately related to political institutions and processes, and also to the law and law enforcement.

If we broaden our gaze to look globally rather than locally then we can see that factors that influence health come increasingly from outside national boundaries. This has been the case to a degree for centuries (e.g., the spread of bubonic plague from China to Europe in the fourteenth century, and of smallpox to the New World in the sixteenth century), but it has become increasingly important with increasing globalization and the expansion of mobility regarding goods and people. This has, for example, opened and facilitated routes for transmission of ill-health both from less to more developed countries but also in the reverse direction – including trafficking in drugs, medicines and humans and environmental degradation – with and serious diverse impacts on health. Developing countries face particular challenges, with inadequate public health systems matched by militarised police agencies, resulting in uni-dimensional 'public security' approaches to common health issues (e.g., mental health, some infectious diseases and illicit drugs). This situation is even worse in conflict and post-conflict states (Brogden 2005; Bayley and Perito 2010). The operation of public health therefore of necessity includes engagement with these political and even global processes; for some issues more than others – as with tobacco, alcohol, pharmaceuticals and illicit drug regulation compared with

sewerage and safe water supply. Even seemingly noncontroversial measures, with unquestionable evidentiary support (such as compulsory seat-belt legislation (Hingson et al. 1988)) can face social and political resistance from ideological or self-interested quarters. Clearly, the challenges for public health are increasingly characterised by their global dimension with diverse local impacts; and the development of political institutions and related operational solutions to deal with these challenges has often failed to keep pace with the challenges.

The same holds true for law enforcement, and especially for public policing. There is clearly a wealth of LEPH topics at diverse levels including socio-political debate influencing legislation, policy and funding; institutional change, strategy and priorities in the various organizational segments of the LEPH nexus; cooperation and interaction – or lack of it – at the operational level between occupational groups; the consequences of failure, scandal and of reform cycles; and the definition, and redefinition, of the populations who are involved in LEPH activities with concern for their current and potential needs, demands and growth. It is clear that much attention has been paid especially to three major areas: these are mental illness; domestic violence and sexual violence against women and children; and the global, mega-issue of drugs.

Of interest is that despite debate about a narrowing of the police mandate (Millie 2013, 2014) there has been, as noted above, an expansion of the police remit to embrace a wide range of vulnerable groups (Herrington 2014). This is also, alongside the political discourse, visible in research attention. Existing and potential research areas beside the 'big three' mentioned above include female genital mutilation; diverse LEPH aspects related to sex work; human trafficking and slavery; online abuse and grooming; `honour' based crime; traffic safety and epidemiology of accidents; alcohol, violence in public places and violence reduction; disability and hate crime; immigration, refugees and related health problems including trauma; incarceration, prisons as 'asylums' and post-sentence issues; military and NGO workers returning from missions and projects abroad with PTSD; problems associated with health and safety of the elderly at home, in the community and in residential care; coping with LEPH factors during and after disasters and civil emergencies; suicide prevention; health related issues for those in police custody; and health related matters for professionals working in the LEPH area.

It is fair to say that the police are still struggling to find a legitimate (adapted) role in a changing society and this is accompanied by constant pressure on resources and reorganization. Peter Neyroud (UK) states that the 20th-century model of policing cannot respond effectively to crimes without boundaries. And there is a question of legitimacy as well (Neyroud 2015):

> "Meanwhile, police legitimacy in their core mission has been under pressure. One the one hand, the very deterrence-based strategies – particularly stop and search – that were deployed to reduce crime in public places have

> created a gulf between police and young people and minority communities. On the other, there have been failures to tackle domestic violence and the sexual exploitation of children".

The LEPH area has no definitive boundaries but is increasingly at the core of the societal debate on the future of public service delivery and traditional organizations – both in LEPH – are constantly 'crafted' into new institutional arrangements (Aalbersberg and van Dijk 2016). And although the police currently seem to experience most pressure to reinvent themselves, the tolerance for failing public health is decreasing fast as well.

So there has been a growing awareness of the importance of the intersection of LEPH. Community safety and well-being (health in particular) were increasingly seen as fundamentally intertwined and requiring a collaborative approach by multiple actors, the police and public health often at the centre of these professional 'arrangements' or 'coalitions'. It is however not self-evident that LEPH will continue to strive for an ever closer union. In many countries at present, driven by neo-liberal ideologies, politically induced narrowing of the police mandate to focus almost solely on crime control has put pressure on police agencies to cut back on 'social' tasks and public health partnerships. At the same time severe austerity measures – budget cutbacks, downsizing of the workforce, and relocation of services to the private sector – are being applied to both police and to health and welfare services – precisely at a time when demand for integrated services is rising (van Dijk et al. 2015). The results of this nexus include an inability to provide adequate welfare and public health services, pushing people with problems best dealt with in the health sector into the criminal justice sector and further increasing incarceration. They also include tensions within police circles, with for instance complaints from senior police of the amount of resources spent dealing with control of demented patients in nursing homes (*Daily Mail* 2014).

The common ground of law enforcement and public health has thus far failed to become anybody's core business, despite the growing importance of the domain and the growing demand for it. There is a very real risk of regressing and, as we have said, a return to the traditional silos as a consequence of the combined impact of austerity and societal insecurity under conditions of what Bauman at the turn of the century aptly called 'liquid modernity' (Bauman 2000). The traditional boundaries – of organisations, domains and even of countries as exemplified by the recent refugee crisis in the EU – are increasingly contested and new frames of analysis are needed. These contested traditional boundaries seem to be the most promising place to look for new common ground and could be the foundation of newly defined core business. There is an urgent need for setting a 'LEPH' agenda and progress beyond combining the strengths of both domains as just 'an option', as the reinstitution of the classical boundaries between the two fields is an unproductive but at the same time very real scenario.

Academics of LEPH

Politics interact – obviously – with the endeavor to establish LEPH as a field of inquiry in its own right, with both academic and practical dimensions. To begin with, there is a clear global dimension but like much social science (in English) there are disproportionate contributions from the UK, North America, Canada, Australia and New Zealand. We are conscious of this and it needs to be rectified: if LEPH is to be a field of inquiry it needs to study the full universe of cases. It is also the case that many of the innovations and changes in LEPH derive largely from those 'Anglo-Saxon' societies mentioned – but not exclusively: for example, Scandinavia and the Netherlands – and that this is related to socio-political developments impacting on LEPH. The fixation on risk and harm (Ericson and Haggerty 1997), discovery of the victim and attention to vulnerable populations are not universal but are typical of certain post-modern societies[5]. Indeed, it is rather ironic that a key feature of several of those societies is that they are retrenching on social provision and aim for 'lean and mean' institutions of LEPH precisely at a time when demographics (including especially immigration) and other developments are stretching the increasingly limited front-line services which can hardly cope with the volume and chronicity of a new range of clients alongside their usual but also expanding clientele.

It is always difficult to position multi-disciplinary work on complex multi-agency constellations. LEPH is a field at the edges of well-established policies, organisations and disciplines. And hence it requires alternative (institutional) arrangements as well. To state the obvious: we cannot come up with a new 'traditional' organisation that deals with LEPH. The LEPH area is inescapably characterised by a multitude of actors and 'what works' always depends on the context. With LEPH this is more than a platitude because the context includes fundamental dimensions of the state and society, as are visible for example in the perceived tasks and roles of the police in radically different societies. Also, there is the need to make a distinction between tasks and objectives, and related techniques, *within* law enforcement and public health. Not everything is LEPH: a complex murder investigation or a vaccination campaign seem to be clearly in their respective classic fields. However, setting out from these presuppositions there seems to be enough common ground to develop LEPH.

For example, both policing and public health interventions can be viewed as positioned along a spectrum from participatory, community-based, aimed at prevention; to authoritarian, enforcement, aimed at repression. A second axis can be thought of as the spectrum of engagement and partnership between law enforcement and public health around particular issues: from separation, performing tasks

[5] This shift in orientation and police priorities to protect the vulnerable from harms as 'core business' appears to be a professional conversion (Brown 2014). But it could be related to the fact that crime is falling and police are facing austerity measures: this could be the somewhat convenient rediscovery of social welfare functions to justify retaining personnel and resources by claiming them as fresh and demanding territory.

in isolation from the other; to integration, when law enforcement and public health personnel are completely integrated into a team. The degree of engagement depends on and has consequences for:

I. the use of knowledge and information: for example, the need for police awareness of mental health issue;
II. related productive or non-productive interventions: for example, the law enforcement strategy with regard to illicit drug users;
III. the model of organizational cooperation: collaboration, coproduction, network, integration;
IV. integration of policy: separate policies for health and crime or an integrated policy.

It is important to realise that all combinations of positions on these two continuums can be justified, depending on cases and circumstances, so we cannot draw the conclusion beforehand that 'prevention is better than repression' or that 'integration is better than separation' – it all depends. And perspectives like this can be used with regard to different subjects within LEPH but also for a comparative approach of countries, both developed and developing. Framed comprehensively LEPH becomes an intelligible area and what is creating most of the complexity are the existing silos – organisational, cultural, intellectual, and so on.

The majority of work in the emerging field is done on substantive issues which we have mentioned throughout this article, where LEPH clearly is a crucial perspective. All of these as research areas raise issues of access, funding, methodology, dissemination of findings and implications for practice (where appropriate). Research funding tends to flow far more readily in the health domain to medical research based on clinical trials than to public health analyses, and LEPH is not yet an established field within either policing or public health studies. The cultures, funding streams, data infrastructures, and so on, of the two fields are plainly not well adapted at this moment: hence the task ahead is something of a cultural battle within the research world to demonstrate the need for this work and partly in the world of policing, politics and health policy to show its value.

There is an emerging theoretical body of work to match the substantive research work, much of it so far under the rubric of *epidemiological criminology* (Akers et al. 2012). Whether this is a more fundamental contribution than the application of epidemiological methodology to criminology is debatable, but clearly the motive is strong to do away with disciplinary blinkers in engaging with these complex issues.

There is much current research work on aspects of LEPH, both academic and 'on the ground' – and increasingly work that fruitfully integrates both academic and pragmatic (practitioners, policymakers, etc.) endeavours. The LEPH field has an inescapable practical dimension related to the solving of societal problems and the related politics. At a high level of abstraction LEPH is about what could be referred to as

system change. From this perspective evidence sought is about 'what types of strategies have what types of effects for different groups under different conditions' (Willis et al. 2014). It is important to focus on the relationships between mechanisms, contexts and outcomes. This type of research should be very relevant for concrete operations as well, leading to practical rules or design principles and related indicators, instead of prescriptive statements of 'what works' that neglect the time and place specific context (Best et al. 2012). Clearly scholars will follow their own speciality but one central orientation could be studying the interface within front-line LEPH in terms of context, personnel, mandate, resources, personnel, stated policy and policy in use, negotiated realities and outcomes. Case studies could indicate what appears to be the most fruitful manner to operate in specific circumstances. Although multiple methods could be employed this does suggest qualitative methodology with observation, interviews and documentary evidence.

This evidence and related strategies will have very limited impact if they are not accompanied by endeavours to make sure that professionals have the adequate competences – knowledge, skills and attitudes – to implement them. Crucial in this is the acquisition of a collaborative worldview, and training in LEPH can be seen as one critical point of connection between strategic vision and operational action. As Carpenter et al. (2016) convincingly state:

> "It is the 'front line' officers who interact with key populations who may have complex social and health needs. As such, they possess the responsibility and capacity to translate organizational culture and strategic direction, and to deliver public health and human rights driven policy programs, and in doing so, shape the way management and leadership intend is delivered".

Further progression in the establishment of LEPH clearly hinges on the ability to integrate this perspective in the ongoing professionalization of law enforcement and public health alike.

Final thought

We see LEPH emerging as a field of inquiry in its own right, with both academic and practical dimensions. We are aware that this opens a vast territory with complex, fluctuating changes across societies in two key institutions which are themselves in a near constant state of change. It is early days for the establishment of a LEPH field. But with the material from three (including the autumn 2016 one) conferences, with (forthcoming) journal articles, in this special edition and other journals, and with a planned handbook, we see the development of the field both academically and practically. And, we do believe that it is important for the future of both law enforcement and public health that LEPH develops from something that is happening at the edges of traditional fields into a core business, both in developed and developing countries. There are many promising examples of productive LEPH, and *at the*

same time there is the constant pressure – especially with policing – to return (or stick) to their traditional 'core business'. We hope the establishment of LEPH will reduce the risk of that happening.

Chapter 3. Running on empty. Reinvigorating policing through 'what matters'

van Dijk, A., Hoogewoning, F., and Punch, M. (2018). Running on empty. Reinvigorating policing through 'what matters'. *Cahiers Politiestudies,* 48 (3), 179-194.

The difficulties surrounding the cumbersome Dutch reorganization closely reflect problems with police reform in other societies and this refers to common underlying factors and developments (van Dijk, Hoogewoning and Punch, 2015). Especially neoliberalism and New Public Management – combined with the changing impact of the media – have under conditions of threat and austerity shaped recent European police reforms. At the moment there is an urgent need for reorientation with regard to the future development of policing as a public service. Services essential to the quality of life for many in modern society are perilously on the verge of 'running on empty'. Three perspectives are of special importance: paradigms of policing, organisational structure and culture, and professionalization. The article concludes that – given societal trends and what matters in policing – there is a need for placing people at the core of future developments, with a strong focus on competences, solidarity and compassion.

Introduction

Where does the Dutch Police – some five years after nationalisation – stand and where should the organization go from here? The *Commission for the Evaluation of the 2012 Police Law (Commissie Evaluatie Politiewet 2012* or *Commissie-Kuijken)* has made a critical and useful analysis of the Dutch police reorganization. This analysis is primarily geared to governance and organizational issues and the commission's recommendations for refinement and improvement (2017; *Doorontwikkelen en verbeteren*) relate predominantly to these issues. Also, the Commission appeals to all parties involved in the governance – minister, mayors, public prosecution and the police – to find common ground and regard the new Dutch police as a common concern. But the key question is, where should the Dutch police be going?

The difficulties surrounding the cumbersome Dutch reorganization closely reflect problems with police reform in other societies and this refers to common underlying factors and developments (van Dijk et al. 2015). In this article, our concern is not with the Dutch case in isolation nor primarily with issues of organization and governance. Instead, we will take a closer look at what has been happening in policing in the Netherlands (paragraph 1) and in Scotland (paragraph 2). Next we will identify some key societal developments – looking at the Western world and especially the United Kingdom – that are driving police reform (paragraph 3). Then, we will deal with the question 'what is policing?' (paragraph 4) to provide a reference for our evaluation of what is actually happening in policing as a consequence of the identified major societal developments (paragraph 5). Finally, we will argue that based on

our findings policing has to undergo a substantial reorientation geared to organizational style, internal functioning and relationship with the public from a perspective of 'what matters' (paragraphs 6 and 7).

Police reform in the Netherlands

In the Netherlands policing was reorganized into a new National Police Service (NP[1]) in 2013. This was the largest governmental institutional reform in recent history and with over 60,000 personnel the NP became the largest public agency in the country. Previously the Dutch Police was structured, following a 1993 reorganization, into 25 regional forces and one national agency (*KLPD*[2]). In this regional system the mayor of the largest or most important municipality within the region was responsible for the day-to-day force maintenance (*korpsbeheer*) while policy decisions on maintenance were made by a board of all the mayors and the Chief Prosecutor within the region. The mayors in charge of regional force maintenance (*korpsbeheerders)* answered to the Ministry of the Interior while the Chief Prosecutor was part of the hierarchical structure of the Chief Prosecutor's Office under the Ministry of Justice. The Minister of Justice was responsible for the maintenance of the national agency. The traditional dual governance structure in operational matters at the local level was under the mayor for public order and the public prosecutor for crime and prosecutions. Police chiefs had, then, two bosses and engaged with them in the so-called triangle for policy and decision-making on operational matters. This traditional dual governance structure at local level continues to exist under the 2012 Police Act. However, in the new situation maintenance decisions are made at the national level begging the question how to balance local and regional priorities on the one hand and national and international priorities on the other.

Importantly and for reasons beyond the scope of this article, the Netherlands which had been known for its progressive tolerance and enlightened criminal justice system, has in the past decades moved to the political right with a preoccupation on crime and security (Wansink 2014). This background created a window of opportunity to end an ongoing discussion about the need to centralize authority over the police and to end the difficult decision-making by the informal board of 26 police chiefs as well as that of 25 regional *korpsbeheerders* in relation to the two police ministers. With the 2013 reorganization the 26 forces were merged into one agency under one chief and now only one Ministry, renamed as 'Security and Justice'.[3] The increased power for the Justice Minister, now responsible politically for the Police Service, went hand in glove with the loss of power of the regional mayors. Putting

[1] Originally referred to as '*Nationale* Politie' to indicate the move away from the *regional* police services; more recently, under the new Chief Constable, it became 'Nederlandse Politie', hence from *National Police* to *Dutch Police*.

[2] *Korps Landelijke Politiediensten* – National Police Services Agency.

[3] In October 2017 with the forming of a new coalition government the name was changed into 'Justice and Security'.

the new force solely under Security and Justice made people frown since it also indicated a possible shift to a primary orientation to crime control and away from local policing.

At the onset of the reorganization critical remarks from the advisory bodies as well as from Parliament, were countered by the government by repeatedly adding new goals to the reform (Terpstra and Gunther Moor 2012), whereas the presumed savings of ending fragmentation and centralizing force maintenance after reorganization had led to a budget cut of 250 million euro's at the start of the reorganization process in 2013. As with many flagship governmental reforms this substantial operation was accompanied by glowing rhetoric promising enhanced coordination, effectiveness and efficiency regarding crime and security along with substantial economies. However, these promises had largely not been fulfilled by 2015 and led to the so-called 'recalibration' of the process (Ministerie V&J 2015) while the prolonged process required extra funding to compensate the earlier budget cuts in advance of the presumed economies whereas the reform process dragged on[4]. The first national police chief had made way for a new chief as of March 2016 who clearly stated that the (political) ambitions had been too high and that the centralization of the Dutch police had gone too far and that rebalancing was needed (*Trouw*, 27 February 2016). These statements predated similar conclusion of the aforementioned Commission 1,5 years later.

Symptoms of unrest and stress amongst staff are evident in Dutch policing and have been mainly associated with the restructuring processes in which geographical boundaries are changed and police officers have to be redeployed in a new organization with the possibility of being transferred across the country or have to seek employment elsewhere. Furthermore, many Dutch police officers had earlier gone from smaller forces to regional ones and had experienced recurring cycles of reform with successive chiefs and external specialists promoting change.[5] This constant reform agenda over more than two decades has fostered widespread dissatisfaction, insecurity and lack of motivation. The percentage of absenteeism is in 2017 a worrying structural 7%.

The reorganization of the Dutch police has been subject to evaluation by the *Commissie Evaluatie Politiewet 2012* (*Commission for the Evaluation of the 2012 Police Law*) which presented its findings by the end of 2017. The main focus of the evaluation has been on issues of organizational structure and governance. Accordingly, the Commission made sensible recommendations on adaptations of the organizational practices and governance of the police system in order to meet some of the

[4] It didn't help that the Ministry of Security and Justice was itself dogged by affairs with two ministers and a junior minister having to resign in relation to failures in communication and accountability.

[5] A Dutch officer of long service who was asked to speak about the 'reorganization' relating to the new National Police asked 'which reorganization?' For some 40 years, he had known nothing else but reorganization (Bangma 2014).

original goals of the reorganization. Unfortunately, the Commission has not been able to pass judgement on the *performance* of the Dutch Police in comparison to the period before the reorganization and how this has impacted on *public trust*. Both items were – next to *economies* and increased *professionalism* – important pillars of the policy theory behind the 2012 reorganization and seen as contributing to a safer and securer society (‘t Hart 2018).

…. and in Scotland

The analysis of the Commission is primarily geared to governance and organizational issues and to the Dutch case in isolation (*Commissie Evaluatie Politiewet 2012*, 2017). However, the difficulties surrounding the cumbersome Dutch reorganization are not unique. In recent years we witnessed police reforms in several European societies – England & Wales, Scotland, the Nordic countries and others (Fyfe et al. 2013) – and it is useful to look at other countries because the similarities seem at least as important as the differences (Van Dijk et al. 2015).

Scotland is of particular interest in the context of this article because of the nationalisation of the police at almost the same time as the Dutch. Furthermore, the Scottish reform is also under evaluation. A first assessment after two years of reorganization has been followed by a second dealing with the four year period. As in the Netherlands, the police centralization process in Scotland has also experienced highly negative exposure regarding governance, leadership, accessibility and conspicuous operational failures (Terpstra and Fyfe 2014, 2015). As is the case in the Netherlands, the restructuring processes and the redeployment of police officers is seen as the cause of dissatisfaction, insecurity and lack of motivation amongst personnel.

In both Scotland and the Netherlands, the withdrawal of local policing, closing of smaller stations, poor communications and lack of local knowledge have all been cited as factors in citizen dissatisfaction (Fyfe et al. 2013). In some rural areas with almost no policing criminals seem to have moved into the vacuum for various activities such as wild-life crime in Scotland and drugs production in the Netherlands. Furthermore, police increasingly focus on the so-called core tasks at the expense of for example traffic. The low priority given to traffic duties conflicts with the fact that a vehicle is used in much criminal activity and that many deaths and injuries occur in traffic because of various offences including criminal ones: but such offences have effectively been decriminalized.[6]

[6] These include dangerous driving, drunk driving, poor maintenance, underage driving, driving without a licence and not being insured. Sometimes offences can be related to companies which use unlicensed staff, make drivers work beyond legal limits and fail to carry out maintenance: if this leads to deaths or serious injury of personnel or others then this could lead to prosecutions for corporate manslaughter and/or related serious offences.

There are, then, diverse negative consequences of upscaling and withdrawing from enforcement which attract dissatisfaction and critical debate. Although policing can never be omnipresent there is something disquieting about once visible and accessible police retreating from the local level and which can enhance feelings of insecurity. In the cities the police threaten to become more distant and impersonal at the detriment of – we believe – security and legitimacy. The ideal of a police closely connected to local communities decreasingly resembles what is happening in practice.

Both in Scotland and the Netherlands improving local services was a prominent goal of the reorganization, but in fact service delivery is under pressure due to the emphasis on efficiency and lack of (local) capacity. Of considerable importance societally is that while the Dutch police was reorganized into a national service, several health and welfare services were decentralized putting local government in charge but with smaller service budgets. Cuts in wider Dutch public service budgets have also fostered unrest in other sectors, such as education, social work, health care and related front-line services. Furthermore, institutions for people with mental health issues have been closed as well as nursing homes for the elderly based on the assumption that ambulant care organized by the municipal authorities is more effective and less costly. Curiously, there has been at the same time a cutting back on home help and community support. All of this has to be related to the impact on the vulnerable and to the predictable rising demands on services – including policing – from an ageing population.

Societal trends

Some of the pivotal trends of recent years that have characterized police reform are: centralization, militarization, privatization and civilianization, internationalization and politicization (Van Dijk et al. 2015). These have collectively brought a major shake-up in the conventional structure and functioning of policing (Brodeur 2010; Brown 2014). Behind these trends are important social political developments that have changed the perspective on what policing is about, which we will discuss below. We are conscious of wielding a broad brush and cannot expand on the diversity within policing across cultures; and we remain aware that policing is highly context driven – nationally, regionally and locally (Reiner 2010, 2016).

Probably the most influential factor in recent decades has been the predominance of neo-liberalism (Verhaege 2014; Monbiot 2017) and New Public Management (NPM). This strongly influenced US and UK governments from the early 1980s and stood for a leaner state, primacy of free enterprise, cuts in public welfare, opposition to unions and tougher approaches to crime and disorder with emphasis on tackling organized crime and combatting terrorism (especially after 9/11 in the US). These approaches drew on the conservative 'punitive' ideology in US criminal justice fostering tougher policing, longer sentencing and harsher prison regimes. This 'tough on crime and on criminals' was exported through the influential 'zero toler-

ance' style of enforcement (Tonry 2004; Punch 2007). This significant shift to harder approaches to social issues has come to dominate government policies in several societies. Later this was even embraced by ostensibly 'leftish' governments, as with 'New Labour' in the UK (from 1997), and became widely the new normal.

A central pillar of neo-liberal thought was that private enterprise was superior and public services an unreformed burden on the public purse. The answer was to transfer managerial practices – rooted in competition and consumer choice – from the former to the latter (Leishman et al. 2000). Police leaders were now expected to become 'executives' and to consider efficiency, planning, budgets and 'customers'. Furthermore, they were under increasing pressure to perform and were held to account by diverse government agencies and by the increasingly intrusive media. In the Netherlands we saw the introduction in 2001 of (partial) performance based-financing followed by the National Framework for the Dutch Police 2003-2006 (*Landelijk Kader Politie 2003-2006*) and related regional covenants (performance contracts) as a form of output management under a government programme 'Towards a safer society' aimed at 20% reduction of crime and disorder by tougher enforcement of the law (Burger et al. 2004).

Ostensibly NPM promised improved service and 'customer' satisfaction. And in enlightened organizational management development there is advocacy of engaged leadership, room for debate and dissent, a determination to improve with learning from mistakes, investing in personnel and taking customer feedback seriously. But the neo-liberal element in many government policies and corporate practices draws on the bottom-line reductionism within the Chicago School economist Milton Friedman's free market adage "the business of business is business". What one sees across the board of services which have been pushed to reorganize with reduced budgets is a top down management style – often with a new layer of highly paid 'corporate executives' – pushing to increase productivity with less personnel, cheaper personnel on flexible contracts with less security and benefits along with a time consuming demand for bureaucratic accounting. This goes against all the principles and practices of enlightened management of service agencies leading to high dissatisfaction among personnel and 'customers', especially because they are not paying customers. This is also evident in policing and is, we maintain, undermining both police motivation and public satisfaction.

Of fundamental importance emanating from this powerful ideology at governmental level was that services had to be pruned to balance budgets, to stimulate economic success and to advantage a substantial proportion of the electorate. This was particularly dominant during the recent global economic crisis starting in 2008. One consequence in recent years has been to cut substantially policing budgets in the UK and to an extent also in the Netherlands. The results of the budget cuts have been particularly savage in UK policing with reductions in numbers of officers, cuts in pay, freezing of promotions and lengthening the pension age. In some British forces police property is being sold, mounted units disbanded, traffic duties largely

abandoned, diverse services outsourced and civilians are increasingly taking over certain policing tasks. In short, many officers are being asked to do more with less: and with fewer qualified co-workers, diminishing resources and with a low chance of reward. As a result, there is evidence of widespread disillusion and alienation among police personnel with high rates of sickness and premature retirement.

At the same time, there is abundant evidence in western societies of an increasing gap between the wealthy and the less advantaged with the latter experiencing long-term employment insecurity given the major changes in labour markets along with increasing levels of poverty. For the disadvantaged class or *Precariat* (Standing 2011) this raises the likelihood of various social and health problems including psychiatric issues, domestic violence and a higher tendency to certain forms of criminal activity than other social groups. In this context the NPM ideology is even more damaging then it would be in more egalitarian conditions.

Furthermore, as a consequence of the changing media landscape – with information and communication technologies as important drivers – politics has become increasingly short-term, media focused and the horizon frequently is reaching the evening's headlines with a sound-bite. In the UK ministers harass and brow-beat police chiefs who are in their eyes not performing and try to badger them into resigning. And Theresa May as Home Secretary brayed at a police meeting that police officers only task was to cut crime. This not only flies in the face of over 50 years of accumulated research evidence but is also insulting in telling a profession what its mandate should be (Skogan and Frydall 2004). Police chiefs, then, are under constant political pressure to reorganize and to achieve goals but with limited means while under intense media scrutiny. Furthermore, this is increasingly the case with other services.

Moreover, policing, crime, terrorism and disorder – increasingly linked to immigration and alien conspiracy threats – have become staple diets of the media and have moved to centre-stage in reporting police failings. For when a force nationalizes there's only one force and one chief to focus on so the news now becomes how incidents reflect police shortcomings at the national level. This has happened in Scotland, the four Nordic countries and the Netherlands.[7] In the latter there have been some failures in service delivery that were widely reported; scandals related to dubious spending and ineffective accountability; and revelations of resilient racial and gender prejudice (*NRC* 2017b). Some negative police conduct is also increasingly being exposed in the social media including through persistent harassing by vloggers and the images are instantly spread on the internet. In the UK in particular certain

[7] In the Netherlands a damning incident involved a young woman who had been sexually attacked but was not taken seriously by the police. Yet she was able to trace the offender herself though the phone he had stolen from her (*NRC* 2017a). In Scotland it was a road accident that was reported to the police but it took three days for officers to respond by which time one wounded passenger had died and another was in a critical condition (*Independent 2017*).

sections of the populist, right wing media aggressively hound leading people in the various services including policing – especially if the latter are seen as 'soft' on crime – and endeavour to unseat them by malicious campaigns of 'naming and shaming' (Paddick 2008).

What is policing?

To make sense of the trends and developments we have described, to evaluate their impact and suggest possible remedies, we should first establish what 'policing' actually means. This is also of more fundamental importance as it is often glibly spoken of as if it is self-evident. The police in western societies typically refers to a public agency with a legal mandate to enforce the law and maintain public order. But in practice policing is a complex emergency and social service agency with a baffling range of tasks related to regulation, inspection, political intelligence, counter-terrorism, immigration, traffic, diverse forms of crime and crime prevention, patrol of public spaces and aid to those in need. As Marenin (1982) put it, policing stretches from class repression to parking tickets. Hence, it is different at different times in different places to different people in different societies. There are five particular features we wish to accentuate.

Firstly and crucially, the police is the only 24/7 uniformed and (ostensibly) accessible service with the powers to interfere directly in the lives of citizens and if necessary deprive them of their freedom with the use of force including fatal force. Police can kill fellow citizens in the name of the state. This makes the police institution unique. And, 'unique' implies that we should be cautious in treating it like other social agencies.

Secondly, in major emergency response mode policing has to change from devolved and routine functioning to being central, hierarchical and focused on critical incident deployment. Many people have to change roles, sometimes instantly, with different tasks, responsibilities and accountability. This could be regarding a natural disaster, terrorist incident, major fire, serious traffic accident, large-scale riot, major shooting, plane or train crash or large-scale criminal investigation. This further implies that everyone involved has been trained, tested and certified for those roles and that they – and the institution itself – are ready to be held to account.

Thirdly, the first officer – or officers – on the scene of incidents, major and minor, is usually low in rank. The worst air disaster in UK history – as a result of a bomb explosion on board a US passenger plane above Lockerbie in 1988 – occurred above a small Scottish town and in the smallest police force in the UK. Burning debris fell on the town and over 200 bodies were spread over a large area. Ordinary police officers were confronted with an extreme situation requiring an immediate response to something they could never have visualized in a peaceful rural area. In the Netherlands, the same instant reality shock occurred when in 1992 a Boeing 747 cargo

plane crashed into a block of flats in Amsterdam shortly after take-off causing massive damage and a raging fire. This was right next to the local police station and officers were dramatically confronted with mayhem and had to react immediately before support started to arrive. Those two crashes were mega-incidents but a similar dynamic implies to other small scale emergencies – a house fire, a shooting, missing children, serious car crash, etc. – and the implication is that officers, sometimes on their own, can be relied on to take control temporarily, to report back the details quickly and to direct others until the hierarchy of senior personnel and specialists arrive. Front-line officers have, then, ideally to be able to think for themselves and to be able to take charge independently. They have to be empowered legally to do so and trained for that initial holding role.

Fourthly, allied to the latter is that the organization at all levels is competent to deal with such incidents and is ready to be held to account in public fora. And, that higher ranking personnel are competent and confident in their roles and are prepared to be held to account internally and externally for operations. The lower ranking officers should be able to rely on that and the institution should be able to provide it.

Finally, much routine policing is conducted by one or sometimes two officers – in the Netherlands routinely two officers – who may well face challenging and threatening situations on their own. The consolation is that support is on its way. But what if there is no back-up? Among the complaints in UK policing related to pressure of work and lack of prospects – leading to resignations of once motivated people worn down by the poor work climate – are that there are just not enough personnel. Charman's (2017) longitudinal study of young British officers in their first four years reveals them to be originally motivated but increasingly frustrated at the lack of personnel and quality of equipment. This not only weakens the delivery of service but is also potentially dangerous and raises the issue of the legal responsibility of the organization to display a duty of care to the public and its own personnel.

As we have argued elsewhere (Van Dijk et al. 2015) policing includes many and diverse tasks and where and when urgent issues occur cannot be fully known in advance. Furthermore, issues that have a low probability of occurring, may have an enormous impact, as shown in the examples above. This broad spectrum of what polices services do can be divided into three main pillars of policing: crime and security management, social-welfare and community outreach, and order maintenance. We argue that policing should be based on a philosophy or *comprehensive paradigm* which is built around all of these three main pillars. Traditional thinking about philosophies of policing tends to distinguish between the *control paradigm* and the *consent paradigm*. The former focusses on crime control and public order maintenance with a police force at arm's length of the community and with a small mandate, whereas the latter, based on the Peelian principle "the police are the public and the public are the police" places emphasis on police community relations with a police service in close contact with the community and with a broad remit. The *comprehensive paradigm* helps to escape the traditional thinking in terms of

control versus *consent* and serves to reconcile divisive dichotomies, such as 'force' versus 'service, 'crime' versus 'social', 'hard' versus 'soft', 'central' versus 'local' by integrating the three main pillars of policing (Van Dijk et al. 2015).

Making sense of what is happening

Earlier, in paragraph 3, we touched upon a range of developments in western societies which raise acute problems in policing as well as in other front-line services to the extent of a major crisis in personnel, motivation and quality of provision. Taking all this into account there is ample reason for concern about the state policing is in and there is the need for a profound review of the pressures and demands being exerted not only on policing but also on other related services with potentially grave consequences (Loveday 2017). This is an urgent matter, because services essential to the quality of life for many in modern society are perilously on the verge of 'running on empty'. They will stop functioning as genuine public services if we accept further 'simplification' of what a public service – especially policing – is about. For the police there is the added burden that, in the absence of provision elsewhere, people will increasingly turn to the police if they need assistance. In this paragraph we evaluate what is happening in policing using three perspectives: paradigms of policing, organizational structure and professionalization. Our aim here is to find clues on how to reinvigorate policing.

If we look at the changes in policing from the perspective of underlying philosophies or paradigms of policing we come to the conclusion that the *consent paradigm* is under great strain. The tougher approaches to crime and disorder with emphasis on tackling organized crime and combatting terrorism are indicators of a narrowing of the police remit discarding the fact that crime and security management is but one of the three main pillars of policing. This indicates that the *control paradigm* is gaining momentum. In the UK this is a more or less explicit process, whereas in the Netherlands this is happening implicitly or even surreptitiously (*Volkskrant* 2015). In the 2012 Police Reform the espoused paradigm is still that of *consent* as might be deduced from the accompanying rhetoric of strengthening local embeddedness of the police service as one of the many objectives of the nationalization process, while government funding is mainly geared towards counterterrorism and restructuring of the police organization. Recently, the resulting withdrawal of police capacity from the local level creating a vacuum which local governments try to fill in with local ordinances enforcement personnel, has come under much criticism (SMV 2018). It is our view that – regardless of rhetoric – the control paradigm is the current dominant model, at the expense of the police as a legitimate crucial social service.

A second perspective on the changes that have taken place in policing is that of Mintzberg's (1983) five types of organizational structures. Although police organizations are unique in the sense of their powers to interfere directly in the lives of citizens, they are also front-line service agencies which closely resemble Mintzberg's professional bureaucracy. For, at least a part of the police work is done by highly

trained professionals providing services to the public that potentially have a huge impact on members of the public who are highly dependent on the service provider. Therefore, the classic image of the professional bureaucracy can help understand some of the mechanisms in today's police organisations. Characteristic of the professional bureaucracy is the tense relationship between highly trained professionals with a great amount of discretionary powers on the one hand and a stringent structure of top down assignments from the management as well as demanding accountability from below on the other hand. It is our view that under the neo-liberal ideology embraced by governments accompanied by the NPM-thinking within organizations the bureaucratic logic has become too dominant narrowing the operational space of professionals and thus fostering widespread dissatisfaction, insecurity and lack of motivation amongst personnel.

The third perspective is that of professionalization. The move to 'professionalize' policing with a body of knowledge disseminated through higher education to improve performance and service delivery as well as to enhance the status of policing is found in several societies. Since much of policing involves working in partnerships with professionals from other agencies, the latter aspect has gained importance. Two currents in professionalization can be distinguished. One emphasizes the content of the profession and embraces the image of the police officer as a reflective practitioner (Schön 1983, 1991). Important aspects are ethics and values, a body of knowledge and practice, responsibility and accountability. The other emphasizes the structural aspects of a profession such as professional body and a registered membership. The College of Policing for England and Wales (founded in 2012), for example, is modelled on the medical profession with the aim of an all-graduate membership and with a code of ethics, professional standards and 'evidence-based policing' providing the knowledge base (Sherman 2013). In the climate of neo-liberalism and NPM the institutional current has gained the upper hand leading to a rush towards 'certification' through higher education to enhance the status of policing. This trend is clearly visible in the UK and, to a lesser extent, also in the Netherlands (Huisjes et al. 2020).

These developments have raised again the dichotomy of 'management cops' and 'street cops' first flagged by Reuss-Ianni (1983). For UK and US policing was traditionally an artisan institution with everyone starting on the streets and senior officers rising through the ranks. Reuss-Ianni conveyed that this shared culture and experience was evaporating with senior officers espousing new management practices that created a rift with lower personnel. The development has since then brought about a new layer of what we call 'corporate cops' at the top with the 'management cops' becoming the middle layer. This cultural and operational gap with front-line policing has been accentuated by the recruitment and promotion of senior officers largely on educational qualifications and management competence along with direct entry schemes in some forces (Lee and Punch 2006). There are, then, serious questions about the growing social distance between ranks and also

the operational ability of new-style senior officers in demanding situations. This predominance of the bureaucratic side of the professional bureaucracy is increasingly problematic since front-line police work frequently calls for police officers to cooperate with professionals from other front-line agencies which requires a reasonable amount of discretionary powers or 'professional space' to act according to the circumstances.

Reorientation

Bearing in mind the unique nature of the police with considerable powers backed up with the potential for use of force and with a broad remit to intervene directly in citizens' lives; that policing is varied, delicate and at times dangerous work which needs to be conducted primarily by fully trained and certified law enforcement officers; that an essential element is surplus capacity for emergency response which can only mean sufficient numbers on duty at any one time (Brodeur 2010); and that engagement with communities at the local level is essential, what should be done to reinvigorate policing to recover from the fall-out of neo-liberalism and NPM?

The short answer – referring back to the last paragraph – is: policing should be about *people*. Budgets, governance and organizational structure are not the things that matter. What matters in policing is people and we argue that the solution is in focussing on three salient 'human' areas which could underpin improvement and a reorientation within the existing system. These relate to police officers and how they are equipped to do their jobs, on how the organizational style and internal functioning of the police organization supports officers in their work and on how police officers constitute their relationship with the public. Drawing on our analysis above as well as the wider literature in the policing domain we suggest three key focal points to re-orientate policing in a positive direction: competencies, solidarity and compassion. We argue that seriously investing in these three areas will improve relationships inside and outside policing while enhancing institutional effectiveness.

Competencies

We have pointed out that the police service is a unique service with a baffling range of tasks which makes the police a service with a potential (or actual) huge impact on people and society. And, that as a front-line service policing is about direct non-routine contact of professionals with citizens and other agencies which comes down to 'handling the situation' (Wilson 1968). However, 'handling the situation' is not applicable only to working on the beat, but to all police tasks. Whenever things are unclear, police professionals have to assess the situation they find themselves in, identify other potential actors and agencies, define the situation and act accordingly.

This is not only a characteristic of street level policing or emergency response but the same applies in fields as criminal investigation, crime prevention, cyber, intelligence, traffic, or immigration. This implies that each and every police professional

should be equipped for this general role with the necessary knowledge, skills and attitudes (generic competencies) in initial police education and training as well as trained, tested and certified once working as a police officer. Furthermore, it underlines the need of investments in personnel and to distil the specific competencies necessary for specialist roles and functions and train, test and certify officers for those tasks. We are thinking particularly of higher ranks in operational roles, for example in command and control situations. The key is that it is institutionally irresponsible to put an officer in a command role on the basis of rank who is not fully qualified and not well experienced for the task. It is also about the accountability structure: the higher the command role the greater should be the accountability.

As society becomes more complex front-line professionals should be able to handle complicated situations on their own and to deal with vocal, demanding citizens. Thus, police officers need to be equipped with a broad range of generic competencies relating to, for instance, communication, cooperation, problem solving and 'digital skills' also known as 21th century skills. These broad generic competencies are generally associated with higher levels of education and training. In recent years, police organizations, especially in the Nordic countries, have raised the level of education required to enter the police to associate degree or bachelor degree. In the Netherlands the discussion about raising the entry level for community beat officers (Politieonderwijsraad 2017) as well as for policing in general is fairly recent (Politieonderwijsraad 2018), although bachelor and master courses in policing have existed since the restructuring of police education and training in 2002 (Huisjes et al. 2020). These are positive developments but as mentioned it is important to see professionalization in the context of the importance of the reflective practitioner and not as a means to enhance the status of policing.

Solidarity

Police organizations are notorious for being segmented into tribes, clans and factions with a strong occupational hierarchy with patrolling rated low and specialist functions (firearms, organized crime and counter-terrorism) deemed high. That's doubtless difficult to eradicate but the organization and its senior officers simply have to hammer away that in policing everyone is important. When a large-scale, pre-planned operation takes place or a spontaneous reaction to major incident occurs, then everyone plays a role including the support staff and the catering. *Mutatis mutandis*, the same should be the case in daily routine operations.

Another factor is that senior officers should be formally obliged to spend time observing operations and experiencing the work of the lower ranks. Everyone should be suffused with the idea that they all work for the same organization and that all ranks play a role. Senior officers simply have to remain in contact with the front-line in order to be effective leaders. In short, 'joined up' policing does not happen of itself but has to be managed.

Furthermore, 'corporate cops' and 'management cops' thinking along the lines of NPM and/or working with smaller budgets tend to believe that police work – as in a machine bureaucracy – can be easily divided into relatively simple tasks that can be done by junior staff, less qualified officers or even civilians. For instance, one feature of recent developments in England and Wales has been to downgrade and downsize the role of community beat officers. Yet, the strongest internal promoters of re-energizing that function are ironically the elite, counter-terrorism squads because they miss the eyes and ears of beat officers noticing the signs of radicalization in largely ethnic or religious communities. Sound local knowledge can prevent attacks and save lives, including police lives. This underlines the importance of organizing policing on the basis of the comprehensive paradigm in which crime and security management, social-welfare and community outreach, and order maintenance are equally important and interconnected fields of the police organization.

This perspective on the police function as 'indivisible' and 'holistic' should be translated into the organizational structure and should be reflected in the way the professionals are 'equipped'. Obviously, we are not implying to have no specialization, both at the organizational and individual level. We are arguing that there is a limit to specialization because different tasks are interconnected. So, at the organizational level, it would be deleterious to separate investigations totally from, for example, policing in the neighbourhood. At the level of the professionals it means that all police officers – as mentioned above – are in a sense 'general policeman', next to may be being a specialist in a specific task as well. Thus, the comprehensive paradigm places the police professional at the centre of the required future development of policing and 'the police'.

Service, with compassion

'Compassion' is not always associated with policing but we use it here to emphasize that the relationship with diverse publics – especially the vulnerable – is of the essence. That relationship depends on motivation, taking the public seriously and delivering a multi-agency service. Also when police are called to serious emergencies or incidents of violence, sudden death or injury their behaviour strongly influences how victims, bystanders and victims' families assess the legitimacy of policing and, in turn, their willingness to cooperate later with the police. Hence this is enlightened self-interest. Furthermore, police aid to those requiring help has in various forms become increasingly institutionalized and even statutory in recent decades. Police are now involved with aiding the vulnerable – as victims or potential victims or simply needing care and protection – including the mentally ill, sex workers, the disabled , the elderly, traumatized war veterans, the young and females facing domestic violence while officers investigate hate crimes against the vulnerable and historic sex crimes. Much of this work is being conducted in partnerships with other agencies. In short, in the area of 'law enforcement and public health' the police agency is more often taking a proactive, preventive role with widespread cooperation with multiple partners (Punch and James 2017; van Dijk and Crofts 2017).

What matters?

We have emphasised that policing is a unique agency within a democracy subject to the rule of law; that it requires engaged leadership closely involved with the primary processes and front-line personnel; that motivation is of the essence and that there is investment in creating skilled and motivated staff who are taken seriously; and that service delivery – especially with the vulnerable and needy – is performed in a professional, concerned and even compassionate manner. If you draw on the accumulated knowledge in police and management studies then this the path to reinvesting meaning in policing and regenerating police officers to do what they want to be doing as professionals. This can be achieved largely within existing structures but it does require reallocation of existing resources, and a paradigm shift. Our position is that we are at a turning-point in policing and that choices need to be made urgently which will not only determine policing for a generation but will also determine in what sort of society we are living.

Chapter 4. Recognition and enhancement of joined-up solutions

van Dijk, A.J., Herrington, V., Crofts, N., Breunig, R.V., Burris, S., Sullivan, H., Middleton, J., Sherman, S., and Thomson, N. (2019). Law enforcement and public health: recognition and enhancement of joined-up solutions. *The Lancet*, 393, 287-294. DOI: https://doi.org/10.1016/S0140-6736(18)32839-3

Public security and law enforcement have a crucial but often largely unacknowledged role in protecting and promoting public health. Although the security sector is a key partner in many specific public health programmes, its identity as an important part of the public health endeavour is rarely recognised. This absence of recognition has resulted in a generally inadequate approach to research and investigation of ways in which law enforcement, especially police at both operational and strategic levels, can be effectively engaged to actively promote and protect public health as part of a broader multisectoral public health effort. However, the challenge remains to engage police to consider their role as one that serves a public health function. The challenge consists of overcoming the continuous and competitive demand for police to do so-called policing, rather than serve a broader public health function – often derogatively referred to as social work. This Series paper explores the intersect between law enforcement and public health at the global and local levels and argues that public health is an integral aspect of public safety and security. Recognition of this role of public health is the first step towards encouraging a joined-up approach to dealing with entrenched social, security, and health issues.

Introduction

The health of the public requires and is dependent on the safety and security of the individual; therefore, public health as a discipline promotes safety and security. The law exists to promote safety and security and the enforcement of law is part of the same endeavour. The public health and law enforcement sectors should work together with overlapping goals and collaboration to achieve safety and security for populations. The fact that they are often unable to achieve, or inadequately achieve efficient collaboration, even when dealing with the same populations or issues, is to the detriment of both sectors.

Although the past few decades have shown an unprecedented growth in collaboration between these sectors, especially in welfare states in developed countries, the collaboration has not led to a unified political agenda. Consequently, there is a permanent and real risk of returning, perhaps temporarily (but at great cost), to the specialisation perspective of the industrial era, especially considering the trends of austerity and neo-liberal ideology in many developed countries. Increased worries about state security, encompassing mass migration, terrorism, and economic inse-

curity, could lead to a return to a siloed approach in dealing with problems, emphasising the importance of forging structural collaborations on the basis of interdisciplinary evidence. In this Series paper we focus on high-income countries specifically. However, developing countries, with their surfeit of complex social problems magnified by the complications of democratic fragility, have even more to gain from a coherent understanding and complementarity coordination of law enforcement and public health efforts.

At the boundaries of established fields

The global population is faced with complex social issues that have an effect on health and criminal justice, including social and economic inequalities; vulnerability to violence, especially gender-based violence in domestic settings; mental health crises; alcohol and drug dependence and related harms such as HIV infection; dementia and expected increases in calls for assistance; and modern slavery and human trafficking. Recognition of the multidimensional character of such issues is increasing. The aforementioned issues, particularly violence, alcohol, and mental illness, can intersect and interact, increasing their complexity.

The importance of the intersection of law enforcement and public health is reflected in the growing number of academic publications on this topic (Punch and James 2017; Bellis et al. 2012). A discourse is emerging in which public health and law enforcement are seen as alternative perspectives on social issues that overlap, driven by the growing understanding of what produces both crime and ill health, among other things. An impressive body of knowledge exists in the health sector with regard to social inequalities, drug and alcohol abuse, mental health, and domestic violence.

The relatively new field of brain science is providing a physiological basis for how positive behaviours might be hard wired into the human brain from very early on in development, within the first 1001 days. The findings also show how adverse childhood experiences set up contrary neurophysiological feedback loops that make it more difficult for positive self-image and constructive behaviours and relationships to be formed in a developing child's mind. The neurophysiological understanding of adverse childhood experiences will become increasingly important in law enforcement and public health (Shore 1997; Perry 1997).

This wealth of knowledge does not necessarily translate directly into alternative approaches to urgent societal problems. Considering that the overlap of public health and law enforcement is an emerging field (van Dijk and Crofts 2017) it is sensible to concentrate on mapping and analysis of practices central to academic progress. From a practical perspective, the importance of the intersection between law enforcement and public health is strongly supported by concrete observations from professionals of both sectors, often dealing with the same people and related issues. It is important to understand what is happening on the frontline (i.e., situations in

which health and law professionals interact directly with the general public) because it is here that professionals have to act, developments at the boundaries of traditional domains are most visible and have real consequences, and, as a result, collaborations develop. Hence, this Series paper focuses on the frontline of both law enforcement and public health.

Both law enforcement and public health can be characterised, in part, by the professionals and organisations involved in these respective sectors, and both aim to contribute to the safety and security of the population. We define law enforcement as the organised and legitimate effort to produce or reproduce social order – evident in rules and norms – to enhance the safety and security of society. The principal actor is the (public) police, with criminal justice and offender management elements. Although the so-called pluralisation of policing and the emerging public–private partnerships in policing and law enforcement are relevant developments, we concentrate here on the public police as the most important (symbolic) actor in law enforcement and as the starting point of exploration of the intersection between law enforcement and public health. Contrary to popular belief, policing is not limited to catching thieves and maintaining order, but involves protection of vulnerable individuals, groups, communities, and those at risk of crime by way of activities such as safeguarding, surveillance, community or public safety, and public protection. Similar to public health, evidence-based policy making has become increasingly recognised and valued in law enforcement (Lum et al. 2011).

Public health is even harder to demarcate than is law enforcement. Consideration of public health as the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life among populations through the organised and informed efforts of society, as adopted by the Faculty of Public Health (Marks et al. 2011), reflects its breadth and diffuseness. The public health system is geared towards outcomes at the population level, as opposed to the individual's health, with the definition of population depending on the problem and the desired health outcome. Addressing inequalities in health and underlying structural issues are key public health concerns (WHO 2008; Marmot et al. 2010). Effective maintenance of good public health requires a wide range of societal policies, interventions, and services, but also requires specialist intervention – e.g., against infectious diseases and environmental hazards – to generate evidence-based health improvement policies and services, and to evaluate effectiveness of services. Because public health coalitions are broad and vary depending on the issue and desired health outcome, there is no single public health authority managing all aspects of public health.

Both law enforcement and public health use concrete interventions, with an emphasis on changing unhealthy or criminal behaviour. The two sectors are involved with people or populations in need, and both have an obligation to protect those susceptible to crime, ill health, or both. In their attempts to change behaviour and in their response to incidents, they can directly influence each other and societal

outcomes. Importantly, the right intervention is always context specific, regardless of general valid guidelines or rules in public health or in law enforcement. Professionals are required to make judgments on the basis of shared values and positive societal outcomes, an activity that requires professionals from both sectors to work together.

Synergistic approaches, such as those described above, require reciprocal understanding of the potential for action by the respective agencies, and a high degree of respect, dialogue, and partnership. However, there are many practical and conceptual barriers, including the fact that public health and law enforcement systems originate from very different cultures and have strong incentives to stay in their silos; incentives to use an intersectoral approach are often scarce. Another conceptual barrier is that neither law enforcement nor public health are self-evident concepts, and the intersection of both even less so. These barriers can harm the collaborative vision and strategy development, as well as diminish structural multidisciplinary research. The practical and conceptual challenges are related, as are the social practices and the related institutions (Giddens 1979).

An emerging agenda

Public health and law enforcement are products of the process of modernisation, intimately related to the state and to urbanisation. In (hypothetical) small communities in which all individuals know about the condition and behaviour of others, separate institutionalised and professional law enforcement and public health would be absent. Therefore, modern public health and law enforcement replicate the support provided by kin in small communities that has been lost in the rise of modern life and the anonymity of city life. Both public health and law enforcement developed as specific organisations with a similar mandate to protect the public, bodies of practice and knowledge, technologies, mentalities, and ethics (Johnston and Shearing 2003).

This crafting process was especially prominent in the advent of what is now considered the modern institution of the welfare state. Police reform in Great Britain throughout the 18th and 19th centuries was multifaceted and originated in many locations. The emphasis on policing as a crime prevention measure was well established in England through a system of parish government that was described by Reynolds (1998) as “a pivotal arena not only for the implementation of national policies but for initiatives that strengthened government as a whole”. In addition to detecting crimes and preserving the peace, the duties of the early police included enforcing liquor laws, regulating traffic, assisting Poor Law officers, fire prevention, improving the paving, lighting, and cleanliness of streets, and the general detection and removal of so-called nuisances and annoyances. The modern police institution then emerged from this amorphous situation.

As a consequence of fundamental societal changes in the 20th and 21st centuries – e.g., from industrial to networked, from modernity to postmodern or reflexive modernity – modern institutions are under pressure, not because of their lack of success but as a consequence of it. Societal problems are at the centre of both law enforcement and public health; however, the complexity of these issues has led to the recognition that the problems cannot be adequately addressed by either party alone. Traditional organisations are no longer defined by strict boundaries (Aalbersberg and van Dijk 2016), which has led to the need for constant negotiation by professionals (frontline officials and agencies) regarding future progression. Health and risk perspectives are central to both domains, and multiagency approaches and cross-discipline developments are gradually – at least in liberal democracies – becoming the norm.

Historically, the development and recognition of an overlapping clientele of law enforcement and public health has been observed in the aftermath of deinstitutionalisation and substantial disinvestment in social services: people who have mental health problems, a poor education, substance dependence, or housing problems are more vulnerable, more stressed, and more likely to present at hospitals, social service agencies, and police stations than the general population (Bassuk, and Gerson 1978; Dear and Wolch 1987). The discussion on ineffective and unacceptable mass incarceration – especially in the USA – has contributed to an emphasis on the intersection of law enforcement and public health (Waller 2013). The emancipation of vulnerable populations (increase of basic human rights for marginalised populations) has been accompanied by a decrease in acceptance of institutional failure. Modern cities and their inhabitants have needs or demands for government action that are no longer manageable within the service silos built in earlier times.

The conception of ideas – visions, strategies, research, and practices – that can inform the progression of public institutions and services is important. Public health systems and policing have to some extent been reinvented, as is evident in the prevalence of police reform (van Dijk et al. 2015). Without exception, the policy documents that guide these reforms emphasise the importance of holistic approaches (rather than organisational logic) that put citizens and communities first. All organisations struggle with the concept of how to implement change, and if not similar mandates of public protection, then what other options are available that could guide priority setting?

Public health and law enforcement both present an ideal world image, although the respective images are not self-evident and are essentially contested. For public health, the ideal image could be a society free of disease, in which people are healthy and have a long-life expectancy with the highest quality of life possible. Clearly there is no definitive solution attached to this ideal world image, because the demand for health is logically infinite; however, increased research initiatives or inclusion of extra dimensions in the definition of health could be implemented. For example, WHO defines health as “a state of complete physical, mental and social

well-being and not merely the absence of disease or infirmity" (WHO 1946). This open-ended definition immediately shifts attention to a discussion on values and principles in the drive for a health utopia, with fundamental questions: who defines what the principal health issues are and on which grounds? Should access to health care be distributed evenly among the population? What is the weight of individual liberties in the collective health endeavour? How do governments or communities prioritise different public health goals? When should decisions be made to invest in other social goods such as the arts or infrastructure, rather than in directly furthering the public health agenda?

In turn, law enforcement presupposes the law and much can be said about qualities of the law-making process and of laws themselves. The theme of integration of law enforcement and public health presupposes a human rights framework, without which there would be no place for law enforcement to engage in public health issues. The human rights framework also applies for public health: without human rights as a foundation, one could strive for a healthy nation at the expense of susceptible communities. For example, the campaign against drugs by the president of the Philippines serves as a warning against the integration of law enforcement into public health without a human rights framework.

This ideal world image of law enforcement is a social construct, and hence an important and permanent subject of political debate. A society in which all members obsessively obey the law would come at the cost of fairness and freedom. Consequently, the same fundamental questions arise as with public health, including who defines law enforcement and how are the resources distributed?

The actual and desired relationship between law enforcement and public health depends on the political, economic, and cultural context and is also affected by the characteristics of the targeted issue. However, this intersectoral field must be put on the agenda for both law enforcement and public health actors. Many urgent issues will be influenced by whether investments in law enforcement and public health are implemented separately or together.

Areas of common ground for law enforcement and public health

Substantive themes for the International Conference on Law Enforcement and Public Health (LEPH) 2016 – reflecting the priorities assigned by the burgeoning law enforcement and public health community – were mental health (many aspects), violence (especially gender-based), trauma (especially road and occupational), crises and catastrophes, infectious diseases, and alcohol and other drugs. However, the range of topics that was covered 2 years later at LEPH 2018 was even wider than in 2016, and illustrative of the breadth of the relationship between law enforcement and public health. Topics can explicitly be related to political issues, such as radicalisation of youth and its links with terrorism, or ethnic profiling by police services. Susceptible populations or leadership in an intersectoral field were themes that

spanned both sectors. Here we exemplify common areas between both sectors to give a general impression of the intersectoral landscape.

Community safety and security

Concepts of security are common topics of discussion for policy makers and practitioners in law enforcement and public health. The 1994 Human Development Report saw security as "freedom from fear and freedom from want" and described issues relating to food security, social and welfare security, political, economic, and environmental security, as well as civil and military security (UNDP 1994). Likewise, a concept of public protection is common to law enforcement and public health to identify at-risk individuals, communities, and situations, through child and adult safeguarding committees (Munro 2011), community safety partnerships and licensing committees that facilitate information flows – e.g., the community safety and alcohol licensing in Cardiff, UK (Florence et al. 2011), and in emergency planning forums (UK Government 2004). Such wider notions of community safety have required full partnership activity, developed to varying degrees in different political administrations and cultures.

A community development approach can support better community safety and health by use of local community assets to minimise tensions and prejudice, promote good relationships, and mobilise positive energy towards common life-enhancing goals and facilities (McKnight and Kretzmann 1993).

Violence

The conceptualisation of violence as a public health problem is only relatively recent (Dahlberg and Mercy 2009). In 1983, the US Centers for Disease Control and Prevention established a specific branch on violence epidemiology to focus public health efforts into violence prevention, which showed the usefulness of the application of epidemiological methods in resolving problems associated with violence (Dahlberg and Mercy 2009; Mercy and O'Carroll 1988). Violence was placed on the international public health agenda in 1996 when the World Health Assembly adopted Resolution WHA49 that declared violence as a leading worldwide public health problem.

Extensive research has since documented health costs resulting from violence; one influential 2012 English report by Bellis and colleagues (2012) estimated that of the nearly £30 billion cost of violence to society, more than a tenth was a direct cost to the health system. The authors found that violence has many characteristics that allow it to be considered a public health issue, including the cost to the health service, its so-called contagious or hereditary character, and a very strong inequality gradient (Bellis et al. 2012). Over the past three decades, a wide range of interventions have become available to the public health practitioner that are effective and efficient, predicated on multi-agency (especially police, health, and welfare authorities) plans for violence prevention in specific localities.

Mental health

A public mental health approach builds positive personal psychological assets in the community to help people build their confidence and self-esteem, and to negotiate and express their needs without frustration or resorting to violence. Police have historically been part of the management of people with behavioural disorders, especially those with mental health problems (Bittner 1967). Almost 50 years ago, Bard (1969) led the call to examine the use of police officers as mental health resources "within the context of [their] law enforcement function", with the formation of "family intervention police teams". Major social structural changes have occurred since then – most notably deinstitutionalisation and the impact of neoliberal political agendas – which have increased the frequency of contact between people with mental illness and the police, and resulted in complications in the ability of the police to respond (Teplin and Pruett 1992). Different methods of linking psychiatric or social work with law enforcement responses in crises involving mental health issues have been examined. One approach involves enhancing police capacity in handling of mental health issues through training – e.g., crisis intervention training (Compton et al. 2008; Herrington and Pope 2014). Other programmes consist of various forms of partnership between police and mental health agencies, such as using a team composed of a police officer and a mental health professional to respond to individuals having acute and severe mental illness crises thus avoiding criminalisation of patients with mental illnesses – a joint response approach (Lamb and Weinberger 1998), or using a mobile mental health response team that the police can call upon (Borum et al. 1998). A comparative evaluation of these methods found substantial benefits for both police and for patients with mental health illness, but a greater benefit was observed from the joint-response approach than the mobile mental health response team (Borum et al. 1998). A study comparing three different approaches involving specially trained police officers, a joint-response model comprising police and mental health professionals, and a mobile mental health team in three different localities in the USA found that all three programmes had relatively low arrest rates with the specialised response, concluding that "collaborations between the criminal justice system, the mental health system, and the advocacy community plus essential services reduce the inappropriate use of US jails to house persons with acute symptoms of mental illness" (Steadman et al. 2000). Similar findings were shown in reviews of the effectiveness of crisis intervention training (Teller et al. 2006; Morabito et al. 2012). Lamb and colleagues (2002), in their review on police and mental health, concluded that "collaboration between the law enforcement and mental health systems is crucial, and the very different areas of expertise of each should be recognized and should not be confused".

Sex work

Police policies and practices can directly and indirectly increase HIV risk among female sex workers, who have little power to navigate, let alone control, these environmental factors (Footer et al. 2016). In locations where sex work is criminalised, female sex workers face the negative health consequences of a punitive legal environment and are afforded few legal protections. Police behaviour towards female

sex workers extends well beyond implementing policies that criminalise sex work. For example, police harassment of this group has been documented worldwide, with police leveraging their power and threatening arrest to extort bribes or sex. Police perpetrate sexual violence against female sex workers in many settings, compromising the sexual and mental health of those violated. This behaviour from the police also directly affects the risk of HIV and sexually transmitted infections in female sex workers – e.g., when police confiscate or destroy condoms, a practice documented extensively in the USA and worldwide. Despite some research documenting the effect of police behaviour on female sex workers and drug users, only a small amount of this research actually included police as participants, a fact that exacerbates the perceived gap between public health and public safety.

The involvement of the police in partnerships to reduce violence against female sex workers and decrease their HIV risk is more than feasible. Analysis of a pioneer project in Karnataka, India, concluded that "context-specific structural interventions can reduce police arrests, create a safer work environment for female sex workers and protect fundamental human rights" (Bhattacharjee et al. 2016). This finding exemplifies the value of structural interventions directed at police in the context of HIV prevention programmes for female sex workers, even when sex work is criminalised. In a 2015 review of such programmes, Tenni and colleagues (2015) found they "create a better understanding of the sex trade among police officers, improve access to health and social services for female sex workers and have shown a clear reduction in police violence toward female sex workers". Even in regions where sex work is criminalised, structural approaches involving partnerships with police to address violence can be effectively delivered to reduce harassment, arrests, and violence against female sex workers (Beattie et al. 2010; Beattie et al. 2015; Deering et al. 2013).

Common agenda

For all the aforementioned themes, a shared agenda and coordinated practices are important for the quality of the outcome. An example of an attempt to come up with such an agenda was a summit organised by Public Health England in 2016 to create a shared purpose for policing and health, and the publication of an associated report on police and public health innovations (Public Health England 2016).

The challenge of meaningful collaboration

An analysis of health and welfare service provision to individuals with complex needs found that combining medical and social models was very difficult, because they have different financial and regulatory systems, roles and responsibilities, and organisational and professional cultures (Glasby et al. 2011). The analysis did not include collaborations with law enforcement. Although societal problems are at the centre of the endeavours of both law enforcement and public health, the organisation principles and cultures differ and are often contradictory.

The objectives driving the behaviour in each sector can also differ. For example, public health programmes aimed at prevention of transmission of HIV try to reduce transmission among people who inject drugs by provision of sterile injection equipment. This approach is considered good public health practice. However, police can be suspicious of programmes that remove disincentives for injection of illicit drugs, thereby potentially increasing crime.

The adherence to each sector's organisational objectives and the world view is reinforced through competing performance indicators. A modern public sector that is not preoccupied with the pursuit of results and the measurement of performance (van Dooren et al. 2015), heavily influenced by the so-called new public management approach and the agendas of managerialism, evidence-based policy, measurement, and audit (Newman 2001), is difficult to imagine. Effective collaboration requires movement past siloed performance frameworks towards more sophisticated means of measuring collaborative action both formally (through key performance measures) and informally (through cultural norms).

A movement towards collaborative action is difficult and complex. Although objectives might be identical, the ways in which success is measured will differ, and can inadvertently drive organisational intervention in counteracting ways. For example, law enforcement might focus on reducing the number of call outs for domestic violence, whereas this outcome would be seen as a negative from a public health perspective because fewer violent encounters would be reported. Arrest quotas applied as performance measures for police in dealing with illicit drug users or sex workers are further examples of objectives that conflict with public health aims (Wolfe and Cohen 2010).

Often the most important outcomes are the hardest to measure, but rather than this being an argument against trying to evaluate or quantify complex action, it should be a call to improve evaluation of the interventions that are currently difficult to measure. The temptation to value only what can be quantified needs to be avoided; the social sciences have made great strides in quantifying factors that are usually difficult to measure, such as environmental amenities and value of time with family, using contingent valuation and other methods. The first step is to identify the desired shared outcomes. With a commitment to serious evaluation, even when difficult, law enforcement and public health sectors must consider how to measure these outcomes with improved tools, data, and methods.

What could the relationship look like?

The fact that law enforcement and public health address the same or related problems in the same communities does not automatically lead to cooperation; they are distinct in culture and methods. Two levels of linkage are needed to support effective cooperation. One consists of a conceptual interface between the fields, at which they can achieve a shared understanding of their respective contributions to each

other's mission; a simple model of health and policing that shows how police activities influence health and how health can be a guide to police practice and a measure of police impact on social wellbeing. The second is the practical integration of police agencies within the health system, so that care and treatment are networked, complementary, and consistent. This integration entails development and implementation of interlocking programmes and clinical standards, referral systems and practices, and diffusion of data and records across systems, which is particularly important in systems in which high-risk and repeat customer strategies are being deployed. Links such as this are being constructed in processes of local experimentation and practical problem solving. Evaluation and implementation of beneficial models and practices is the long-term aim for police and health engagement.

Programmatic collaboration between law enforcement and education, and law enforcement and employment, can be very informative (Cook et al. 2015). The crime laboratory at the University of Chicago, Chicago, IL, USA, is an interesting example of collaboration between law enforcement, education professionals, employment programmes, and public health professionals. Rigorous academic evaluation is provided by locating the laboratory in a university environment, and effective public policy is achieved by collaboration with agencies that implement programmes. This model is interesting because rather than create an overarching bureaucratic structure to bring different interests under one agency, university researchers provide an intermediary and hopefully neutral platform. For example, if law enforcement and public health were to jointly fund and manage a university-based research centre, university-based researchers could provide the rigour for research evaluation and the so-called outsider perspective to assist law enforcement and public health agencies to rise above bureaucratic constraints.

Public sector leadership has a crucial role in the attempt to ensure efficient collaboration between the two sectors. When problems span the domains of and rely on input from multiple stakeholders, boundary spanning and shared leadership inside and outside of the organisation, at all levels, is vital (Herrington and Calvin 2015). Nowhere is the importance of shared leadership more evident than at the frontline, which is the practical interface between practitioners. Frontline professionals in both sectors must regularly make decisions about how best to interact and partner with each other. To effectively achieve this collaboration they must draw on their shared loyalty to positive health and the safety and security outcomes for the community. Empowering frontline staff to collaborate effectively is a role for formal bureaucratic leaders who must identify and encourage these shared outcomes and create a climate of innovation and problem solving, while examining unintended consequences and deleterious effects of their own organisational motivations. The two sectors must adapt to a new learning culture, accepting that when dealing with complex social problems, some initiatives will work and some will not.

Conclusion

The emerging agenda regarding the intersectoral field of law enforcement and public health is that a holistic approach will generate the best results, but it seems very hard to achieve this approach in practice. The gap is increasing between knowledge of actions necessary to deal with complex social problems – both in law enforcement and public health – and what can be achieved, which is related to the mismatch between classic institutions and the increased demands for security and health. The police are not delivering what is expected of them, including protecting vulnerable and at-risk populations. From the public health perspective, it is unsatisfactory that the great advances in this field are offset by, for example, an increase in mental health problems in the population or the failure to prevent domestic violence. An approach that takes both law enforcement and public health into consideration might prevent complications occurring in this intersectoral field, but such an approach might not necessarily lead to a change in practice; there is always the risk of each sector retreating to their original ideas and related protocols.

We emphasise here the importance of practices, and hence of the practitioners, in this intersectoral field in bringing about changes, and further training and professionalisation are required. Health is an already established sector encompassing many professions, and policing is quickly moving in that direction, with the UK as leaders in this transition. This intersectoral field must remain on the societal and political agenda, and a change in discourse and institutions is necessary to reinvent the government; however, instead of new public management, new public value must be incorporated to achieve efficient, effective, and legitimate outcomes. Calculations change fundamentally if efficiency and effectiveness are related to outcomes (e.g., a reduction in violence) instead of being applied to the working of separate silos. As stated, measurement of the outcome of complex interventions is important, and might require different types of research. Such measurements are crucial to the sustainability of the intersectoral field of law enforcement and public health.

In this Series paper we have focused on affluent societies; however, we are aware that the most pressing needs, and highest potential gains, are to be found in less well-resourced and post-conflict societies. The line between public health and law enforcement needs to be redrawn in a way that is conducive to both security and health. We believe this collaboration to be a worthy cause that requires dedication from policy makers, academics, and practitioners alike, both in high-income and low-income countries.

Chapter 5. Nursing and policing as boundary-spanning professions

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Introduction

There is considerable overlap in the types of people that the police and mental health professionals provide services to. This concerns a wide variety of cases, ranging from people in distress to those who commit serious offences, all of which *might* be related to mental health problems. This essay suggests that there is a need for the continuous development of new, collaborative ways of working between members of these two professions at their different stages of interaction with their "shared clients". This would also necessitate the acquisition of new knowledge, skills, and attitudes by members of these professions. There is a need for not only change, but also innovation across the professions. The authors of this essay – with backgrounds in policing, acute psychiatric care, and public health, respectively – were recently involved in programmes with the collaboration between policing and mental health as a focal point. These programmes, which are set in the policy context of the Netherlands and, more specifically, are in relation to the capital city of Amsterdam, serve as examples in this essay.

Although it is becoming increasingly difficult to draw sharp distinctions between the professions, it is obvious that we cannot – nor should we want to – turn police officers into qualified mental health workers or vice versa. Instead, the establishment of networks and knowledge and accompanying practices between the professions is necessary for innovation. The appropriate term for this phenomenon in traditional innovation literature is "boundary-spanning" (Tushman 1977). Professionals from both the nursing and policing professions are increasingly reaching across disciplinary and organisational borders to deal with the invariably complex problems of vulnerable populations. This defines them as boundary-spanning professionals (Williams 2002). As also indicated in this essay, innovation across the professions is also needed, as this would enable focus beyond crisis situations and, rather, the development of new ways of working collaboratively to prevent the escalation of crises. However, true innovation across professions is never easy and can be hampered by societal and professional perspectives, along with a multitude of practical challenges.

The examples of alternative policies and practices described in this essay were developed because of public order and safety issues that involved the police and jus-

tice system, in which traditional ways of cooperation were not working or insufficient. These new, alternative ways of working brought about new challenges for the professions involved. In this essay, we specifically focus on issues relevant to the psychiatric and mental health nursing profession. We are quite aware that we are addressing a specific aspect of the broad nursing profession, and that we do this from the specific perspective of a legitimate and sustainable policing response. The latter is justified by the fact that all examples involve the police, as stated above. Thus, this subject (i.e., innovation across the two professions) might be seen as straddling nursing and policing. The overlap between these fields is – as we will discuss – gaining importance not only within the professions, but also in public and academic debates (Punch, 2019).

Mental health incidents and policy responses

In the last two decades, we have witnessed the emergence of the new field of Law Enforcement and Public Health or LEPH (van Dijk and Crofts 2017). This field serves as evidence that population outcomes in justice and health are fundamentally related, and that in turn, this suggests an urgent need for the development and improvement of joint solutions in this regard (van Dijk et al. 2019). An important, substantive issue within this field is the link between policing and public mental health. There is considerable overlap in the types of people that professionals in the policing and public mental health sectors work with or come across. These individuals often have difficulty generating sufficient (crucial) means of subsistence (e.g., shelter), have little social support, experience various personal and psychosocial problems (e.g., domestic violence, addiction, anti-social behaviour, debts, and mental illness), and do not receive support services. In most cases, professional intervention for these individuals is sought by neighbours or the family (Aalbersberg and van Dijk 2016). In some cases, such as when individuals exhibit violent or persistent anti-social behaviour – with or without mental illness – or repeatedly experience mental health crises, the police become highly involved.

The target population of this essay is broadly defined as a vulnerable one. In many instances, it is not evident as to which profession is best suited or responsible for dealing with issues in different contexts. Given this overlap, cooperation between stakeholders is a logical option. There are many examples of successful cooperation between police and mental health services. The two sectors have been cooperating since the inception of modern policing. However, there has recently been a qualitative change in the relations between the two sectors that goes beyond cooperation. This change has – and should have – an impact on the respective professions.

The relations between the police and mental health services have, at times, been the subject of heated public debates in the Netherlands. An important dimension fuelling this debate is the increase in the number of so-called mental health incidents (MHI); situations in which police officers become involved with individuals who might have mental health problems. After all, the police are typically the first

to be called in case of urgent situations involving persons with mental illness. In such instances, finding a common language immediately becomes a challenge for the police and mental health professionals, thereby requiring considerable communication between the two sets of professionals. What is referred to as anti-social behaviour in policing might be regarded as stigmatizing to health professionals. On the other hand, the police might find it difficult to accept that someone who is clearly emotionally disturbed is said not to have a psychiatric disorder by mental health professionals. Clearly, boundary-spanning is needed to bridge the divide.

In the Netherlands, the number of the police's encounters with people who might have mental health issues is registered in police data files under the non-criminal police code, 'nuisance by a confused or stressed person'. This registration code E33 (MHI) is assigned by police officers on duty in relation to incidents involving Emotionally Disturbed Persons (EDP). Obviously, this police code is not primarily a mental health coding, but refers to a person who behaves in a disorderly manner, *causing public nuisance or feelings of insecurity*. The number of these registrations more than doubled in the period between 2011 and 2018, from 40,094 to 90,605 in a population of about 17 million people (Police of the Netherlands 2019).

The possible structural factors driving this increase have been a subject of inquiry (Koekkoek 2017). Various hypotheses in this regard have been put forward in the public debate:

- Deinstitutionalization, referring to the closure of traditional, large mental health institutions, and the consequential influx of people with severe mental illness into communities;
- Cutbacks and hypothesized reductions in the quality of outpatient mental healthcare;
- Registration effects because of the police's increased willingness to report incidents under the MHI heading, and decreased tolerance for disorder in society;
- Changed social circumstances related to, for example, globalisation, urbanisation, individualisation, increased migration, and – in capital cities – tourism;
- An ageing population, coupled with few elderly people being housed in retirement homes;
- Increasing prevalence of mental disorders and substance use disorders.

These hypotheses are difficult to test, in part because, due to confidentiality issues, the police data could not be paired with the data of health institutes. Despite the absence of analyses, it seems clear that those involved in MHI (i.e., EDP) are not strictly persons with mental health issues. The characteristics of EDP vary from those of people with mental problems, addiction, 'challenging behaviour', dementia, and intellectual disabilities (Koekkoek 2017). Typically, individuals will present with different combinations of these characteristics. The Dutch National Institute for Public

Health and the Environment (RIVM, 2018) studied registrations of EDP in 2016. Out of 80,000 registrations, more than 61,000 reports could be traced back to almost 34,000 unique persons. Out of the 61,000 reports, 66% could be attributed to a relatively small group of 13,000 persons who were already present in the police database. If this specific group of people who come into contact with the police repeatedly could be identified and provided with adequate help, future contact with the police could be largely prevented.

These findings emphasize the importance of an early-warning system, support, and care for this relatively small group. However, in the Netherlands as elsewhere, many approaches focus on training police in dealing with people experiencing mental health crises. These approaches entail general training such as Mental Health First Aid, specialist training, and co-responder models. Less attention is paid to collaborative models that are characterised by a pro-active approach and that stress the importance of prevention. This is related to another important dimension fuelling the debate, namely, increased media attention towards violent crimes involving offenders with mental health issues. Often, particularly in instances of aggressive outbursts, the media report that the perpetrator had telling signs that were already known to different organisations, and that incidents are a consequence of institutional failure. The connection between criminal justice and mental health continues to be primarily 'framed' by violent incidents. Again, it is difficult to prevent polarisation in the debate regarding the law enforcement and health perspectives.

In 2014, Bart van U. murdered two people in the Netherlands while he was supposed to be in prison. One of the victims was the former Minister of Healthcare, a fact that obviously helped generate a high-profile case. As did his family, Bart van U. repeatedly reported himself to the authorities, including the police and correctional facilities, as constituting a risk to society. However, the authorities were not willing to take him in custody. This case led to the installation of a special governmental committee to evaluate what had gone wrong (Hoekstra 2015). An increase in police-related MHI, analysis of bottlenecks in acute mental healthcare, and the aforementioned violent murder and the subsequent Hoekstra Committee, led to the establishment of a national Taskforce (Taskforce 2018) on dealing with EDP. EDP were broadly defined as people who are (at risk of) losing control over their lives and might cause harm to themselves or others. The goal was to establish appropriate support systems for these individuals and involve their family/social networks in the context of local communities, and to conceptualise a comprehensive approach that would, for one, bridge the gap between the criminal justice and (public) mental health sectors. The Taskforce operationalized the concept of a comprehensive approach by formulating the following nine concrete principles or 'building blocks':

1) The *involvement* of EDP and their social environment in determining what is needed to bring about a sustainable outcome. Although this sounds obvious, it is a common professional pitfall to decide for people, and not with them, especially if their behaviour is perceived as dangerous.

2) A focus on *prevention* and the provision of a so-called *life structure*. The explicit aim is to prevent a crisis or, at least, recurring crises.
3) This implies developing mechanisms for *early recognition*. Combining different signals from a multitude of sources is crucial.
4) How to *report* and to whom in various situations – ranging from emergency calls to reporting to a general practitioner – and how to adequately respond to such; quick and appropriate referral.
5) *Evaluation and risk assessment* that is multidisciplinary, with no consideration of the entry point (see 4).
6) Appropriate *institutional care*, with specific attention to the complexity of criminal justice, coupled with the necessary care.
7) Appropriate *transportation* of EDP, aimed at minimising transportation by the police, as this could be traumatic in itself, however well intended.
8) Appropriate support, care, and disciplinary measures in a *community context*.
9) Organising appropriate *Information provision* (i.e., data sharing) that is necessary for reaching and maintaining a sustainable outcome.

All the so-called building blocks have consequences for both the police and mental health professionals. It is easy to imagine the kind of practical problems and professional frictions that this comprehensive approach might generate between the two fields and related professions, at different stages and in different contexts. If members of the policing profession were to be tasked with operationalizing the nine building blocks, the outcome would differ substantially from that generated by members of the healthcare profession, if tasked with doing the same. Reasons for these differences are ingrained in the respective professions. An obvious example of such an instance would be (bullet point 5 above) evaluation and risk assessment; members of the two professions would most likely make different assessments. There is, however, a growing realisation that there are many contexts in which both perspectives could be valuable, although the translation of these diverse perspectives into interventions in either or both professions is not straightforward. At the same time, joint solutions seem like a sensible approach, both from the perspective of the person involved and the community or, for that matter, society at large. Below, we describe three cases at different stages of professional interaction, where a combined perspective makes sense, while at the same time, introducing challenges for the psychiatric and mental health nursing profession. We will start at the 'criminal justice end' of the intersection, focusing on violent repeat offenders, and work our way to the 'public mental health end', where community psychiatric nurses are the key professionals.

Case I: The Top600 approach of high-impact crimes

Similar to other Western countries, the Netherlands has seen a decline in crime rates since the 1990s. This trend includes so-called high-impact crimes (HIC), typi-

cally violent crimes with a large impact on victims, and frequently generating feelings of insecurity in the community. A significant number of violent crimes tend to occur in larger cities like Amsterdam. As is commonly known, a large percentage of these violent crimes are committed by a limited group of repeat offenders. In part, these offenders are known to both the police and health services, and persist in violent behaviour, in spite of the implementation of a multitude of regular interventions by different organisations. For this reason, and because, at the time, a series of high-impact crimes had caused a lot of commotion within the population, in 2010, the new Mayor of Amsterdam – with the explicit support of the Amsterdam Police and the Municipal Public Health Service – launched a new diversion programme that focused on this specific and dynamic group of violent offenders. This programme was referred to as the Top600 approach. The target population of this approach had had some 15,000 encounters with the police within the previous five years, most of which were street robberies, raids on shops and businesses, and aggressive burglary. The Top600 programme came to involve some 40 agencies, namely, the police, probation services, social services, and healthcare and educational agencies, among others.

The Top600 approach is person-centred – as opposed to an institution-based approach – and aims to reduce recidivism by promoting structural behaviour change. It combines a firm reaction to crimes, with targeted interventions on multiple life domains (e.g., housing, finances, and healthcare) to improve individuals' outlook. To achieve this, every person enrolled in the programme is assigned a case manager (e.g., from the police, probation services, or the municipality), who is responsible for drawing a personalized plan of action and ensuring that the interventions are actually implemented. The Municipal Public Health Service conducts a social-psychiatric screening that informs these personalized plans of action and subsequent interventions. The screening consists of a semi-structured interview and, provided that consent from the Top600 member is obtained, a review of available reports of recent evaluations by other medical or mental healthcare institutions. The screening is conducted by a small team of psycho-diagnosticians (e.g., psychologists, psychiatric nurses, and forensic pedagogues), supervised by a psychiatrist. The screening may result in a referral to, for example, mental healthcare, social work, a general practitioner, or addiction care. In addition, the results are used to advise the programme's case managers on how to deal with a specific individual. For example, case managers can be advised to be patient with a person who has been diagnosed with a mild intellectual disability, or receive an explanation on how an individual Top600 member may be provoked and what behaviour is to be expected subsequently. This is all done without sharing specific personal details and with the explicit consent of the Top600 member, because of the confidential nature of the medical information. This may explain why so many Top600 members had no objection to being screened; participation is voluntary. By December 2018, 1,381 offenders had entered the diversion program at some point, 865 (62.6%) of whom had been screened.

While many persons from the target population have been screened and subsequently guided towards appropriate services, there have been professional concerns around the approach. For example, there were initial concerns among screening staff regarding the potential for violent incidents when engaging with this population. In addition, there was hesitation in response to the prospect of working with a patient population with more than the average prevalence of personality disorders. At times, healthcare providers had to solve cases outside forensic healthcare settings. Any care and guidance in those cases has to be provided on a voluntary basis. This did not always sit well with law enforcement partners and sometimes created challenges for constructive collaboration. It was sometimes seen as a 'soft approach' not suited for a population that has committed serious crimes. Moreover, police officers often wanted to obtain more personal information than the health professionals were allowed or willing to give. Learning to understand each other's professional position was an important dimension of the approach.

Next, information from the screenings, combined with data from youth care files (Segeren et al. 2016), enabled the Municipal Public Health Service gain better insight into the group as a whole. Accumulation of problems in the past (i.e., adverse childhood experiences) and present has resulted in the notion that at least one third of the Top600 population may be considered a target group for the public mental healthcare system (Fassaert et al. 2016). An interesting aspect of the Top600 program in this regard is the choice to consider family circumstances and siblings who are at risk in the same environment. In due course, the Top600 was extended to include not only the top repeat offenders, but also 400 juveniles who were most at risk, shifting attention more towards prevention in the so-called Top1000. What we see happening here is that a person-centred approach towards violent repeat-offenders is developing into a truly public health-oriented approach, shifting from tertiary to secondary prevention. Practically, this is related to boundary-spanning, enabled by collaboration on urgent cases.

The institutional context is important in enabling the above-mentioned shift. The Top600 approach has also brought to light some critical success factors related to organisational matters and professional culture, which include a culture of approachability between partners and agreement on a legal framework that addresses issues regarding information-exchange, based on a need-to-know and need-to-share perspective. Important in this case was strong, determined leadership, and support from the authorities. Principally, the work is done by professionals in participating organizations. However, in instances of (institutional) barriers or conflicts, there needs to be a clear 'escalation model' that goes above and beyond the involved parties. In the Amsterdam context, the mayor – who had authority both with regard to the police and public health – was pivotal.

Case II: Procedure for EDP that are suspected of committing an offence

The police frequently fulfil the role of "referee" in deciding whether a person with emotionally disturbed behaviour enters the mental healthcare system or the criminal justice system. In the Dutch system, specific mandated police officers are appointed as representatives of the public prosecution and make vital "first decisions". The aforementioned Hoekstra Committee (2015) concluded that the decision as to which system – between the criminal justice and healthcare systems – an Emotionally Disturbed Person (EDP) suspected of an offence will end up is relatively arbitrary. Such a statement is difficult to fully comprehend, considering the possibilities of ending up in the "wrong system". An integrated system, however, entailing both criminal justice and healthcare may sound attractive – or scary, for that matter – and might be extremely difficult to put into effect.

As is well known, unjustified criminal prosecution of people with mental health issues –'criminalization' – may occur if the referee role is not performed appropriately. To prevent individuals from entering – or getting deeper – into the criminal justice system, several points of interception can be identified. In systematically addressing criminalization, interventions can range from law enforcement and emergency services, to community corrections and community support (Munetz and Griffin 2006). In many (high-income) Western countries like the Netherlands, local developments – for example, the constitution of Psychiatric Emergency Rooms, paramedics, or mental health response teams – have led to successful deflection of people with mental health issues from the criminal justice system to mental health services. In those countries, the opposite of criminalization might also occur, namely, the 'psychiatrization' of criminal behaviour. In this instance, 'psychiatrization' is the false assumption that criminally culpable conduct results from a psychiatric disorder, without adequate investigation (Visscher et al. 2015). The consequence is that a suspect (with or without an actual disorder) is not held responsible for his or her behaviour, and thus escapes appropriate correction (e.g., incarceration). This is considered unjust and, in some cases, might regarded as posing a threat to society. The criminal justice system is sometimes unjustly bypassed when it is wrongly assumed that an apparent dangerous EDP will be compulsorily admitted, if he or she is not arrested, but instead transferred to mental healthcare. So, the *expectation* of what will happen if a person is transferred to the healthcare system (e.g., compulsory admittance) plays a central role in the decision, but the decision is not based on formal medical information. This might lead to situations wherein, for example, someone who publicly threatened to blow up his apartment and was apprehended by the police returns to the neighbourhood two hours later, with public unrest as an obvious consequence.

In order to achieve an integrated approach for criminal justice and mental healthcare in urgent cases of EDP suspected of an offence, communication between the public prosecutor and a mental health professional is required. In the Dutch Mental Health Act, this communication is legitimate, but seldom applied to these situations. Justification for this communication is that the public prosecutor and the

(outreaching) psychiatric emergency service both have clear roles to play in the execution of the Mental Health Act, in advising on compulsory care and as independent assessors of the psychiatric state of the person concerned. There is a strong reluctance in the health profession to share information with the police and public prosecution because of mental health professional–patient confidentiality. However, in this case, healthcare is truly public health and the societal outcome should be taken into account. The police and the public prosecution *will have to make a judgement* on the nature of the disturbed behaviour, and are currently doing that without obtaining the appropriate professional judgment of a mental health professional. This leads to a situation wherein, as mentioned above, the choice between criminal justice and health care becomes highly arbitrary.

A new procedure was introduced in 2017, such that all EDP suspects in Amsterdam are brought to police headquarters, where the public prosecutor can request an emergency assessment from the psychiatric emergency service. The screening is conducted by a community psychiatric nurse or a resident in psychiatry. Assessment (including specialist assessment) is completed by a psychiatrist on call. The psychiatrist makes an assessment within two hours and, with the consent of the person concerned, informs the public prosecutor as to whether or not someone meets the criteria for compulsory care. On the basis of this information, the public prosecutor can make a better assessment of the expected – and appropriate – follow-up, which includes the following: correction, further psychiatric treatment, or both or neither. Although, in most cases, the severity of the offences is relatively low, prosecutors and psychiatrists evaluated this exchange as useful and necessary.

In the Amsterdam trial, professionals of the Psychiatric Emergency Services experienced three types of problems. First of all, there was a lack of *knowledge*. These professionals did not know enough about the workings of criminal procedures, such as who takes which decisions regarding incarceration, what the decision moments and related timeframes are. In addition, it turned out that the professionals were not always well informed about the legal forensic psychiatric treatment options available in prison. Secondly, there were problems related to access to both criminal and medical *information* on the specific case. It was not always clear as to what information was received regarding reasons for arrest and regarding related circumstances. Moreover, did the person already have a criminal history? What is their psychiatric history? A recurring issue was concerned with what data could be shared with third parties, with and without the consent of the person concerned – in this case, the Public Prosecution Service. Finally, there were problems related to *availability and time*. The mental health professional had to be at the police station within two hours of arrest, in order to be able to give advice before the Public Prosecutor would make a decision. Sometimes, it was difficult for the mental health professional to say anything substantive within such a short period of observation since arrest about the mental state of patients, who often did not cooperate and, sometimes, had serious mental dysfunction.

Case III: Combined frontline nursing and policing in neighbourhoods

In the early 1990s, Amsterdam had several no-go areas in various city districts that were known for extreme nuisance, intimidation, and crime. Traditional approaches were not working; institutions stayed in their respective silos and none of them took responsibility for the societal problem at hand. In 1992, the city implemented a new approach in several disadvantaged boroughs in which community psychiatric nurses from the Municipal Public Health Service, if necessary with a police officer, paid visits to people who caused substantial annoyance and nuisance to their neighbours. Basically, the police were there to 'uphold the law' and create a 'safe place' for the neighbours and for the nurse to work in. The community psychiatric nurse (CPN) screened and guided patients towards appropriate care, including mental health and addiction care. A tragic incident in 1993 involving a person diagnosed with a severe mental health problem who killed a 12-year-old girl who was playing in front of his house, was an important factor in accelerating the implementation of this approach. Soon, the police and the CPN were active in every borough in Amsterdam.

Today, CPNs and the police regularly respond to calls together. These can, in fact, be about anything: noise nuisance, citizens facing financial debts and home evictions, lonely elderly people, people with addictions or a mild cognitive disability, youth groups, tourists on drugs, or asylum seekers who have exhausted all legal possibilities. A so-called home visit is still the most important intervention. If there is (imminent) danger, the nurse and the police officer always go together. If it is evidently only a care problem, the CPN goes alone. As a duo, the CPN and the police officer can almost always initiate constructive dialogue with people in troublesome circumstances.

For diagnostics, the CPN screens for unmet care needs. This requires an integrated view, because there is almost always a multitude of problems characterizing individual cases, as is the case in, for example, the Top600. The handling of a case then takes the form of a referral and, if necessary, care coordination. This is often a somewhat longer and complex process. The necessity to introduce compulsory elements in this process is always considered. Introducing these is often necessary and includes strict conditions under which the person who caused the nuisance can move into a rental home, or for a possible eviction due to rental debt to be postponed. In addition, an important goal is that the relevant parties assume their respective responsibilities and that the case not be 'released' by the CPN until (personal) transfer has taken place and appropriate care has been initiated. The CPN is responsible for monitoring whether the parties involved adhere to the agreements made and ensures the client actually ends up in care. There is obviously some necessary 'enforcement' – on both individuals and organizations – and the nurse, not the police officer, takes centre stage in this regard. Between 2017 and 2018, as a result of the aforementioned national Taskforce, the Ministry of Justice and Security started promoting and financing this working approach.
To date, a number of challenges can be pointed out. For example, growing caseloads combined with increased administrative work limit the possibility of the community

psychiatric nurse monitoring clients who may be most vulnerable to experiencing multiple/recurring crises (e.g., people with serious mental illness). However, monitoring these clients is a key feature of the above-mentioned, comprehensive approach pertaining to EDP. In addition, having nurses and community police working closely together is challenging in several ways. For example, it is important to note that there are currently 220 community police officers working in Amsterdam neighbourhoods, with approximately 15 CPN to support them in this type of work. Moreover, 'quasi social work' is not an area that is always valued highly by police officers. Consequently, community psychiatric nurses are sometimes linked with police officers who are not enthusiastic about handling cases that involve (mental) health issues. In addition, an important challenge – as in many settings – is sharing information, and more specifically, maintaining adequate professional standards in handling confidential information. For example, community police officers are much more visible in neighbourhoods than are CPNs, and are therefore often the first point of contact for worried neighbours. In this role, police officers may be asked to explain why an EDP is, for example, not compulsorily admitted to a psychiatric ward. Not being able to share this confidential patient information sometimes puts strain on the professional relationship between CPNs and police officers.

Conclusions and implications

Many new ways of collaboration between policing and mental health find their origin in crisis situations and publicly unacceptable (institutional) failures to cooperate. Politically, there will be most progress where the societal costs of not introducing new practices are high. The inability to solve urgent societal problems traditionally fuels innovation at the intersection of law enforcement and public health. There is a tendency to consider crises first: increasing numbers of crises, failing interventions and instances where things go horribly wrong. This seems only logical – it is the sharp end of both law enforcement and public health that, by definition, is urgent. However, part of the emerging field is, clearly, the shift from crises and towards the generation of sustainable solutions. The general idea is to move away from crisis intervention and towards prevention and proaction (Russell and Taylor 2014). However, we do believe that crises can be a versatile starting point for initiating that development.

The Top600 approach provokes thinking about how dealing with repeat offenders could further develop. Several academics including Ogloff (2009) and Drucker (2011) have argued that, to prevent this potentially high-risk group entering crime and prison, new-style public health institutions are required, based on a combined policing and public health perspective, which is crucial for determining the most fruitful course of action for individuals within the population. Driving this is the enlightened self-interest of prevention, in that the 'deviant path' at the population level is highly predictable and that a combined effort is necessary for helping members of the population choose another path. This will lead to substantial, reduced financial

and social costs to society, by diverting persons from 'life-course-persistent delinquency'. Related to that, for persons who have a forensic profile based on their history or risk assessment, but who have not committed a criminal offence, a highly structured treatment in a forensic setting currently is inaccessible. There is an increasing demand for a form of 'trans forensic care', referring to highly structured forms of intensive care for high-risk patients, but situated in regular mental health institutes, and financed as regular mental healthcare. Considering the initial worries of mental health professionals in the Top600 project, what would this mean for professional development?

The procedure for Emotionally Disturbed Persons that are suspected of committing an offence in Amsterdam is similar to the NHS England Liaison and Diversion (L&D) Programme. L&D services identify people with mental health vulnerabilities when they first come into contact with the criminal justice system. The services aim to improve individuals' overall health outcomes and support them in reducing re-offending. In the Belfast model, the service is provided by experienced community psychiatric nurses who have completed a two-year RCN-accredited (Royal College of Nursing) Diploma in Forensic Health Care (Scott et al. 2016). The psychiatric assessment differs from a standard assessment in three important respects. First, sources of information are relatively few. Previous judicial history is usually not available and neither are one's own therapist and relatives important sources of additional information. Second, the environment in which the assessment or interview is conducted is, to say the least, less than desirable. Third, the time available for assessment of health issues is usually quite brief. The point is, new collaborative approaches have consequences for the profession that might not seem ideal from a traditional perspective.

The combined frontline example stresses the importance of acting and thinking both physically and metaphorically 'outside the institutions'. An example of a service integration model is 'community-care networks' (Parker et al. 2018). The network coordinator (often a community psychiatric nurse) receives reports from network partners about any person of concern and gathers the relevant information, establishes a plan of action, and monitors implementation. Responsibility is transferred to the most appropriate agency as soon as possible. In such a scheme, the required knowledge and competencies might go well beyond those required in the classical nursing profession, and might include knowledge of legislation regarding privacy and possibilities of coercion, knowledge of the different steps in the criminal justice system (with its decisive moments: i.e., arrest, incarceration, prosecution, trial in court), and some knowledge of the role of public prosecution, probation, and forensic services. Alongside knowledge, there is a need to strengthen competencies necessary for performing in a network context.

The cases point to different issues that should be translated in education (training) and inspire further research at the intersection of nursing and policing, both with

regard to the substantive issues – as mental health – as with regard to how the respective boundary-spanning professionals develop their profession 'on the job'. Substantial work has been done to identify and enhance collaborative ways of working between police and mental health services. In addition, the idea that the main effort should be directed towards *preventing* arrest and/or a mental health crisis – also because of the extremely high human and financial costs – has prevailed for a long time. However, it seems incredibly difficult for professionals in both fields (law enforcement and public health) to actually progress in that direction. Part of the explanation for this difficulty is the vested interests of traditional sectors. However, probably more important, is the fact that better efforts towards collaboration are not enough and that rather, it is necessary for boundary-spanning professionals who are willing to assume a broader perspective to make true innovation possible. There are some necessary conditions to achieve this, as we discussed above. So, people and their contexts should take centre stage. Next there is a need to develop common concepts and related measures, so as to enable communication between professions; and the realisation that every innovation across professions might look less than ideal from a mono-professional perspective; that such innovation always requires the gaining of new knowledge (i.e., skills) and attitudes, and that it might undermine classical professional authority and requires endurance. Hopefully, the police and mental health professionals are prepared for these.

Chapter 6. Policing the pandemic

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This article delves into the relation between policing and public health in the context of the COVID-19 pandemic. The police have been seen as a crucial and extensively mobilised resource that has been utilised in responding to a public health crisis. The response to the pandemic shows the police mainly as enforcing state orders in which they have a traditional function related to the use of force. It is argued here that the classic definition of policing in terms of the use of force allows for the police becoming 'decoupled' from the institutional frames of criminal justice and public order. The perspective of a decoupled police would have real consequences for its involvement in public health. The article concludes with the conditions necessary for police to be a legitimate force in the public health domain.

Introduction

On 11 March 2020, the World Health Organization declared the COVID-19 (Sars-CoV-2) coronavirus outbreak a pandemic. In the context of the pandemic, public health requirements have necessitated widespread behavioural change that citizens are required to adopt. With this pandemic, the central initial issue was to slow down the rate of new infections in order to retard the spread of a virus by limiting human-to-human contact. This involved reducing taken-for-granted and widely accepted freedoms of movement. These measures included not only social distancing at a community level but also the closing of national and regional borders. Across the globe, in accordance with shared standards of public health practices, nations responded by declaring states of emergencies and, in many instances, adopted extraordinary legal measures aimed at addressing the acute pressure on health care systems and preventing further spread of the virus (DECAF/ISSAT, 2020, p. 3).

Central to these developments and the widespread support they received has been a deeply entrenched cultural understanding that states are required to protect their citizens from harms and that those who do not will lose legitimacy. A corollary that cuts across very different political cultures is that the greater the perceived risks, the more acceptable the restriction of freedom required to ensure citizens' safety: extraordinary measures are acceptable in times of extraordinary threats. The police role has varied among nations but has generally been important in states' responses to the pandemic. For example, in New South Wales, Australia, during the early stages of the pandemic, the crucial role played by police in responding to the pandemic was symbolically demonstrated at the daily briefings of the Premier, as the two principal players the Premier called on at these briefings were the chief medical officer and the police commissioner. At the root of these developments is the fact

that within public health, behaviour shifts, in addition to more established medical interventions, constitute health intervention.

The COVID-19 pandemic has brought the relationships between policing and public health to centre stage. This occurred first and foremost because the strategies being used to stem the spread of the virus, in the absence of medical options such as an effective and safe vaccine, were focused on shifting people's behaviours, that is, creating new orderings – specifically, limiting spatial movements, closing establishments, physical distancing when people are in the same location, hand washing, and wearing masks. These interventions, which had very significant economic consequences, were mandated by behaviourally focused regulations enacted by governments, and also by private authorities, on the advice of epidemiologists.

A constant issue around these regulations is how and to what extent they are enforced and what the role of the public police should be in that respect. To monitor and apply public health requirements, police have been mobilized as public health actors, precisely because of their legitimate capacity to ensure compliance with these requirements, with force if necessary. As a consequence, public health has become a matter of operational policing directed at enforcing public health interventions. The fact that police typically have the capacity to legitimately both *threaten* to use force and *actually* use it – both physical force and more indirectly by fines (O'Malley, 2010) – means that they are called upon to respond to a wide variety of situations where force is deemed to be likely to produce a desired outcome. For example, and this is directly relevant to the COVID-19 response, police have authority and the ability to "gate" people, that is to compel them to remain within and outside of particular areas. White and Fradella (2020, p. 705) make this point in the following passage:

> "We ask police to enforce [stay-at-home/shelter-in-place orders] because they have the authority to use force to overcome the resistance of violators. Police can force violators to disperse. Police can issue tickets or fines, and they can even deprive violators of their liberty through arrest".

This has been a regular feature of policing in response to COVID-19 across the globe, where enforcement of social distancing and quarantining was a feature of police work, often, as was the case in Australia, with police issuing fines when regulations at either the state or federal level were violated. Police have effectively participated in an essentially public health domain, where their capacity and licence to deploy non-negotiable force (Shearing & Leon, 1977) has been extensively used.

It is this same characteristic, however, that has been the source of pressure on police legitimacy. In a number of cases – for example in the United States – police leaders expressed concerns and were decidedly hesitant about being used as law enforcement agents because of concerns that this would damage relationships and

trust, particularly within minority communities, that they had been carefully nurturing for years as part of their social service role with an emphasis on community policing (PERF, 2021, pp. 22–27). One chief of police expressed it this way (Cauley, 2020):

> "In the last several years, all of us have tried hard to earn the support and trust of our communities. We've been very deliberate in our approach to everything related to COVID to be sure that we stay true to who we are, and do not erode the trust and support that we've worked so hard to earn".

While policing the pandemic primarily shows the police as enforcing pandemic-related public health orders, it puts pressure on the so-called social dimension of policing. As a matter of factual practice, police spend much of their time performing a myriad of public service functions, something that Maurice Punch (1979) recognised in his insightful designation of police as a "secret social service". This has established two sides to the police coin: as law enforcers and as a readily available social service. When political leaders were calling on police as law enforcers, this presented front line police officers with a difficult and precarious balancing act, one that highlights a systemic feature of public policing that has for years provided something of an elephant in the room: namely, the growing tension between the two sides to the police coin. The two sides are also increasingly associated with differentiating between the state and the community.

Clearly, it has been states that have taken the lead in the response to the pandemic. This follows from the fact, and this is true across a variety of legal systems, that only states can make a legitimate claim to restrict what, in many parts of the globe, are regarded as basic human rights. Relevant in this context, however, is that fairly early in the public health crisis, policing the pandemic had also become intertwined with policing protests – first, protests for and against COVID-19 health mandates, and then protests sparked by police use of force. Pandemic-related health concerns intersected with widespread and heated "Black Lives Matter" and "defund the police" protests, prompted by the use of deadly force on George Floyd (May 25, 2020) by a police officer in Minneapolis in an incident that was widely shared on social media. These protests were not limited to cities within the United States but also took place in many other cities across the globe – for example, London, Amsterdam, Paris, and Sydney.

While on the one hand, police legitimacy – in this case as related to enforcing public health measures – is based on a direct relationship with the state, it is at the same time a possible ground for institutional criticism. The police are in this context seen as the wrong answer and instrumental in reproducing an order that is not characterized by social equity – with ethnicity as the most urgent dimension in this respect. In that sense, policing the pandemic seems at odds with the public health endeavour, which generally is seen as less contested and clearly for the public good. Police

are primarily perceived as an instrument of the state and easily associated with "politics", an arena that has become more and more polarized and thus, by definition, straining the preferred frame of an objective police service guided by professional considerations.

Some would say there is no place for policing in the public health endeavour (McNeil, 2020), because "to do harm" is the essence of policing and therefore the antonym of public health. However, the pandemic clearly showed the importance of the (potential) use of force by the police to "prevent harm" as well. As will be discussed below, the fact that policing – especially enforcement – is part of public health is not a new phenomenon. The issue is not – we will argue – the potential use of force but the currently dominant conceptualization of the public police. Why is it that the police seem to get drawn into so many of society's chronic and emergent problems to begin with? Specifically, in regard to public health, should the police be in or out?

Public health and double-sided policing

Policing and public health are historically connected in that health issues have always required enforcement roles. Punch (2019, p. 4, referring to Carroll, 2002) gives a vivid description of this, referring to the eighteenth century and well before:

> "Historically there is a long association between certain enforcement officials in cities and societies – religious, civil, lay – who took some form of responsibility for maintaining order and control in diverse law enforcement roles and also for a range of health, safety, medical and inspection tasks (as on human and animal waste) and during epidemics and plagues as well as regarding prostitution, the poor, indigent and mentally ill".

It was in the nineteenth century that both policing and public health emerged as institutions in the process of modernization, particularly fuelled by technological innovation and urbanization (van Dijk et al., 2019a, p. 289). The complexities of the city required explicit policing, be it primarily as an instrument of state control – the Continental model – or ideologically based on the consent of the public – the British Policing or Anglo-Saxon model (van Dijk et al., 2015, pp. 29–68). When city police were established in England in the early 1800s, they were expressly focused on prevention more than enforcement and investigation. In the following years in the United States, when city police were formed, they had very broad remits, including public health, since sanitation systems had not been established and nor was there any reliable infrastructure of health or medical systems.

A view of police history in the United States has been that the police mandate had narrowed to law enforcement by the early to middle 1900s, in a way that was ultimately problematic (Kelling & Moore, 1988). There was an effort to "professionalize" police through training, standards, and bureaucratization in order to reduce

corruption and misconduct. Part of professionalizing was to unburden the police of myriad "non-police" responsibilities so that they could focus on law enforcement and fighting crime. This unburdening was never accomplished to any great extent, yet both the police and the public gradually adopted the belief that policing was, or at least should be, mainly a matter of law enforcement.

Important in that was – according to Kelling – the invention of the metaphor of the Criminal Justice System. This had a significant impact on both public perception and on police self-perceptions (Kelling, 1991, para. 23):

> "For over the last thirty years this metaphor, largely unrecognized as such, has radically transformed the way police define their jobs, revolutionizing both police missions and tactics, and powerfully distorting the way we think about crime control".

It became most common – especially in the United States – to think of policing occupying the front end of the Criminal Justice System, a perspective that gives priority to crime, crime control, criminal law, and law enforcement. Within this conception, the criminal justice system has been established and maintained by states to implement orders, defined by the laws of the land, intended to promote the safety of citizens. To enable the criminal justice system to enforce orders, the institutions that make them up have been accorded powers as a means to act to achieve public safety. For police, a crucial feature of these powers is the right to use force, including, if necessary, deadly force – something that is expressed in the tools of their trade, for example, batons, Tasers, and firearms. This accounts for the popular designation of police organizations as law enforcement agencies.

However, this narrowing of the police role, along with deteriorated police–community relations, also fuelled the popularity of community policing, starting in the 1960s. As community policing developed, there was an acknowledgment that society looks to the police for assistance in all manner of situations, and that police actions frequently involve providing a service rather than enforcing a law. When one looks at what the police actually do, one sees a lot of activity associated with mental health crises, domestic violence, substance abuse, homelessness, unsupervised children and the like (Cumming et al., 1965). The classical sociological research into modern policing around this time consistently showed the broadness of policing, explicitly referring to the social services mandate of the police (Banton, 1964; Bittner, 1970; Wilson, 1968).

The public health perspective sits well with a community policing perspective associated with prevention and solving problems rather than perceiving officers primarily as "bandit catchers" or "crime fighters". A public health approach can be broadly described as follows (van Dijk & Crofts, 2017, p. 263):

> "The fundamental basis of public health is evidence of the distributions of states of health and the causal chains involved in their production: this is the remit of the science of epidemiology. Using this evidence, loci for interventions can be identified; policies can be developed to address health issues at the population or community level; interventions can be devised and implemented; and further evidence can be garnered to refine and improve interventions and the understanding of the causation of ill-health".

What is striking even at first glance is how much this description resembles an apt definition of policing; especially, if we put in "security/safety" where it now reads "health," we get a surprisingly adequate description of community or problem-oriented policing. Problem-oriented policing, in particular, uses the public health analogy to encourage police to look for, and address, underlying conditions of crime and disorder, as a way of having a greater impact by preventing future occurrences (Goldstein, 1990). And, as mentioned with regard to community policing, many policing issues have a social service and more or less explicit public health character. These issues have tended to be conceptualized by referring to the importance of preventing harm and protecting the vulnerable as part of the police function, or by pointing out that some issues should be perceived primarily as public health issues and not as part of criminal justice (Asquith & Bartkowiak-Théron, 2017).

A consistent message within the law enforcement and public health debate with regard to policing has been to strengthen the problem-oriented and community-based approach, while the public health sector is encouraged to see the police as a valuable partner in the public health endeavour. The police have in many cases been responsive to this, realizing that they are confronted with a number of issues which cannot be solved by enforcement: "we cannot arrest our way out of this problem". More pointedly, on many subjects, law enforcement was explicitly seen as endangering public health – as in the case of the war on drugs or with regard to HIV/Aids – and contributing to structural social inequity. The same remarks could be made with regard to the role of the police in dealing with the COVID-19 pandemic. And yet we see the dilemma, as there also is a clear enforcement imperative from a public health perspective. There is a need to take a closer look at the intersection of law enforcement and public health, and the use of non-negotiable force is a good place to start.

Non-negotiable force

The police role in response to COVID-19 is first and foremost based on their authority to deploy non-negotiable force. With respect to health security, long a central feature of public health, police officers, and the police organization, are now acting in support of health professionals. What is striking is that this is occurring without a challenge to the established understandings of police as state officials with the authority to deploy non-negotiable force against non-complying citizens. As noted by Bittner (1970, p. 44):

> "In sum, the role of the police is to address all sorts of human problems when and insofar as their solutions do or may possibly require the use of force at the point of their occurrence. This lends homogeneity to such diverse procedures as catching a criminal, driving the mayor to the airport, evicting a drunken person from a bar, directing traffic, crowd control, taking care of lost children, administering medical first aid, and separating fighting relatives".

It is this feature of police that makes them unique among security providers, and that has made them a problem-solver that is often mobilized – calling 911 (or some other emergency telephone number) is a ubiquitously available option for mobilizing police that is used by both individuals and organizations (Shearing, 1984). This traditional problem-solving role, backed up by the authority to use force, is still very much in demand. At most times and in most places, the police have performed many functions. What has unified them has been their authority and capacity to use force, which equipped them to be the appropriate service provider in cases of "something-that-ought-not-to-be-happening-and-about-which-someone-had-better-do-something-now" (Bittner, 1990, p. 249). This remains a prominent expectation of citizens (Muir, 2016):

> "If you ask the public how they want the police to go about their work they say pretty much what they have always said: they want more Bobbies on the beat, speedy response to calls for help and for the police to be accessible and to engage with local communities".

It is the emergency response role that has put high pressure on the availability of the police, and this is related to choices made with regard to other services, such as those related more directly to public health. Being available on a 24/7 basis at no cost to those calling on them for help has led to their involvement in an ever-broadening set of issues, as shifts in the provision of services have led to an increase in issues about which "someone-had-better-do-something-now". Police dealing with mental health crises is a clear example in many societies as diverse as the United States, the United Kingdom, and the Netherlands. For example, in the United States, "mental hospitals" were significantly downsized – starting in the 1960s as part of the progressive deinstitutionalization movement – to be replaced by community-based services for those with serious mental health issues, but the community-based services have never been adequately funded (Lamb et al., 2002). More broadly, since the 1980s, there has been strong political momentum in favour of market forces and smaller government (van Dijk et al., 2019b). Many of the demands and problems that other services used to handle, or handle more completely, have subsequently fallen in the lap of the police, in part because police haven't been as systematically underfunded, because they are open for business 24 hours a day, and because they still make house calls.

The police might be involved in many "social services" but maybe they should not be? As is stated in one recent well-grounded research paper on US policing (Friedman, 2020, p. 1):

> "Crimefighting actually is a very small part of what the police do every day, and their actual work requires an entirely different range of skills, among them: mediation skills to address conflict, social work skills to get people the long-term solutions they need, interviewing and investigating skills to really solve crimes, and victim-assistance. Yet, the police are barely trained in any of this, so, it is no surprise harm is the result".

This author disaggregates the police function, and finds the police performing many different roles that require many different skills. The concern here is that police are lacking appropriate skills *while at the same time* having the authority to use force. However, it was exactly the authority to use non-negotiable force and the lack of other skilled public service providers that got the police involved in the first place.

It is very clear that the police will not solve problems alone. With the development of community policing for example, partnerships with social service providers came to be seen as one of the key elements (Cordner, 2014). This stance has synergies with the conception of police officers first and foremost as problem-solvers (van Dijk et al., 2015, p. 178, referring to Christie Report, 2011):

> "People approach the police for myriad reasons, and it is clearly not the case that officers should respond equally to all these calls for help and advice. But "problems" do not come with a simple label and issues that the police encounter – say, related to drug use, sex work, mental health, domestic violence or child abuse – all have a potential law enforcement element as well as social welfare and health elements. This brings the police into contact with multiple agencies seeking cooperative solutions".

What is especially relevant in the above quotation is, firstly, that the level of analysis shifts from the "police officer" to "the police" as related to multiple agencies. And, secondly, that there is no juxtaposition of law enforcement and social tasks, as these two sides to the police coin are, in the end, based on the authority to (potentially) use non-negotiable force.

As policing (as opposed to "the police") has increasingly emerged as a multi-agency function – what has been termed the "pluralizing of policing" (Bayley & Shearing, 1996, pp. 585, 597) – this has shifted the context in which this double-sided coin finds its expression in what the late Jean-Paul Brodeur (2010) termed a "web of policing," which involves a host of other players engaged in the governance of safety and security that includes, but is not limited to, "the police". On top of – and accompanying – this, there has also been a pluralization of the idea of security, from its

initial focus on state-endorsed orders to a much wider conception evidenced in concepts such as food security, water security, climate security, health security and so on, a usage that references what have come to be termed the UN Sustainable Development Goals (Blaustein et al., 2018). The complexity of our new nodal and networked societies (Castell, 2000) has translated into numerous "security assemblages" around risk and associated harms. In recognizing this, Berg and Shearing (2018) have coined the term "harmscapes". Contemporary harmscapes, Mutongwizo et al. (2019) have argued, will generate all kinds of crises and disasters, including climatic events. Events that are characterised by both radical uncertainty and unpredictability; the COVID-19 pandemic clearly being a good case in point.

These developments have done much to reinforce the extension of the idea of security beyond its traditional meanings. With this, the police ability to use non-negotiable force has been extended to include a broader definition of security than that of "crime fighting," something that resonates with the idea of "homeland security" that emerged in the United States following the 9/11 terrorist events, and an idea that has begun to be taken up internationally. Technological developments are also important and have changed the traditional focus on policing the streets. Today these "streets" include the new cyber "streets" and, increasingly, dealing with "future crimes" (Johnson et al., 2019), for example. As a consequence, the core business of the police has widened considerably.

The emerging field of law enforcement and public health (van Dijk & Crofts, 2017) is itself an example of how current pressing societal problems cannot be neatly labelled and dealt with by specific and specialized public organisations. And policing the pandemic makes very explicit that numerous assemblages come into play, ranging in scope from global to the explicitly local. It is primarily the authority to use non-negotiable force that has implicated police across security assemblages, including public health. Since the matters at hand in these various assemblages are often not crimes, and also because the threat of force or threat of enforcement is frequently sufficient to resolve the immediate problem, police are decoupled from their usual connection to the criminal justice assemblage, instead playing a significant role in other domains, where they have been able to use their definitive authority and associated capacities towards the governance of security (Cordner, 2019, pp. 416–417). Also crucial is that they are seen as representing the state, which still is – for better or worse – the institution that is issuing the particularly invasive measures in the context of the pandemic.

This is true of numerous other domains where police have become directly involved in public health issues. As always, police still find themselves responding to situations about which something has to be done now, including online and within private settings, as is the case with domestic violence, for example. In these assemblages, the police role, in ways that harken back to the historical role that Bittner identified, is frequently based on the authority and capacity to use force. Police

seem to respond to every human problem still, but now it is also translated on an institutional level by their involvement in these numerous assemblages.

With these developments, police have found themselves spread very thinly and required to act in areas outside of their established domain of expertise. Also, where the use of force was explicitly "in the background" and it was the human problems that were at the centre, the high demand for policing comes with the risk of the actual use of violence becoming a more prominent characteristic of policing by police. This has led to a need for strategic choices, not only with regard to traditional policing but also and especially with regard to the current and future assemblages, in this case related to public health.

Requirements for policing public health

Referring back to the introduction, the answer to why the police get drawn into so many of society's chronic and emergent problems still is that "the police are nothing else than a mechanism for the distribution of situationally justified force in society" (Bittner, 1970, p. 39). And – looking at public health – the answer to the question as to whether the police should be in or out is that they are in, in the maybe uncomfortable sense that public health cannot do without non-negotiable force, as is especially clear in the context of the pandemic. There are, of course, challenges here as there have always been, as police sometimes can and do use the non-negotiable force to which they have access inappropriately and dangerously, as the recent death of George Floyd has made abundantly clear. Bound up with these concerns are also long-established concerns that police may, and often do, use the force at their disposal in unacceptably biased and inappropriate ways, something that the Black Lives Matter protests and the related "defund the police" movement have highlighted. The defund movement is essentially arguing that, if the police can't be controlled, then we need to get rid of them or at least cut them down. This might or might not be a viable strategy, depending on the context, but without an effective body with the authority to use non-negotiable force, such as police, it is not apparent how a society would meet its need for a mechanism for distributing non-negotiable force in uncertain and unpredictable circumstances (Perry, 2020).

In the light of these developments and arguments, the question that arises is the following: What is required if police are to situate themselves as trustworthy and responsible niche players whose role is to be bearers of non-negotiable force within the policing web? In considering this question, it is important to recognize that the pluralization of securities is related to changes in the nature of contemporary societies, which, in turn, has implications for the policing web and the role of different participants in it, both state and non-state. As a consequence, it is no longer viable to design a police strategy in isolation. One of the central issues is how to position policing vis-à-vis other players, for example, the domain of public health. What could be – referring to the observations and arguments made throughout this article

– the foundations of a constructive debate on the role of police in the public health agenda?

First, the more recent debate on the intersections of law enforcement and public health started with emphasizing that an exclusive focus on enforcement is harmful and that a community-based and problem-oriented approach is the basis for joined-up solutions in law enforcement and public health. The police have been very responsive to this and it sits well with the problem-solving and community perspective on policing. Hence, also, the hesitation to "enforce" in the context of the pandemic, because it could endanger community–police relations. However, it should be crystal clear – both to the police and to the public health sector – that the potential use of force is why the police are there in the first place, not because they are the best providers of health education or health intervention. Emphasizing the importance of a comprehensive and community-based response to the pandemic (Loewenson et al., 2020) needs to be combined with an acknowledgement of the essential role of enforcement. Obviously, there should be close scrutiny on police misuse of force, but also the public health community should acknowledge the importance of the Bittner role, a role that will not become less important considering present and future societal risks and related harmscapes, especially with increased uncertainty and unpredictability.

Second, it should be clear that the police are clearly reproducing a "state order," and indeed this is precisely what is at the basis of their authority. In that sense, they also reproduce "unjust order," especially if government and legislation are lagging behind societal developments or if the state itself is illegitimate. This is first and foremost an issue of politics, and not of policing, although policing can be a strong symbol thereof. As mentioned, in many countries the police are also bearing the brunt of increased social and economic inequality and diminished government services. This does not mean that it should not concern the police. If, for example, a specific group is over-represented in clearly negative statistics, this should be of concern to the police, not as a political matter but as a professional concern.

Third, the core of policing is to intervene – with force if necessary – if something is happening that should not be happening. The phrase "should not be happening" implies that it is not a structural or "normal" situation. So, if the police are dealing with structural issues, with people with mental illness as a clear example, obviously different structural solutions should be sought. As mentioned, one does not want the police doing the work of other professions just because they are the only ones available. So, again, around mental health in the United States, and related to the argument for defunding the police, it has been noted that persons in mental health crises comprise almost one-fourth of people killed by police, and also that handling such crises is dangerous for police (Earley, 2020), however:

> "It doesn't have to be this way. The movement underway to "defund the police," is a long-needed moment to shift responsibility for the seriously

> mentally ill away from police and put it back to where it belongs: on social service agencies and the medical community".

In this context Wood et al. (2020) point to the relation between the content and appreciation of police work on the one hand and the quality and resources of community health systems on the other. Deficient health systems increase reliance on the police as what is called "mental health interventionists". So, for example, in the Netherlands and Scotland, the police have explicitly asked government for resources related to the growth of mental health incidents, not for the police but for mental health care. Better still would be to dedicate resources to solve societal issues by different parties in the aforementioned assemblages. That would broaden the "defund the police" strategy into a "fund problem-solving" strategy. That has proven difficult for often "compartmentalized" administrations – and inward looking-related organizations – but is of the essence.

Fourth, police should intervene in cases of "something-that-ought-not-to-be-happening-and-about-which-someone-had-better-do-something-now" as it has the authority and discretion to use non-negotiable force in a specific situation. This means the police are actually *there* in the *situation*. Depending on the country, probably others can use force but always in strictly rule-structured circumstances (private guards for a nuclear plant, for example), where discretion is curtailed. The effective and legitimate access to wide discretion presupposes a commitment to a general public good. To exercise this level of discretion effectively, and to do so in ways that are perceived to be legitimately serving the community, requires, in turn, that police be knowledgeable about the communities they are serving, and, *ipso facto*, that communities know their police. This mitigates against a "fire-brigade police" as the pandemic has made clear. An important remark by many police leaders is that their policing model is policing by consent, and that they are reluctant to enforce rules if they feel it runs against public consensus. Obviously, the police are expected to enforce rules if necessary, but the basis is public consent in the institutional sense of "consent to be policed" (van Dijk et al., 2015, pp. 40–45). Policing the pandemic has made this perfectly clear: if rules are not supported, it has either been near impossible to enforce them or – if the police do enforce them – led to public dissatisfaction and, sometimes, abuse of police powers.

Fifth, and finally, acknowledgment that – even if there is consent and procedures are followed – when the police use force, "it often isn't pretty". Importantly, the visibility of police conduct was limited before personal cell phones with cameras, widespread surveillance cameras, and police body-worn video became commonplace. Today when police use force it is increasingly digitally captured and made available through social and news media to a wide audience. It can seem to the public that police use and misuse of force is itself an epidemic, which, though probably not true (Ouss & Rappaport, 2020), takes a serious toll on police legitimacy. So, it is one thing to posit that, inevitably and legitimately, using non-negotiable coer-

cive force is at the core of the police role. But it is another thing to overcome people's visceral reaction to that reality when proposing that police have a constructive role to play in public health. This observation is not meant to downplay police misconduct that has fortunately become more visible and, accordingly, led to a strong incentive for improving police accountability, but only to acknowledge heightened public awareness of a core element of the police role that has long existed.

Conclusion

Returning to Bittner (1970, p. 46), "the role of the police is best understood as a mechanism for the distribution of non-negotiably coercive force employed in accordance with the dictates of an intuitive grasp of situational exigencies". We might wish that this risky approach to handling immediate human problems was not necessary, but as policing the pandemic has made clear, it is. Inevitably, mistakes will be made. The best we can do is to put in place measures to minimize these mistakes. Clearly, then, the use of force is by necessity part of the public health endeavour, emphasising the importance of joined-up solutions. To refer to the "defund the police" arguments: what is clear is that dismantling an institution that is authorized and capable of applying non-negotiable force would leave a very large and potentially dangerous policing vacuum, across a number of safety and security assemblages, that would need to be filled. It might lead to the use of force being distributed and fragmented, and probably dealt with by private partners – as is happening with the military and with cyber – to the detriment of the aforementioned Sustainable Development Goals. As policing the pandemic has highlighted, there is a requirement for a mechanism to distribute non-negotiable force. As the Black Lives Matter protests forcibly remind us, this requirement brings with it huge challenges with respect to the regulation of the use of non-negotiable force as a necessary capacity in social ordering.

Chapter 7. Conclusion and discussion

Introduction

A decade after the *First International Conference on Law Enforcement and Public Health* (LEPH) in 2012, issues raised around the role of the police in the public health domain have not been resolved and, at the same time, have gained greater urgency. In this decade, government policy around the world has been characterised by neoliberalism and, at times, by deep austerity, which has affected the availability and quality of public services, including police services (Innes 2010). However, neoliberalism was called into question in 2020, specifically because people experienced the need for strong government intervention and support as a response to – especially, but not exclusively – the Covid-19 pandemic. In addition to an increasing reliance on the private sector to monitor public health (Leloup and Cools 2021; Wood 2020), there was in many countries a preference for classic law and order solutions in order to solve the complex societal problems arising from the pandemic. This preference has led to a debate around the role of the police in reproducing power relations, including those which can be seen as 'unjust' (Deivanayagam et al. 2021). The police were confronted with increasingly polarised relations in society and anti-government demonstrations that put strains on the classic adage 'the police are the public and the public are the police'. It generated critical questions around the relationship between 'the police' and 'the public'. At the same time, we have observed a renewed interest in the value of community – as opposed to individual citizens or even 'customers' – and, therefore, in community safety and wellbeing, and the role of policing in this context (Krupanski et al. 2020). We thus live in ambiguous times, generating both risks and opportunities for structural change in the field of LEPH and the future of policing for communities.

The preceding chapters on LEPH must be read as attempts to come up with alternative approaches to oversimplified law-and-order models of policing. On the basis of these chapters, conclusions will be drawn regarding the two initial research questions:

1) What characterises the intersection of law enforcement and public health (LEPH) as an emerging field of practices, concepts and research?
2) What is the actual and potential impact of LEPH on (the future of) policing?

Answering these questions will lead to reflection on the conditions under which LEPH can realistically be a valid and sustainable alternative for the future of policing, specifically policing in the context of communities. To reiterate what was said in the introductory chapter: LEPH is not restricted to Western democracies characterised by relative affluence. And even within the West, variations in policing are considerable, as for example differences between the Netherlands, the UK and the USA show. LEPH is fundamentally based on practices in the context of communities

within diverse countries, thereby further increasing variation. At the same time, undeniably, there are shared characteristics among police practices around the world. There are common threads in the way policing is perceived, both by the public and by the police themselves. A similar logic applies to public health. Although these differences and similarities clearly have an impact on the intersection of law enforcement and public health, it will be argued below that there is a common story to tell. Not all elements of LEPH are fully and equally applicable to a great diversity of policing models and practices, but they are, at least, applicable to some extent. An integrated frontline LEPH model is proposed below as a possible future pathway for policing in the context of communities. This chapter will end with policy implications and directions for further research.

Characteristics of LEPH as an emerging field

LEPH is, first and foremost, based on practices where law enforcement and public health professionals meet each other and work together – or *should* work together but are reluctant to do so. The way professionals deal with LEPH issues literally constitutes LEPH practices. In this setting, the involvement of police officers is prominent, and the impact of their involvement on the people involved can be high. This easily generates public and political debate about their powers and legitimacy. This is characteristic of such diverse examples as police dealing with Emotionally Disturbed Persons or policing the Covid-19 pandemic.

Part of the discourse is that the police role in a variety of LEPH issues is currently expanding to a point where the organisation's capacity is 'spread thin' and it becomes necessary to redefine the role of the police. LEPH incidents cannot be dealt with by the police alone. Therefore, law enforcement and public health are increasingly seen as intertwined domains and thus requiring collaborative multi-actor approaches. However, further development towards LEPH cannot be taken for granted and the emerging field might not progress beyond a multitude of practices at the fringes of the established policing and health fields. Discussion of the shifting relationships between policing and public health may even strengthen the divide between both sectors. It is precisely this tension at the boundaries of both fields that requires a clear interpretation.

An important line of reasoning in outlining LEPH starts from professional perceptions and practices. It is important to understand what is happening on the frontline where police officers and public health professionals interact because it is there that traditional boundaries are most visible and have real consequences. Crucial for the development of a shared LEPH framework is the willingness and capacity to work together. LEPH starts with the observation that the broad field of public health fails to include law enforcement – the police – as a key institution to collaborate with in achieving public health goals. Public health professionals often see the police in a negative light, inhibiting public health measures and initiatives. With this, they too

easily dismiss the social role police officers also play. Conversely, from a police perspective, public health professionals may not fully understand the nature of policing. Furthermore, in a somewhat stereotypical vein, the police complain that they are 'picking up the pieces' where public health and other institutions fail to deliver. LEPH's ambition is to overcome this 'tug of war' and provide a fertile breeding ground for different professions and professionals. In so doing, LEPH aspires to break through existing institutional silos and performance frameworks towards collaborative action, with this doctoral thesis representing an academic endeavour in that proposed direction, through the lens of policing. The previous chapters were an attempt to facilitate and inspire LEPH frontline practices to escape the aforementioned silos. Future directions should be grounded in solid research about what works best, and for whom, in specific contexts, in order that institutional legitimacy may be established.

Although much has already happened in terms of conferences, professional practices and research projects, it is still early days for declaring LEPH a field in its own right. One of the main reasons is the lack of a clear 'story' about what defines LEPH as an emerging field. Here, a story is constructed by identifying key characteristics of LEPH on the basis of the preceding chapters, which themselves are a product of 'joined-up' interactions between advisors, policymakers and professionals in both policing and public health domains on the one hand, and an inspiring group of international scholars and LEPH advocates on the other. The common ground of LEPH is constructed through five consecutive questions – why LEPH? what is happening? how is it being done? where is it being done? and for whom? – which will be discussed in turn below.

Firstly, LEPH has a shared mission of creating and maintaining safe and healthy communities. At the highest level of abstraction, this mission is about equating public health with public safety and security – and *vice versa*. Philosophically speaking, LEPH aims to bridge the (implicit) gap between positive and negative freedom and, as such, positive and negative dynamics of safety and security (Schuilenburg et al. 2014). From a negative perspective, law enforcement and public health are about *protecting* people from fears of injury, ill-health and death. Yet, in achieving such goals, professionals in LEPH also need to *stimulate* community safety and wellbeing. Community safety and wellbeing is 'nested' in a global context, including a human rights framework. The WHO (2021) defines 'global public health security […] as the activities required, both proactive and reactive, to minimize the danger and impact of acute public health events that endanger people's health across geographical regions and international boundaries'. Thus, in addition to reactive law enforcement and public health interventions in crisis situations, LEPH aims to proactively create the conditions for safe and healthy communities in which people can flourish, are supported, and are taken care of if needed.

Secondly, LEPH is primarily concerned with regulating human behaviours in their living environment. This requires a wide range of professional activities and diverse

perspectives: helping people suffering from mental ill-health, looking after drug addicts or fighting a pandemic. Also, on a more structural level, both public health and safety/security can grow into a combined perspective, for example by designing cities – or laws for that matter – that are both safe and healthy. Although there is a place for such geographic approaches in LEPH (Cooper et al. 2009), a utopian design perspective is not at the core of its endeavours. LEPH tends to stay close to actual 'behaviours' in the sense that, in the end, humans in their living environment can still make 'choices' that are harmful due to health-discordant behaviours from a public health perspective and due to antisocial or criminal behaviours from the law enforcement perspective. Both types of behaviours can be promoted, encouraged and supported or discouraged and sanctioned. This assumes 'joined-up' action from political, policy and frontline actors and calls for close(r) cooperation between academics and practitioners.

Thirdly, taking this idea one step further, LEPH focuses on issues that escape a sharp definition in terms of either policing or public health action. The logic behind law enforcement can sometimes *only* be understood from a public health perspective – such as seatbelt regulation. However, in general, having an exclusive law enforcement perspective on public health problems is clearly not productive, since we cannot arrest our way out of drug abuse, to refer to a much-debated example, and policing can sometimes be explicitly harmful for your health. Drugs, crime and addiction clearly cannot be solved meaningfully in isolation but assume a shared perspective, not only on regulating undesirable effects but also on their causes. Therefore, law enforcement and public health sectors currently agree on the growing importance of and need for pro-action and prevention, especially because 'waiting for things to go wrong' is expensive – both in terms of money and human costs (Sparrow 2016; Waller 2014). In particular, the police should try to find ways to incorporate the public health perspective in furthering societal goals, for example by introducing other performance measures and pursuing alternative cultural norms (Goulka et al. 2021). Tackling crime is not *the* defining characteristic of policing. Quite the contrary, given the range of social (health) problems and incidents police officers are confronted with on a daily basis. As a consequence, policing must be seen in the wider context of (professional) endeavours to tackle these issues (Wood et al. 2020).

Fourthly, LEPH takes communities as the central locus where the root causes of both ill-health and crime play out. Crime problems as much as ill-health are vastly disproportionately distributed among disadvantaged populations. Institutions reproduce public order related to specific outcomes, including those that can be seen as unjust. Although this line of reasoning has been most prominent in policing, it holds for public health too. LEPH connects to a progressive tradition in policing – dating back to Peel's Metropolitan Police Act of 1829 – with the 'new police' matching the equally progressive 'new public health' (Kalunta-Crumpton 2009; Awofeso 2004). Both in policing and in public health domains, communities represent a crucial social context in which professionals operate and citizen involvement can take place.

Adapting professional institutions to communities – instead of the other way around –by implementing multi-partner collaborations can counter unproductive and unjust institutional outcomes with regard to solving complex human problems.

Fifthly, LEPH pays special attention to vulnerable groups in society. At the intersection of law enforcement and public health, a variety of frontline professionals observe considerable overlap in their so-called 'target populations' and try to take measures in tandem (Enang et al. 2019). Vulnerable populations almost by definition experience complex and multi-dimensional challenges that are hard to address by either law enforcement or public health. Their challenges truly require joined-up approaches between the police and public health domains. While concerns about vulnerability have, for a long time, been part of thinking about policing (Bittner 1967), the topic has remained relatively subsidiary to popular perspectives on fighting crime. However, with the increasing intertwinement between law enforcement and public health, protecting disadvantaged populations has gained prominence in police circles. LEPH explicitly takes sides with vulnerable and powerless (groups of) people.

To summarise, LEPH is about the creation and maintenance of safe and healthy communities through the regulation of human behaviours. This is done by a shared – policing and public health – perspective on how to prevent and mitigate undesirable outcomes. Communities, specifically the protection of vulnerable community members, are the locus of action. With special emphasis on the operational level of frontline professionals and the behaviour of people in their living environment, LEPH takes a broad 'systems perspective' related to the root causes of substantive community ill-health, insecurity and crime. These issues are clear markers of needed institutional change and provide possible clues for the direction of this change by better understanding underlying social determinants, such as enduring poverty, cutbacks in welfare arrangements and social exclusion. Therefore, LEPH could serve as a cornerstone of an integrated or 'whole of systems' approach. In this sense, LEPH is part of a wider universe of public service and governance models, which makes the conventional demarcation between law enforcement and public health domains on the basis of specific sectors and tasks increasingly challenging. What would such a future for policing look like from an LEPH perspective? Or, to be more precise, under which conditions can LEPH be a realistic, valid and sustainable inspiration for the future of policing in the context of communities? We turn to this second question of the doctoral thesis in the paragraph below.

LEPH's actual and potential impact on (the future of) policing

Not least for public health professionals, policing often has a somewhat tainted image. The stereotypical image of police culture is to be macho, cynical and pragmatic, with a strong orientation to action and a preference for 'real' police work, especially crime fighting and making arrests (Loftus 2010). This classic public image is, to some

extent, shaped by incidents or patterns referring to the abuse of rights, using excessive violence, discrimination and corruption However valid, seen from the broader context of governance and public service delivery, police undeniably do have a structural role in the provision of public health. In the previous chapters, reference is made to examples of policing models in the Netherlands and in the UK (with special attention to Scotland) that seem compatible with the basic assumptions of LEPH and signal an abundance of joined-up practices with the public health domain. The future impact of LEPH on the pathways of policing will be heavily dependent on the level of trust that can be built between the police and public health professionals, and between the police and (vulnerable) groups of citizens (Andersson Arntén and Archer 2017). Such trust is based on four interrelated components – a people orientation, a comprehensive policing paradigm, compassion and boundary spanning – proposed below.

The first crucial component is that LEPH has an impact on the (future of) policing first and foremost in the context of communities, where the regulation of human behaviours in their living environment is situated. Communities are not by definition 'local' in an increasingly digital and networked society, yet, as a defining characteristic, LEPH is about the needs of people. This characteristic stems from the observation that LEPH issues are already part and parcel of the police's core business of patrolling the city. It would be counterproductive to perform police work in splendid isolation from public health and from wider partners. Police involvement within LEPH is all about 'handling the situation' (Banton 1964), which presupposes public authority and is, in the end, based on the potential to use non-negotiable force if necessary (Bittner 1970: 46). This forceful police mandate can be an obstacle to a further development of LEPH as public health professionals are reluctant to work with police officers when they potentially inflict harm on people. However, their legitimate mandate to use force is why the police are there in the first place and why they engage with a variety of public and private actors. LEPH specifically posits the formation of (new) coalitions that stretch the boundaries of law enforcement and public health. This is in line with the so-called social police role, which becomes visible in community-oriented styles of policing and implies cooperation with many actors involved in the production of local safety and wellbeing. Since the concept of community policing remains a slippery one with various connotations around the world (Van Steden et al. 2021) and communities are not local *per se*, no position is taken in the academic discussions about whether LEPH must be strongly related to this concept or can be interpreted otherwise. The bottom line is that LEPH is about people.

Clearly, LEPH represents an approach in which policing is, to some degree, 'de-coupled' from classic state interests. The state is not the only institution managing 'harmscapes' (Mutongwizo et al. 2021) or increasingly unpredictable social problems and public health issues. In collaboration with public health professionals, therefore, police officers attempt to allocate their scarce resources effectively to-

wards the wellbeing of citizens, so as to arrive at resilient community safety initiatives. This, in turn, leads to the discussion around the permanent tension between 'consent' and 'control' as the two main paradigms of policing. Broadly speaking, the first takes the community as a starting point, while state order is paramount in the second paradigm. Both paradigms are associated with different types of policing activities. LEPH assumes an emphasis on policing by consent and necessarily includes many and diverse tasks beyond crime fighting, especially where and when the occurrence of urgent social problems cannot be fully known in advance. Responding to such problems can, at time, require (the threat of) force, preferably kept at an absolute minimum. Hence, as a second component, LEPH justifies a 'comprehensive paradigm' of policing, reconciling quite naive dichotomies of 'soft' and 'hard' policing. This paradigm is structured around the pillars of crime and security management, order maintenance and social welfare and community outreach (van Dijk et al. 2015: 183-185). From the LEHP perspective, within such a paradigm, vulnerable populations take centre stage, which implies a broad – 'holistic' (Russell and Taylor 2014) – perspective of community safety and wellbeing. LEPH, after all, revolves around joined-up solutions implying a comprehensive perspective.

A comprehensive paradigm does not lead to fixed roles for policing (or for public health for that matter), but, depending on the situation at hand, requires diverse approaches on the LEPH continuum. Sometimes police officers, sometimes public health professionals, will be in the lead. Given that the work of police officers on the streets remains firmly grounded in their ability to use force, the third component of LEPH is 'compassion' (Punch 2016; Liegghio et al. 2020). This component necessarily represents a core value of policing, which is, in essence, about the delivery of a public service encompassing exceptional powers, and serves as an enabling condition for making LEPH thrive. Although compassion is not self-evidently associated with police work, the term is introduced to stress officers' relationships with diverse publics, predominantly the vulnerable. It underlines once more that LEPH is about real human beings and, as such, serves as critical response to the emergence of what has been called 'abstract police' (Terpstra et al. 2019) – that is, a police force that has become too distant from citizens because of formalised and technological systems. Lipsky's famous 'street-level bureaucrats' show the insidious tendency to develop into 'screen-level' bureaucrats (Bovens and Zouridis 2002: 178). LEPH, instead, builds on the presence of police officers in the community, and who are, together with their partners, capable of empathically understanding and adequately handling public health situations.

The fourth and final component of LEPH refers to the necessity of a different kind of institution that crosses the traditional boundaries between law enforcement and public health. At this point, a lot could be done to stimulate and facilitate the importance of 'boundary-spanning' professionals. Truly joined-up solutions require multidisciplinary teams. A new and currently unfolding pathway of policing is the construction of combined LEPH frontline professionals, who are able to relate to 'all kind of human problems', both in and outside crisis situations, and with sensitivity

for multi-actor settings. For example, Meurs (2021) refers to the concept of 'agency work' as stimulating the 'connective capabilities' of police professionals, merging different forms of knowledge and tackling complex social problems. His idea is important, also because much attention goes to LEPH in crisis situations, possibly to the detriment of highly effective proactive and preventative strategies. Crisis intervention and preventative activities are often seen as 'unconnected', but, clearly, they are not (Wood and Beierschmitt 2014). This makes higher coherence between crisis intervention and prevention a central topic in the emerging LEPH field. Part of the police work dealing with public and mental health issues must go beyond 'picking up the pieces', in order to ensure community safety and wellbeing in more sustainable ways.

Policy implications

LEPH as a field of practices is already there but, thus far, has failed to become anybody's core business. Collaborations between police officers and public health professionals have been around for a long time and in many cases have been successful, provided that the barriers of organisational politics and transaction costs could be overcome. Most of the time, these collaborations work on an ad-hoc – although in some cases increasingly structured – basis, and there is a growing demand for a framework to make these type of interventions more effective and sustainable. LEPH should develop beyond 'an option' for any organisation involved. Most of these organisations by and large agree on the importance of holistic perspectives on community safety and wellbeing. Also, support for LEPHS's explicit choice for a 'human approach' can be reckoned on beforehand.

At the most general level, policy recommendations would classically concern legislation, funding, organisation and education. With regard to legislation, it would be essential to implement regulations that counter the fragmentation of public tasks related to sectoral organisations – the police and their public health counterparts – and encourage collaboration. The organisations involved – and the professionals they employ – should work under a shared regime. This presupposes that various departments in police and public health organisations opt for joined-up LEPH solutions and facilitate context specific interventions at the level of human behaviours in their living environment. The same logic applies to funding. Funders should move away from supplying fragmented – sector specific – financial streams that generate short-term outcomes and instead encourage 'partnership synergy' (Minkler et al. 2003: 1211) through system-level collaboration.

On the organisational level, a host of actions can be thought of to facilitate multidisciplinary teams such as altering training and education programmes with the purpose of aligning the working methods of law enforcement and public health processions. Still, holistic approaches can be hampered by narrowly defined quantitative performance indicators to measure (police) success (Williams et al. 2018). Setting

smart targets should bridge organisational divides. These bridges can be further enhanced through the intra- and interorganisational mobility of professionals. Ideally, professionals performing boundary-spanning work are able to overcome cultural and structural barriers when working across police and public health domains. LEPH intermediaries are capable of acting on behalf of both domains for the accomplishment of shared goals, values and interests.

With this, organisational divides between crisis interventions and 'regular work' should be bridged too. Crises and related integrated interventions can work as an accelerator for joined-up approaches, but crises responses need to be embedded in a wider integrated operational policy. In the context of mental health, Murray et al. (2020) propose five priorities to overcome operational difficulties. Concrete steps can be taken in the directions of (1) risk and vulnerability assessments through triages under a combined public health and criminal justice umbrella, (2) a shared coordination and management of mental health crises, (3) improving decision-making processes, which are ideally guided by evidence-based models, (4) inspiring peer support by sharing education, training and good practices across organisational boundaries, and (5) smoother information and data sharing, where possible with the help of technological devices, to ensure person-centred treatment. These priorities clearly transcend mental health and should be applied in the wider LEPH context.

Some of the aforementioned recommendations imply system-level political and policy changes, which means that 'we are in this for the long haul'. However, police leaders do not necessarily have to wait and can continue developing already existing trends stemming from the LEPH agenda. In particular for Dutch policing, it would make sense to reframe the situation in which they currently find themselves. As mentioned before, on a strategic level objectives are already congruent with dimensions of LEPH and LEPH is also an integral part of many frontline policing activities in the Netherlands. For 2021-2025, formal policies stress the importance of police presence in communities – including those online – and make compelling pleas for integrated approaches and new coalitions in that context (Rijksoverheid 2020a & 2020b). As such, LEPH could be a very useful framework.

Directions for further research

Research that explicitly delves into the LEPH frontline is still relatively scarce. An earlier study conducted in the Netherlands is beneficial for defining what LEPH practices may look like (van Steden 2020). It shows how community police officers and district nurses 'team up' and, in so doing, develop their own working methods. In line with this, participatory action research methods are promising to both capture and inform 'work in process' and guide a further development of LEPH from a bottom-up perspective. Police and public health professionals indeed carry an abundance of practical knowledge that is indispensable for doing the right thing in the right way. Therefore, action research scholars not only gather empirical insights

about organisations, but also try to undertake research in and with organisations with the intention of evaluating, altering and improving practices. Systems thinking, in this respect, perceives organisations as holistic entities, made up of interrelated parts which stretch across organisational boundaries. Building on a 'whole of systems' approach, LEPH has much to gain from such a theoretical lens.

Next, and not unrelated to action-oriented research designs, there is great need for in-depth research that looks into the question of 'what works' at the intersection of law enforcement and public health. 'Evidence-based' methods sometimes exhibit the tendency to firmly stay within an established field of research and remain limited to variables than can be quantitatively measured. For LEPH, by necessity, evidence must be found through interdisciplinary research that reaches beyond police and public health domains. This research should transcend an exclusive focus on evaluating 'what works'. The EMMIE framework (Johnson et al. 2015), deployed by the College of Policing in the UK, takes a promising step forward by also taking into account the mechanisms, mediators, contexts and costs of particular interventions. Although professional intuitions about 'what works best in which situations' continue to be important, ample research is needed to prove and ground such intuitions, search for what might perhaps be superior alternatives, develop more meaningful outcome measures and test them.

Subsequently, information and communication technologies have been redefining both law enforcement and public health domains, not only at a structural level, but also at the very concrete level of the frontline professionals. For example, community police officers are increasingly active on social media and participate in various online groups such as on Facebook, Instagram, YouTube and Twitter (Van Steden et al. 2021). For public health, the importance of new communication technologies has increased too. Covid-19 fuelled a sharp rise in mediated- or tele-interactions between public health professionals and between public health professionals and the clients as an alternative to face-to-face meetings, while at the same time generating concern about the consequences of the so-called digital divide for vulnerable populations (Budd et al. 2020; Farkas and Romaniuk 2020; Gasser et al. 2020; Ramsetty and Adams 2020). But also more fundamentally, changes in the nature of communication have an effect on how policing and public health relate to communities and to each other. Digitalisation may break through existing bureaucratic and professional silos and have the potential to truly redefining frontline practices. Research about these trends is still its infancy.

Finally, as mentioned above, despite many and sometimes very different circumstances, institutions, resources and political systems, LEPH aspires to be a genuinely globally applicable perspective. More work needs to be done on defining the crucial dimensions of LEPH worldwide, including their effects on multifaceted issues of public health and wellbeing and possible solutions. Jardine and van Dijk (2022: 232-234) identify, among others, the role of policing in society, geography and levels of urbanisation, the availability of public resources, and societal structures and (diverse)

local cultures. What is missing at present is a global overview of LEPH problems, practices and possibilities. If LEPH is to become a legitimate field in its own right, it needs to develop a global perspective that pays attention to the full universe of law enforcement and public health cases.

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Summary in English

There is growing academic and societal attention being paid to police interventions that are unrelated to their traditional 'core business' of fighting crime and maintaining public order. As we know from the literature, much police work has nothing to do with crime at all but relates to solving all sorts of human problems and caring for vulnerable people. Many of these activities are in accordance with the – more or less implicit – function of policing in the public health domain.

Public health can be broadly defined as 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life among populations through the organised and informed efforts of society'. The role of the police in public health is increasingly acknowledged and seems to be growing at the same time. Issues at the intersection of policing and public health are the subject of the emerging field of Law Enforcement and Public Health (LEHP).

The core of this doctoral thesis is the meaning and possible impact of LEPH on police work from a policing perspective. Specifically, the focus is on the development of policing in the context of communities, where policing engages in many tasks, 'including responding to the range of problems that citizens approach the police with in search of aid and solutions'. An important dimension of LEPH is the observation that large amounts of police time are spent on issues having an important (public) health component.

Research questions of this doctoral thesis are:

1) What characterises the intersection of law enforcement and public health (LEPH) as an emerging field of practices, concepts and research?
2) What is the actual and potential impact of LEPH on (the future of) policing?

The LEPH agenda is global in nature and sees the so-called Global South (low- and middle-income countries) as crucial to include. However, this doctoral thesis is for the most part restricted to developed Western democracies, mainly concentrating on the UK and the Netherlands, with the USA as both a contrast and a source of thinking on policing. The introductory chapter sets the stage for the main body of the doctoral thesis. Chapters 2 to 6 consist of academic articles, which mirror police-academic cross-fertilisations, the building of an interdisciplinary field of research, the effects of the LEPH agenda on practitioners, and critical reflections on the role of police in matters of public and mental health. The chapters address the following issues.

Chapter 2 (van Dijk and Crofts, 2017) is titled 'Law enforcement and public health as an emerging field' and is published in *Policing and Society*. Law enforcement (especially policing) and public health share much common ground; insecurity and lack

of safety, traditionally provinces of law enforcement, are iniquitous to health and to attempts to improve public health. Considering the maturity of both fields and the growing complexities of their challenges, it is urgent to more consciously 'join forces'. Public health has a strong culture of seeing the individual within their community, as active participants using social capital to build healthy communities. This is matched by the rise of 'community policing', with many of the same influences and approaches. More recently, vulnerability and holistic models of community safety and wellbeing are central to strategy in both law enforcement and public health. Public health is broad, with a huge variety of stakeholders: lists of disciplines engaged in the public health mission are long – but law enforcement officials appear rarely if ever. There is a lack of reciprocal awareness in each sector of the importance of the other in achieving its mission; we wish to raise awareness among both sectors of the importance of the collaboration in addressing the widest range of complex social issues. We argue for closer and better relationships based on mutual understanding of the inextricable entanglement of health and criminal justice perspectives in many complex social issues, and mutual respect for each other's role in addressing them. We have begun exploration of this intersectional area through establishment of an international conference series and a global network of research institutions working in the field.

Chapter 3 (van Dijk, Hoogewoning and Punch, 2018) is titled 'Running on empty. Reinvigorating policing through 'what matters'' and is published in *Cahiers Politiestudies*. The difficulties surrounding the cumbersome Dutch reorganization closely reflect problems with police reform in other societies and this refers to common underlying factors and developments (van Dijk, Hoogewoning and Punch, 2015). Especially neoliberalism and New Public Management – combined with the changing impact of the media – have under conditions of threat and austerity shaped recent European police reforms. At the moment there is an urgent need for reorientation with regard to the future development of policing as a public service. Services essential to the quality of life for many in modern society are perilously on the verge of 'running on empty'. Three perspectives are of special importance: paradigms of policing, organisational structure and culture, and professionalization. The article concludes that – given societal trends and what matters in policing – there is a need for placing people at the core of future developments, with a strong focus on competences, solidarity and compassion.

Chapter 4 (van Dijk, Herrington, Crofts, Breunig, Burris, Sullivan, Middleton, Sherman and Thomson, 2019) is titled 'Law enforcement and public health: recognition and enhancement of joined-up solutions' and is published in *The Lancet*. Public security and law enforcement have a crucial but often largely unacknowledged role in protecting and promoting public health. Although the security sector is a key partner in many specific public health programmes, its identity as an important part of the public health endeavour is rarely recognised. This absence of recognition has resulted in a generally inadequate approach to research and investigation of ways in which law enforcement, especially police at both operational and strategic levels,

can be effectively engaged to actively promote and protect public health as part of a broader multisectoral public health effort. However, the challenge remains to engage police to consider their role as one that serves a public health function. The challenge consists of overcoming the continuous and competitive demand for police to do so-called policing, rather than serve a broader public health function – often derogatively referred to as social work. This Series paper explores the intersect between law enforcement and public health at the global and local levels and argues that public health is an integral aspect of public safety and security. Recognition of this role of public health is the first step towards encouraging a joined-up approach to dealing with entrenched social, security, and health issues.

Chapter 5 (van Dijk, Zoeteman and Fassaert, 2020) is titled 'Nursing and policing as boundary-spanning professions: from crisis management towards community outcomes in mental health' and is published in the *Journal of Psychiatric and Mental Health Nursing*. There is considerable overlap in the types of people that the police and mental health professionals provide services to. This concerns a wide variety of cases, ranging from people in distress to those who commit serious offences, all of which *might* be related to mental health problems. This essay suggests that there is a need for the continuous development of new, collaborative ways of working between members of these two professions at their different stages of interaction with their "shared clients". This would also necessitate the acquisition of new knowledge, skills, and attitudes by members of these professions. There is a need for not only change, but also innovation across the professions. The authors of this essay – with backgrounds in policing, acute psychiatric care, and public health, respectively – were recently involved in programmes with the collaboration between policing and mental health as a focal point. These programmes, which are set in the policy context of the Netherlands and, more specifically, are in relation to the capital city of Amsterdam, serve as examples in this essay.

Chapter 6 (van Dijk, Shearing and Cordner, 2022) is titled 'Policing the pandemic: public health, law enforcement, and the use of force' and is published in the *Journal of Community Safety & Well-Being.* This article delves into the relation between policing and public health in the context of the COVID-19 pandemic. The police have been seen as a crucial and extensively mobilised resource that has been utilised in responding to a public health crisis. The response to the pandemic shows the police mainly as enforcing state orders in which they have a traditional function related to the use of force. It is argued here that the classic definition of policing in terms of the use of force allows for the police becoming "decoupled" from the institutional frames of criminal justice and public order. The perspective of a decoupled police would have real consequences for its involvement in public health. The article concludes with the conditions necessary for police to be a legitimate force in the public health domain.

On the basis of these chapters, conclusions are drawn in the final chapter regarding the two initial research questions. The common ground of law enforcement and

public health – LEPH as an emerging field – is constructed through five consecutive questions: why LEPH? what is happening? how is it being done? where is it being done? and for whom? To summarise, LEPH is about the creation and maintenance of safe and healthy communities through the regulation of human behaviours. This is done by a shared – policing and public health – perspective on how to prevent and mitigate undesirable outcomes. Communities, specifically the protection of vulnerable community members, are the locus of action. With special emphasis on the operational level of frontline professionals and the behaviour of people in their living environment, LEPH takes a broad 'systems perspective' related to the root causes of substantive community ill-health, insecurity and crime. These issues are clear markers of needed institutional change and provide possible clues for the direction of this change by better understanding underlying social determinants, such as enduring poverty, cutbacks in welfare arrangements and social exclusion. Therefore, LEPH could serve as a cornerstone of an integrated or 'whole of systems' approach. In this sense, LEPH is part of a wider universe of public service and governance models, which makes the conventional demarcation between law enforcement and public health domains on the basis of specific sectors and tasks increasingly challenging. What would such a future for policing look like from an LEPH perspective? Or, to be more precise, under which conditions can LEPH be a realistic, valid and sustainable inspiration for the future of policing in the context of communities?

The future impact of LEPH on the pathways of policing will be heavily dependent on the level of trust that can be built between the police and public health professionals, and between the police and (vulnerable) groups of citizens. Such trust is based on four interrelated components derived from the preceding chapters: a people orientation, a comprehensive policing paradigm, compassion and boundary-spanning. The first crucial component is that LEPH has an impact on (the future of) policing first and foremost in the context of communities, where the regulation of human behaviours in their living environment is situated. Communities are not by definition 'local' in an increasingly digital and networked society, yet, as a defining characteristic, LEPH is about the needs of people. Police involvement within LEPH is all about 'handling the situation', which presupposes public authority and is, in the end, based on the potential to use non-negotiable force if necessary. Clearly, LEPH represents an approach in which policing is, to some degree, 'de-coupled' from classic state interests. This, in turn, leads to the discussion around the permanent tension between 'consent' and 'control' as the two main paradigms of policing. As a second component, LEPH justifies a 'comprehensive paradigm' of policing, reconciling quite naive dichotomies of 'soft' and 'hard' policing. This paradigm is structured around the pillars of crime and security management, order maintenance and social welfare and community outreach. From the LEHP perspective, within such a paradigm, vulnerable populations take centre stage, which implies a broad – 'holistic' – perspective of community safety and wellbeing. LEPH, after all, revolves around joined-up solutions implying a comprehensive perspective. A comprehensive paradigm does

not lead to fixed roles for policing (or for public health for that matter), but, depending on the situation at hand, requires diverse approaches on the LEPH continuum. Sometimes police officers, sometimes public health professionals, will be in the lead. Given that the work of police officers on the streets remains firmly grounded in their ability to use force, the third component of LEPH is 'compassion'. This component necessarily represents a core value of policing, which is, in essence, about the delivery of a public service encompassing exceptional powers, and serves as an enabling condition for making LEPH thrive. The fourth and final component of LEPH refers to the necessity of a different kind of institution that crosses the traditional boundaries between law enforcement and public health. At this point, a lot could be done to stimulate and facilitate the importance of boundary-spanning professionals. Truly joined-up solutions require multidisciplinary teams. A new and currently unfolding pathway of policing is the construction of combined LEPH frontline professionals, who are able to relate to 'all kind of human problems', both in and outside crisis situations, and with sensitivity for multi-actor settings.

Research that explicitly delves into the LEPH frontline is still relatively scarce. Participatory action research methods are promising to both capture and inform 'work in process' and guide a further development of LEPH from a bottom-up perspective. Police and public health professionals indeed carry an abundance of practical knowledge that is indispensable for doing the right thing in the right way. Therefore, action research scholars not only gather empirical insights about organisations, but also try to undertake research in and with organisations with the intention of evaluating, altering and improving practices. Systems thinking, in this respect, perceives organisations as holistic entities, made up of interrelated parts which stretch across organisational boundaries. Building on a 'whole of systems' approach, LEPH has much to gain from such a theoretical lens.

Finally, despite many and sometimes very different circumstances, institutions, resources and political systems, LEPH aspires to be a genuinely globally applicable perspective. More work needs to be done on defining the crucial dimensions of LEPH worldwide, including their effects on multifaceted issues of public health and well-being and possible solutions. What is missing at present is a global overview of LEPH problems, practices and possibilities. If LEPH is to become a legitimate field in its own right, it needs to develop a global perspective that pays attention to the full universe of law enforcement and public health cases.

Summary in Dutch

Dit proefschrift betreft de toestand en (mogelijke) toekomst van de politie in relatie tot (lokale) gemeenschappen vanuit het gedeelde perspectief van rechtshandhaving (*law enforcement*) en publieke gezondheid (*public health*) onder de noemer LEPH. Duidelijk is dat de maatschappelijke ontwikkelingen, zoals de toegenomen complexiteit van sociale vraagstukken en de daarmee verbonden vragen over de grondslagen en taken van traditionele publieke sectoren, aanleiding zijn voor een heroriëntatie op de functie van de politie en dat de uitkomst daarvan nog niet vaststaat. Het spanningsveld tussen de zogenoemde beperkende (handhaving) en ondersteunende (hulpverlening) rol van de politie staat hierbij centraal. Hoewel de politie primair wordt gezien als gericht op het bewaken van de openbare orde en het bestrijden van criminaliteit is zij vooral bezig met – zoals de Nederlandse politiewet het formuleert – 'het verlenen van hulp aan hen die deze behoeven'. In dat opzicht lijkt de agent soms meer op de sociaal werker of wijkverpleegkundige, terwijl dat tegelijkertijd niet wordt gezien als een zogenoemde kerntaak van de politie. De grote overlap van doelgroepen, waaronder verslaafden en verwarden, bij politie en hulpverleners heeft in ieder geval geleid tot samenwerking tussen de politie en een veelheid aan andere professionele partijen op het grensvlak van zorg en veiligheid. De vraag is hoe dit grensvlak eruitziet in termen van praktijken, concepten en onderzoek. De onderzoeksvragen luiden als volgt:

1) Wat karakteriseert het gedeelde perspectief van rechtshandhaving (*law enforcement*) en publieke gezondheid (*public health*) onder de noemer LEPH als een opkomend veld van praktijken, concepten en onderzoek?
2) Wat is de feitelijke en mogelijke invloed van LEPH op de (toekomst van de) politie?

Beantwoording van deze vragen veronderstelt het combineren van een academisch en een professioneel perspectief. Daarenboven is gekozen voor een expliciet normatief perspectief op de betekenis van de politiefunctie in de context van gemeenschappen. De onderzoeksvragen betreffen LEPH als een brede beweging die zich niet beperkt tot democratische en hoge-inkomenslanden. In dit proefschrift ligt echter de nadruk – in het bijzonder waar het gaat om de politie – op het Verenigd Koninkrijk en Nederland als twee landen in de voorhoede op het snijvlak van zorg en veiligheid. Beide delen het belang van een politie die opereert met instemming van burgers en ervaren tegelijkertijd dat een fundamentele heroriëntatie van de politiefunctie in relatie tot rechtshandhaving en publieke gezondheid noodzakelijk is.

Het proefschrift start met een inleidend hoofdstuk waarin de context van de onderzoeksvragen wordt geschetst. Bouwstenen voor de beantwoording van de vragen worden geleverd in de hoofdstukken 2 tot en met 6. Deze hoofdstukken betreffen academische artikelen die voortgekomen zijn uit de interactie tussen wetenschap

en professie in het opkomende veld van LEPH. In het concluderende hoofdstuk komen we tot een samenhangend LEPH-perspectief en de consequenties daarvan voor een duurzame toekomst van de politie in de context van gemeenschappen.

Hoofdstuk 2 gaat over de opkomst van LEPH als een veld van praktijken, concepten en onderzoek. Startpunt is dat rechtshandhaving en publieke gezondheid vorm hebben gekregen in verschillende sectoren – in het bijzonder politie en openbare gezondheidszorg – met een andere achtergrond, gerichtheid en bijbehorende cultuur en dat dit een integrale benadering in de weg zit. Er is wel sprake van samenwerking, maar deze is vaak niet structureel en wordt gekarakteriseerd door de nodige barrières die voortkomen uit verschillen tussen beide sectoren. Tegelijkertijd hebben beide sectoren meer en meer met elkaar te maken en neemt het belang van een gedeelde benadering toe. Daarbij is de kennis over de relatie tussen sociale veiligheid en publieke gezondheid de afgelopen decennia sterk toegenomen.

Een belangrijke lijn binnen LEPH is de 'constructie van kwetsbaarheid' en het centraal stellen van kwetsbare personen en groepen. Deze lijn heeft invloed gehad op het beleid en de uitvoering van de politie. Vanuit het perspectief van publieke gezondheid is een belangrijke constatering dat, hoewel een indrukwekkende lijst partners deel uitmaakt van de openbare gezondheidszorg, de politie daar niet structureel deel van uitmaakt. En hoewel er sprake is van het besef dat de politie een effect heeft op gezondheidsdoelen, wordt zij veelal niet structureel bij samenwerking betrokken. Bovendien ligt vaak de nadruk op de mogelijke negatieve invloed van de politie op de publieke gezondheid, zoals bij het nemen van louter repressieve maatregelen tegen kwetsbare groepen. Dit onderwerp is succesvol en in toenemende mate door sociale bewegingen, zoals mensenrechten- en emancipatiebewegingen, op de agenda gezet. Daarentegen kan de politie ook een positieve bijdrage leveren aan publieke gezondheid. Dat perspectief ontbreekt veelal.

Tegen deze achtergrond wordt LEHP geschetst als een wereldwijd opkomend veld van praktijken, concepten en onderzoek. Daarbij wordt expliciet ingegaan op de grote variatie in onderwerpen en mate van integratie tussen politie en gezondheidszorg, die mede afhankelijk is van de politieke context en het nationale perspectief op de politiefunctie. Tevens wordt op basis van de ervaringen en activiteiten vanaf de eerste expliciete LEPH-conferentie in 2012 een kennisagenda en emancipatoire beweging beschreven Een centrale constatering is dat LEPH bij de politie en in de publieke gezondheid aan belang heeft gewonnen, maar dat het tot nu 'niemands kerntaak is'. Dat heeft gevolgen voor zowel politieke keuzen als voor onderzoek. In beide arena's is er de noodzaak om tot een integraal LEPH-perspectief te komen.

Hoofdstuk 3 beschrijft de toestand van de politie in het Verenigd Koninkrijk en Nederland, waarbij wordt voorgebouwd op het eerder gepubliceerde boek *What matters in policing? Change, values and leadership in turbulent times* (van Dijk, Hoogewoning en Punch 2015). Het hoofdstuk behandelt de evaluatie van de totstandkoming van de Nationale Politie in Nederland op basis van de Politiewet 2012. De pro-

blemen rondom deze reorganisatie verwijzen naar een aantal ontwikkelingen die niet alleen in Nederland spelen. Belangrijk is de invloed van het neoliberalisme en het bijbehorende *New Public Management* (NPM) dat ertoe heeft geleid dat publieke diensten in het algemeen – en de politie in het bijzonder – zijn uitgehold. Een exclusief bedrijfsmatige benadering van maatschappelijke functies als zorg en veiligheid leidt tot een afname van de kwaliteit en de beschikbaarheid van publieke diensten. Hoe dit feitelijk werkt wordt beschreven vanuit drie perspectieven: 1) de definitie van wat de politie is; 2) de werking van bureaucratisering, en 3) de betekenis van professionalisering.

Ten aanzien van de definitie van wat de politie is, constateren we dat onder invloed van NPM de politietaak snel wordt versmald tot meetbare doelen, waarbij efficiency centraal staat. Daardoor komt de legitimiteit van de politie onder druk te staan. Hiertegenover en in overeenstemming met LEPH staat het zogenoemde 'omvattende' (*comprehensive*) paradigma voor de politie dat de tegenstelling tussen traditionele paradigma's van instemming (*consent*) en controle (*control*) overstijgt. In het omvattend paradigma speelt sociaal welzijn en verbinding met gemeenschappen een centrale rol. Daarna beschrijven we dat NPM – in tegenstelling tot wat wordt geclaimd – leidt tot een versterking van bureaucratie, waardoor de uitvoering van politiewerk door professionals verder onder druk komt te staan. Tot slot geven we aan dat in de context van bedrijfsmatig denken professionalisering onbedoeld leidt tot een vergroting van de tegenstelling tussen management en uitvoering. Er is een heroriëntatie van politiewerk nodig, waarbij een focus op mensen de kern uitmaakt. Met dat als leidend principe wordt de politie gedefinieerd in termen van publieke dienstverlening met compassie, in het bijzonder gericht op kwetsbare groepen en in samenwerking met tal van andere partijen op het snijvlak van zorg en veiligheid.

Hoofdstuk 4 gaat nader in op de relatie tussen veiligheid en de rol van de politie in de context van publieke gezondheid. Er wordt geconstateerd dat de omvang en intensiteit van de samenwerking tussen beide sectoren is toegenomen – in het bijzonder in een aantal welvaartstaten, zoals Nederland en het Verenigd Koninkrijk – maar dat dat niet heeft geleid tot een samenhangende politieke agenda. Dit wordt gedeeltelijk verklaard door het feit dat publieke gezondheid onvoldoende wordt gezien als een cruciaal onderdeel van politiewerk. Het ontbreken van adequate erkenning van deze rol bemoeilijkt onderzoek en experimenten gericht op het beter werkend krijgen van gezamenlijke multisectoriële benaderingen, zowel op strategisch als operationeel niveau. We staan stil bij het risico van de versterking van een monodisciplinaire benadering van politiewerk gericht op (staats)veiligheid in het licht van mondiale zorgen met betrekking tot massale migratie, terrorisme en economische instabiliteit. Juist dit type complexe sociale vraagstukken – inclusief sociale en economische ongelijkheid – raakt zonder uitzondering aan zowel veiligheid als aan publieke gezondheid. Op het niveau van gemeenschappen en kwetsbare groepen geldt evenzeer dat er veelal een samenloop is van veiligheid en zorg rondom bijvoorbeeld geweld, middelengebruik (alcohol en andere drugs) en mentale gezondheid. Daarom is een breed LEPH-perspectief op de politie noodzakelijk.

Het hoofdstuk beschrijft de constructie van publieke instituties met betrekking tot rechtshandhaving en publieke gezondheid in het proces van modernisering in de 19de en 20ste eeuw. Deze beschrijving biedt handvatten voor de (gedeeltelijke) institutionalisering van het grensvlak tussen politie en zorg in de 21ste eeuw. Het maakt veel uit of toekomstige investeringen vertrekken vanuit de traditionele, gescheiden sectoren of vanuit een overkoepelend perspectief. Voorts wordt een aantal van de belangrijke gemeenschappelijke vraagstukken, karakteristieken en (maatschappelijke) opbrengsten van een integrale benadering beschreven. Vervolgens worden de barrières voor onderzoek naar – en de implementatie van – geïntegreerde zorg- en veiligheidsbenaderingen in kaart gebracht. Er is logischerwijs sprake van een discongruentie tussen integrale benaderingen en de huidige sectorale organisatielogica's.

Een meer structurele verbinding tussen politie en publieke gezondheid vereist in de eerste plaats een gedeeld conceptueel LEPH-model. Dit model kan bijvoorbeeld laten zien op welke wijze politie-interventies van invloed zijn op de publieke gezondheid en hoe andersom het perspectief van de publieke gezondheid kan bijdragen aan het vergroten van de sociale en maatschappelijke impact van politie-interventies. In de tweede plaats vraagt het om een betere institutionele verbinding tussen de politiefunctie en publieke gezondheid en concrete integratie van de politie in netwerken rondom de uitvoering van publieke gezondheidstaken gericht op kwetsbare groepen. Van belang is dat deze integratie werkende weg wordt ontwikkeld, waarbij wordt onderzocht wat werkzame elementen zijn.

Hoofdstuk 5 bouwt voort op de in het vorige hoofdstuk geformuleerde kennisagenda en richt zich op concrete samenwerking tussen de politie en (openbare) geestelijke gezondheidszorg. Meer in het bijzonder wordt gekeken naar betrokken professies en professionals en het belang van *boundary-spanning* – dat wil zeggen: het vermogen om over de grenzen van de eigen discipline heen complexe problemen gezamenlijk aan te pakken. Startpunt is de constatering dat er een aanzienlijke overlap is tussen de doelgroep van de politie en de (openbare) geestelijke gezondheidszorg. Vanuit het perspectief van de politie kan het daarbij gaan om een zeer brede groep: van mensen die onvoldoende voor zichzelf kunnen zorgen en die overlast veroorzaken tot mensen die ernstig misdrijven begaan. In al deze gevallen *kan* er een relatie zijn met de geestelijke gezondheid van personen.

In het hoofdstuk wordt allereerst ingegaan op het stijgend aantal politiemeldingen van personen met verward gedrag in Nederland. De vraag wat de inhoud is van deze meldingen en wat de stijging verklaart is niet eenvoudig te beantwoorden, onder meer door het sectorale karakter van de data. De zogenoemde 'verwarde personen' zijn onderwerp van intensief maatschappelijke en politiek debat, waarbij incidenten een belangrijke rol spelen. Onderzoek naar één van die incidenten is aanleiding geweest te komen tot een voorstel voor een integrale aanpak rondom verwarde personen – een goed voorbeeld van LEPH. Zo'n aanpak in werking brengen vraagt het nodige. In het hoofdstuk worden vereisten hiervoor nader in beeld gebracht aan de hand van drie cases in Amsterdam waar de auteurs in verschillende hoedanigheden

bij betrokken waren. De cases bevinden zich op verschillende posities op het continuüm van strafrecht tot zorg.

De eerste casus betreft de zogenoemde Top-600 benadering van veelplegers van ernstige misdrijven waarbij – klaarblijkelijk – de reguliere aanpak vanuit zorg en veiligheid ontoereikend is. De tweede casus gaat over de beoordeling van de geestelijke gezondheid van verdachten *voordat* de beslissing wordt genomen of het strafrecht de aangewezen weg is of dat het hier vooral moet gaan om een aanpak in de sfeer van de geestelijke gezondheid. De derde casus richt zich op wat wordt aangeduid als de gemeenschappelijke 'frontlinie' van zorg en veiligheid, in het bijzonder de samenwerking tussen (wijk)agenten en sociaal-psychiatrisch verpleegkundigen. De drie cases tezamen laten zien wat de maatschappelijke opbrengst is van integrale benaderingen en geven zicht op verschillende barrières. Deze barrières zijn vaak organisatorisch en praktisch van aard, maar raken ook aan gescheiden professies en de daarmee verbonden *bodies of knowledge*.

Hoofdstuk 6 gaat over de rol van de politie bij de Covid-19 pandemie en wat dit mogelijk zegt over de toekomst van de politie – mede met betrekking tot publieke gezondheid. In de context van LEPH gaat de meeste aandacht uit naar de rol van de politie in relatie tot sociaal welzijn en de verbinding met gemeenschappen. Bij de pandemie werd de politie echter vooral ingeroepen in haar rol van handhaver. Daarbij staat de bevoegdheid van de politie om geweld te gebruiken centraal. Er lijkt zelfs sprake te zijn van een groeiende tegenstelling tussen de inzet van geweldsbevoegdheden en de sociale rol van de politie. Volgens sommigen is het feit dat de politie in essentie wordt bepaald door haar geweldsmonopolie reden om de betrokkenheid van de politie bij bredere maatschappelijke vraagstukken, zoals publieke gezondheid, af te wijzen. Anderen pleiten juist voor herontwerp van de politie in de context van de bredere opgave van publieke veiligheid.

In dit hoofdstuk staat de klassieke notie van de politie gedefinieerd als 'een mechanisme voor de distributie van niet-onderhandelbaar geweld' – het geweldsmonopolie – centraal. Daarbij wordt gesteld dat deze notie niet noodzakelijkerwijs als consequenties heeft dat politieoptreden vooral repressief van aard is. Het is datzelfde geweldsmonopolie dat ten grondslag ligt aan de voornoemde sociale politierol. De kern van het spanningsveld is vooral dat de politie, vanuit het geweldsmonopolie gedacht, primair wordt verbonden met het strafrechtsysteem en vervolgens vanuit dat perspectief wordt ingezet, zoals overduidelijk het geval was bij de Covid-19 pandemie.

In dit hoofdstuk wordt echter betoogd dat de politie niet onlosmakelijk met het strafrechtsysteem is verbonden. Kern van het geweldsmonopolie van de politie is dat zij met kennis van de context beslissend kan optreden als – Bittner (1974/1990: 31/249) parafraserend – 'er-iets-gebeurt-dat-niet-zou-moeten-gebeuren-en-waar-iemand-nu-iets-aan-moet-doen'. De politie is in die conceptie eerder probleemoplosser en hulpverlener dan wetshandhaver. Dat staat dus tegenover de conceptie

van politie als primair de frontlinie van het strafrechtsysteem. Het lijkt aannemelijk dat in het licht van huidige en toekomstige maatschappelijke problemen en soms wereldwijde risico's – zoals pandemieën, maar bijvoorbeeld ook de groeiende gevolgen van klimaatverandering – dit laatstgenoemde beeld in afnemende mate zal overtuigen. Tegelijkertijd blijft het organiseren van niet-onderhandelbaar geweld noodzakelijk en de kern van de publieke politie. De vraag is dan op welke wijze geweldsbevoegdheden kunnen worden gelegitimeerd. Het hoofdstuk eindigt met de voorwaarden waaronder de politie legitiem inhoud kan geven aan het geweldsmonopolie in de context van LEPH, zonder primair gekoppeld te zijn aan het strafrechtsysteem. Het betreft onder meer de noodzaak van politieoptreden als onderdeel van een integrale aanpak gericht op structurele oplossingen voor – en met – lokale gemeenschappen en kwetsbare groepen. Terughoudendheid bij de inzet van geweldsbevoegdheden is noodzakelijk en de gelijktijdige erkenning dat geweld ook een plaats heeft in LEPH evenzeer.

Hoofdstuk 7 sluit af met de conclusie en discussie. Op basis van de voorgaande hoofdstukken wordt een samenhangende redenering opgezet over wat LEPH karakteriseert als een opkomend veld van praktijken, concepten en onderzoek: hoe ziet de overlap tussen politie en publieke gezondheid er uit?

In de eerste plaats is er sprake van een gedeelde missie gericht op de veiligheid en gezondheid van gemeenschappen. Van belang daarbij is dat het perspectief verschuift van 'handhaven' van wet- en regelgeving – zowel het strafrecht als in de context van publieke gezondheid – naar 'bevorderen' van veiligheid en gezondheid.

In de tweede plaats staat in het gedeelde LEPH-perspectief het gedrag van mensen centraal. Gedrag veronderstelt dat er sprake is van keuzemogelijkheden, die tot meer of nadrukkelijk minder gewenste uitkomsten leiden. De focus op gedrag veronderstelt ook gemeenschappelijk en integraal optreden, zowel op het niveau van politiek en beleid, als op het niveau van concrete interventies. Er is een intensievere interactie tussen praktijk en wetenschap nodig om dit gedrag te bestuderen en van richting te voorzien.

Dit leidt in de derde plaats tot het overstijgen van de tegenstelling tussen zorg en veiligheid. De essentie van LEPH-vraagstukken is dat het weinig overtuigend is ze op te vatten als een probleem binnen één van de sectoren: handhaving van de (straf)rechtsorde of openbare gezondheidzorg. Dit betekent ook dat de gerelateerde instituties en organisaties begrepen moeten worden in de bredere context van veiligheid en gezondheid van gemeenschappen – en niet in isolatie.

In de vierde plaats ziet LEPH gemeenschappen, waaronder buurten en kwetsbare groepen, als de plaats waar zowel criminaliteit als gezondheidsrisico's tot uitdrukking komen. Gemeenschappen zijn daarom het aangrijpingspunt voor interventies vanuit de politie en de zorg. De betrokkenheid – en instemming of *consent* – van gemeenschappen bij interventies vormt het uitgangspunt. Zowel de politie als de

gezondheidszorg (re)produceren orde, waarbij sommige uitkomsten gekarakteriseerd kunnen worden als 'onrechtvaardig'. Kritiek hierop is het gevolg van de toename van kennis en agendering door sociale bewegingen, zoals burgerrechtenbewegingen. Binnen LEHP is daarbij aansluitend de aanpassing en vorming van instituties en interventies samen met gemeenschappen een belangrijke strategie. Het is op dit niveau dat nieuwe praktijken zich ontwikkelen en bijbehorende instituties worden 'gemaakt'. Dat gebeurt niet via een blauwdruk, maar werkende weg.

In de vijfde plaats ligt de focus van LEPH op kwetsbare groepen, een perspectief dat ondertussen ook daadwerkelijk invloed heeft op de wijze waarop politiewerk wordt vormgegeven. Dit is zichtbaar in werkwijzen variërend van een integrale aanpak van huiselijk geweld en kindermisbruik tot de samenwerking tussen wijkagenten en wijkverpleegkundigen. Het belang van deze focus is een expliciet normatieve stellingname in LEPH. Wat kwetsbaarheid constitueert verandert door de tijd en is onderwerp van voortdurende dialoog binnen LEPH, zowel vanuit het perspectief van professionele praktijken als vanuit onderzoek.

De hiervoor beschreven opbouw van LEPH wordt vervolgens vertaald in vier structurele componenten van veranderend politieoptreden in de context van (lokale) gemeenschappen. Een eerste component is dat gemeenschappen centraal staan in het politieoptreden. Zoals eerder aangestipt is het begrip gemeenschap niet exclusief geografisch gedefinieerd (denk aan buurten of wijken) en kan het ook betrekking hebben op kwetsbare groepen. Die 'dubbelheid' is ook zichtbaar de organisatie van de politie. Een geografische benadering staat naast het definiëren van thema's en doelgroepen. De vraag is vooral waar mensen bepaald (ongewenst)gedrag vertonen, zowel offline als online. Hoewel de basis van LEPH vaak wordt gevonden in lokale gemeenschappen, vereist LEPH ook samenhangende interventies op verschillende niveaus: van lokaal tot mogelijk wereldwijd, zoals bij migratie, mensenhandel en een pandemie.

Een tweede component betreft de keuze voor een perspectief op politiewerk dat de schijnbare tegenstelling tussen haar beperkende en de ondersteunende rol – tussen 'zacht' en 'hard', tussen 'sociaal werk' en 'boeven vangen' – overstijgt. LEPH veronderstelt een brede definitie van politiewerk (*comprehensive paradigm*) dat bestaat uit drie samenhangende dimensies: 1) criminaliteit en onveiligheid; 2) sociaal welzijn en verbinding met gemeenschappen; 3) openbare orde. Het brede perspectief is dat van veiligheid en welzijn, in een benadering die noodzakelijkerwijs is geïntegreerd met tal van (zorg)organisaties. Een dusdanige perspectief vertaalt zich niet één op één in een precieze vertaling van (kern)taken, de context waarin de politie en gezondheidszorg werken is in hoge mate bepalend.

Meer dan discussies over (kern)taken is een derde component vereist, hier samengevat onder de noemer publieke dienstverlening met compassie. Compassie is een noodzakelijke voorwaarde voor het uitoefenen van de uitzonderlijke bevoegdheden van de politie in veelvuldige interactie met kwetsbare groepen. Compassie biedt ook

een noodzakelijk tegenwicht tegen de opkomst van een 'abstracte' politie die door formele en technologische systemen op grotere afstand van de burgers komt te staan. Politiewerk gaat in de eerste plaats over mensen.

Een vierde component betreft de expliciete erkenning dat er een nieuw LEPH-veld wordt geformeerd en dat dit veld gestalte krijgt in de domein-overstijgende kennis en handelingen van professionals – zogenoemde *boundary-spanners*. Hun praktijken vormen de basis voor nieuwe institutionele vormen die klassieke tegenstellingen tussen zorg en veiligheid overstijgen. Daarbij is belangrijk dat deze nieuwe manieren van werken zowel crisis- als regulier werk – en de verbinding tussen beide – betreffen. Op basis van deze vier componenten kan een heldere beleidsagenda worden opgesteld met consequenties voor wetgeving, financiering en organisatie.

In de opkomst van LEPH speelt ook onderzoek – in het bijzonder naar fenomenen met zowel een criminele als een gezondheidsdimensie – een belangrijke rol. Vooralsnog is er weinig aandacht voor empirisch onderzoek naar het vormgeven van nieuwe manieren van werken en de (mogelijke) consequenties daarvan voor organisaties op het snijvlak van zorg en veiligheid. Actieonderzoek vanuit een overstijgend systeemperspectief – waarbij gedeelde problematieken en niet bestaande organisatiegrenzen het uitgangspunt zijn – is een veelbelovende richting voor toekomstig LEPH onderzoek.

Daarnaast is er de noodzaak tot meer *evidence-informed* onderzoek: wat werkt, voor wie en in welke context? Het gaat bij voorkeur om interdisciplinair onderzoek, waarbij nieuwe indicatoren omtrent maatschappelijke uitkomsten van interventies moeten worden ontwikkeld. De verleiding om vooral te onderzoeken wat eenvoudig op basis van traditionele indicatoren kan worden gemeten is groot, maar doet veelal geen recht aan de verandering van het werk zelf. Kwantitatief onderzoek dient daarom hand in hand te gaan met kwalitatief onderzoek naar de praktijken op het grensvlak van zorg en veiligheid. Op die manier ontstaat zicht op de maatschappelijke opbrengsten van een geïntegreerde LEPH-benadering.

Onderzoek naar de impact en mogelijk gebruik van informatie- en communicatietechnologie in de context van LEPH is – zeker in het licht van de recente ervaring met Covid-19 – is ook relevant. De domeinen veiligheid en zorg veranderen ingrijpend onder invloed van technologie en dit biedt mogelijk kansen om te komen tot nieuwe institutionele mengvormen. Studie daarnaar staat nog in de kinderschoenen.

Tot slot is er de noodzaak meer LEPH-onderzoek te doen in lage- en midden-inkomenslanden, inclusief politieke systemen die we niet kwalificeren als democratische rechtsstaten. Het is juist in de *Global South* dat het LEPH-perspectief een groot verschil kan maken. Bovendien kan LEPH alleen overtuigend als een veld worden gedefinieerd als onderzoek zich niet beperkt tot de deelverzameling van zogenoemde welvaart- of verzorgingsstaten. LEPH heeft immers mondiale relevantie.

"Believing that the real ground for his existence is the perennial pursuit of the likes of Willie Sutton – for which he lacks both opportunity and resources – the policeman feels compelled to minimize the significance of those instances of his performance in which he seems to follow the footsteps of Florence Nightingale. Fearing the role of the nurse or, worse yet, the role of the social worker, the policeman combines resentment against what he has to do day-in-day-out with the necessity of doing it. And in the course of it he misses his true vocation".

Egon Bittner, *Florence Nightingale in Pursuit of Willie Sutton: A Theory of the Police* (1974: 40).

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