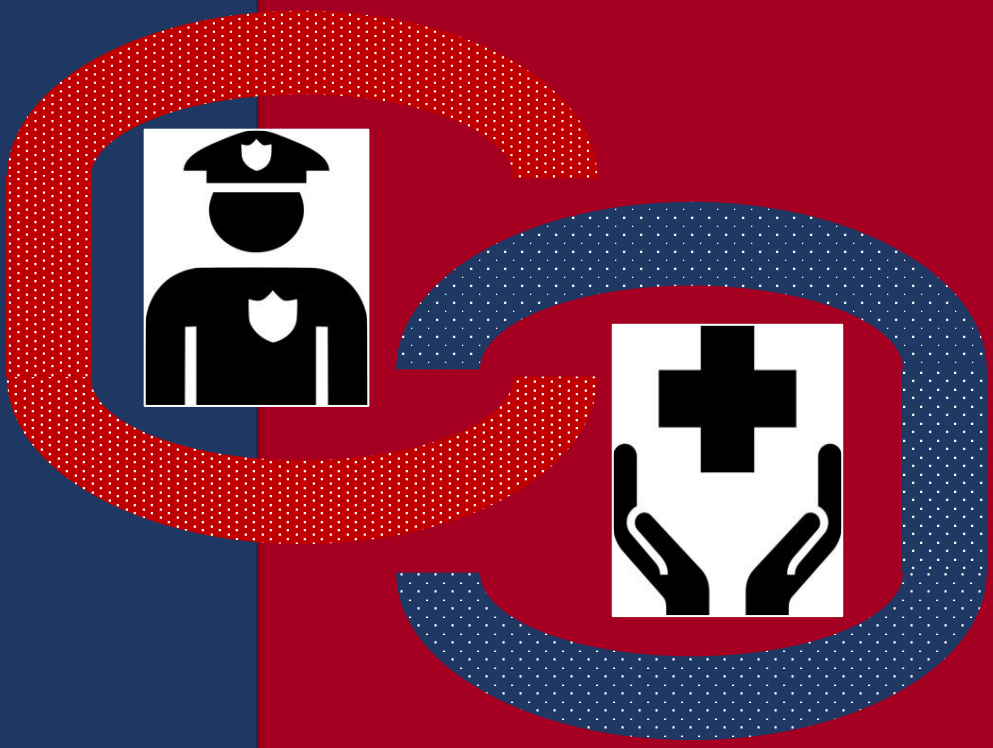
Law Enforcement and Public Health: An Overview



Maurice Punch

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Abbreviations

A & E	Accident and Emergency in UK: *Spoedeisende Hulp* / "Emergency Help" in Dutch)
ACPO	Association of Chief Police Officers (England and Wales; for Chief Constables, Deputy Constables and Assistant Chief Constables; until 2015)
CJS	Criminal Justice System (general)
CSA	Child sexual abuse
CSE	Child sexual exploitation
CIT	Crisis Intervention Training (term widely used in USA)
CLEPH	Centre for Law Enforcement and Public Health (Melbourne)
COP	Community Oriented Policing
CPS	Crown Prosecution Service (England and Wales)
EBP	Evidence based policing
ECHR	European Court of Human Rights
EU	European Union
FGM	Female Genital Mutilation
GGD	*Gemeentelijke Gezondheidsdienst* / Public Health Service, in Dutch cities
GGZ	*Geestelijke Gezondheidszorg* / Mental Health Service, in Dutch cities and communities
GLEPHRN	Global Law Enforcement and Public Health Research Network
GP	General practitioner (local doctor, British use); elsewhere "family doctor" or "family physician" (USA)
HMIC	Her Majesty's Inspector of Constabulary (England and Wales)[1]
HR	Human Rights

[1]The HMIC is an independent inspectorate which traditionally examined the efficiency and effectiveness of police forces in England and Wales: recently it has become more concerned with policy and performance and has also taken on a governance role with the Fire and Rescue Service.

HRC	Harm Reduction Coalition
IDLO	International Development Law Organization
IPCC	Independent Police Complaints Commission (England and Wales; established 2004; currently Independent Police Conduct Office / IPCO since 2018)
LEAHN	Law Enforcement and HIV Network
LGBT	Lesbian, Gay, Bisexual and Transsexual
LICs	Low income countries
MHS	Mental Health Service (for each country)
MP	Member of Parliament
MPS	Metropolitan Police Service (London: colloquially referred to as the "Met")
NCCS	National Police Chiefs Council (England and Wales; for Chief Constables only; established 2015)
NGO	Non-governmental organization
NOP	Neighbourhood Oriented Policing
NHS	National Health Service (UK)
PD	Police Department (USA)
POP	Problem Oriented Policing
PTSD	Post-Traumatic Stress Disorder
RUC	Royal Ulster Constabulary / later PSNI – Police Service of Northern Ireland (2001)
TVP	Thames Valley Police
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WWII	World War Two (1939-1945)
ZTP	Zero Tolerance Policing

Foreword

In October 2019, the Fifth International Conference on Law Enforcement & Public Health (LEPH) took place in Edinburgh (UK). The fact that this was the fifth edition (after Melbourne 2012, Amsterdam 2014 and 2016 and Toronto 2018) is an indication that the emerging new field, in which Law Enforcement (or should we say "Policing"?) and Public Health engage, is here to stay. LEPH was an initiative of Nick Crofts (Melbourne) with a strong harm reduction element expanding into other areas. However, academic and practitioner attention to the specific topic is fairly recent and what exactly the LEPH field encompasses is far from clear. Here Maurice Punch endeavours to shed some light on the nature of LEPH in Western societies, in particular the UK and the Netherlands but also Australia and the USA. His description of initiatives of inter-agency cooperation, some fragile but others more lasting, aimed at protecting vulnerable people, provides an intriguing sample of diverse forms of engagement between LE and PH. Furthermore, Punch addresses the variety of specific areas within the LEPH field, for instance mental illness, disability, sexual abuse, sexual violence, domestic abuse, trafficking, and slavery. This illustrates the width of the focus in this field and the various lenses that can be used to analyse what is happening. For instance, LEPH is not only about the health, safety and security of citizens, but it also deals with the health of the professionals in the front line who might suffer from PTSD – "PTSS" in Dutch - as a result of what they have to cope with on a day to day basis or from major incidents.

This overview contains many examples of successful engagement between LE and PH, and of compassionate professionals crossing the boundaries of their separate professions to secure a better outcome. The work of Dutch family liaison officers ("family detectives") supporting the bereaved families following the MH 17 plane crash in the Ukraine in 2014 is an impressive case in point. However, the message that Punch conveys is not always a positive one. Firstly, even if agencies from the fields of LE and PH are willing to engage the actual cooperation in the front line can sometimes prove to be an obstacle course with differences in occupational culture and standard operating procedures, not knowing how far to cooperate with other agencies, inadequate leadership, etc. Secondly, the overview contains examples of poor inter-agency cooperation or even cooperation going dramatically wrong. The cases of Victoria Climbié, Daniel Pelka and Baby P. in the UK reveal the shocking consequences of multi-agency system failure. They show us that protecting the vulnerable from harm requires investment in organizational change, personnel, development and training, and in learning how to cooperate with other agencies. And, thirdly, that LE and PH are growing towards one another is far from self-evident. In times of austerity with the consequences of New Public Management evident – such as shrinking budgets and shortage of staff – this can lead agencies to withdraw from engagement with other agencies and narrowing their remit to so-called "core" tasks. Reorganization and downsizing in front-line service agencies can put the clock back several years and stand in the way of multi-agency approaches. Punch teaches us to be aware of how the wider societal and political context influences the chances of success or failure of engagement in LE and PH.

Punch's overview – drawing on the work of leading members of the LEPH field – is of considerable value for several reasons. I shall pick out two which relate to my work within the Dutch Police along with Auke J. van Dijk and Maurice Punch, and more recently as General Secretary to the Police Education Council of the Netherlands. Firstly, it illustrates that – contrary to popular belief, but in accordance with the findings of some fifty years of research – meaningful police work is more than maintaining order and "catching crooks". In practice policing is a complex emergency and social service agency with a wide 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. Social-welfare and community outreach deserve to get recognition from politicians and media, as well as from the public, as one of three key pillars of policing and it is this pillar that comes to life in this overview. As Punch points out, there is some good news from research by Charman (2017) in which British police recruits discussing the role of the police placed "protection of citizens" first followed by "protect society", then "catching criminals", then "upholding the law" and then finally "crime fighting". Perhaps this can be seen as an indication that the police are evolving from "a secret social service" (Punch 1979b) to a more engaged emergency and social service. It is my opinion that this pillar will become even more important as Western European and other societies face challenges as with ageing populations, migration issues, damaging and even fatal drug use (as in the USA), people trafficking, consequences of climate change to emergency response and the strong evidence of serious and often less evident victimization within families, care institutions and faith based facilities including churches. All of these areas will put increasing pressure on LE and PH resources.

Secondly, and linked to the variety police tasks, Punch's overview demonstrates that police work, especially working on the beat as first responders, is highly demanding. As societies become more complex front-line professionals should be able to handle complicated situations on their own and / or in cooperation with professionals from other agencies and jointly face demanding situations and demanding citizens. Thus, police officers need to be equipped with a broad range of generic competencies relating to, for instance, communication, cooperation and problem-solving skills as well as specific knowledge of the fields involved. This is not only a matter of initial police education and training, but also of job training and lifelong learning, supported by the leadership and facilitated by the various organizations involved. For multi-agency cooperation has become the name of the game. Therefore, as LE and PH grow towards one another it would be valuable to see initial education and training becoming a joint effort as well, which will facilitate inter-agency communication and cooperation on the beat and at major incidents.

To conclude, this book is a must read for practitioners, students, academics and policy-makers and I strongly recommend those interested in the field to get acquainted with Maurice Punch's comprehensive overview of LEPH.

Frank Hoogewoning

Preface

The notion of *Law Enforcement and Public Health / "*LEPH" as a specified field for academic attention and professional practice is relatively recent (Anderson and Burris: 2017). It could be argued, however, that the issue of the interaction between the two *"*systems" – albeit in different ways and forms – is not all that new and is, in fact, a perennial one which long predates the formation of modern agencies of law enforcement and public health. These began to develop in various forms from around two centuries ago in Western Europe: and we shall return to that subject below. The current attention for LEPH as a promising area for debate, learning, research and practice is largely due to Professor Nick Crofts. Nick has a medical background as a GP / general (medical) practitioner, researcher, epidemiologist and consultant with global experience and an extended global network. He used Amsterdam as a base from 2014 and organized two conferences in Amsterdam (2014 and 2016). Auke van Dijk (Dutch Police Service) was instrumental in bringing the second *Law Enforcement and Public Health* meeting to Amsterdam in 2014: and again in setting up and bringing the third meeting to Amsterdam in October 2016. He has been closely involved with Nick since the first conference in Melbourne (2012) and also in the later meetings in Toronto (2018) and Edinburgh (2019). At times he was supported in Amsterdam by Frank Hoogewoning (Dutch Police Service) who later moved to the Police Education Council. I had known Auke, Frank and Dutch policing for some time and assisted them and Nick in the period 2014-2018 after which I resorted to my own work in other areas. That close cooperation with them and others has been instrumental in my writing of this overview: and to an extent it returned me to my early interest in policing in the 1970s with a focus on its social functions (Punch: 1973 & 1979). Here are our CVs.

Nick Crofts is an Honorary Professor at the University of Melbourne's School of Population and Global Health and Director of the Centre for Law Enforcement and Public Health Limited (CLEPH, Melbourne – https://cleph.com.au) which is a not-for-profit company registered in Australia: "It was established by a group of interested and expert individuals for the purpose of pursuing projects and advancing knowledge in the joint fields of policing and other law enforcement and the many aspects of public health". He is an epidemiologist and public health practitioner who has worked in the fields of HIV / AIDS, illicit drugs, harm reduction and law enforcement for 30 years. His major epidemiological work has been on the control of HIV and hepatitis C among injecting drug users in Australia and globally, including almost every country in Asia. As a designer and technical director of AusAID's flagship HIV / AIDS programme in Asia, ARHP 2002-2007, he was instrumental in building capacity among South East Asian police forces in relation to HIV, and has worked in many settings forging relationships between police and public health. He founded the Law Enforcement and HIV Network (LEAHN) in 2009, and is Director of the Law Enforcement and Public Health Conferences. He was previously at the Burnet Institute for Medical Research and Public Health for 19 years, where he was instrumental in building its Public and International Health arms, and was Deputy Director for five

years. He was Director of Turning Point Alcohol and Drug Centre for three years, and then at the Nossal Institute for Global Health, developing its Law Enforcement and Public Health Program. His most recent appointment was as Visiting Senior Research Fellow at the UN Interregional Crime and Justice Research Institute in Turin. He has been a member of Australia's National Council on AIDS three times, and has performed multiple consultancies for WHO, UNAIDS, UNODC, AusAID and other bilateral and multilateral agencies. He edited the first *Manual for Reduction of Drug Related Harm* in Asia, founded the Asian Harm Reduction Network, and for his work in Asia was awarded the International Rolleston Award in 1998. He is author of over 150 articles, book chapters and editorials in refereed journals; his most recent book, co-edited with Fifa Rahman, is *Drug Policy Reform in East and Southeast Asia* (2017). He was technical director for AusAID's regional HIV programme, ARHP, technical director of AusAID's Indonesian harm reduction programme and principal investigator on an AusAID funded research project in Cambodia, Laos and Vietnam, on the influence of harm reduction on police policy and practice. In 2017 he was invested with the *Member of the Order of Australia* by the Australian Ambassador in The Hague. He has been resident in the Netherlands from 2016 into 2019.

Auke van Dijk (Dutch Police Service) was instrumental in bringing the second *Law Enforcement and Public Health* meeting to Amsterdam in 2014: and again in setting up and bringing the third meeting to Amsterdam in October 2016. Auke is a strategic policy advisor with the Dutch Police Service (The Hague and Amsterdam). His academic background is in International Relations Theory and International Political Economy. In the late 1990s he worked at the Dutch Organization for Applied Research / *TNO* on the consequences for government of the emerging network and information society: later he became senior advisor with a focus on security issues at the Strategic Council for Public Administration / *Raad voor het openbaar bestuur*, an independent think-tank advising the Dutch Cabinet and Parliament. In 2004 he was senior advisor for the Commission of Evaluation for the Intelligence and Security Services, an independent committee advising government on the National Intelligence Agency. He was a member of the "Project Group Vision of Policing" – formed by the Council of Chief Police Commissioners – which developed a new vision and strategy for policing, *The police in evolution* (2005). In 2006 he was co-founder of the "Agora Police and Security" of the Amsterdam Police. In 2012-14 he worked on the National Programme for Future Police Leadership leading to a proposal for redesigning leadership training for the Dutch Police. He has written numerous reports and policy proposals. Since 2012 he is on the Advisory Board of the Centre for Law Enforcement and Public Health (CLEPH) in Melbourne. He was involved in and contributed to the LEPH conferences in Melbourne (2012), Amsterdam (2014 and 2016), Toronto (2018) and Edinburgh (2019). Those two Amsterdam conferences drew strongly on Auke's efforts to stimulate and engage the cooperation of key national and Amsterdam agencies including especially the Police Service.

Maurice Punch has worked in universities in the UK, USA and the Netherlands: he is currently Visiting Senior Fellow at the LSE and is a former Visiting Professor at LSE

and King's College London. His areas of specialisation in policing are change, leadership and accountability: and he has published in English, Dutch and US journals. His books include *State Violence, Collusion and the Troubles* (Pluto: 2012), Shoot *to Kill: Police, Firearms and Fatal Force* (Policy Press: 2010), *Police Corruption* (Willan: 2009), *Zero Tolerance Policing* (Policy Press: 2007), *Conduct Unbecoming* (Tavistock: 1985) and *Policing the Inner City* (Macmillan: 1997). With Auke van Dijk and Frank Hoogewoning he has written *What matters in policing? Change values and leadership in turbulent times* (Policy Press: 2015). This book was awarded the Dutch "Foundation for Society and Safety" (*Stichting Maatschappij en Veiligheid*) Publication Prize 2017/2018: this led to a presentation at a related conference in the Netherlands in 2019 and also an article "Running on Empty" in a Dutch-Belgian criminal justice journal (the book and paper were both in English). He is a member of the Centre for Crime Policy & Research Advisory Group, Flinders University, Adelaide: and was on the Advisory Board of CLEPH in Melbourne. He was involved in and contributed to the two LEPH conferences in Amsterdam in 2014 and 2016 and is co-editor of a special edition of *Policing and Society* on Law Enforcement and Public Health for which he wrote, with co-editor Steve James (Melbourne), the editorial introduction (Punch and James: 2017). For fifteen years he served on the Board of the "Compass" (*Windroos* in Dutch) Foundation, as founding member and chair, which developed two recovery centres (in Amstelveen and Leyden) and a methodology for aiding young people to continue their recovery after treatment for a mental health condition. This meant delving into psychiatry, stigma, exclusion and recovery as well as involvement in fund-raising, lobbying and negotiating with diverse public health, insurance and government agencies (Punch-Venneman and Punch: 2013). In recent years he has been writing a comparative study on "excellence in higher education" and also on "deviance and crime on campus" (including the excesses of elite student societies and regarding sexual violence largely against female students in universities).

The Dutch Police Service became a national force in 2013 with ten regional "units" and a central agency. The Amsterdam Police Unit's Chief Pieter-Jaap Aalbersberg, the Amsterdam Public Health Service, the Free University of Amsterdam and the City of Amsterdam with the enthusiastic support of the then Mayor (the late Eberhard van der Laan), diverse city officials and other agencies helped to support and / or fund the 2016 Amsterdam conference (Aalbersberg and van Dijk: 2016). This generous sponsorship from diverse Amsterdam agencies had also been the case in 2014 with funds towards the meeting's costs and to subsidize attendance for selects groups including Dutch personnel involved in the LEPH area. The Australian Institute of Police Management / AIPM, which is important in research and in courses for senior officers from Australia and New Zealand, has been an enthusiastic contributor to all three meetings. At Amsterdam 2016 there were around 500 attendees from a wide range of countries with over 60 participants from North America, about 30 from Australia and there was a strong UK contingent of roughly 50. One of the opening, key-note speeches was given by Chief Constable Sara Thornton, then Chair of the National Police Chief's Council / NPCC (England and Wales). A valuable resi-

due of those three meetings and other international activities is a mailing-list of some 8000 people. Allan Rock, former Canadian federal minister (Justice / Attorney General and also Health) and now President of the University of Ottawa, was the orator at the 2016 meeting. He proved crucial in facilitating the conference held in Toronto in 2018 and aided in mobilizing law enforcement and health leaders to support it. The fifth conference is being held at the time of writing in Edinburgh (Scotland, October 2019). "Police Scotland" is a force for all of Scotland and has a different governance and judicial structure to policing in England and Wales and in Northern Ireland. It also has a close relationship with SIPR – Scottish Institute for Police Research – set up by Prof. Nick Fyfe in 2007 and comprising 14 universities. It is, then, a "national" agency that to an extent operates from a knowledge base and strongly espouses a social, multi-agency approach to societal and local problems. For example, the Scottish Violence Reduction Unit / VRU is a national centre of expertise on reducing violence and is part of Police Scotland: the "VRU targets violence wherever it occurs whether it's on the streets, in schools or in our homes. Supported by the Scottish Government the unit has adopted a public health approach, treating violence as an infection which can be cured" (from its website: www.actiononviolence.org). Police Scotland, SIPR and VRU as well as governmental and civic support contributed to the Edinburgh LEPH conference. Prior to the 2019 Edinburgh meeting there was a related "Consultation on 'Gender in public health & safety'".

The first three meetings generated a great deal of interest and have garnered a rich accumulation of papers and cases. Some of those conference papers appeared in an edition of the *Journal of Criminological Research, Policy and Practice* in 2017: and a set of original, non-conference papers came out in a special edition of *Policing and Society*, edited by Maurice Punch and Steve James (2017). My thanks are due to the editor, Prof. Jenny Fleming, who was most supportive. An overview article by Nick Crofts, Auke van Dijk, Vicki Herrington and others appeared in *The Lancet (*van Dijk et al: 2019*)*. There is, then, already a wealth of material in a wide-ranging set of papers from these and other sources along with extensive public documents and media reports and much of this material can be found on, or traced through, the CLEPH website as well as through the *Global Law Enforcement and Public Health Research Network* / GLEPHRN.

It is plain, however, that the data and examples I have drawn on are skewed towards a limited number of western countries. Third World countries are often afflicted with major public health issues – particularly related to drugs, addiction, pollution, contamination, mental illness, disease and epidemics – but usually there is scarcely a functioning and resourced health and social service capacity to deal with these. And the police may be corrupt, indifferent, predatory or even complicit in some situations. There are, however, a number of initiatives in the LEPH area in diverse countries including "Burma, Ghana, India, Kenya and Kyrgyzstan" (Cloud and Davis: 2015, 9). In Kenya, for instance, more than 600 police officers "were trained alongside sex works and health experts – to help understand the lived experiences of people who engage in sex work or drug use" and to raise issues around health services for such groups: and in Kyrgyzstan the police academy "provided training for more than 800 officers on harm reduction, sex work, and HIV prevention" (Cloud

and Davis: 2015, 9). One of the agencies founded in 2009 by Nick Crofts and others – the "Law Enforcement and HIV Network"/ LEAHN – aims to promote partnerships, locally and globally, between LE and PH agencies on dealing with vulnerable groups. An important imitative of LEAHN was to get some 10,000 police officers from over 30 countries in 2014 to sign a "statement of support for the incorporation of harm reduction principles in police work to control HIV among vulnerable communities" (Cloud and Davis: 2015, 9).

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Chapter 1. Introduction: The LEPH Field

This work will outline the field of *Law Enforcement and Public Health* as we lack a broad overview for CLEPH members, academics, students, policy makers and above all for practitioners in both fields and the affiliated professions. Moreover, our field carries implications not only for society, politics, legislation and professional practice but also importantly for the *quality of life* of diverse vulnerable groups and victims. For both the law enforcement and public health domains contain key state institutions in the lives of citizens: and how these perform – and interact – is of considerable significance in the lives of many but especially those who are sick, vulnerable and in need of care and protection. But to understand that interaction and its consequences requires some examination of the changing landscape and architecture of both domains as prime agencies within two wider and highly influential systems (the criminal justice system / CJS and health systems – in some cases "national health" systems – respectively). There has also to be some attention to societal change and institutional developments as a context for the inter-agency negotiations that help define what happens within and between those respective systems (Loader and Walker: 2007). Furthermore, attention is required on the front-line reality of interactions in homes, on streets, in police stations and Accident and Emergency / A&E wards, in face-to-face contacts with those in trouble and those causing the trouble and during inter-agency case meetings and negotiations in diverse agencies (Lipsky: 1980; Jones: 2014). My aim is to cover those broad issues in a brief overview for all those interested in, and involved in, this field and for a broad public.

At one level this work is about the interaction between law enforcement and public health and the varying socio-political issues raised by this (Loader: 2014; Manning: 2010). The results of that interaction and related debate are driven by ideology, political interests and social needs in relation to the two influential institutions under consideration. It will draw on diverse sources in the media as well as research publications, diverse government and NGO reports, specific case studies and on specific institutional developments. There are a wealth of sources from transnational and international agencies, governmental departments, professional and voluntary associations, local authorities, oversight agencies, commissions of inquiry, court cases, academic research and publications and media revelations. As a lone researcher largely working from home it is beyond me to delve into that vast array of data so I have confined myself to a limited sample and material gleaned from the LEPH conferences and CLEPH site and various other sites. The latter include *The Crime Report* and *Marshall Project* (USA) and *Police Oracle* and *Policing Insight* (UK)[2] while I regularly scan the international public health sites as well as the Dutch media and relevant Dutch and LEPH web-sites.

[2] The "UK" refers to the United Kingdom of England, Wales, Northern Ireland and Scotland; there are, however, differences in governance, laws and local authorities which influence the structure, powers and functioning of both LE and PH: in policing there are effectively three separate systems – England and Wales, Northern Ireland and Scotland – although Northern Ireland has become closer to England and Wales in recent years.

Yet at another level to the global, national and macro institutional levels there is an alternative contextual reality that is continually reconstructed in the "coal-face" of interaction between professionals in the two sectors and between them and their clients. Much of the material in this work will, then, reflect that tension between those two levels. For instance, in law enforcement there has been a tendency in recent decades to reach out to communities – as also has happened in public health – and to engage in multi-agency cooperation and to widening its mandate (Crawford and Lister: 2005; Bullock and Leeney: 2013). But that widening of the mandate has come under critical scrutiny in the last few years (Millie: 2013; Millie and Bullock: 2012). Such developments, and the implications for the two sectors, need to be anchored in the national socio-political context within which such shifts take place.

For example, the data emerging from the epidemiology of crime and the impact on life chances highlights the imbalances in quality of life in diverse social strata and how the disadvantaged disproportionally enter one or both systems as victim, suspect, perpetrator or as a client in need of care (Peay: 2010) . But that does not mean that it leads to the appropriate provision of services to those in most need which is ultimately a matter of ideology and ensuing political choices in a context of persistent if not growing inequality which impacts on service delivery (Dorling: 2015). For certain developments are also being driven by the fact that there is an increasing number of people in society being defined and identified as vulnerable and requiring care from a number of agencies. The problems among those diverse sectors within the population are immensely damaging for them and for society and require coordinated attention and considered measures for support and prevention of ill-health.

What is evident, however, is that the material from numerous sources indicates that the needs emanating from the various vulnerable groups are crystal clear. And it is equally plain that there is enthusiasm and dedication among certain professionals within the two systems for tackling those specific and often pressing needs in cooperative ventures. At times you can witness "passionate professionals" fruitfully working side by side (Punch, Hoogewoning and van Dijk: 2016). Emerging from this context is the central issue – what is driving the cooperation; who has primacy; what seems to work and what not work; and are these schemes budget-limited efforts with a short life-cycle or is there continuity and collective learning?

For the LEPH field holds out the prospect of improved, coherent and coordinated treatment for the needy and the vulnerable from front-line emergency and other agencies. But it is posited on having properly trained, responsible and cooperative personnel willing and competent to function in multi-disciplinary teams to the benefit of their clients. Clearly that is not always the case and the weaknesses and failures can be within systems or within societies including the absence of a well-developed PH system and the unwillingness of LE to embrace multi-agency efforts. Of importance, then, is that much of what we are portraying emanates from a limited number of western societies that have developed extensive law enforcement and public health systems with a strong ethic of care for those in need and in some cases within a strong welfare state. Hence the focus is predominantly on the UK, Australia, Canada, the Netherlands and Scandinavia (Bartkowiak-Théron and Asquith: 2016). For in these societies there is an explicit institutional commitment to this area alt-

hough this may in practice be limited in scope and provision. But, as we shall see later, that promise of fruitful cooperation can fail in some circumstances with dramatic consequences including long-term health difficulties and even fatalities.

The USA is a special case in that in many respects the LEPH "systems" are chronically deficient. Indeed, provision varies greatly between public and private institutions and between the PH policies and facilities within the 50 states: and for LE in the roughly 18,000 police departments / "PDs" as well as state and federal police. The American CJS, moreover, is excessively carceral and punitive while infringing on many fundamental rights that have been accepted in almost every UN country except for a couple of the most repressive societies in the world. Importantly, there is nothing like a comprehensive, national health system and it's estimated that more than 40 million Americans have *no health provision at all*: that is staggering for a rich, powerful and well-resourced nation. In contrast to the malign neglect of the poor and needy in the USA there are some of the best hospitals, research centres and health facilities in the world in America along with some enlightened police forces. Ironically, then, many of the innovative initiatives in our field, which have gone on to be influential elsewhere, have often emerged from the USA over several decades (Wood and Watson: 2016; Anderson and Burris: 2016). One example is the small town of Gloucester (Massachusetts) which is in effect a "sanctuary" for those with a drug problem because of a progressive police chief and a supportive local government. Here the earlier "harm reduction" ethos of some in the PH sector in relation to drug users has been adopted in the LE area:

> "– a person seeking treatment for substance use can walk through the doors of any [police] precinct house without fear of arrest and be voluntarily directed to treatment on the spot" (Cloud and Davis: 2015, 2).

In another US police force officers use lap-tops to connect directly to those on the streets with mental health problems to their own psychiatrist or with another mental health professional. The face-to-face contact on the spot with the person's carer or other professional can help to calm a distressed person down more effectively than a phone-call or a referral to a later appointment.

In certain respects, then, the very fragmentation and variety in the USA allows a high measure of innovation and experimentation to take place. Moreover, there are first-rate research institutes and interest based voluntary agencies – as regarding mental illness, drugs and domestic abuse – which stimulate projects and publish valuable reports and recommendations globally through the internet and other outlets. For instance, the work of the Vera Institute of Justice – see *First Do No Harm* (Cloud and Davis: 2015) – reflects a prime example of sound, well researched, problem-solving proposals geared around harm reduction within the USA but also elsewhere.

In short, LEPH is a dynamic and shifting field across societies which is of great importance to many when law enforcement and public health meet. The prime focus, then, is on these main two sectors within much broader institutions – law enforcement as the main gatekeeper for the CJS and public health as a growing and influential terrain within the wider health services. But particularly I examine the

interchange between front-line professionals and semi-professionals, as well as third sector voluntary and self-help agencies, endeavouring to cooperate in the interests of the weak and the vulnerable. Furthermore, for a number of reasons this area tends to draw more attention from law enforcement and allied personnel than from public health professionals and especially from health academics. One aim of this work is, then, to bring them closer together. Hence this book sets out to be both wide-ranging and practically relevant for members of both agencies and also for a broad range of readers including, importantly, those involved in shaping public policy.

"Law enforcement" and "public health"

What is meant by "law enforcement" and "public health"? As mentioned above this new area is not that "new". 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 (Carroll: 2002). But the idea of permanent, professional agencies in both domains is relatively new and they were initially often fairly rudimentary and limited in scope while often facing political and institutional resistance to innovations and occupational change. In the UK, for instance, many politicians in the early nineteenth century were advocates of free markets along with low political interference and low costs and fought health reform and professional law enforcement change – not unlike hard-line Republicans in the contemporary USA. And the traditional medical world – mired in conservative practices which were often ineffective if not dangerous – often displayed virulent opposition to reforms based on experiments and innovative practices.[3] There were, however, gradual local and national government measures through the 1800s onwards regarding sanitation, housing, pensions, education, working conditions, health provision and also law enforcement. There were, then, diverse reform efforts throughout the nineteenth century with advances in medicine and health and public facilities: but the early ideas of some form of state provision were initially geared to developing healthy males for industry and the military.[4] Then early in the last century piecemeal reform – in response to an expanding right to vote, demands from organized

[3] There is much written on resistance to innovation and to change in the medical world. A classic case was in mid-1800s Edinburgh when James Simpson began to demonstrate the anaesthetic properties of chloroform on humans, including for women in childbirth. He encountered considerable opposition from colleague obstetricians and the clergy who considered the birth pains to be salutary for mothers.

[4] When modern societies turned to large armies with universal conscription it was discovered how poor the physical, educational – and in many cases mental – condition of a substantial proportion of recruits really was: and to an extent that remains the case given the higher standards and improved vetting in contemporary armed services (Stouffer et al: 1949; The Nation: 2014, 4 March).

labour and the socialist movement's influence on certain political parties – began to frame the elements of what eventually became the "welfare state".

The catalyst for a more extensive welfare state in western European societies was WW II / "World War Two" which was a bitter struggle against primarily Germany and Japan but along with the hope among many of constructing a more equitable society following victory. For example, the seminal document in the UK was the *Beveridge Report* in 1942 which was produced within a war-time National Government comprising uniquely both Conservative and Labour politicians. But it clearly leant strongly towards the liberal views of the latter with idea of the war effort leading to improvements for many throughout society. Beveridge powerfully argued for eradicating what he called the five "giant evils" – want, disease, ignorance, squalor and idleness – and proposed a welfare structure where health and educational provision should be *free and universal*. Implicit in those early ideas on health reform was that the measures would produce an increasingly healthy population – and in a more equitable society.

This was quite revolutionary in class-bound Britain but through legislation and a post-war Labour government many of the proposals were implemented. In the UK and other western societies that developed welfare states, as in the Nordic countries, the key notion was that *all* citizens should have the fundamental *right* to free medical provision and certain other services. This was also the case in various communist and socialist societies but within repressive regimes. Our concern is largely with developments since 1945 with fairly rapid changes in recent decades and in part stimulated by the funding and guidelines of NGOs including the UN, WHO, UNHCR, IDLO / International Development Law Organization, Open Society and the *United Nation's Convention of Rights for People with Disabilities.*

Public health

It is fairly clear that academic PH has low interest in the LEPH field which is reflected in the fact that there are hardly any university based courses which approach its terrain. There is one in Melbourne entitled *Law Enforcement and Public Health* at the Melbourne School of Population and Global Health[5] and one close to it within Public Health Law at Temple University which is run by Scott Burris who is Professor of Law and Public Health at Temple University (Philadelphia, USA) and directs the Center for Public Health Law Research. There are other examples of the topic being taught and developed under another label or within a specific subject area: for instance, Ruth Jones is a leading expert on the area of domestic and sexual violence, who teaches widely on it at home and abroad and who deals with it within the Institute for Health and Society at Worcester University (UK). The academic and institutional medical world remains, however, a separate and somewhat disdainful silo.

[5] With a public security focus on law enforcement, military, criminal justice and non-state actors: "Issues to be addressed include managing mental health in the community, responding to alcohol and drugs, disaster management and preparedness, violence prevention (family violence), infectious disease management, global population migration and incarceration" (from the course description on the University of Melbourne's website).

Public health, however, has altered in recent decades from being a relatively neglected and under-resourced "basement" in the medical hierarchy to becoming a specialism attracting resources and personnel as the health system has become more proactive and geared to prevention. And as the focus is on health in relation to harm and risks within vulnerable populations it is clear that "health" also relates to the caring professions of social work, child protection and probation and to relevant "third sector", voluntary agencies. "Public health" is, then, a concept which is not synonymous with the medically defined provision of health care by medical professionals but also includes other professionals, semi-professionals and voluntary agencies engaged in care and prevention in a broad sense.

Furthermore, a major shift in PH has been the move to prevention, education and harm reduction which was central to learning from the drug and HIV epidemics, with their high mortality rates, and also drew on the wider health emphasis on prevention to enhance quality of live and to reduce costs. For instance, the "Harm Reduction Coalition" was formed in 1993 in the USA, now with offices in New York City and Oakland (California), with a background of needle exchange programmes for drug users. The Law Enforcement and HIV Network (LEAHN) was set up by Nick Crofts and others in Melbourne in 2009 and was related to his work on HIV / AIDS, illicit drug use and harm reduction in Australia and globally but especially in South East Asia. He saw the importance of building capacity among police forces in relation to HIV and worked on forging relationships between police and public health which in turn led to the LEPH initiative. "Harm reduction" is defined on the LEAHN website as,

> "– a realistic and comprehensive human rights and public health approach that has successfully addressed not only drug-related harms, but other public health issues the world over. The particular success of harm reduction has been in reducing the spread of HIV, which can be transmitted through the sharing of contaminated injecting equipment. Harm reduction programs have evolved over a long period, and have been extensively researched and evaluated".

Law enforcement

"Law enforcement" was also – like much pre-modern medicine and public health – historically fairly rigid and primitive and often provided by private initiative while civic provision was typically patchy, venal and unreliable (Critchley: 1978). Changes in this began to be made towards the end of the eighteenth century and early nineteenth century. But it's important to note here that while the notion of law enforcement suggests a prime role for police, they are just part of the developed CJS which encompasses the cycle of police, prosecutors, courts, prisons and rehabilitation and which those processed – and with some arrested and incarcerated – pass through. We shall keep that extensive CJS in mind: and are also aware that the wider concept of "law enforcement" also relates to private policing and informal forms of enforcement. Pragmatically, however, we are also aware that much of the available material – and a major audience for LEPH and related meetings and publications – relates to public policing within the "law enforcement" nexus.

Indeed, the fact remains that the police organization is the prime front-line agency that encounters, and has to cope with and process, those people requiring attention for a range of problems that may, or may not, be related to criminal or other offences. And that the welfare of such people and others effected has become an increasing part of the police role. It is important, moreover, to distinguish between two main styles of policing: and how those styles in a way influence how police operate and how police interact both with those requiring care and attention and with the diverse social and medical agencies that also play a role in the care of those same populations.

Firstly, there was the Continental European, post-Napoleonic policing system largely based on the French *gendarmerie* as a para-military agency with a prime focus on crime control, public order and intelligence gathering (Brodeur: 2010).[6] It can be taken as a model for central agencies operating with a prominent control paradigm. The French *Gendarmerie* as the national police force came under the Ministry of Defence and officers received joint military-police training, could be deployed nationally, were armed and housed in barracks. Police officers may have incidentally helped people in trouble but it was certainly not part of their remit while the ethos was to retain distance with local populations. Indeed, in post-revolutionary Europe there was a preoccupation with public order and the need for paramilitary units which could be rapidly mobilized.

For instance, the British also had the equivalent of the *gendarmerie* which was the *colonial* policing model drawing on the RIC / Royal Irish Constabulary with roots in a paramilitary force established in 1814 in Ireland (Conway: 2014). Much British colonial policing in Asia, Africa, the Middle East and parts of North America (e. g. the RCMP / Royal Canadian Mounted Police) and in the Caribbean was subsequently based on this RIC model. And just as the RIC model was transferred to the British colonies so was the *gendarmerie* model exported to the colonies of France, Portugal, Italy, Spain and the Netherlands. These diverse paramilitary agencies could also perform certain civil functions and even health roles – as first responders to accidents and calamities as well as in control roles related to epidemics and diseases – but both models formed a central control apparatus over largely indigenous peoples (Newsinger: 2006). Clearly these systems have developed in various ways but they typically reflect a style of centrally controlled, semi-military policing with a measure of distance from populations and with restricted functions. If one adds corruption in some parts of the world and / or political repression – as in the former Soviet Union and its satellites (Appelbaum: 2012) – then there are policing agencies of *gendarmerie* or *colonial* origins which have come under state control and which are typically not open to embracing the "public health" needs of citizens. In turn people in need usually avoid such agencies and have to solve their problems elsewhere by relying on families, private initiatives, churches or NGOs.

Secondly, and in contrast, there was an alternative "British" model to the paramilitary ones which can be traced to developments in the UK in the early nineteenth

[6] Brodeur (2010, 51) writes of how the seventeenth century concentration of power "begat an administrative culture of top-down centralized authority characterized by rigidity, which has lasted until this day in France".

century (Reiner: 2010). This relates to the founding in London of the Metropolitan Police / MPS in 1829 by Sir Robert Peel (Ascoli; 1979; Hurd: 2008). For various reasons Peel proposed police who were not militarily trained and equipped and were visible and accessible through 24/7 foot patrols. The "Bobbies" (from *Robert* Peel) were largely from ordinary, "working-class" backgrounds, received a practical training and everyone started at the bottom out on patrol. The MPS and the British and other forces that followed the model established themselves as independent of direct political control, answerable to the courts and as largely not corrupt: above all the officers began to be seen by many as a benign, civilizing feature of civic life. This is not to say that they willingly embraced social tasks but that they had a different relationship with the public than in the *gendarmerie or colonial* models. Indeed following the founding of the MPS in London constables were said to have run boy's clubs, arranged picnics for poor children and gave them second-hand clothes: they also took on school attendance duties and,

> "– administered first-aid at accidents and drove ambulances, administered aspects of the Poor Law, and supervised the prevention of disease among farm animals" (Emsley: 1996: 3 & 83).

This may have been incidental to their main functions but it reflects a style of policing which is close to the public and where officers were likely to be seen as approachable and trustworthy. Like the colonial model this too was exported abroad and was highly influential in the USA and in the developing cities of Canada, Australia and New Zealand within the then British Empire and even to a certain extent in some Continental European cities.

In short, we maintain that there are two dominant styles of policing – between the *gendarmerie* / colonial and British models – which continue to shape contemporary policing and, in turn, the willingness of forces to engage in our "LEPH" field with implications for how the public view law enforcement as a reliable and approachable agency. To complicate matters there is also a dichotomy running within much policing, including within the British model, in that there are periodic debates and shifts between "the force" and "service" perspectives with some arguing that the prime police mandate should be public order and crime control ("catching crooks") while others promote a broader mandate of "to serve and protect" which is geared to a wider "social" role for policing. This dichotomy is also implicit in the related and partly overlapping concepts of "control" oriented policing and policing by "consent" of the public. What this conveys is that law enforcement and especially its public police component is open to societal and political pressures – sometimes related to changes in threat levels, patterns of crime or moral panics around specific high-profile cases. Public police agencies may oscillate between paradigms or even have diverse segments of the organization operating within competing paradigms.

Taking that sometimes complicated, confusing and shifting background into account I now turn to a highly condensed description of four important phases in post-war LEPH development and then look at why there is a resilient degree of reticence from PH to engage with LE at the institutional level.

Early post-war phase

To generalize sweepingly, much early post-war policing was limited in scope as was the PH provision. Much traditional policing had a limited and legalistic mandate, was primarily reactive, geared to incidents and focused *downwards* largely on dealing with what the establishment defined as the "troublesome" and "dangerous" classes. There were no doubt incidental contacts with other agencies in relation to people in trouble and the vulnerable but any significant involvement in cases that not were considered "police business" was lacking and the police would quickly pass on the issue to other agencies. Matters taken most seriously now – such as "domestic disputes" involving violence against women – were routinely not pursued with vigour on the grounds that the female victim would not make a formal complaint against the male aggressor (typically the husband). This would have been exacerbated by the fact that most police officers were male with masculine values about social issues while many agencies were hostile to outside scrutiny and institutional change. To a large extent policing in this period was conservative in values and style and limited in its technical resources.

Sixties: social movements / research / change

From the sixties onwards there were new social movements clamouring for change and attacking established institutions. There was the civil rights movement in the USA along with opposition to the Vietnam War in several societies, the early gay movement (with an openly gay mayor elected in San Francisco in the late 1970s), student rebellion in France and elsewhere and the emergence of feminism. This was a turbulent period of rapid social change with virulent antagonism to many conservative institutions and practices. In particular a critical eye was turned on the police. In the USA, for example, there were accusations – amplified by evidence – that many police agencies were corrupt, violent and racially prejudiced. And referring to the Dutch Police in the late 1960s, van der Vijver (2009) conveys a strictly legally oriented agency that instrumentally processed people – narrowly viewed as suspect, witness or victim – for the criminal justice system. It scarcely bothered itself with anything like "policy" and was effectively a defensive, unreflective, inflexible and insular bureaucracy that in public order situations would often resort to excessive violence. And the public was viewed as the "enemy" as its members could be critical complainers. This is not to say that there were not in diverse societies, or in particular agencies, forward thinking and humane people who willingly cooperated with other agencies. But institutionally there was typically low if not poor coordination across and within agencies to the disadvantage of the populations in need.

Such manifest deficiencies fostered for the first time academic research of the police along with a reform movement for policing. On the one hand there was an institutional and academic focus on crime control but, on the other hand, also a stream of ideas about change around the themes of "community oriented policing" / COP and "problem oriented policing" / POP (Goldstein: 1979). The former argued for community engagement – which some forces in other countries claimed they had long been doing (as in Britain) – but also multi-agency involvement to solve

people's problems rather than passing the buck. Around the late 1970s and early 1980s many western forces became strongly influenced by COP and POP and these concepts and their application were typically grounded in decentralized teams with a local mandate and a strong service orientation. The concepts and practices emanated primarily from the USA and UK and were exported abroad: hence they were typically "Anglo-Saxon" proposals adopted in a limited number of societies. For the first time in the USA there were officers assigned to community duties in a relatively systematic way along with in the late 1970s the first mention of specialist "family crisis intervention units". The latter indicated that police work was not just about crime and order in public places but also frequently related to conflict situations in the domestic sphere. And it also carried the notion of officers with a measure of specialization and with a POP approach (Reiner: 2010).

These seemingly "progressive" innovations represent something of a paradox for in the USA there were, and are, some awful police departments – violent, prejudiced, systemically corrupt and unaccountable – yet there also have always been a number of enlightened forces implementing innovative practices. With some 18,000 agencies there were some which with political support, an innovative chief and quality recruitment could make positive changes. Then public reports stimulated change but especially the influential *President's Commission on Law Enforcement and Administration of Justice* (1967) that for the first time comprehensively studied the American criminal justice system and laid out reorganization plans and a range of reforms for policing. The Commission along with private funds – a donation of $ 30 million from the Ford Foundation helped to set up the research based Police Foundation (Washington, DC) – led to a series of experiments and innovations.

In brief, fresh ideas have often emanated in the USA but the deep divisiveness in political perspectives and institutional practices remains and these have perhaps even become exacerbated in recent years.

Rapid change: "New Public Management", partnerships

Of considerable significance was the impact in western societies of neo-liberal ideas on government policies which brought "New Public Management" / NPM into the arena of public services from the 1980s and 1990s onwards. This evinced a two-sided impact. On the one hand it maintained that private management was superior to public management and that services needed to be reformed to enhance efficiency and effectiveness. But on the other hand underlying this was a market model of competition between agencies and of service consumers *having a choice*. This caused a major shake-up in service agencies on standards of care, treatment and communication within and between agencies. Police forces and other agencies were now to take their "consumers" seriously and function through inter-agency cooperation as otherwise the "problem" cases confronting them would remain unresolved and keep returning. This was reinforced by academic research, government reports and data from interest groups continually revealing that a disproportionate proportion of those being processed by LE and the CJS were the poor, disadvantaged, marginalized and people with a limitation.

Specific interest groups have become important and are sophisticated promotors of diverse groups by use of the media, raising funds, engaging in public debate, publishing reports, stimulating research, taking part in multi-agency projects and mobilizing local and central politicians for their cause. Social movements, for example, have powerfully campaigned for attention to the previously neglected victimization of women, children, gays, the elderly and the disabled. Attention was also increasingly being paid to this area by the media which focused on scandals and the harrowing examples of system failure which at times generated much public and political concern leading to campaigns, proposals for reform and legislation. There was too a response at the international NGO and individual government levels recognizing the rights of those with a disability or vulnerability and issuing proposals and passing legislation to encourage inter-agency responses to their victimization. This started to raise consciousness of the issues and encouraged coordinated efforts to tackle the problems confronting LEPH.

All of this has fostered a veritable sea change in LEPH. The major emphasis in LE had nearly always been on the suspect and the perpetrator with the victim being seen as merely the initiator of the criminal process. There were usually low attention to, or separate facilities for, the female victims of sexual violence with at time an attitude that they must have "deserved it" in some way. 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 and / or prolonged victimization and this 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 a differential response. 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 LE as victims, or indeed as offenders. That has only started to change considerably in the last few decades.

Strong duality: "back to basics" versus police advocates for the vulnerable

What we are witnessing, then, is increased attention to the vulnerability of people with "disabilities" – the blind, deaf, physically disabled, elderly suffering from dementia, etc. – who can be prone to accidents and who are also vulnerable to victimization at home or on the street. Accelerating in recent years there has been a growing commitment to tackling vulnerable populations, a shift towards prevention and the "discovery" of the victim. Although this may be patchy and vacillating in practice there is a fresh vocabulary based on dignity, respect, fairness and transparency which is also reflected in the move towards procedural justice (Hough: 2014). To a degree this drew on the longer tradition of, and experience with, COP and POP while

with crime decreasing and resources diminishing this move could be seen as a form of self-interest with police claiming new "social" tasks and in engaging in intersectoral initiatives. At the same time there has been in the UK and elsewhere a stream of reports, at times followed by legislation, regarding the needs of the vulnerable in society along with measures against discrimination on grounds of race, gender or disability. This started to raise consciousness of the issues and encouraged coordinated efforts to tackle the problems confronting LE and PH. Most British public agency and police websites, for instance, are explicit in banning any form of discrimination and promising support for the vulnerable: and this would be true in some other countries.

Yet governmental pressure in the UK was a few years back strongly aimed at law and order performance. Indeed, the then Home Secretary Theresa May bluntly stated in 2011:

> "Some people ask why we are reforming the police. For me, the reason is simple. We need them to be the tough, *no-nonsense crime-fighters* they signed up to become … the test of the effectiveness of the police, *the sole objective* against which they will be judged … is their success in *cutting crime*" (Millie: 2013, 147, my emphasis).

She explicitly added that police are not "social workers" and promoted a deterrent, reactive, crime-fighting model. Such crass retrograde pronouncements from a police minister reflect an a agenda pushed by the populist British media which is not only harsh on any lack of police effort against crime and terrorism but also (selectively) disparaging about any shortcomings among personnel and functioning in the social and health systems (as in the "Baby P." case in London: see below).

It could perhaps be said that within some western policing there has been an institutional shift leading to a redefinition of tasks and mandate within a LEPH perspective. It would, however, be naive to assume that this is universal, espoused by all and has replaced the fundamental roles of maintaining order and tackling crime. There are certainly more proponents of a socially engaged policing: and from being just a partner in multi-agency coalitions some police have become vocal and visible advocates of concerted efforts to aid the diverse vulnerable populations through multi-agency partnerships. The wider acceptance of the need to say tackle sexual violence against women and discrimination against LGBT / "Lesbian, Gay, Bi-sexual and Transsexual" [7]people, has led not only to police forces taking formal and explicit standpoints on these matters but to certain officers becoming undaunted advocates for systematic approaches with other agencies. Such new-style advocates are prominent in the Anglo-Saxon countries including the USA, Canada, Australia and New Zealand. To a large degree, then, it could be said that the LEPH matrix, as we envisage it, is largely a western preoccupation of a few relatively affluent democracies. This is not to say that there are no concerns, debates and creative initiatives in Third World countries but that there is often a weakly developed public health system as

[7] More recently LGBT became LGBTQ+ / Lesbian, Gay, Bisexual, Transsexual, Questioning and other sexualities such as pansexual, asexual and omnisexual.

well as a police system which many people avoid for a number of reasons. The latter may be corrupt, indifferent to the plight of people who cannot afford bribes and is discriminatory on political or other grounds such as ethnicity or gender.

This can only be a condensed sketch but the elements contained in the overview of the four stages of development will inform later attention to specific populations and the varied efforts in the two domains to assist them.

Reluctance of PH regarding LE

Earlier I mentioned that there is more enthusiasm within the LEPH field institutionally from law enforcement than from academic public health. What might explain that reticence which has been noticeable from early on in efforts to establish the field? It was also evident in preparing the five conferences in four different societies (Australia, the Netherlands, Canada and Scotland) suggesting that it is widespread and deeply rooted across cultures.[8] I surmise that there are two main reasons.

Firstly, one reason is related to *professional status* and with links to higher education. The medical world, of which public health is an allied segment, is a profession of high standing with a strong scientific basis. In the rankings of social prestige in most societies senior judges are usually at the top but closely followed by surgeons. Moreover, medical training is university based and public health training is also within higher education. This is also true of "social work" and "care" occupations which play a significant role in a number of key areas alongside PE and LE. Typically the social worker, nurse or other medical practitioner has a professional or higher education and / or training of several years. In varying measures their practical work is underpinned by a knowledge base which is subject to continual expansion and refinement. They are also driven occupationally by a professional code and ethos of care for their clients and patients. They function – at least in theory – according to an ethical code with professional norms of compliance and discipline that provides for internal, professional adjudication with sanctions, including suspension and disbarment. The code, for example, specifically defines that there is a confidential relationship of trust between the client / patient and the social worker / medical practitioner. This clearly limits sharing confidential information with others.[9] Above all, the professional is expected not to act in any way to the detriment of their clients and patients. In brief, in terms of knowledge required, length of training, relationship with the client, professional discipline, code of ethics and the obligation not to harm the client, there is a major institutional and occupational difference with policing. This shapes a caring ethos where the prime aim is to aid those in need – individually and collectively – on a basis of trust and of respecting the rights of the needy requiring help and attention.

[8] In Germany "PH" is even a suspect term as it was used by the Nazi regime in its extermination policies during WWII (personal communication: Joachim Kersten, *Deutsche Hochschule der Polizei*, Münster).

[9] There are, however, certain professional areas – such as clinical psychology – where under certain circumstances the professional warns the client that any incriminating disclosure will be reported to the police.

Policing, in contrast, has had relatively low status professionally in many countries. Until quite recently front-line police officers were recruited from mainly working class backgrounds, were given a short, rudimentary training by other police officers at a police training establishment. In some systems there was a separate entry stream for senior officers who were largely insulated from the realities of street work (see below). In the Anglo-American model policing was not even a semi-profession but was rather an artisan institution with limited functions and tasks. In some early US forces there was often no formal training at all – and even no uniform (Klockars: 1985) – and even now it can be just a few weeks. It is the case that educational standards have improved in recent years in UK policing and on the Continent police training tends to be more extensive (roughly two years in the Netherlands).[10] Basic training in most forces will, however, still be on internal procedures, discipline regulations, drill, physical fitness, use of force and weapons, public order, attending court and especially legal rights and obligations. There is typically little time devoted to interactional learning on how to cope with people in different scenarios and probably low attention to specific populations with a limitation. The primary focus of most operational policing is disturbances and crime in public places, processing suspects for the rest of the CJS and public order. In short, much policing has not been knowledge based, not geared to the vulnerable and not suffused with an ethos of a duty of care. Indeed, there was and still is often a duality in practical policing between aiding people in trouble – which as often happened in some forces and some areas but then on a calculus as to those who "deserved" aid – and mostly viewing them as potential suspects or witnesses: while some even became victims of police deviance.

In brief, policing has largely been a non-professional organization with relatively low levels of entry, a weak knowledge base, multiple – and even competing – tasks, at times a low ethic of service, a predominant focus on crime and public order and an underlying duality towards victims and the vulnerable. Above all it was mostly not based on university learning but had its own educational institutes with relatively short, practical courses and with weak links to a "scientific" knowledge basis.

[10] Typically in the Netherlands it was a year in a police training college and a year of practical learning in a police force. That has changed in recent years as the Dutch police educational system has become tied to university level qualifications. The Dutch Police Academy "ensures that the police have the best people available, and enables these people to develop their skills and talents on a continuous basis. One important focus is the combination of expertise, skills, professional attitude and behaviour. The academy uses available innovative technology such as apps, professional gaming and virtual reality training. – The Basic Police Training is aimed at recruits who stand at the threshold of their policing career. There are various basic training levels, varying from vocational (levels 2, 3 and 4) to college and university level. The police training system is competence-based, to tie in with police practice and the authorities and competencies police officers need to be able to do their job. Students alternately following training at the academy and then an internship within the police force. Both at the Police Academy and in the police force, students work on their assignments to complete their proof of competence. These assignments are tasks and problems police officers are regularly faced with and which are characteristic for their profession" (from www.politieacademie.nl).

European educational systems, however, had long maintained a near unbridgeable schism between university education and vocationally based education for business, technology and trade: this was far less true in the USA (Punch: 2019a). That schism was particularly the case with the British police model which was viewed as an artisan institution recruiting those with fairly low educational qualifications and with everyone starting at the bottom of the rank hierarchy. This was quite unlike the officer caste in the *gendarmerie* model (of militarily trained police) which was recruited separately from the lower ranks and was educated, and still does so, at elite military academies (as at the French Army's St. Cyr). And in the Netherlands at national ceremonies the head of the *gendarmerie* (known as the *Marechaussee*) parades alongside the leaders of the Army, Navy and Air Force. In general the armed services, as well as the higher professions, tend to see the police service as a poor cousin. Indeed, the major professions and the academic institutions allied to them – in medicine the university teaching hospitals and research centres – are typically highly status conscious and wary of encroachment from outsiders and newcomers. Then the professional associations in health and medicine are powerful and prestigious institutions that protect their professional status and limit membership. Hence the LEPH area has yet to establish itself as a solid subject within higher education. It would seem, then, that PH feels institutionally and professionally superior to LE in certain respects which might explain the reluctance to cooperate in joint projects and meetings with this, in their eyes, low status, "semi-profession" (Etzioni: 1969).

But secondly, the other possible reason is that policing remains something of a "tainted" occupation. The history of policing – in many countries and across time – is replete with cases of corruption, discrimination, extra-legal violence and evasion of accountability (Punch: 2009; Brodeur: 2010). While policing is largely a positive element in some societies in other societies it is a malign force of state, factional and ethnic repression and may use illegal violence to eliminate criminals and those opposed to the sitting regime (Belur: 2010). Moreover, police forces in some societies may have a low affinity with "health" tasks and with any notion of care for victims. This means policing and other government agencies are often deeply mistrusted and widely avoided by the public. And even when police violence is legitimate there is perhaps a kind of psychological schism and professional distance institutionally between those dedicated to health and the sanctity of human life and those who have a monopoly over violence and who can kill in the name of the state. This schism is exacerbated by police systems with a history of gross illegal conduct from incidental to systemic. Indeed, if the underlying ethic of the medical and health professions is "first do no harm / *primum non nocere*" (often wrongly attributed to the Hippocratic Oath), then that simply cannot apply to law enforcement which is doubtless capable of much good but also of causing considerable harm: and then often against the vulnerable and those in badly in need of care. In general with regard to harm, for instance, coercion or intimidation play almost no role in much public health but there are exceptions as in secure mental health facilities.

Combining these two factors can mean there are institutional, educational, cultural and even ideological hurdles between PH and LE which impact on occupational

interaction. Certainly in the Netherlands in the 1970s and 1980s, when there was a strong swing to left progressivism with radical views permeating certain semi-professions, there was among social workers and some medical personnel a strong animosity to the police and an unwillingness to cooperate with police officers. This could also be true of social movements including the feminist movement and among diverse self-help groups who were often antagonistic to most professionals in positions of authority in both sectors of LE and PH. It clearly took some time to generate mutual trust between actors in the two domains and that trust could take a dent if there was a scandal in policing related to this area or if officers turned up at community meetings in full operational gear with a side-arm (as in Seattle: Herbert: 2006). This conveys that interaction between the two sectors is a matter of situational negotiation and a range of contingent factors with tensions and fissures as distinct possibilities.

Indeed, I shall later show that there can abject failures in the LEPH context and with severe consequences. Furthermore, although my primary focus is on innovation, improvements and "lessons learned" within LEPH, I am also conscious that the populations we cover may proceed further within the CJS and that we have to remain aware of the defects and biases within that protracted trajectory. I am unable here to pursue that topic at length but shall touch on it briefly.

Negative features of CJS

Another factor of importance following from the "tainted" element in LE is the negative impact that the wider CJS can have on those who pass through it but especially those who are vulnerable and / or in need of care and treatment. For it remains patently clear from academic research, successive government reports and extensive data from various interest groups in diverse societies that a disproportionate number of those being processed by the CJS – leading at times to arrest, questioning, trial, sanctioning, incarceration, probation and later trying to find work and housing with the stigma of a criminal record – are the poor, the disadvantaged and those with a limitation. And that, in turn, a significant number of these are from ethnic minority backgrounds in some societies. Hence, for many of these people the CJS is a hostile, intimidating, unforgiving system.

For instance, in the USA the evidence indicates that many arrests for "street crimes" are related to drug use and minor drug possession and "public nuisances" (drunkenness, "causing a disturbance", soliciting for sex work) and are carried out in deprived areas with mostly vulnerable people from minorities (Cloud and Davis: 2015, 6). A substantial proportion of this group are in fact in need of care but they make for easy arrests for there may be an informal quota for arrest rates demanded by superiors while some officers can be motivated by earning from arrests – known as "collars [arrests] for dollars".[11] But incarceration may mean that, instead of the care the vulnerable need, they are put into harsh regimes and retain the stigma of

[11] Moskos (2009, 121-123) writes of officers in Baltimore calculating to make arrests which would earned them extra pay for working overtime or for going to court: one officer said "court is like our heroin – It's what we need".

a conviction which will handicap them later after release with gaining employment, loans, education and accommodation. In that sense much routine police work in the USA is, for various reasons, working *directly opposite* to what the LEPH movement is campaigning for and which only reinforces stigma and perpetuates the vicious circle of recidivism and exclusion. This almost certainly holds true for policing in many other countries.

In practice the CJS is to a large degree favourable to people with social and cultural "capital" (in Bourdieu's terms), and / or financial resources, who can present themselves favourably (in dress, demeanour and language), give convincing explanations, can play a deferential role to authority in court and display repentance, express a determination not to reoffend, have a supportive family and / or social support network and can return to employment or have prospects of employment. It is valuable if the person is literate, is a native speaker or can cope with the language of the system: and nowadays is computer literate. And maybe they can pay for a good lawyer: or bribe the prosecutor or even the judge (depending on the country and jurisdiction including some judges in the USA) (Punch: 2009). These social and other resources and presentational attributes are of especial value in the moral drama of the court-room in countries with an adversarial legal style along with a jury that can be swayed by appearance and presentation. For instance, someone with a condition on the autism spectrum can be at a disadvantage at all stages of the processing from arrest to court through officials misinterpreting her or his behaviour (Carter: 2015). In brief, the CJS is almost everywhere typically authoritarian, bleak and punitive in style and practice and in some places it is truly awful and woefully inadequate for those in need of care and treatment.

Indeed, throughout the processing cycle of those exposed to the CJS the institutional impact is mostly intimidating, hostile and threatening to personal autonomy and a sense of worth. There is arrest (use of force, handcuffs, stripping and body search, police holding cell); investigative and judicial processing (cold and clinical if not aggressive); initial court proceedings (formal and technical), remand prison (cheek by jowl with diverse types of detainee); trial and sentencing with cross examination perhaps on intimate aspects of one's life including one's medical condition; public scrutiny from the gallery and from jury members along with media exposure; and incarceration with a stripping process, adjusting to the prison regime and surviving in the harsh informal system. And then there is the insecure process of release, parole and rehabilitation. The CJS is, then, for many a debilitating and humiliating set of processes and experiences in which the weak and vulnerable are at a disadvantage at every stage.

This is graphically portrayed for the USA in the grim media reports conveyed by the *Marshall Project* and *The Crime Report* / TCR websites. Throughout the CJS processing in the USA, for instance, the poor, weak and vulnerable are too often discriminated against, abused by officials and inmates, not given their rights, denied the medical treatment due to them and become victims of a cruel and inconsiderate system. This continues despite the case that, "In 1976 the Supreme Court ruled in *Estelle v. Gamble* that prisons are constitutionally required to provide adequate medical care to inmates in their custody. As a result, prisoners are *the only group of*

Americans with a constitutional right to health care" (emphasis added).[12] There may even be a motive of some officers helping someone in need of treatment in "mercy bookings" to get someone treatment in prison while people with mental health problems, who are dependent on medication for their treatment but cannot afford it, may periodically commit offences in order to get the medication in prison (Cloud and Davis: 2015, 7). But too often that right to treatment is ignored or not properly honoured and this is especially for those with mental illness despite the fact that prisons in the USA – but also elsewhere – have become the "New Asylum'" (see " When Jails Become Mental Health Facilities": *The Crime Report*: 2016, 9 December).[13] Repeat offenders with a mental health background can get into a cycle of imprisonment for minor offences when the real, and evident, need is for treatment in a MH facility.[14]

The "weak" include vulnerable people and especially those with a disability or limitation either as a suspect, witness or as a victim. In diverse ways the more vulnerable in society are typically among the young, the elderly and females; hence gender and age are factors and added to that there's ethnicity and social class; and then there are those with a physical or mental disability or other limitation. There are people with a physical impairment, say reliant on a wheel-chair or scooter, or are deaf or blind: and those with some kind of mental impairment which can be on a wide spectrum including dementia, autism, bipolar and schizophrenia. Then there is the impact of social class in that families and groups with social and other problems are disproportionately located at the lower end of the social and economic spectrum. A further feature is the use of alcohol, drugs and other stimulants and the vulnerability to problems associated with those as well to sexually transmitted diseases. Drawing on this it is possible to sketch in vulnerable populations some of which have multiple problems: the homeless, for example, may have "double" or "treble" trouble related variously to drugs, alcohol, HIV, mental illness along with the likelihood of becoming a victim.

To a large degree the thrust of LEPH is that there should be societal concern about the issues, should be more involvement in these matters within LE and should be fruitful cooperation between LE and PH. There is a further assumption that both segments are essentially benign in intent and performance. Yet that is not always

[12] This remained the case until the introduction of the so-called "Obamacare" federal health care programme: formally the Patient Protection and Affordable Care Act this was passed in 2010 and implemented from 2014: the current administration of Trump is endeavouring to alter, reduce and replace its provisions.

[13] A particular issue is using solitary confinement for mentally ill prisoners which can seriously exacerbate their condition (*Guardian*: 2016, 3 May; *The Crime Report*: 2016, 12 January).

[14] "In Wyoming as well as around the country, jails and prisons operate as de facto mental health facilities, treating a disproportionately high number of offenders with mental illnesses, substance abuse issues and often both. That reliance on the criminal justice system means 'Mary' [name changed] and others with mental health problems often find themselves in a revolving door of incarceration and hospitalization, a harrowing experience for individuals and a costly burden on communities and justice facilities – 'Mary' was diagnosed bipolar with paranoid schizophrenic tendencies at age 19. Now 33, she estimates she's been to jail 14 or 15 times" (*Star-Tribune*: 2014, 27 April).

the case. At times joint work between LE and PH has led to failure and avoidable fatalities as in the "Victoria Climbié" and "Baby P." cases in London (see below): despite the frequent involvement of LE and PH a young child at risk – known as "Baby P." – died at the hands of adults in a "troubled" family (Jones: 2014). In residential care within PH the old and the young may be mistreated and this – alongside negligence – may lead to injuries, malnutrition, financial exploitation, sexual abuse, inappropriate medication and even preventable deaths. If one assumes that LE and PH both have a duty of care and a paradigm of protecting the vulnerable from harm, then it is deeply insidious and most alarming that both systems can at times neglect and harm those people to the extent of long-term false imprisonment, serious injury or even death.

In a particularly awful case in a South-East UK county, a clearly psychotic man (Christopher Edwards) was apprehended by the police and, after consultation with a mental health professional, was placed in an ordinary prison cell with another inmate instead of alone within the prison's mental health-care centre (Edwards: 2002, 26). Moreover, he was placed with someone who was known to have severe mental illness: the next morning Edwards was dead and he had been killed, and appallingly cannibalized, by the latter. Thanks to the determination of his parents and with the help of *Liberty* (civil rights organization) the case eventually reached the ECHR / "European Court of Human Rights" which found that the UK government had "denied Christopher his right to life and the criminal justice, mental health and inquiry arrangements were found wanting" (Edwards: 2002, 124-126). The general issue was later addressed by the BMA / British Medical Association in the report *Health care of detainees in police stations* (BMA: 2009). Here in this distressing case the police, mental health service and prison staff had collectively failed. In practice public systems can not only fail to act adequately but can also prove most recalcitrant in fulfilling their legal and social obligations of accountability to victims, victim's families, oversight agencies and the law (Rock: 2004).

Furthermore, there is the element of possible abuse within LE and PH systems. At times those in need of care and attention can be abused and / or exploited within both LE and PH. Within LE, for example, those who are vulnerable in some way, as with a limitation, can be pressurized or intimidated into false statements and confessions with severe consequences for them and others including long prison sentences for them or others (as mentioned above regarding terrorism investigations). To an extent that has been evident for some time within LE but it is less to be expected in PH. But In care facilities for the elderly and the mentally ill the staff may physically or sexually abuse their clients, expose them to neglect and exploit them financially. Some care homes or clinics can make false diagnoses, give wrong or excessive medication, mistreat clients and even cause their deaths through negligence or using excessive force. In mental health facilities when staff face an aggressive client it can happen that the client suffers a serious injury or even is killed: you then get LE having to investigate PH or in some circumstances that both are investigated. Indeed, Michael Brown, a West Midlands police officer who is an expert in policing and mental health "pointed to the high-profile cases of Seni Lewis and Kingsley Burrell as examples of the risks involved":

> "Both men died after NHS staff called in police officers to help restrain them. In both of these cases police officers were asked to attend a psychiatric inpatient unit in order to restrain a patient, and in both cases it ended in death" (*Guardian*: 2017, 27 January).

There has long been a pattern in private facilities in the USA – in what is known as the "medical industrial complex" – where nursing homes exploit their clients with false diagnoses and over-medication and then release them abruptly when their insurance provision expires (Mohr: 1994 & 1997). This is referred to in the UK as "streeting" – literally putting someone in need out on the street due to lack of space or of insurance coverage – and in the US it often involves simply dumping them at the bus station.

You can then get LE having to investigate PH if a suspected crime has been reported. To the extent that PH is increasingly pushed by economies and by a new public management style driven by budget restrictions on treatment and medication, then the more likely it is that such deviancy will occur in private and public PH facilities.

Finally, this background material touches on the large numbers of vulnerable people with a wide diversity of limitations and impairments raising a bewildering matrix of issues, problems and interactions with regard to the interchange between such people and the agencies they encounter and that deal with them and to the interaction between those agencies. Furthermore, the attention to these issues and populations is relatively recent so that agencies are often in a learning – and for some seemingly an unlearning – curve: and that attention to them in turn fosters increased demand. The pivotal issues, then, are:

- What precisely is LEPH? And what is its right to be accepted as a specific area of study, debate, research and innovation?
- Who deals with those in these populations as victim, potential victim, suspect, witness, offender, in residential care, in court, in prison, after prison, within the family and regarding substance abuse, sex work, sexually transmitted diseases and other health risks? When does LE come into play in all this and when is there interaction with PH and other services?
- What are the boundaries and hurdles in cooperation and what has been learned about the processes of multiple agency engagement in diverse societies (management, leadership, finance, learning, evaluation, skills and training, etc.)?
- What is the state of knowledge about not only "what works?" but also "what matters?" meaning the fundamental issues emanating from this area;
- What would be the appropriate research agenda to explore this area?
- What is the impact of legislation and government policies in the diverse areas?
- Where are innovative initiatives taking place in multi-agency cooperation in diverse societies outside of Australia, UK, USA and the Netherlands such as Eastern and Central Europe, Africa, Asia and South America?
- And what is the nature of these initiatives; to what extent are they pilot projects and what is their funding, life-cycle, evaluation and dissemination?
- What do case studies tell us and what are the learning points for replication and

the hurdles for policy transfer? What are the dynamics of successful inter-agency projects with regard to mandate, finance, time scale, leadership, primacy, composition of the team, learning moments, team dynamics, evaluation, life-cycle, etc.?

- The field needs some attention to the development of the CJS in diverse societies and the values and practices they espouse and adopt. One key feature is the punitive level of processing, sanctioning and incarcerating people within the system: think of "SuperMax" prisons in the US (Shalev: 2009) compared to some enlightened prisons in Germany, Scandinavia and the Netherlands. What impact do such regimes have on people with a limitation and in particular those with a mental health problem?
- What are the changes in the definition of, and approaches to, victims, risk, harm and rights? What are the functions and impact of interest groups and formal agencies (for health and mental health, human rights, victims, prisoners, ex-prisoners, etc.) as well as voluntary organizations, campaigns, social movements (feminism) and media scandals in aiding change?
- The impact of neo-liberal policies at central and local government level leading to cuts in LEPH services?

Police, ambulance service and fire brigade in a joint operation (the Netherlands)

Chapter 2. Where law enforcement and public health engage

> "The changing face of crime is creating new demands on policing, *with public safety and concern for welfare incidents now representing the largest category of incidents in some forces.* While recorded crime continues to fall, calls related to modern slavery, child sexual exploitation, vulnerable adults, domestic abuse and mental ill health are all increasing – the Metropolitan Police Service [London] estimates that mental health issues now account for *at least 20 per cent of police time*. And all this is happening just as resources are being severely squeezed and agencies are withdrawing from partnership working to focus on their core statutory duties." (emphasis added) from *Policing and protecting vulnerable people: improving the police response to harm and risk: The Police Foundation's annual conference* (London: 2015).

Increasing demand

A major theme in this work is that in a number of western societies there is across LE and PH agencies an increasing demand from more diverse populations in need along with a growing demand for inter-agency cooperation yet accompanied by financial austerity. The statement above from the UK's *Police Foundation's Annual Conference* (2015) conveys the contemporary perspective of British policing regarding the LEPH field in that there is increasing demand yet with decreasing resources. It was mentioned earlier, moreover, that universal medical provision in the new post-war welfare states was meant to create an increasingly healthier population. To a degree that has happened in certain respects but it has also created a new demand for medical services which have improved enormously leading to higher life expectancy but also spiralling costs with increasingly sophisticated health care and highly expensive apparatus and medicines. Then the development and expansion of "caring professions" in many areas – such as mental health, child care and sexual violence against women – has again created rising demand. But the recognition and structured response to that demand has been, in certain sectors, a relatively recent development. For instance, it was rare to hear of Post-Traumatic Stress Disorder / PTSD until the 1990s: and in the Netherlands dedicated centres to assist the victims of sexual violence (primarily female) are largely a matter of the current decade with the first in the Netherlands opening in 2012 (*HulpPost*: 2017).[15] Indeed, I set up a seminar in Essex University in 2000 with academics, police and public health related professionals (coroner, psychiatrist, psychiatric nurse, police doctor). We were informed of a "pilot" project in London where psychiatric social workers were assigned to police stations to assist with the diagnosis and placement of those brought in with a possible psychotic condition either as a suspect of an offence or for their own safety. But that pilot was *19 years* ago in 2000 and similar practices – such as

[15] "Post-traumatic stress disorder did not exist when I was a medical student in the 1970s" (Jones: 2018, 75).

"street triage" where police and public health professionals patrol jointly (see below) – are largely a matter of the last few years. The first in the UK was when Sergeant Paul Jennings (Hampshire Constabulary) set up "Operation Serenity" which was a mobile street triage response team of police officers and mental health crisis nurses: but that was in 2012 which meant that from a "pilot" scheme inside a few stations to joint response teams took over a decade.[16]

In earlier decades there was undoubtedly the necessary ad hoc interaction between front-line emergency workers – especially from the Police, Fire Service and Ambulance Service, A&E staff at hospitals, social workers and volunteer agencies – but it was largely unregulated and based on customary cooperation between separate silos. Furthermore, political and public assumptions about policing were traditionally focused on "law and order" tasks until there was early evidence from police research commencing in the USA and UK from the 1960s onwards about the highly varied nature of police work. For example, one of the leading pioneers of police research, Bittner (1967), was the first academic to reveal that US police had to cope with the mentally ill on the streets with regard to apprehension prior to being taken into care ("sectioned" in British jargon).[17] Then Punch and Naylor (1973) carried out an analysis of phone calls to the police in a British county force which revealed that most calls from the public were not crime related but were for help, advice or PH related issues. This was not the first piece of research on this topic using calls to the police (Cumming, Cumming, and Edell: 1965) and other such projects followed which have all came to similar results. Indeed, in 2015 the (British) College of Policing "published a report showing that an extraordinary 84% of incoming calls to command and control centres were for 'non-crime' incidents" (Blowe: 2017).

Several decades back, and building on wider material then available regarding the "social" tasks of the police including health issues, I wrote of policing as the "secret social service" Punch (1979b): perhaps "reluctant social service" might have been more accurate. But since then, for a number of reasons, some law enforcement systems have in recent years embraced a broader and more explicit social and caring role in cooperation with other professionals. For example, the statement below would not have been made some years back and indicates the sea change – at least in rhetoric – with law enforcement seemingly taking on a duty of care for the vulnerable:

> "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." Sir Thomas Winsor, Head of the HMIC, in his *State of Policing Assessment* (HMIC: 2015a).

For the HMIC – Her Majesty's Inspector of Constabulary – has shifted in its previously narrow role of assessing police efficiency and budgets to becoming influential

[16] Paul Jennings became a mental health specialist and in October 2014 he "recruited a specialist clinical team to deliver 'Serenity Briefings': a crisis response course for over 300 multi-agency staff from the NHS, Police, Fire, Local Authority and 3rd Sector partners" (from Paul Jennings' biography, LEPH Conference, Amsterdam, 2016).

[17] This relates to the Mental Health Act (1983) *Section* 136 which is used to commit compulsorily a person to a psychiatric hospital or other "place of safety".

on policies and a wider span of performances. This broader shift was very clear in the 2016 Amsterdam LEPH conference with wide interest, intense debate and a wealth of practical examples. Driving the increasing visibility of the area has been the rise of social movements and special interest groups demanding change – as with women leading the protest about sexual violence and gender imbalance in criminal justice and other agencies – which has in turn brought about political and public debate, media attention, influential reports, legislation and institutional developments. All this has drawn attention to the nature and needs of the vulnerable and the issues and challenges of dealing with these in the law enforcement and public health domains.

For example, there was in Britain *Hidden in Plain Sight* by the Equality and Human Rights Commission (2011) on disability related harassment; *Police Custody as a "Place of Safety" under the Mental Health Act 1983 from the* Independent Police Complaints Commission / IPCC (IPCC: 2008); and the *Bradley Report* and its follow-up report (2009 and 2014) on people with mental health and learning disabilities encountering the criminal justice system. Then there was the new College of Policing (opened in 2013) and the then Association of Chief Police Officers / ACPO signing a Mental *Crisis Care Concordat* which promised enhanced attention to this area. Hence much of what we cover relates to relatively recent developments. This shift is supported in diverse ways within the UK's constituent parts but in England and Wales by the HMIC, College of Policing, ACPO and the Police Foundation. ACPO, later replaced by the NPCC, had a coordinating committee on "equality, diversity and human rights": its 13 portfolios covered Hate Crime, Religion and Faith, Gender, Gypsies, Roma and Travellers, Mental Health, Disability, Race Equality, Lesbian, Gay, Bisexual and Transgender, Age, Human Rights and Children and Young People. The NPCC reached a national consensus in 2018 between "policing, health and social care organisations to improve people's health and wellbeing, prevent crime and protect the most vulnerable people". This engaged a bevy of institutions with the NPCC and including the Association of Directors of Public Health, Association of Police and Crime Commissioners, College of Policing, Local Government Association, Nacro / National Association for the Care and Resettlement of Offenders, National Association for Voluntary and Community Action, NHS England, Public Health England and the Royal Society for Public Health.

Furthermore, the 2015 Police Foundation's annual conference was on dealing with domestic violence and the Police College's 2016 annual conference was on *Vulnerability – New Approaches, Better Outcomes*. Yet another agency supporting this area was the Police Superintendents' Association and its president stated:

> "The area of 'vulnerability' has in the main been tackled within forces by their Public Protection Units (PPUs). Their mission has grown from what was their key raison d'être of investigating child abuse, primarily within the family, to now cover everything from 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).

Then at the 2016 Amsterdam LEPH conference there were valuable presentations from Michael Brown, Mental Health Coordinator at the College of Policing: and also from Paul Jennings who is a mental health specialist (Hampshire Constabulary) and a pioneer of triage teams, diversion and mental health ambulances. A useful indicator of positive change – and how far British policing has come – is the overview by Public Health England, *Police and Public Health* (2016) and in *Police and Public Health Collaboration in England and Wales* (2018) with Duncan Selbie, CEO Public Health England, stating in the latter:

> "The factors which lead to poor health such as adverse childhood experiences, poverty, social exclusion and addiction are also the factors which increase the likelihood of being involved in crime. Police forces and health organisations serve a common purpose and by working together we can improve outcomes not only for individuals, but for wider communities. This landscape review provides a comprehensive picture of the ways in which we are collaborating as we strive to improve public safety, reduce crime and improve health outcomes".

How that thrust is reflected in practice can be taken from the example of Reading, within the Thames Valley Police / TVP (Gilmour: 2018). This is an illuminating example of a coordinated effort between LE and PH in the Borough Police of Reading which is based on a combination of partnerships taken as "business as usual" along with the well-known concepts of NOP and POP, evidence based policing (e. g. tracing "hot-spots" of drug-related deaths and violence) and other applied academic research.[18] There are national guidelines on this approach promoted by the Police College but to a large extent Reading's arrangements are based on a local initiative: but within a police force, Thames Valley, which has long been seen as "progressive" and which has become strongly geared to early intervention. Then there's a supportive local authority in Reading willing to fund various projects within its budget limitations. It draws on the work of the parliamentary *Youth Violence Commission* in Parliament (Westminster) and on research-based public health policy in Wales related to "adverse childhood experiences" / ACE (Public Health Wales: 2015).[19] Underpinning it are two main elements: one is that multi-agency partnerships are SOP (Standard Operating Procedure) and the other is that the arrangements are defined as a form of *enforcement* within which the "social care" element is integrated with the "control" factor. Its focus is solving problems together. For examples, there are police staff imbedded in the local hospital; there is involvement with schools and the youth in various ways (including them taking part in peer in peer community courts);

[18] NOP / "neighbourhood oriented policing" is a variant of COP / "community oriented policing" for smaller localities where it's perhaps difficult to speak on any coherent sense of "community" as in a say a multi-cultural area where minorities barely interact and are reluctant to take part in communal activities. In US policing such COP and NOP approaches are often stigmatized as effeminate and not "real" policing while NOP is dubbed "No-one on Patrol" or the "empty holster cops" (Tilley: 2003).

[19] There is also the Child Sexual Abuse Centre – www.csacentre.org.uk – which is a voluntary agency that engages in research, advice, and multi-agency efforts and has 500 CSA support services in England and Wales.

and joint patrols to look at the homeless and at drug use with police, social workers and street pastors.

This is most encouraging – and there are doubtless many such examples throughout the UK and in other countries – but we should recall that previously in some law enforcement areas the weak and the vulnerable were ignored, exploited or harassed and other agencies were kept at a distance. There can even be collective deviance against the vulnerable. A New Zealand scandal revealed that young, homeless women, some of whom were minors, were being sexually abused by police officers.[20] The vulnerable have been manipulated in the USA by the FBI / Federal Bureau of Investigations as informants and witnesses in criminal and terrorist investigations (*The Crime Report*: 2015, 22 July). They can be persuaded to become pliant informants incriminating others by gullibly laying allegations which have been fed to them by the police. Particularly vicious and predatory is when officers force a false confession out of a person with a limitation leading to a long period of imprisonment. In a notorious miscarriage of justice case related to a number of IRA / Irish Republican Army bombings in Britain which were allegedly committed by the "Guildford Four", the psychiatric evidence on one of the four accused was withheld from the court. She had allegedly confessed to involvement in three bombings and subsequently served *eighteen years* in jail before being released after the conviction had been quashed. And a man was given a long sentence for sex crimes he could not have committed as he was impotent but this crucial evidence was held back: he died in prison before the miscarriage was revealed. Then these cases led to revelations that a number of grave miscarriages had occurred with other vulnerable people who were easily manipulated (Punch: 2009). Furthermore, the risk of "being killed [in USA] during a police incident is 16 times greater for individuals with untreated mental illness than other civilians" (*Guardian*: 2015, 10 December).[21] Even in relatively "civilized" Amsterdam homeless people proving "troublesome" in police eyes were in the past sometimes forcefully bundled out of the station – with one subsequently dying of his injuries – or were driven out of town and dropped at a park. This has long been a traditional practice in many law enforcement agencies and was assumed to have ceased in Amsterdam until a homeless men died in a park outside the city during a cold spell in the 1990s having been dropped there by police.

The vulnerable remain, then, vulnerable at different times and in diverse ways. Indeed, criminal justice systems generally process a disproportionate number of the weak and vulnerable who face major difficulties in the courts, prisons and on returning to society with a criminal conviction. They can also encounter discrimination, violence and neglect from those who are charged to support them and that can be in police encounters, custody, foster homes, residential care, at school or in the community. So it is not just a rosy case of positive developments while adoption

[20] "Operation Austin" launched in 2004 investigated accusations by women of sexual assaults (so-called "pack-rape") by officers or former officers in Auckland; some victims were minors and one was 13. *New Zealand Press Association*, 12 December 2007.

[21] Virginia (USA) has had a particularly high rate of police shootings of the mentally ill (Virginia Pilot: 2016): and a dilemma facing police is "suicide by cop" with disturbed people inciting violence with threats or waving a gun or knife or what looks like a weapon.

of, and commitment for, programmes for the vulnerable may be confined to certain segments of the police organization which can be a complex matrix of diverse and sometimes warring occupational cultures and practices.

There is, in short, clearly increasing consideration in recent years to illness, disability and vulnerable populations with a growing number of people in society being defined as vulnerable and requiring care from several agencies. The problems among the diverse populations within the vulnerable are immensely damaging for them and for society and require coordinated attention and considered measures for prevention. In certain areas law enforcement officials and agencies are being drawn into arrangements with professionals, semi-professionals, social agencies and volunteer groups including those in the public health arena. Taking that background into account it is important to realize that it opens up a growing and demanding list of the vulnerable and those in need as fresh areas of concern are brought within the remit of the LEPH field.

The long list includes: the mentally ill; the disabled and intellectually disabled; asylum seekers / illegal immigrants[22]; the vulnerable elderly; "honour" based crime and forced marriage; bullying and cyber-bullying at school, work and on the internet; sexual harassment and violence, largely against women but also others including LGBT people and the young; stalking; historical cases of sexual abuse; discrimination; on-line grooming and cyber related offences; domestic violence, particularly against women, children and the vulnerable; the homeless; drugs and intoxicants; missing people; health hazards and epidemics; slavery and human trafficking; FGM / female genital mutilation; sex workers as victims and sex work as a health hazard; Sinti, Roma, travellers; military personnel and war veterans with trauma and / or PTSD also among care and emergency service workers; abuses in residential care and other institutions (including the military, education, religious, etc.); deaths in custody and as a result of police enforcement; road violence and road deaths; violence reduction and other prevention programmes such as alcohol and drugs; dealing with the immediate care and the aftermath of disasters and emergencies.

The list is extensive, challenging and growing: but a key element is that these areas ideally require an inter-agency response when coping with such populations with their diverse problems that cross institutional borders. All of those groups and issues itemized are important and each could be treated at length in a larger volume. Probably in terms of numbers affected and societal impact the three dominant issues relate to mental illness, domestic and sexual violence and drugs: and they may in practice be linked. Given the demographics of ageing populations with attendant vulnerabilities, including dementia, it may well that in the near future age-related issues join that trio or even come to lead it. In relation to the increased involvement of staff in the LEPH domain with heightened risks and threats, there has also been growing attention to their own needs during their work and their likelihood of themselves suffering from abuse, aggression and subsequent work-related

[22] Some having had traumatic experiences of war and / or being trafficked into Europe while there are also many unaccompanied juveniles who have lost their parents or other relatives en route (Hansson: 2017).

ailments. At the same time there is an enhanced chance that LEPH staff in increasingly litigious societies – and with a higher likelihood of media and social media scrutiny – will face institutional and professional investigations and sanctions and possibly criminal charges.

There is, then, a noticeable dynamic currently for law enforcement in several societies to engage in cross-agency arrangements to cope with and to assist specific vulnerable groups and in multi-agency prevention schemes. At the same time it is clear that many initiatives do not typically challenge the prime concerns of crime and public order within policing and that they can often depend on limited funding and institutional champions: this could mean that initiatives did not survive if the champion moved on. A significant factor in arrangements and interaction is that medical and social work professionals typically have a higher education qualification in their area of expertise and also function full-time with an explicit ethic of care for their clients. Police officers, in contrast, are usually not professionally trained for this field, may perform the role part-time and may move on after a number of years to other policing areas. In short, while partnerships have been functioning for some time there are multiple factors determining outcomes including institutional, professional and disciplinary boundaries and occupational identities. And while there are examples of highly committed professionals from both systems cooperating fruitfully, there are also some horrendous scandals when there has been a systemic failure of communication and coordination (see the following section). In effect, we are focusing primarily on the terrain where law enforcement / policing and public health *interact* rather than looking at the two professional institutions as systems.

That interaction, moreover, can be ambiguous and can engage shifting partners. In child care, for example, teams of police and social workers engage in assessing the risk to health of the child within a family context while the regular health service may also be involved if the child is examined by a doctor or admitted to A&E. There is in that interaction, however, not only an ethic of care for the child and the family but also the possibility of taking the child away from the family with even a criminal investigation and prosecution of the parents / carers.[23] In the past, for instance, "cot deaths" of young babies (later redefined as "sudden infant death syndrome") were treated in some jurisdictions as potential crimes with suspicion falling on the parents or carers and with a forensic team entering the house. Hence that interaction can carry a "care versus control" duality that can evolve into either a care or control outcome – or both combined in some way – as a result of the encounters or series of encounters. There emerges, then, a field of shifting coalitions, blurred boundaries, occupational redefinition; of inquiries, reports and legislation; of media exposure and public campaigns; and of policy and legal change in diverse societies. Undaunted by this breadth and complexity I shall focus on those who deal with those individuals and groups in society – at risk and / or in need of care – and who are

[23] At a conference in June 2016 at Canterbury Christ Church University that partly addressed Policing under Stress, an officer recounted that one of the most emotional events in his career was removing three young children from parents who did not speak English and were clearly distressed and bewildered by the proceedings. He was "Nathan Constable" – a pseudonym of an officer with a well-read blog (of that name) containing an account of that event.

dealt with by members of the police and public health communities in an effort to cope with their situations.

Hence this overview will position that interaction between police and public health as an emerging but essential field in a changing society – taking into account demographics, ageing, immigration, inequality, austerity and poverty – but which is contested and fluctuating. A major theme is that many of the significant developments have been in recent decades, if not recent years, and that it is vital to consolidate these, learn from them and maintain them for those institutions dealing jointly with the diverse populations in need. At times, however, systems and the actors within them fail: and although each one gone wrong can be viewed as a learning experience – and contributing to change – some are simply awful and indicate system failure.

When inter-agency cooperation fails

The LEPH field holds out the prospect of improved, coherent and coordinated treatment for the needy and the vulnerable from front-line emergency and other agencies. It is posited on properly trained, responsible and cooperative personnel who are willing and competent to function in multi-disciplinary teams to the benefit of their clients. Yet there is evidence that inter-agency partnerships do not always function well with issues of primacy, resources, culture clashes, mutual miscomprehension, failure of some parties to deliver on their responsibilities, difficulties in communication, conflicting interests, maintaining continuity in personnel and care and even of a near unbridgeable gap between the divergent worlds of agencies and systems (O'Neill and McCarthy: 2014; Martin et al: 2017).

Unfortunately, the promised care and cooperation can even in practice fail abysmally – even with fatal consequence – while some cases of failure are not only appalling but also suggest systemic deficiencies. The Dutch Ombudsman for Children, for example, warned in a 2014 report about the extent of the problem in the Netherlands and the "grim picture" shed by the inadequate response to child protection by agencies and the authorities involved (*Dutchnews*: 2014, 21 May). Those involved in care functions could be dealing with a range of problem families in which there were sometimes difficulties of language and culture and where parents / adults were shrewd, manipulative and capable of convincing case workers and others that there was no cause for concern (Alison and Crego: 2008). For all sorts of reasons there was – according to Crego[24], who conducted debriefs with case-workers after certain calamities in the UK – a continuous exposure among practitioners to such "problem" families leading to a major difficulty in predicting when a suspicious circumstance would lead to the extreme of a fatal beating in a particular home. And to have adopted an assertive, interventionist, doubting style would have disturbed

[24] Jonathan is the "designer and owner of Hydra, Minerva and 10,000 Volts debriefing methodologies. He has driven these methodologies for over 25 years In Policing, Fire Service, Counter Terrorism, Major Incident and Multi-Agency management of critical incidents. – He has delivered over 350 debriefing events with expert practitioners in areas such as catastrophic disaster, child abuse and murder investigation" www.hydrafoundation.org.

relationships with the many families they were trying to assist and which were perhaps not caring all that well for their children in some respects but were in no way deliberately harming them (personnel communication Jonathan Crego).

In the UK, moreover, there have been some horrendous examples including those of Victoria Climbié, Daniel Pelka and "Baby P." (Jones: 2014). All three relate to violence against the young. I consider it of great importance to explore not only best practice but also "worst practice" in order to look for explanations and lessons to be learned. These three cases were within the UK – where specific features of British politics and the populist media played a significant role – but some of the factors on inter-agency cooperation are applicable widely in other societies.

Victoria Climbié Case

Victoria Climbié aged eight years died in a London hospital in early 2000 having been subjected to violence and torture at the hands of a female relative acting as her guardian and the woman's then partner. Victoria was born in the Ivory Coast and was brought to the UK in 1999 via France by her great-aunt, Mrs. Kouao, who registered her as her daughter "Anna". Kouao later formed a relationship with a man, Carl Manning, and she and Victoria moved in with him. From early on in London people who knew the two new arrivals became worried about Victoria's condition – she was wearing a wig, had bruises and displayed signs of neglect – to the extent that an acquaintance twice anonymously phoned social services in the Borough of Brent in North London: but there was an "unbelievable" three week delay in logging this (according to the subsequent *Laming Report*: 2003).

Shortly after leaving their accommodation to stay with Manning some concerned acquaintances took Victoria to a hospital where an examination came to the conclusion that the injuries were non-accidental and she was admitted: but Kouao managed to persuade the staff that they were self-afflicted while Victoria came across as timid and never contradicted her "mother". However, the police and social services were alerted and prepared a 72 hour protection order but, due to reporting difficulties at the hospital and miscommunication with other agencies, the medical condition was downgraded and the police agreed that she could return home. When social workers in Brent went to see them on a house visit they found that they had moved but there was no follow-up.

Later there followed a second hospital visit with signs of scalding but the police officer assigned to the case and the social worker, who had paid them only a few perfunctory house visits, allowed her to return home. By this time their case came under the supervision of the Borough of Haringey. On a number of occasions Kouao took Victoria to churches rather than seeking treatment for Victoria's injuries. When Victoria's condition deteriorated rapidly Kouao ordered a taxi to go to a church but the driver was so alarmed at the girl's appearance that he drove straight to a hospital. Victoria died the next day, 25th February 2000, of hypothermia, malnutrition and multiple organ failure. On that very day Haringey administratively closed her case. Victoria had been scalded and burnt with cigarettes; slapped, punched with a fist and hit with a bicycle chain, hammers and

wires; and at times she had been tied up for more than 24 hours wearing a bin-liner and lying in her own excrement. The pathologist detailed 128 wounds and scars on her body and considered it the worst child abuse he had ever witnessed. Victoria had been physically abused and tortured for some time and this increased after she had moved in with Manning. Kouao and Manning were tried and convicted of child cruelty and murder and both were both sentenced to life imprisonment.

The repercussions of this truly appalling case were profound and there followed a number of measures:

- An official inquiry was set up under Lord Laming that examined the functioning of the social services, police and NHS: it heard 270 witnesses and made over 100 recommendations;
- In 2004 The Children Act was passed establishing reforms;
- A national agency for families and children was established, the Office of the Children's Commissioner, led by the Children's Commissioner;
- The *Every Child Matters Foundation* was established;
- A database to cover all children in England and Wales, *ContactPoint*, was formed: this proved to be expensive, aroused criticism and was closed down in 2010 by the incoming Conservative-Liberal Democratic coalition government.

The Laming Report (2002) was damning.

- It detailed that during her short time in London Victoria was known to 12 agencies: four social services, three housing departments, two police child protection teams, a NSPCC / *National Society for the Protection and Care of Children* centre and two hospitals.
- During the inquiry there were issues about delays in supplying documentation, missing data and the validity of some reports and the failure of some witnesses to appear before the commission. Laming asserted that there was signs of a "blatant and flagrant disregard" shown for the inquiry;
- The key finding was that the borough councils and diverse agencies concerned were *poorly managed, underfunded and understaffed;*
- Some agencies were seriously dysfunctioning as were individual personnel of whom some were inexperienced yet carrying high case-loads: some were "blindingly incompetent" according to the trial judge. A swathe of mistakes was made because there was a lack of an inquiring mind about Victoria's timidity and Kouao's claims and because people failed to follow through without bothering about the appropriate action within the multi-agency chain. This shaped an unprofessional evasion of responsibility in what had become a dysfunctional non-system;
- As part of the trail of inquiries, discipline tribunals and court cases, some personnel were dismissed or otherwise sanctioned and the councils involved and certain individuals apologized for their failings. In the MPS six officers faced disciplinary measures: it emerged that the personnel of the police child protection teams had been reduced to focus on high-profile crimes. And both Brent and

Haringey Councils had diverted funds from child protection to other areas: as a result of underfunding and understaffing some children at risk were "warehoused" in Bed & Breakfast accommodation and were never even allocated a case worker;

- Haringey Social Services was subsequently placed by the government under the supervision of the Social Services Inspectorate.

The Laming Report (2003) concludes, in essence, that the agencies had *collectively* failed to protect Victoria: and it particularly criticized senior management. On no less than a dozen occasions they could have prevented her death. The formal "system" that should have prevented this tragic death was simply not functioning: it lacked coordination, commitment, resources and leadership. This can be the reality in certain large, tough urban areas – with a shifting, multi-cultural population – where there is a concentration of "problem" families in a context of austerity and of difficulties in attracting well-qualified staff at all levels. For nearly all the actors in nearly all parts of the chain just did not deliver what was expected of them and what they were professionally and legally obliged to do.

There followed, as mentioned, a series of measures with fresh legislation and new agencies. Yet some commentators were not convinced and could point out that there had been some *70 public inquiries in this area since 1945*: one sceptic stated that the "script" following them had become predictable.

> "The Minister goes on TV to insist that: 'this must never happen again'. Responsibility is pinned on a few expendable front-line staff, all conveniently sacked in advance. Criticisms are made about poor communication, with earnest recommendations about better co-ordination and possible restructuring. Council officers – all new appointments – go on TV to say that everything has changed since the case began. Everyone looks very earnest. Voices crack with compassion. *Nothing essential changes*" (G*uardian*: 2003, 25 January – emphasis added).

Daniel Pelka Case

Daniel Pelka was a four year old boy who died in 2012 in Coventry from a blow to the head: he had over time been beaten, tortured and starved by his parents from abroad who were tried and convicted of his murder. Daniel came to school where he was seen to be eating out of garbage bins and with injuries which were assumed to be accidental. Furthermore, the police had visited his home no less than *26 times* but neither they nor members of other agencies seemed to appreciate the gravity of his predicament. A *Serious Case Review* (2013) concluded that "at no point were practitioners who had contact with him prepared to think the unthinkable and consider that he might be suffering abuse". Yet his parents beat him, locked him in a tiny room with a dirty mattress, force fed him to eat salt and starved him: he finally died from a massive blow to the head. He had come to school with black eyes and a broken arm and was described as looking "like an old man", a "bundle of bones" and before his death – weighing only 11 kilogrammes – as like a "concentration camp victim". The review concludes that the police, educational authorities, social services and NHS had all collectively

failed. The failure was appalling – and it was not an isolated incident – but it needs to be explained in individual, occupational and institutional terms. What can explain why the seemingly glaring signals of abuse were not picked up on and why were the explanations of the parents so readily accepted?

This appears to be a case of "system failure" where the actors were not fully in control and collectively nobody asked the critical questions to break the cycle. The case brought about reports and recommendations including the "Daniel Pelka Review" (Wonnacott and Watts: 2014) and the *Daniel Pelka Serious Case Review* (2013).

The case of "Baby P."

This was yet again a truly shocking case. What caused particular consternation was that it occurred in the London Borough of Haringey which several years earlier had faced the equally grim case of Victoria Climbié's murder. This had led to broad media coverage, to a public inquiry by Lord Laming and to reform measures. "Baby P.", as he was referred to before his real name (Peter Connelly) was released, 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 GP 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, Haringey then 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 incredibly 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 injuries to his fingers and nails while he had swallowed a tooth as a result of a blow to the head.

The case attracted intense media attention, political concern and intervention and a series of evaluations and reports. It was a high visibility case because it attracted a slanted media-driven campaign, apparently prompted by Conservative politicians; by parliamentary concern and direct political intervention; and by a bevy of evaluations and reports. The popular tabloid press, highly influential in the UK, focused primarily on the failures among social workers and especially pilloried certain individuals but especially the Head of Haringey's Children's Services, Mrs. Shoesmith. She was on record as a committed, competent and respected manager but Haringey was one of the toughest boroughs in London: and with a fairly "left" local council. The media attack on her revealed a contempt for social work – seen as politically correct welfare for the undeserving – and also for public officials. It employed the

full battery of nasty tricks to pursue Mrs. Shoesmith in order to attack Haringey Council[25]. That politicians of both camps avidly followed the media's line was evidenced when, in a most unusual move, she was publicly sacked on TV by the Labour Minister, Ed Balls, during a press conference. After legal proceedings Mrs. Shoesmith was later reinstated and awarded substantial damages but some of her colleagues and local politicians resigned or were dismissed. For several of them their lives were turned into a nightmare of prolonged media intrusion and of harassment, threats, having to move house several times, official tribunals and legal battles.

There followed several inquiries and a national review of social service care. At Haringey there was an internal SCR / "Serious Case Review": subsequently the Minister, who was dissatisfied with that SCR, called for a second report. And there were two other reports with one about possible breaches of the professional code of practice and the other reviewing the dysfunctioning of all the agencies involved. Notably, the media and political focus had been narrowly on the failures in the social services but had not looked at failures in the police, medical services or local authority. Indeed, the lesson of this gruesome case is that once again there had been a multi-agency *system* failure.

This was emphasised in Lord Laming's 2009 national overview report that too many local councils had not taken enough steps to implement the proposals in his previous 2003 report following the death of Victoria Climbié. The system had failed because it was incapable of learning from earlier failure in relation to weaknesses in personnel, communication, training and synergy in the cooperation. One reaction to this bleak history was to set up a "Multi Agency Safeguarding Hubs" (MASH) which improves the way that local safeguarding partnerships deal with child protection referrals, bringing a range of partners together into a single hub to share information quickly and efficiently as soon as a notification of possible harm to a child is received. This involves a partnership of local government, health, police and probation in major cities.

[25] A contributory factor in this sad case is that above the front-line staff there was a management cadre along with the local politicians who in a tough London borough were functioning in a high pressure, stressful environment of accountability to a network of stakeholders, political scrutiny and critical media attention. There was a tendency to defensiveness, curbing critics and side-stepping discomforting signals. Some practitioners did draw attention to recurrent institutional problems, dysfunctional teams or inadequate individuals only to face inaction, denials, selective publication of material or even gagging measures with sanctions. Driven into short-term, opportunistic responses from pressure for results but with diminishing resources, there was a tendency to ignore warning signals and to neglect the reform proposals of previous reports and regimes. This could be a recipe for repeating mistakes in a defensive context that had undermined organizational learning and turned a blind eye to persistent and glaring red lights.

Dutch police officers in contact with a homeless man

Chapter 3. Specific Areas within the LEPH domain

Now, I shall address several specific areas commencing with mental illness. There is a degree of overlap between some categories – e. g. "sexual violence against women" and "domestic abuse" – but they are dealt with separately in relation to the differential emergence of the issue and the diverse measures taken. The list is not meant to be definitive while the selected topics were chosen to cover the most salient issues arising from the LE and PH interchange. Clearly there is a mass of data on each topic but here I simply touch on the key elements with some subjects being given more attention than others. These are: Mental illness; Disability and "Hate Crime"; Sexual Abuse of the Young; Sexual Violence Against Women; Domestic Abuse; The elderly; Trafficking, Slavery, FGM.

Mental illness

> "'Officers often lack the training to approach the mentally unstable', experts say – 'This is a national crisis' said Chuck Wexler, executive director of the Police Executive Research Forum, an independent research organization devoted to improving policing, 'We have to get American police to rethink how they handle encounters with the mentally ill. Training has to change'" (*Washington Post*: 2015).

Those with mental health problems form a diffuse, widely ranging group in society that can require residential or extra-mural care and attention. The numbers involved are staggering with estimates that one in five Americans – over 40 million – struggle with some type of mental illness. "Mental illness" is, however, a container concept covering a diversity of classifications and taking many forms; it is often not diagnosed and can be a single episode, recurring or permanent; and some forms can be treated with various levels of success. Many sufferers receive little or no treatment and are reliant on family support or voluntary agencies but some receive no help at all. Indeed, in the UK mental illness is reported to be massively neglected at an immense cost to society and with substantial difficulties for those afflicted (LSE: 2012). A very small number of those with mental illness can be highly dangerous and can commit violent crimes including sexual crimes and if convicted can be imprisoned permanently or on long sentences with treatment carrying the possibility of eventual release. However, the vast majority of those held to have mental illness are not violent but some sufferers can prove troublesome in relation to vulnerability, self-harm, threatening or causing harm, delusions, creating a disturbance or proving too difficult to handle in the family circle, public or semi-public spaces (shopping malls, restaurants) or in residential care facilities. They also form a vulnerable group which opens them to victimization (Kitt and Rogers: 2017).

The police and others may be involved in reaction to calls for a single instance or be called multiple times to a known person who periodically causes a problem to neighbours or bystanders but not to the extent of being forced to move from the location despite successive reports from the police, social services, Mental Health

Service / MHS and housing authority. In brief, there are a range of scenarios regarding mental health sufferers with a varied involvement of LEPH and other agencies depending on the situation, the locality and the society.[26] For those receiving residential care there was a major shift to deinstitutionalization from the 1960s onwards with the closing of many facilities and with treatment moving to "care in the community" allied to the use of medicine. This has often proved problematic when the community care is inadequate – which may in turn be related to budgets and financial provision – and / or the person ceases to take their medication. And in recent years this situation has become acute where there have been economies in support facilities along with a shortage of trained psychiatric staff.

Senior police officers in several societies are now seeing that troublesome cases in this area are taking up an increasing amount of police time: and this would apply to others in control functions such private security in shopping malls and diverse community safety agents. For instance, one ailment that has become prominent in recent years is dementia which is allied to the increasingly ageing population. One British newspaper account described dementia care home staff calling the police "thousands of times each year" when the staff are unable to cope: this led a chief constable to view policing as becoming "an extension of social services – and an outpost of the NHS [National Health Service]" (*Daily Mail*: 2013, 4 November). This problem, along with a range of accompanying issues including use of force by staff and their subsequent accountability in the case of injury or death, has become the new reality in various countries for psychiatric and social care workers and for law enforcement officials.

Some of the population with manifest difficulties in public present a particular challenge to law enforcers and others as most non-psychiatric professionals will be unable to form a diagnosis while they typically perceive such people to be unpredictable and even potentially violent (although, as mentioned, most are not violent). They can come to public and police attention for acting "strangely" in public places and dealing with this can be relatively straightforward but also time-consuming. For example, in the Netherlands a man who was plainly psychotic climbed up a high-voltage electricity mast and it took some 14 hours before he could be brought down. This was not a particularly challenging incident on the scale of emergencies but it did keep the combined emergency services tied up for all that time in case he would fall or jump: they eventually brought him down. Then it can at times happen that those suffering from a psychotic episode may be taken into police custody having committed no offence while there follow efforts to mobilize the MHS. In the past this has often met a negative response from the MHS leading to some mutual friction and, occasionally, even a death in custody when the health service did not respond swiftly enough. This can make police sceptical if not hostile about the MHS which they may see as difficult to mobilize, especially at night, while the duty psychiatrist may refuse to respond on the grounds of priorities and / or lack of "beds".

[26] The range of articles, and expertise of the diverse contributors, makes the forthcoming book by McDaniel, Moss, and Pease (2019) (eds) Policing and Mental Health: Theory, Policy and Practice (Routledge) look most promising and informative.

This can be illustrated by observations from my fieldwork with the police in Amsterdam in the 1970s.

Police and mental health in Amsterdam in the 1970s

My research in Amsterdam in the 1970s (Punch: 1979a) was in the red-light district of Amsterdam which contained the usual concentration in such areas of sex work, predatory street crime, drug use and dealing, gambling, drinking and drunkenness, aggression and fighting but it also attracted people with mental health and / or addiction problems some of whom were "stoned" or suffering from an overdose. The police were routinely confronted with people who were behaving in ways that attracted attention such as being confused, aggressive, threatening, causing dangerous situations for themselves or others, disputing bills in shops or with sex workers, molesting people, shouting and gesticulating, disrupting traffic, and so on. If such people were brought to the station and the desk sergeant felt it was it an urgent matter, he (it was an all-male station) would call the GGZ / Mental Health Service and ask for the duty psychiatrist to come and examine the person and if necessary take him or her into care. But often the typical reaction was that the psychiatrist would not come unless the person was clearly a danger to himself and / or others: and anyway he had no "beds" available ("beds" was the term for the limited slots available for emergency care). The mental health professional involved was usually young, inexperienced, under pressure of work, with limited resources and with strict criteria for admissions from his superiors. The disturbed person in question in such situations, who was badly in need of help, was treated by both sides almost as an unwanted parcel. One police response to this was that plain clothes officers drove the disturbed person in an unmarked police car to the local hospital and pushed him or her into the Emergency Room and then speedily drove off. On one occasion, however, a man who was clearly psychotic entered the station; the duty sergeant called the GGZ / MHS but the duty doctor was not prepared to attend as the man was not violent or overly troublesome. The man in question was told to leave but he went to the Central Station close by, climbed on to the roof and jumped off: he died as a result.

In short, the relationship between the police and GGZ / MHS in the 1970s was poor with much mutual mistrust and misunderstanding and almost no formal protocols for cooperation so that a positive outcome depended on individual officers who were good at negotiating or medical professionals who were prepared to be flexible. At that time there appeared to be no awareness in the station of the particular problems of vulnerable people, no knowledge of their needs, no training on this for officers, no thought of privacy for women reporting sexual abuse and no clear arrangement for inter-agency cooperation. It was clear that such incidents could leave the police feeling that they were saddled with a problem they were not equipped to deal with; that they did not have appropriate accommodation; and were taking the blame for an avoidable death. It was also the case that at that time in a busy inner-city station there was little attention by the police to the needs of the vulnerable

and low awareness of their needs. This might appear to be a story of past gloom and that since then much has improved.

But then some 20 years later from that particular fatal case I met the senior police officer responsible for the Amsterdam city-centre district and asked him about dealing with the mentally ill. He claimed that after five o'clock in the afternoon it was almost impossible to reach anyone at the GGZ / MHS; that officers were forced to take disturbed people into custody overnight who might be in the cell for 10-12 hours or more; and that he had encountered a suicide in his cells after the person was refused care because of supposed lack of capacity in MHS facilities. He strongly felt that a police cell was not a proper place for such people; never wanted another suicide in the station with someone having to wait too long for medical care; and spoke of the potential legal liability of the MHS for any death in custody if it turned out that "beds" were available but were being kept for "more urgent" cases. This illustrates that for some time in Amsterdam there was a measure of antagonism and hostile distrust between the two services.

One suspects that that was also true in some other Dutch cities at that time and, indeed, in other societies. At the multi-agency seminar I organized in Essex in 2000, for example, the participants were informed that police and the MHS could spend hours trying to find a suitable treatment location for someone with an acute mental health problem and that he or she might have to be sent a long distance as there was nothing available locally or even regionally. This sort of problem with capacity has become increasingly acute as "mental illness" in its various forms is beginning to constitute the major challenge in contemporary policing. Indeed, several police chiefs in the larger major Dutch cities have stated that people suffering from mental health issues who are not receiving adequate treatment, or refusing it, have become their prime concern and largely due to budget cuts in the MHS. Such people cause disturbances in public places and can be a danger to themselves and to others: in several high-profile Dutch cases people have been murdered or seriously injured because of inadequate care or failures in communication between agencies.

Moreover, it is clear that a disproportionate number of the mentally ill enter the CJS and are incarcerated. Cook County Jail in Chicago, for example, is described as *America's Largest Mental Hospital* with an estimated one in three inmates having some form of mental illness:

> "At least 400,000 inmates currently behind bars in the United States suffer from some type of mental illness—a population larger than the cities of Cleveland, New Orleans, or St. Louis—according to the National Alliance on Mental Illness. NAMI estimates that between 25 and 40 percent of all mentally ill Americans will be jailed or incarcerated at some point in their lives" (*The Atlantic*: 2015).

This acute matter – the increase of people with mental problems encountering the police and front-line psychiatric services with limited resources – forms one of the most pressing issues in contemporary societies. But although there is research data strongly indicating "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), the problem remains of getting that insight adopted widely. Nevertheless, as I shall show below there have been a number of inter-agency schemes across societies to provide more coordinated care and attention for this population.

Disability and "hate crime"

There has been in recent years increased cross-agency attention to the vulnerability of people with "disabilities" and / or vulnerabilities – the blind, deaf, physically disabled, elderly, etc. – who can be prone to accidents and who are also vulnerable to victimization at home, on the street or in institutions. Indeed, a connection is now being made in Britain and elsewhere between vulnerable populations, harassment and *hate crime (Guardian*: 2015, 22 July*).* This last concept has been receiving increasing attention in recent decades in many countries leading to legislation on crime related to discriminatory offences against specific groups. Specifically vulnerable populations are now being viewed in terms of risk, harm, vulnerability, their involvement with police / criminal justice and interaction between LE and PH agencies. As with child abuse this is a relatively new area of coordinated attention for LE and PH: and, like the failures in child protection illuminated by a number of harrowing cases, this too has been driven by some gruesome scandals and by high-profile reports outlining reforms. I shall illustrate this for the UK with the Fiona Pilkington case and the report "In Plain Sight".

Fiona Pilkington

In October 2007 Fiona Pilkington drove with her daughter Francecca to a quite spot near Hinckley (Leicestershire): she then set the car on fire and both of them died in the blaze. 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 the 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 their deaths. Francecca, and to a certain extent her brother Anthony who had milder learning difficulties, became targets of abuse from groups of youths who subjected the family home to a campaign of unrelenting torment. The inquest heard in grim detail how gangs of youths, some aged only 10, had effectively laid siege to the Pilkington's house. It was "pelted with stones, while youths smashed bottles outside and jumped into the front hedge. On some weekend nights young people hung outside the house for hours on end, shouting taunts and insults" (quotes are from *The Guardian,* 24 May, 2011). The IPCC / Independent Police Complaints Commission examined the police failure to respond and detailed incidents which the police should have responded to more assertively as when Anthony, aged 13, was threatened with a knife by youngsters. The IPCC concluded that the force did not identify the Pilkington family as vulnerable and at risk which meant there was not a structured and cohesive response.

The IPCC Commissioner stated:

> "Fiona, her mother, her neighbours and MP had all contacted the police to inform them that she had repeated and justifiable concerns about her family's predicament – Yet, no one person gripped these reports and took charge to strategically manage and oversee what should have been a targeted police response – There was nothing in place to ensure the Pilkington family were considered by police as vulnerable or repeat victims, contrary to the force's own strategy. Systems were in place for officers to have linked the catalogue of incidents but these were not well utilised. Police missed several opportunities to take robust action, inadequately investigated criminal allegations on some occasions and failed to record information on their own intelligence system" (IPCC: 2009).

The jury at the inquest concluded that failings by the police – as well as by county and local agencies – had contributed to the deaths and subsequently four officers faced misconduct charges. The Chief Constable stated that the force:

> "– offer our unreserved apologies for whatever extent the force's actions contributed to Fiona's mind-set at the time that she and Francecca died. We acknowledge, as we did following the inquest in 2009, that our actions failed to meet the family's needs and in retrospect we would have done things differently" (*Guardian*: 2011, 25 May).

This harrowing case led to an inquest and because of the police failings an IPCC investigation followed (IPCC: 2009) which, in turn, led to internal misconduct hearings at which four officers were cleared of misconduct. But this – like a number of other cases – was a collective failure of several agencies. Moreover, the case caused broader concern that many forces were neglecting to identify properly "hate crimes" motivated by disability and hence viewed them more as antisocial behaviour with a lower priority. Disability campaigners such as David Congdon, head of campaigns and policy for *Mencap* (the major support agency for the disabled), claims this too frequently happens and has stated, "If similar cases [to the Pilkington one] are to be prevented from happening again this [IPCC] report underlines that police must treat disability hate crime as seriously as racial, religious and homophobic crime". Of importance here is the redefinition of what was earlier the assumed and limited occupational remit of law enforcement under the influence of social movements, legislation and policies to encompass new areas – with a new conceptual vocabulary, e. g. "hate crime" – along with a strong multi-agency involvement. Influential in this process was the report *Hidden in plain sight: Inquiry into disability-related harassment* from the *Equality and Human Rights Commission* (2011). In essence, this argued that the harassment of disabled people had become a serious issue but it was something of a submerged problem due to under-reporting and low public awareness: "A culture of disbelief exists around this issue. For this reason, we describe it as a problem which is 'hidden in plain sight'". The report further maintains that there is a cross-institutional failure of definition, urgency and response

which should be replaced by a culture of recognition, awareness, support and intervention in order to tackle forcefully the harassment and abuse of disabled people. The work of Fineman on the "myth" of autonomy – and on self-reliance and "caretaking relationships" – is of value in this area (Fineman: 2016; Fineman and Greer: 2016).

Sexual abuse of children and young adults

It is clear that former and recent revelations about sexual abuse of the young in certain areas – including residential education, religious institutions and care homes – have brought acute attention to the plight of the victims and to the offences of often high-profile figures (*Guardian*: 2015, 27 November). This is a grim area affecting some of the most vulnerable in society who become victims to close family members, sexual predators, carers in institutions and even to elite members of society in positions of trust. Given their age and vulnerability they sometimes endured the abuse for years, did not know where to turn to and carried the traumatic scars of sexual abuse and / or physical violence into adult life. In recent years the focus has shifted from individual, episodic cases – in the home and private or certain public locations and which remain of major importance – to including groups, institutions and *systemic* abuse and to abusers – priests, politicians, executives, training staff – who were high in the social hierarchy and who have long evaded scrutiny and investigation.

A major insight has revealed the cynical ability of certain adults to skilfully manipulate youngsters to take part in sexual activity even to the extent of grooming them for filming their own abuse. Then given the nature of the offences and the difficulties of getting young people to come forward to make a statement and name their accusers from fear of reprisals the investigations can be prolonged, complex and demanding for the agencies involved (*Guardian*: 2016, 3 May). Within institutions there is the power differential between staff and inmates but externally with elite crimes against the young, there is also the defence wall of privilege and status leading to inquiries and court cases to creating disbelief of the victims, undermining their credibility and testimony, employing stone-walling backed by denial, manipulative media management and drawing on unlimited funds to employ skilful, unscrupulous lawyers. In general the bulk of cases in this category relate to individual cases or a small number of victims and suspects.

However, there have in recent years been a number of major scandals and investigations into widespread child sexual abuse / CSA and child sexual exploitation / CSE in several societies in recent years. In the UK, for instance, there have been "historical cases" of past offences with many victims and multiple offenders at times involving established institutions and members of the elite stretching back to 1945 (*Guardian*: 2015, 5 February). Some cases have, then, been about large-scale, systematic abuse in a particular region, institutional context and / or involving the internet. These mega-cases have changed views on the risks and harm in this category to focus not only on individual cases in homes and private places but also on premeditated group, or individual, abuse of the young on an extensive scale, over a

long period of time and at all levels of society and even across societies. For example, one major, high profile, transnational case involving the internet and child pornography was the "Amsterdam Vice Case" (van Dijk, Hoogewoning and Punch: 2015, 102-103).

NL: Amsterdam Vice Case

Police, social services, mental health services and public officials in City Hall and elsewhere worked closely together in Amsterdam to cope with an unprecedented and demanding situation which brought with it intense public and press attention. This case began when a suspect in the USA was arrested in 2010 for possession of child pornography and through Interpol some of the material was traced to the Netherlands. This subsequently led police and officials to a day-care centre in Amsterdam where "Robert M." was arrested.[27] M., originally from a Baltic country, had been working in day-care centres in Amsterdam and via internet contact as a child-minder. He often took a camera with him to work and was at times alone with babies and toddlers. M. eventually confessed to abusing 83 very young children from the age of several weeks to talking age, while he had also taken photos and filmed the abuse which, with the aid of his Dutch husband, was placed on internet sites. He was found to be in possession of nearly 50,000 photographs and 4,000 movies of a pornographic nature. Especially shocking was the unveiling of extensive global networks of child pornography sites, some run commercially, including – as in this case – babies just a few weeks old being seriously abused and photographed. M. has since been convicted and jailed as has his husband while subsequently there were 43 arrests abroad (Sterling: 2012).

There were around 700 relatives associated with the three establishments in Amsterdam who had to be informed. Parents were asked if they would watch the gruesome material to identify if their child was involved: obviously this was most stressful and some refused. This case caused wide concern among many parents with young children in Amsterdam and elsewhere; involved a broad multi-agency effort with especially the police and the Amsterdam MHS / GGZ supporting the parents; and there was continual communication with the media and the wider public with the Mayor playing a significant role. For in some Continental European and other countries the mayor is not only responsible for the police but takes a key role in coordinating efforts in such high profile cases with wide public unrest. This particular case also fixed the spotlight on the extent of a global network of producers and consumers of gross child pornography.

Locally in Amsterdam it brought attention to the management, recruitment practices, screening and supervision of staff in child care centres: and internationally to sharing data on perpetrators as Robert M. had a previous conviction in Germany but the particular database there was not linked with international

[27] The full surname of a suspect is not published in the Netherlands prior to conviction and even later the person is often still referred to by the capital letter of his or her surname.

sites. Not surprisingly this disturbing case caused some of those working on it to experience psychological and emotional difficulties from having to deal with serious offences against the most vulnerable and defenceless in society and with having to deal with the impact on their relatives. For a key element is the psychological impact of working on such stressful cases for the occupational health of all those involved. Indeed, there was a panel on this case at the 2016 Amsterdam LEPH conference and it was clear that nearly everyone involved – police, prosecutors, mental health staff, prison personnel guarding the suspect, City Hall officials but above all the relatives of the victims – were scarred in some way by this case and some will require long-term support. GGZ personnel, for example, spent several weeks screening hundreds of parents and relatives for symptoms of trauma: it left many of them emotionally shattered according to the head of the GGZ who said he had never encountered such a collective impact on his staff (personal communication). This impact on professionals will be an important thread in some other categories.

Of considerable importance in the inter-agency efforts, for example, can be the role of police "family liaison officers" / FLOs (in UK) who were central in communications with the families in the Amsterdam Vice Case in what many officers saw as the most stressful and moving case they had ever encountered. FLOs are called in the Netherlands "family detectives" and I shall address their functioning below. The Amsterdam Vice Case was one of a number of major cases across societies which raised awareness of sexual abuse of the young occurring within educational, custodial and care institutions where there is both an assumption of a legitimate custodial or a pastoral role along with a professional ethic based on the duty of care.

It was most disturbing, then, that grave revelations have emerged in previous decades and recent years of abuse in residential, sometimes religious, institutions in Ireland, USA, UK, Australia and the Netherlands. Much of this was historical relating in Ireland partly to residential establishments for young, unmarried, pregnant women whose children were taken from them and illicitly given away for adoption. But in some cases it was sexual abuse of the young by the clergy and in the Netherlands involving vulnerable children with a limitation in residential accommodation. The diverse evidence indicates that in some cases the abuse was recurrent if not systemic and was covered up by the church hierarchy. Priests or personnel were moved away to evade investigations and evidence was destroyed as in the mega-case within the Catholic Church exposed by the Boston Globe in 2002 (portrayed in the film *Spotlight*). In all four countries mentioned this has led to inquiries, investigations, court cases and sanctions against members of the clergy.

Another revelation has been the uncovering in Britain of large-scale abuse with many victims and many suspects as in Cleveland, Oxford, Telford and Rotherham. In Rotherham (Yorkshire), for instance, it was thought that some 1,400 children had been abused in the period 1997-2013. A group of males was deliberately focusing on young, vulnerable women who were induced through alcohol and drugs to become involved in systemic abuse and in some cases prostitution. Responding to this large-scale criminal activity with many victims requires a major investment of re-

sources to trace victims, to persuade them to come forward to make a statement, receive support and aid in taking multiple suspects to court. This particular case in Rotherham revealed a range of failures in the local authority, in social agencies and in policing and led to public inquiries and to a number of officials resigning (Jay: 2014; Casey: 2015). But these failures occur in other cases as well leading to wide popular concern about the suspects being allowed to operate for years, of the damaging impact on the young victims and of the recurring failure of the inter-agency cooperation. However, the scandal can lead to significant efforts to reform the agencies involved (*Guardian*: 2018, 26 February).

For yet another mega-case regarding child abuse has been exposed by the relatively new phenomenon in the UK of "historical investigations" which have retrospectively focused on elites and child abuse**.** The contours of such cases is that they are highly complex, absorb considerable resources, attract intense media scrutiny but have major problems of garnering evidence, tracing victims and having reliable witnesses. Such complex and costly investigations may produce little in terms of convictions while having a tendency to spread their scrutiny and to point upwards. For example, the major historical police investigation in Britain into the alleged sexual abuse of young children during several decades was *Operation Yewtree* launched in 2015 which was coordinated by the MPS (London) together with the NSPCC / *National Society for the Protection and Care of Children* and which investigated around "1,400 individuals, including 178 from the broadcasting and entertainment industries and seventy-six politicians" (McLaughlin: 2015). This led to the arrests and convictions of several high-profile people (see *Giving Victims a Voice*: Gray and Watt: 2013). However, it has transpired that Yewtree – and a related operation, "Midland" – conducted by the MPS was seriously flawed indicating the nefarious impact of a media driven moral panic combined with dubious police activity geared largely to the revelations of one main witness who had invented his accusations (*Guardian*: 2019, 4 October).[28]

UK: Savile, Residential Care Establishments

Among the high-profile suspects was the (deceased) iconic and eccentric entertainer and philanthropist Jimmy Savile – who was granted a knighthood and papal knighthood for his charity work – who is now suspected of being a pathological serial abuser and even to have indulged in necrophilia (Davies: 2014). He seemingly used his position in the media and in philanthropy to sexually abuse mostly young girls but also boys, to abuse patients in hospitals, in an approved school (custodial) for girls, in the two secure prisons for inmates with a psychiatric condition (Broadmoor and Rampton) and in care homes including those with inmates with a disability. Somehow he inveigled open access to this broad

[28] Paul Gambaccini was a distinguished broadcaster who was arrested as part of Operation Yewtree but the case was not pursued and he has written of the experience: "He has no faith in the operational competence or ethics of the Metropolitan Police or the CPS / Crown Prosecuting Service. He believes that they have launched a cynical, self-serving witch-hunt of elderly celebrities to deflect attention away from the shoddy way that they have treated genuine victims of heinous sexual abuse" (McLaughlin: 2015).

> range of institutions and enjoyed such a level of trust that he survived rumours and accusations. A joint report by the MPS and NSPCC, for instance, detailed the extensive deviancy of Savile who is alleged to have abused some 450 people including the most vulnerable in society. His victims are estimated in the hundreds: and Savile is but one of several high-profile entertainers said to have abused young girls at BBC studios and other media locations.

This and other scandals led in turn led to the Independent Inquiry into Child Sexual Abuse / IICSA , currently led by Prof. Alexis Jay, which was initially announced by the Home Secretary in 2014 (www.iicsa.org.uk; *BBC News*: 2016a). The Inquiry has launched 14 investigations with some stretching back 60 years: an interim report was issued in 2018 (IICSA: 2018). These inquiries convey major recurrent failures in multi-agency functioning including police failures in not taking victims seriously and in not following up with investigations. They have also turned attention upwards to people of standing and influence who could use their status to evade suspicion and to engage in systemic abuse committed at times by those with a duty of care in institutions (*Daily Mail*: 2015, 20 May). There is convincing evidence in the UK and elsewhere of systemic sexual offences committed over a long period of time and largely against vulnerable youngsters, male and female, in residential institutions – some of them faith based – where the offenders were not outsiders or strangers. Within the Catholic Church, for example, there have been umpteen examples in the USA, UK, Ireland and the Netherlands of systemic sexual abuse and forms of exploitation in residential establishments which were denied and covered up for decades. In recent years, however, there have been investigations, exposure of offences, court cases and convictions. The many victims were frequently vulnerable; the deviance was systemic and the consequences severe; and often multiple supervisory and control agencies failed (IICSA: 2018). It is clear that a number of areas – think of the "MeToo" movement and sexual violence against women (dealt with below) – have become elevated to the status of major societal issues of great concern (Guerra: 2017; Anitha and Lewis: 2018). Here child sexual abuse has moved from largely a domestic offence to an extensive matter affecting many victims in diverse settings and in a systematic way. This places considerable demands on the agencies involved – at times related to a lack of capacity (*Guardian*: 2018, 25 February) – and there have also been some serious institutional failures. But there is also pressure from government and many other sources to learn from the errors and to engage in substantial reform. Sexual abuse of the young is a highly sensitive matter and hence the societal pressure to improve enforcement, prevention and support is powerful. Above all, the central message from this material – and reinforced in positive and supportive statements from diverse sources to improving care for the young – espouses the essential necessity of sound inter-agency cooperation.

Sexual Violence Against Women: Sex Work

Sexual violence, harassment and intimidation of women have become headline issues in the last few years and these have drawn attention to it in the home setting but also to its systemic nature in certain occupations and institutions including the

film industry, modelling, media, sport and education. With regard to the latter there was a report in 2017 that sexual harassment was "at epidemic levels" in UK universities and another conveyed that half of female university students in Australia had been "harassed" (*Guardian*: 2017, 5 March; *BBC News*: 2017, 1 August). Moreover, that scrutiny has also become relevant to LGBT students (Anitha and Lewis: 2018). And increasingly abuse can take place digitally through the social media which, in turn, can lead to physical contact, stalking and public humiliation. This is clearly a global issue and there is wealth of material on it from international organizations, nation states, NGOs, academic research, the media and from voluntary agencies. From all this it is plain that women are likely to be subject to regular abuse in many societies, including the sexual violence we are focussing on here, and in some of them there is low or even no trust at all in the police and few medical facilities to assist those who have been raped or assaulted in some cases at a very young age. A pertinent illustration of this was the abysmal conduct of some officers of the Indian Police regarding several virally publicized cases of gang rape and murder against "westernized" young women in 2012 and later (*New York Times*, 2012; van Dijk, Hoogewoning and Punch: 2015, 72). The police response was unprofessional, callous and blatantly discriminatory.

But probably the same was true to some extent of police and health services in many societies – with prejudiced views and lack of specialist attention – until comparatively recently. Crimes of a sexual nature can take place in homes within families; between people who know each other well; in workplaces and institutions where hierarchical relationships lead to men in positions of power abusing their role to subject women to their predatory conduct; and in situations with strangers including some using extreme sexual violence against women which sometimes is of a serial nature and at times with fatalities. The overwhelming number of sexual abuse cases relates to female victims but there can also be male and transgender victims. The issue here is what role do LE and PH play in this area: what is the police and public health response and in what ways has this changed or is changing? This opens a massive assignment of examining sexual violence against women cross-nationally and examining the past and current record of LE and PH in dealing with it.

This is beyond the remit of this overview and hence I can only make a short scan of the topic. Feminist criminology and the women's movement – including the current MeToo movement – have for some time agitated about sexual violence against women. This and wider societal pressures have led to a greater emphasis in western and some other societies on diversity and gender discrimination leading to commissions, legislation and awareness in occupations and institutions relating to women's rights with sanctions regarding discrimination and abuse. However, there have been resilient failures to address this within the CJS. The police – until recently a largely male occupation – have often been seen to be prejudiced in dealing with such cases; prosecutions were few and frequently failed; and the health response was typically medical and forensic. The response was inadequately geared to female victims while there were few secure refuges for women to escape the abuse.

One might think that matters have improved somewhat in LE but the record of the MPS in London in dealing with female victims of sexual violence in recent years

has been distinctly poor, to say the least (*BBC News*: 2014, 26 April; Williams and Stanko: 2016). Betsy Stanko is an American criminologist who once headed a research based unit within the Corporate Development Department of the MPS (2003-2014) and she and her staff examined that record from the past ten years. The data indicates clearly that women with a mental health condition or learning problems were far less likely to have their cases pursued by the police for a prosecution than women without those characteristics:

> "'Rape of vulnerable women especially those with learning difficulties has been decriminalized', says the former head of research at the country's largest force – Stanko claims that despite a decade of reform the percentage of prosecutions and convictions of rape has remained consistently low, and this is largely because two thirds of rape allegations drop out during the police investigation. The problem is particularly acute for people with vulnerabilities such as mental health issues and learning difficulties for whom the likelihood of getting their cases solved is extremely remote. 'These women face almost unsurmountable obstacles to justice,' Professor Stanko says. 'Their rape is highly unlikely to carry a sanction, and in that sense, it is decriminalised' – Victim vulnerabilities effectively protect suspects from being perceived as credible rapists, says Stanko. Stanko calls for a fundamental change in the way rapes are investigated by the police saying that anything other than a complete change is 'tinkering around the edges'" (Newman: 2014).

Here Stanko not only draws attention to the MPS's abysmal record in dealing with sex crimes against women but details that the vulnerable with some form of disability are doubly disadvantaged in not having their case taken seriously let alone reaching a conviction. This echoes the evidence on vulnerability in other areas dealt with in this overview. There is also a suggested link with government policy with austerity playing a role in the collapse of rape cases in court according to the Shadow Attorney General, Shami Chakrabarti (*Guardian*: 2017, 23 December).

There has, however, been a shift in police policy announcements in recent years among forces in diverse societies. To an extent this is tied to the feminization and civilianization of policing – e.g. with roughly 30% of Dutch officers now being women – and to the impact of the women's movement on legislation and on promoting refuges for women (and their children) to protect them from the violence of a partner or ex-partner. Within recent decades a number of voluntary and professional facilities have been established in many societies including shelters for women, and children in some cases, needing immediate accommodation having fled from an abusive partner. In the Netherlands these shelters are known as *Blijf van mijn lijf* / "Stay off my body" houses (later renamed "Orange Houses") and the first one was already opened in 1974. They are for the immediate social and legal support for women and their children: one for men was opened in 2004. Their location has to be kept secret and about 16,000 people receive assistance annually. Moreover, a significant development has been the establishment of multi-agency arrangements for female victims facing sexual violence. In the UK, for instance, there are *Sexual Assault Referral Centres* / "SARCs" – in the USA "SART´ / *Sexual Assault Response*

Team – with a dedicated team with medical expertise on sexual offences in a multi-disciplinary network which has to balance medical, forensic and social aspects in the long-term interests of the victim. Sexual offences have elements of self-blame, reputational damage, fear of publicity and reprisals as well as the possibility of infection, pregnancy, abortion and long lasting trauma. Also previously – and still in many societies – female victims were often treated with social disdain if not rejection, were not taken seriously by police and, as mentioned, encountered a flawed or no investigation.

In British SARCs, in contrast, the needs and wishes of the victim are central. This is also the case in the Netherlands where the first multi-agency "Centre Sexual Violence" / *Centrum Seksueel Geweld* was set up in 2012 and there are now 16 of them throughout the country giving national 24/7 coverage for victims. The victim is assured that she – in Sweden and elsewhere such centres are now not exclusively for women – is not required to report the assault to the police but that the forensic evidence will be retained if required in the future. Prior to this new network of centres there were hospital clinics for sexual violence which were primarily geared to medical care and with varied relations with the local police conducting the investigation. There was also – as in most societies – a wide reluctance of victims to report the offence for a range of reasons. In this Dutch network of centres there are medical personnel, psychologists and police working together and each victim has a case manager who is their contact person: confidentiality is of the essence.

The driving force behind this Dutch initiative, Dr. Iva Bicanic, stresses how serious such cases are – with acute consequences for victims in a number of ways including suicide – and how important it is that victims come forward quickly for help. Some victims have suffered extreme violence with considerable external and internal injuries. The centres provide not only acute medical treatment along with an examination for evidence but also offer support with coping with the long-term effects of such an assault (Bicanic: 2017). Given the crucial importance of these Dutch centres for victims it is surprising that they are supported primarily not by government but by the voluntary "Victim Support Fund" */ Fonds Slachtofferhulp* meaning their long-term future is not secure.[29] Given the current attention to sexual violence this appears untenable and these Dutch centres should surely be guaranteed by local and central government.

For years there have been all sorts of barriers for victims of sexual abuse to be taken seriously and to receive adequate attention and treatment and such specialized, multi-agency, victim oriented centres are of essential importance and they clearly need to be permanently secure facilities which are widely accessible (Walby: 2018). We also have to recognize that sexual abuse of women is a massive global phenomenon and that in many societies victims are helpless and have nowhere to

[29] There is a voluntary agency, "Victim Support Netherlands" / *Slachtofferhulp Nederland*, mainly for the victims of crimes and road accidents – but also when someone goes missing or following a disaster – and for their families: this is financed by the Ministry of Justice, town councils and the "Fund for Victims" / *Fonds Slachtofferhulp* which finances diverse projects including the one related to sexual violence.

turn to and that the well-resourced and highly protective multi-agency centres to aid victims are located in a handful of western societies and even there are often few and far between. In the Stanford sexual violence case, for instance, the offence occurred on the campus of a major university located in a relatively affluent community yet the city did not have a SART / Sexual Assault Response Team facility meaning the victim had to be taken to a town some forty miles away (Miller: 2018).[30]

Street sex-workers

A largely female group which potentially faces discrimination and violence is formed by street sex-workers some of whom are addicted to drugs. They are easily victimized and can also form a health problem if not using condoms. Major Dutch cities have in recent decades started to make provision for this vulnerable group, partly in response to pressure groups of sex workers. For example, *De Rode Draad* / "The Red Thread" in Amsterdam was an advocacy-support group for sex-workers in the Netherlands already set up in 1985. Some cities had already in the 1990s set up specific locations for street sex workers where they could solicit unhindered and meet their clients in allocated parking bays. There was social and health support available with needle exchange, condoms and methadone: usually there was a caravan with voluntary personnel and / or social workers dispensing warm drinks and advice or just a chat. These schemes were not always successfully sustained indicating that such projects often have a life-cycle that can end in closure for a variety of reasons including violence against sex-workers, robbery of clients, attracting drug-dealing, causing a disturbance for people in the locality with much nightly traffic and police no longer having the capacity to patrol the vicinity. To a degree such schemes reflect the long-standing Dutch tolerance for sex work which led to its legalization in 2010 (Weitzer: 2012).

In the UK, however, proposals in this area remain a highly contentious issue. For instance, a female Assistant Chief Constable, who leads on Prostitution and Exploitation for the NPCC / "National Police Chief's Council" recently proposed treating sex workers more as victims than offenders and allowing them locations to work unhindered as in the Netherlands. But this drew many sharp comments from fellow officers rejecting this position and expounding harshly negative stereotypes of street workers and other groups. These acerbic remarks may not be representative of wider police opinion but they reflect a resilient hostility among some officers, and the right-wing media, to recasting approaches to sex work (Hickey: 2016).

Indeed, there was in the Netherlands a further redefinition in that, despite legalization, organized crime has retained its hold on sex work. In response city ad-

[30] During a fraternity party at the prestigious Stanford University (California) a male student athlete took an intoxicated woman outside and aggressively sexually assaulted her. He was interrupted, identified and the case went to court (*Guardian*: 2016, 6 June). The trial has received massive attention for the victim's moving court statement which has been read millions of times through Buzz Feed: she has since gone public with a book (Miller: 2019; *BBC News*: 2019, 23 September; Punch: 2019).

ministrations, prosecutors and police have used new civil and criminal measures to close down certain establishments and to prosecute suspects for trafficking, slavery, sexual offences and money laundering. Some cases have led to sex workers being freed from effective captivity and to needing treatment for their traumatic experiences. There are sex workers who, in part through their informal "trade union" (*My Red Light*), can articulate well that they engage in sex work of their own free will and view it simply as a legitimate occupation with rules on health, rights and taxation. But there are clearly others, mostly from abroad, who are forced into it, are physically abused and exploited, are made to abort pregnancies and who suffer long-term health effects (Weitzer: 2012). In short, legalization has turned sex work for some into a legitimate occupation but for others they are forced into it through organized crime networks. In the Netherlands there has been a concerted effort – from central and local government and from multiple agencies (police, prosecutions, tax, immigration, health) using a variety of legal powers – to close down establishments, buy up property in so-called "red-light" areas, prosecute offenders and to offer support and health care to those women freed from a form of slavery (Gemeente Amsterdam: 2013).

Hence sex work is often a matter of dispute and this is also the case with domestic violence / DV with the police and authorities often criticized for doing too little. Yet a British woman on a BBC Radio programme recounted that if the police had not immediately removed her from an abusive situation her ex-husband would have killed her and probably her children as well. She said "that officer saved my life": and she praised the professionals and voluntary personnel in the shelter and social services who supported her when she was in a desperate situation. A single case is a drop in the ocean with thousands of women at risk of DV in a range of countries but this does convey what is needed when a mother and her children are in dire danger. And in an accountable, democratic society the individual is important. But if a Home Secretary states that the only task of a police officer is to "cut crime" and that a police officer is not a "social worker" and that leads to police abandoning social roles, then that is potentially making it more difficult to prevent the deaths of women at the hands of abusive partners and to prosecute the offenders.

Indeed, an essential element in a democracy is that accountability is drawn upwards: and that ministers and prime-ministers should be held to account for the consequences. And this includes the personal suffering and societal damage of their policies. "Brexit", for instance, could undermine the rights of women which took decades to achieve:

> "Women in the UK risk losing hard-won equality and human rights protections, including employment rights and funding for women's services, when the UK leaves the EU, according to the Equality and Human Rights Commission (EHCR). In its largest review of women's rights in the UK, the EHRC warns that although the government has promised protections in the Equality Act will continue to apply once the UK leaves the bloc, 'this political commitment is not included' in the European Union (withdrawal) bill – Brexit could mean future equality and human rights protections under the EU are not binding in UK law and that existing ones may be removed. 'Employment rights and funding for women's services

are areas of particular concern,' it states. It recommends that the government should make sure 'there is no regression in the respect, protection and fulfilment of human rights' and that the loss of EU funding 'does not undermine the UK's equality and human rights infrastructure, including the already scarce funding available to specialist services, *such as those that support women survivors of violence and domestic abuse' (Guardian*: 2018, 23 July, emphasis added*).*

Domestic Abuse

Diversely referred to as "domestic violence" , "domestic abuse "or "family violence", it's central focus was and still is abuse of women but increasingly along with males, children and also others in the family network. There is a measure of overlap with the sections on violence against women and child abuse above. With a broad generalization I maintain that both PE and LE were for long relatively reactive institutions: and that private violence against women in particular was widely ignored (Fineman: 1994). This was especially true of LE which was largely focused on visible crime on the streets, public order and on responding to emergency calls from the public. However, both sectors started to look at causes in their respective areas, to explore prevention and to launch preventive efforts (see section on prevention below). In PH it was earlier than in LE as there was an increasing wealth of evidence on causes allied to reducing the rapidly rising costs of highly predictable medical conditions which could be substantially reduced by life-style changes. In LE the shift was aided by trying to solve the problems behind recurring crime patterns in particular locations as well as costly repeat calls from certain homes and families. This was stimulated by the "POP" approach of Goldstein (1979).[31] Moreover, behind the LE shift was increasing evidence through crime and victim analyses that many offences were committed in the home, between family members and people who knew one another; victims were typically the vulnerable ones meaning female partners (but not exclusively), children and the elderly; and while the offences were widespread there was clear evidence of certain social and ethnic groups having higher levels of risk and of cases of DV.

There is a general fear of violence in certain public and private places and at certain times but much evidence points to the family and the home – but to a degree also the workplace and certain institutions – as a significant source of threat, abuse and violence. A parent, for example, can kidnap his or her child and take the child abroad so that the other parent, and any siblings, never sees the child again which is incredibly cruel while causing life-long pain. In 2017, for example, some 288 children in the Netherlands were reported kidnapped and taken abroad by a parent –

[31] There was also the early Minneapolis Domestic Violence Experiment (Sherman and Berk: 1982) which concluded there should be routine arrest of the offender (usually male) to bring down partner victimization. This led to the widespread adoption of this mandatory arrest policy domestically and also abroad: unfortunately the unanticipated consequence was that the policy led to more partner victimization and not less in more violent cases. And Sherman has since stated that the original policy implication is not sound and that mandatory laws are "unwise and should be repealed" (Punch: 2016).

in 70% of the cases by their mother – according to the International Child Abduction Centre (www.dutchnews.nl: 16 May 2018). And it's also a chilling fact that in the relatively pacific Netherlands around 50 children a year are killed at home (with about 80 such cases annually in the UK): and it can happen that a mother is stabbed to death in her home in front of her children by her partner who is the father of the children (van Kleef: 2018). Indeed, Walby (2018) states that:

> "On average, two women a week are killed [in the UK] by a violent partner or ex-partner and domestic violence comprises 18 per cent of all violent crimes, accounting for one in six of all violent incidents reported to the police and a third of all female homicides. Notwithstanding the human and emotional costs, it is estimated that domestic abuse costs public services, such as criminal justice, health, social services and policing, almost £16 billion".

Next to crime figures based on reported and documented crime there are crime surveys which try to bring out the extent of unrecorded crime such as the British Crime Survey (England and Wales). For 2015 / 2016 (March to March) there were responses indicating there were some 1.2 million female victims of domestic abuse and 650,000 male victims with around 750,000 children a year witnessing abuse of whom some became victims. The Office for National Statistics / "ONS" estimated that incidents of domestic abuse "mostly involving violent attacks on women, make up one in ten crimes reported by the police" (*Guardian*: 2016, 8 December).

The British figures are staggering while in the USA the estimate is that about 10 million people annually, mostly female but also male, encounter some form of abuse from a partner. There is a mass of data on this from diverse sources with wide differences across societies while even in the ostensibly enlightened Scandinavian countries (Sweden, Norway, Denmark) it is prevalent (*Today in Sweden*: 2014, 5 March).

DV has also been described as "massive" in Australia with the Australian Institute of Health and Welfare (2018) stating that:

> "Family, domestic and sexual violence is a major health and welfare issue. It occurs across all ages, socioeconomic and demographic groups but mainly affects women and children. Indigenous women, young women and pregnant women are particularly at risk. This report explores the extent, impact and cost of family, domestic and sexual violence in Australia, and looks at what could be done to fill important data gaps.Findings from this report:
>
> - 1 in 5 (1.7 million) women and 1 in 20 (428,000) men have been sexually assaulted and / or threatened since age 15;
> - 1 in 6 (1.6 million) women have experienced physical and / or sexual violence by a cohabiting partner since age;
> - 152,800 women and 560 men were hospitalised in 2014–15 after being assaulted by a spouse or partner;
> - Intimate partner violence causes more illness, disability and deaths than any other risk factor for women aged 25–44".

In contrast to "stranger-danger" forms of violent or non-violent abusive conduct here the victims and the perpetrators are not random; know one another intimately; the location of the offences is mostly private; abuse can continue for years and can even become inter-generational; and access to what is really going on in the collective lives of victims, families and those at risk in private homes is not always easy for LE and PH staff.

In the adversarial relationships of a family in conflict when the abuse becomes known there can be widely discrepant accounts of what is actually taking place while some of the actors in the drama can be highly devious and manipulative which can make it difficult for intervening professionals to decipher precisely what happened and where blame is to be laid or where support is desperately needed. And a seeming settlement can lead to years of social and legal harassment whereby the accused suspect can succeed in making the original victim appear to be an offender and / or not competent to care for the children (*Guardian*: 2015, 28 December).

It is also difficult for many people to comprehend that parents can bring up their children in squalor, filth and neglect and that they somehow can cover it up for years. Also the intensity of emotions in private relationships can lead to drastic and unforeseen violence; on two occasions Dutch police officers went home from work and shot their wives and children dead and then committed suicide; and a British man – whose wife had left him for a woman – followed her into a shop, cut her throat and waited for the police to arrest him. The tensions and complexities within families and intimates can, then, foster a bewildering range of deviant conduct from neglect, years of harassment and to murder.

As with several other categories dealt with elsewhere in this overview the serious coordinated attention to this topic is relatively recent. This is despite the fact that the data on it reveals widespread misuse making it a significant societal issue with major implications for LE and PH. In Britain the HMIC produced four reports – one was entitled *Increasingly everyone's business* (HMIC: 2015b) – on the police response to domestic abuse and it was most critical of that performance (HMIC: 2015c, d, e). That title is rather ironic in that not so long ago it was not the "business" of the police – and certainly not of the HMIC – to take this matter seriously and to promote coordination with other agencies. But then in a follow-up report in 2017 it again conveyed, according to the *Huffington Post* (2017, 27 November), that "How Police Deal with Domestic Violence Makes Very Grim Reading". Indeed, this has been an area of considerable criticism of police performance emanating from official sources, media exposure, voluntary agencies, interest groups (especially for women and children) and from engaged, critical legal groups. Especially influential in the UK have been the *Coordinated Action Against Domestic Abuse* / CAADA, the *National Centre for Domestic Violence*, *Early Intervention Foundation*, *Refuge* and *Women's Aid*. There are equivalent agencies in many other societies.

This is, then, another area of expansion for the LE sector into a previously neglected areas and with a background of criticism about its failure, ineffectiveness and neglect. In the UK DV / domestic violence relates to those above 16 years whereas in other societies, including the Netherlands, it includes other children and

other relatives. Traditionally the matter was defined as abuse between partners (married or otherwise)[32] in the home situation but more recently this has broadened to not necessarily in the home situation as some offences, such as stalking or cyber-abuse, can occur outside of the home, on other premises or via the internet. In the UK it is officially defined as:

> "Domestic violence**:** *'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass psychological, physical, sexual, financial or emotional abuse.'* Controlling behaviour**:** *'A range of acts designed to make a person subordinate and / or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'* Coercive behaviour: *'An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.'* (Home Office, 2013). The definition also encompasses 'honour' based violence, female genital mutilation (FGM) and forced marriage"[33] (www.police-foundation.org.uk).

This is clearly wide-ranging, and even perhaps over ambitious, as it covers a diversity of behaviour -some strongly culturally influenced as with FGM – and in locations, often private homes, that are not readily accessible and in environments that are not always easy to influence. It is, moreover, an area that suggests broad inter-agency cooperation.

For example, abuse of children can be sexual, psychological and physical but also with deprivation of food and lack of proper clothing. Ostensibly, these can be apparent in loss of weight, bruising, cadging food from other children, seeking food in refuge bins, poor school attendance, weak school performance and shabby attire. One might think that this would be evident to GPs, school health services, teachers, sport instructors, fellow pupils, social workers attending the home and neighbours. In practice children can become skilled at cloaking the deviance and institutions – educational, medical, social care and policing – can collectively and individually miss the signals even, when in retrospect, they appear to be glaring (as in the Daniel Pelka case above). Then abused women, as mothers or partners, may remain in an abusive situation for a long time simply because they see no alternative after leaving perhaps regarding income, children's schooling, housing and location. There simply

[32] A 1990s British parliamentary committee defined it as: "Any form of physical, sexual or emotional abuse which takes place within the context of a close relationship. In most cases, the relationship will be between partners (married, cohabiting, or otherwise) or ex-partners – In most cases of domestic violence, the abuser is male and the victim is female. But the following forms of domestic violence are also included in this definition: a male victim abused by a female; a partner or ex-partner of the same sex in a close relationship" (from Crown Prosecution guidelines, 1995).

[33] This *Police Foundation Briefing* (2014) contains extensive references.

may be no DV shelter in the region, no support from social services and little sympathy for their plight from police officers. There may be other inter-personal and psychological reasons why some women remain – perhaps vulnerable in some way – in relationships despite the abuse and these are currently being ventilated within the MeToo debate.

But in the broader perspective of "family" violence and abuse we are clearly dealing with a major societal issue of immense proportions that effects female and male parents or partners, their children and at times some other relatives. There can be physical, sexual, mental, financial, digital and occupational factors involved with various forms of violence, intimidation, starvation, failure to provide adequate clothing and schooling for children, stalking, sexting and exploitation of relatives in near slavery conditions. And at times the offences are fatal and with long-term consequences for the survivors. For instance, there may be no visible bruises following DV but there can be "traumatic brain injury", say from attempted strangulation, leading to behaviour change with diverse negative symptoms but the violent cause remains undetected: and also a failure to assess the behaviour as being related to a crime (Snyder: 2015).

The main issues arising from this topic are threefold. Firstly, there is the need to explore the nature, causes and extent of these phenomena in order to outline factors which can explain it and which can act as warning signals about where such incidents may take place. Secondly, there needs to be coordinated efforts to make all the agencies involved well-tuned to the signals and strongly geared to collective action. And thirdly, there are issues to be resolved about how agencies, especially LE and PH, enter the intimate lives of citizens in their private spaces with sensitivity and skills but which is balanced with effectiveness in outcomes.

For instance, in the UK the hard learning experience in this area has fostered a number of initiatives.[34] And the British police performance in this area was reviewed by the HMIC (2015a) a year after the initial 2014 *Increasingly everyone's business* report. The measures include:

- Specialized courts geared to this highly complex topic: the *Specialist Domestic Violence Courts* / SDVCs were set up in 2006 and there are now over 150 of them;
- To better coordinate inter-agency efforts there are now some 260 "MARACs": *Multi-Agency Risk Assessment Conference* (also for child protection);
- *Independent Domestic Violence Advisors* / DVAs provide support for victims and function as a link with the MARACs while there influence can help to prevent victims withdrawing from the process which is a constant issue relating to reporting and then resilience in pursuing the case despite all sorts of emotional and practical hurdles;
- In LE and PH the *Domestic Abuse, Stalking and Honour Based Violence* / "DASH" screening model for "Risk Identification, Assessment and Management" was widely implemented including in all UK police services from 2009;

[34]Primarily for England, Wales and Northern Ireland as Scotland has similar initiatives but within a different regulatory and judicial system.

- There are also a number of restraining orders under civil law which people under threat can apply for directly including a non-molestation one and one to keep the potential offender who might pose a threat away from a specified area.

This is an area where – during several decades – a social movement, voluntary agencies, media exposure of scandals, public and private reports, political support and legislative efforts have made a significant difference in several western societies. This has led to a range of multi-agency practices to help tackle the issue of domestic violence / abuse. But having outlined these positive developments it has to be said that there have been some disturbing failures in recent years in the UK policing in this area which helped to foster improvements but it remains a contentious matter (HMIC: 2014). Above all the data reveals across societies that the scale of the problem is palpably immense: and unlike other crimes, many of which are declining, it is mostly either stable or increasing (probably due to a rising willingness to report it). These improvements in western societies are of little solace though to the many victims – female, male and the young – who in other societies face systemic abuse which is culturally justified and where there is almost no social and legal support for the victims.

There is clearly a wide gulf between attitudes and initiatives in this area between certain western societies and some other societies including some Low Income Countries / "LICs" but the guiding values – as with human rights – are based on the fundamental principles espoused by the major international NGOs and in HR legislation. As with other areas there is a mass of evidence and continual debate on this complex and resilient matter with many initiatives across societies and it is not a question of one particular country serving as the paradigmatic case but of learning from cross-cultural experience.

Vulnerable Adults

Plainly there has been throughout this work a strong emphasis on *vulnerability* and on vulnerable populations. Indeed, the Vice-President of the Police Superintendents' Association (England and Wales) has stated that "Protecting vulnerable people is the new 'volume demand' in policing" (Thomas: (2016). One category is certain adults including the elderly with one or more specific type of vulnerability. One sees here both the recognition of the problem area and subsequently the need to address it with specialist, cross-agency attention. For example, the West Midlands Police (centred in Birmingham) has established a specialized *Vulnerable Adults Unit* which is geared to aiding those adults who are frail, disabled and vulnerable and are defined as "in need of care services due to mental, physical or learning disability, age or illness and is unable to take care of themselves or protect themselves against harm or exploitation" (from https://www.west-midlands.police.uk). Such adults are especially vulnerable to financial exploitation and / or physical abuse and can become harassed or victimized in the home situation, within the community or in care institutions. As with some other categories this brings the focus of LE within the intimate and often closed world of the home and the family where it is a sad matter

that the highly vulnerable victim may experience persistent abuse and even fatal violence. This leads, then, to critically examining "accidents" and sudden deaths in the home for possible criminal offences which is a highly sensitive matter which can cause much consternation within the family especially if there is no subsequent conviction. For example, in one year (2014), the West Midlands *Vulnerable Adults* team investigated 56 deaths "to determine whether neglect played a part and has also followed up referrals from local authorities ranging from general care concerns to allegations of medication blunders" (https://www.west-midlands.police.uk/ 18 May 2015).

Trafficking, slavery, FGM

The enforced movement of populations from war zones, legal and illegal immigration from many societies during previous decades and more recently refugees fleeing conflicts as well as poverty and lack of opportunity, have altered many western countries into multi-cultural societies. There were subsequently major challenges to social institutions being forced to adjust in what were largely mono-cultural societies. London, for instance, now has some 270 nationalities; over two thirds of the inhabitants of Brussels are registered as of foreign origin; Amsterdam houses some 180 nationalities and 45% of its population is of ethnic origin; and in New York 36% of the population is classified as foreign born. In consequence many countries and major cities now have inhabitants who are widely diverse regarding ethnicity, religion, culture and social values. To varying degrees these newcomers have settled and integrated in positive ways but some can bring customs and practices which do not fit with the cultural, health and legal norms in the host countries.

Female genital mutilation / FGM, for example, is practised in certain countries in relation to religious and cultural values but is considered abhorrent in western societies. Prohibition of the practice has taken place in North America, Europe, Australia and New Zealand: it was already outlawed in the UK in 1985 but the original act was replaced by the *Prohibition of Female Genital Mutilation Act* (2003) although enforcement has only been taken seriously in recent years and then with few cases and convictions given the private nature of the practice and reluctance of the victim to report it.[35] Moreover, in some ethnic communities perceived misbehaviour by young women can be sanctioned by their parents, relatives or siblings with physical violence, maiming or even death. The chastisement is socially unacceptable in most host societies while the related offences are treated as serious crimes.

Moreover, it is also the case that along with patterns of migration and immigration that ease of travel and porous borders have long presented opportunities to transnational organized crime, at times assisted by lax controls and corrupt officials in certain states, for drug trafficking, people smuggling, slavery and prostitution (Allum and Gilmour: 2011; Ellis: 2016). The import and manufacture of illegal and counterfeit drugs in particular have brought immense health problems to many societies as well as challenging enforcement issues (*The Crime Report*: 2016, 16 November).

[35] There was similar legislation in Scotland taking into account its separate judicial system.

In turn these movements of population – and the accompanying shifting crime patterns – confront western societies with demanding law enforcement challenges as well as certain health issues. Some of those illegally trafficked – including women for enforced sex work – can face psychological and physical health damage and long-term care needs if they are taken out of slavery conditions. Others who are effectively treated as slaves over a long period of time – as in domestic services, agriculture, hotels and restaurants – may have been recruited in other societies including Asia, Africa and Eastern Europe and on being rescued may also require extensive health care in cases of physical and psychological damage. But they may also face legal issues regarding their residence status so that enforcement and prosecution practices have to adjust to their victim status and subsequent health issues.

In response to the pressures on PH and LE arising from legal and illegal migration and from the negative impact of certain domestic and international crime patterns, it is necessary that the institutions and personnel of both PH and LE adjust to the ethnic and cultural aspects of having clients, victims and suspects of crimes among those they encounter. There has to be an understanding of the backgrounds of diverse ethnic groups; information for them in several languages; reliable translators in health and legal facilities; knowledge of health issues in diverse societies and appreciation of how newcomers view and treat medication and health care. And further an awareness is needed of legal systems and crime patterns in certain other societies where transnational organized crime plays a significant role in criminal activity that brings illegal products and trafficked migrants to other parts of the worlds.

Chapter 4. Disasters, Trauma, Teams, Prevention

Disasters and Emergencies

A major area for the LEPH field is the multi-agency response to disasters, civil emergencies, epidemics and terrorist attacks often with many casualties, much damage and / or risk to health and intense, immediate pressure on many agencies and even governments in national or international crisis response mode. It is clear that PH and LE personnel have to work closely together in such emergency situations and are usually well prepared for them through joint exercises, simulations and planning. Typically there are extensive manuals for crisis situations along with a sense that those involved may have to face one they had not anticipated and will need to react flexibly. For instance, there are plane and train crashes, accidents or emergencies with ships at sea, industrial accidents (perhaps with explosions, dangerous fumes, radiation, pollution), terrorist attacks with explosives and high casualties, storms, flooding, disasters at sport events and major emergencies with prominent health hazards including epidemics. Some of these categories involve considerable danger, high casualties and widespread dislocation over a period of time such as mass evacuations, loss of power, disruption of transport and economic activity and major health risks.

For example, although there was no loss of life in the flooding in the Netherlands in 1995 it led to the mass evacuation of around 500,000 people with attendant health and security concerns putting high pressure on personnel, resources and facilities in PH and LE agencies, as well as many other services, due to the huge scale of the operation. In general most western societies and many other societies have learned to deal with such emergencies and have set up well defined protocols for the many agencies that can become involved including the military, NGOs, police, medical and health agencies, voluntary agencies and churches. At times there may be national direction from government from within the central crisis centre for calamities, natural disasters and conflicts abroad.[36]

In the UK the police play a central role as they have "primacy" in coordinating the emergency response to disasters and emergencies while in other societies the lead agency is the Fire and Rescue Service or a separate national emergency response unit such as the Federal Emergency Management Agency / FEMA in the USA.

[36] In the UK this is "COBRA" – the Cabinet Office Briefing Room in Whitehall – comprising government ministers, often the Prime Minister, senior officials and military and emergency services and it coordinates information and the response at the governmental level. In the Netherlands the government's "war room" is located within the Ministry of Justice in The Hague and it is where the leading ministers and officials of the "National Core Team Crisis Communication" / *Nationaal Kernteam Crisiscommunicatie* meet in relation to national emergencies and international crises: there is also a crisis centre in the Ministry of Defence for emergencies with a potential for armed conflict or in relation to humanitarian missions with a hazardous or immediate repatriation component: this was in operation during the MH17 crisis in the Ukraine.

The police often have multiple roles with regard to site protection, traffic control, evacuation, and forensic work at the scene, identification of victims and possible criminal investigations. In some major accidents and industrial explosions, for instance, there may an issue of corporate negligence leading to gathering evidence to prosecute a company and / or its executives for manslaughter or other violations regarding Health and Safety. The UK has faced a range of disasters in recent decades, a long period of terrorist threats during the "Troubles" related to the Northern Ireland situation (1967-1997) and several radical jihadist terrorist attacks including the London bombings of 2005 with 52 deaths and over 700 wounded.[37] Then in 2017 an entire 22 storey block of flats, Grenfell Tower in central London, was engulfed in flames with 72 fatalities and over 200 people escaping. With some 250 fire officers and 100 ambulance personnel attending this was one of the major fires in recent decades and the worst in fatalities since WWII. Some 600 people were made homeless and many agencies, public and voluntary, have been involved in dealing with the aftermath with regard to investigations but also to the multiple needs of the homeless families. When people have lost everything in a life-threatening event then the families and individuals need an immediate support arrangement including accommodation, financial support, new documents (passports, driving licences, birth certificates, etc.), clothes, bank and credit cards, computers and in some cases new schools for children moved to temporary accommodation: and funeral services for the deceased.

All this typically involves a bevy of organizations and agencies along with the close involvement of all the emergency services but especially those from LE and PH as well as highly important voluntary agencies and sometimes spontaneously arranged self-help groups. The ambivalence of "LE" in the wider sense of the control agencies network may mean that such a catastrophe also unearths a number of illegal aliens, people wanted by the police for a criminal offence, illicit occupants or those with tax arrears or unpaid debts.

There is, however, the possibility that alongside the professionalism and heroism of some emergency services personnel there will be civil and / or criminal action be taken against agencies and individuals which were held to have failed during the emergency response to a major incident. For instance, there was the Hillsborough (Yorkshire) Stadium Disaster in 1989 when 96 people died in a crush due to overcrowding at a football match (Scraton: 2016). Since then there has been recurring press coverage about what went wrong along with a number of official inquiries, two inquests, several prosecutions and diverse books as well as investigatory newspaper and television programmes. A turning-point came in recognizing this unrelenting effort when the Labour Government in 2009 allowed a new inquiry and the

[37] During some 30 years there was a grave security situation in the UK – especially in Northern Ireland – regarding a conflict between "nationalist" armed groups (predominantly Catholic) seeking reunification with the Republic of Ireland and the security forces (military and the Royal Ulster Constabulary) along with "loyalist" armed groups (predominantly Protestant) seeking to maintain Northern Ireland within the UK. There were shootings, bombings and assassinations within the UK, Republic of Ireland and on the Continent until the "Good Friday Agreement" of 1998 which ended the conflict for all but a few dissidents (Punch: 2012).

Hillsborough Independent Panel Report was published in 2012. It exposed multiple failures before and during the event and stated: "as a result, rescue and recovery efforts were affected by lack of leadership, coordination, prioritisation of casualties and equipment". It estimates that possibly some 40 wounded could have been saved if proper procedures had been immediately followed. Hillsborough is, then, the prime example of a disaster that harshly exposed the police, and others, regarding deficiencies in the main institutional actors such as the South Yorkshire Police, the Ambulance Service, the Football Association and the Sheffield United Club owners which collectively did not heed warnings and did not keep to guidelines. The case especially reveals that the trail of a disaster can extend for many years and can haunt the reputation of institutions and individuals some of whom are being prosecuted for a second time.

In short, responding to major incidents and getting it wrong can lead to serious consequences for those involved meaning those who engage in multi-agency arrangements have to think accountability and liability in case things go wrong and LE and PH personnel are held to account in tribunals, the media, inquests and courts.

There is also the issue of responding to mega-disasters – such as the tropical storm *Katrina* which hit New Orleans and surrounding areas (2005) and the utterly devastating Asian Tsunami (2004) – which will require the mobilization of many national and regional agencies including some from abroad to assist the efforts. Katrina was one of the worst storms ever in the USA and it caused immense damage and disruption to New Orleans, other parts of Louisiana and some other states and it led to the deaths of an estimated 1,245 people although some sources put the toll at over 1,800. This was overshadowed by the victims of the Asian Tsunami which are said to have reached around 280,000 fatalities and there was simply horrific destruction mainly in India, Indonesia, Malaysia, Myanmar, Sri Lanka, Thailand, Bangladesh, Japan, Kenya and Tanzania. Next to local officials there can be LE and PH personnel from a range of other countries in a programme of aid and reconstruction in response to disasters (Jones: 2018). Overseas aid and expertise was essential in the effected countries in the aftermath of the Tsunami regarding recovery, aiding survivors, identifying the dead, combatting health hazards and rebuilding communities. Dutch forensic police officers not only assisted in the identification of victims but also developed techniques of streamlining the identification process which they applied subsequently in other disasters including in the aftermath of the shooting down of MH17 and which were widely adopted by other forensic personnel.

Some regions in certain societies are prone to tropical storms, flooding or earthquakes and periodically face such devastating mega-disasters: 2017 and 2019 in particular were appalling years for natural disasters impacting on many countries. Becoming involved in the aid and reconstruction process is always a learning experience for domestic LE and PH personnel but this also holds true for help missions abroad. Some who have experienced responding to a disaster and whom may become experts on standby for foreign mission. They may have been on several UN led or other missions, have developed expertise in dealing with large-sale relief and have learned to work together in ad hoc international teams in the most challenging of circumstances.

Trauma and related health issues

An important feature of this field is that the personnel in both LE and PH may themselves develop health problems as a result of their work given the risk and stress factors in some features of their work. This is a wider issue within emergency and social care services where personnel have to learn in their occupational socialization to develop coping mechanisms to deal with the sometimes harrowing aspects they encounter. They can face stress from dealing with macro incidents including mass shootings, large fires, serious road accidents, disasters and dealing with the flood of refugees into Southern Europe which is a major humanitarian crisis with sometimes boats capsizing, many people drowning and children separated from their parents (Hansson: 2017): or at the micro level of a single, small-scale case that nevertheless has a powerful impact (Warner: 2015). For example, several prison staff, who presumably had become professionally hardened by the harsh realities of custodial work, nevertheless reported ill after entering the cell where someone in custody had been horrifically cannibalized by the other occupant (Edwards: 2002). Then regarding major incidents with high casualties, there was following the Hillsborough Stadium Disaster – with 96 mostly young people crushed during a football match – a number of officers with long experience, and until then seemingly able to deal with gruesome incidents, reporting symptoms of PTSD weeks or months after the event. At yet another level of prolonged conflict with many incidents and casualties, as during the 30 years of The Troubles in Northern Ireland (mentioned above), British security and other emergency services faced constant danger; no less than 300 police officers of the RUC / Royal Ulster Constabulary were killed and some 9000 were injured with many requiring prolonged health, psychological and social support. And certain hospitals in Northern Ireland became at times like a front-line casualty clearing station in a war zone (Punch: 2012; Ryder: 2000).

One can also imagine the stress experienced by the police and medical personnel who went into the Bataclan theatre in Paris in 2015 when radical jihadist terrorists had caused a blood bath with gunfire and grenades leaving 58 dead and many wounded (Ayed: 2015).[38] Then in Las Vegas in 2017 a gunman shooting from the Mandalay Bay Hotel killed 89 concert goers while over 800 were wounded in the worst mass shooting in the history of the USA; in Norway there was the horrific mass shooting with Breivik killing 69 mostly young people on a small island in 2011 (Seierstad: 2015); and in London in 2017 at the Grenfell Tower conflagration the emergency workers, primarily from the Fire Service, were rescuing people in intense heat,

[38] (Ayed: 2015) is an account of Patrick Pelloux, an emergency response doctor, who attended the Charlie Hebdo killings – he also contributed to the satirical magazine so the victims were also his colleagues – and was one of the first on the scene of the November 2015 Paris attacks. He says that hospitals and doctors have to be ready for battle-field injuries: "People were attacked with weapons of war – they were riddled with bullets, and terrorists blew themselves up in order to kill more people. They put bolts and pieces of metal in their [bomb] jackets to hurt as many people as possible". He also discusses trauma and the psychological aftermath of attending such incidents which long affect those involved in emergency response: and he feels that "We're at war, and I'm a medical soldier".

with just one staircase and the possibility of being engulfed through the collapse of the building.[39] Many were drained and distraught at not being able to rescue more people. Indeed, despite the first responders heroic efforts the Fire Service has since been heavily critized for telling people to stay in their apartments and not evacuating them earlier (*Grenfell Tower Inquiry*: 2019; *Guardian*: 2019 a & b, 30 October).

The ultimate scenario is, of course, "nine eleven' in the USA in 2001 which was like a war situation with four planes hijacked by terrorists attacking targets in a suicide mission: there were some 3000 fatalities including around 300 fire-fighters at the Twin Towers in New York. This must have led to some serious psychological problems among emergency personnel and those in LE and PH who were involved. But it is unpredictable as to who is likely to be effected by what sort, and scale, of incident and at one length of time after the event (Jones: 2018). For trauma and other forms of stress can go unrecognized for some time, appear long after the event, be triggered by seemingly minor incidents and can affect people who seem the least likely to suffer from such after effects.[40]

I shall not go into this topic in detail as my prime focus is on victims and people at risk, but it is a vital feature arising from our field. It must be stressful for all professionals involved in cases of a very young child murdered within a family; or at a plane disaster when bodies and body parts of the many victims have to be recovered from a wide area and brought to identification; or at the 2005 London terror attacks on public transport when the emergency services were confronted with three explosions on underground trains and on a bus with many fatalities and appalling injuries and having to work in the most trying of conditions amid wreckage in narrow tunnels (Punch: 2011; Zimonjic: 2008). An additional factor is that some social care and PH personnel, but especially police officers, are at risk of violence arising from their work. And there are claims in some societies, including the Netherlands, that the levels and frequency of aggression are rising while some incidents involve fatalities of professionals responding to incidents. In the USA, for instance, a substantial number of police deaths and injuries occur when responding to domestic disputes: and as mentioned earlier in cases with the mentally ill.[41]

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[39] "It is likely that the horrors of the Grenfell Tower blaze will linger in the minds of the fire-fighters for years to come. 'Before they went off duty, they were all spoken to individually by a counsellor and they've all had follow-up phone calls. When they are back on duty next week they will have access to a counsellor, and my own in-house counselling team is being reinforced by officer support from the NHS and other fire and rescue services – there are a lot of people who need a lot of help'": senior fire officer on the night of the Grenfell blaze (*Guardian*: 2017, 17 June).

[40] Some officers who have at close range faced fatalities from serious burns report that the smell haunts them or that they find barbeques upsetting: by coincidence two near identical descriptions of this reaction appeared in a Dutch and a UK source on the same day (*Policing Insight*: 2018, 24 April; *NRC*: 2018, 24 April).

[41] In a US report of the "National Law Enforcement Officers Memorial Fund" (2016) it was stated that some 20% of the 132 officers killed when answering calls in the period 2010-2014 had died responding to a domestic dispute (Sport: 2017). Protective orders that an offender should not approach his former partner and not own a firearm were poorly enforced and in

The violence can, then, be in people's homes but also in street encounters, PH offices, prisons and custodial mental health institutions and in A&E wards. A specific area that receives little attention is violence against psychiatric staff. In the Netherlands there was recent concern about the rising number of incidents while many aggressive encounters were not reported, victims were poorly instructed on how to respond, and only a few incidents led to a police intervention and even less to a criminal trial. This resulted in the setting up of a Dutch "Violence in Clinical Psychiatry" work-group to examine the issue and offer advice to victims and other staff.[42]

There are diverse accounts that in the past this topic of stress and trauma was not fully faced in emergency services. Moreover, with tight fiscal regimes in some countries in recent years there can be internal occupational tribunals with legal disputes about levels of suffering and incapacitation in relation to claims about extended sick leave, early retirement and compensation as the costs involved for the organization can be high. There can even be prolonged and bitter disputes over such claims with the victim feeling a lack of recognition from her or his own organization (van Vliet: 2018).[43]

However, to a certain extent many LE and PH institutions and caring professions have become aware of stress and trauma among personnel and are increasingly geared to training, prevention and treatment. For instance, in one British police force there is "Trauma Risk Management" / TRiM and the TRiM "Counselling and Wellbeing Manager" states:

> "Good supervision and leadership is the key. It is important that officers and staff have their experiences acknowledged with the all-important check-in. Hopefully, if you are a police employee reading this, you are in a service that provides support for situations such as this. In the police service I work for, they have TRiM (Trauma Risk Management) which is a peer-based risk management process which captures officers and staff who are vulnerable for developing longer term mental health issues and ensuring they receive psychological support, such as counselling, to get them back on track. Predominantly, however, TRiM encourages peer support and provides gentle psycho education that enables officers and staff to feel reassured that what they are experiencing is normal" (*Policing Insight*: 2018, 24 April).

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most cases the officer, and sometimes also the offender's former partner, were killed with the firearm of the revengeful abuser.

[42] At the 2014 LEPH Conference in Amsterdam there was a session on "Violence against care workers in psychiatry" with sessions by M. van Leeuwen (researcher and senior psychiatric nurse at Inforsa, Arkin); J. Harte (Associate Professor, Free University Amsterdam) and J. Drapers (medical board, Amsterdam Medical Centre / AMC).

[43] The Dutch Police Union / NPB – the main police union – has detailed cases where people with the symptoms and diagnosis of PTSD have to battle with the organization about the employment consequences of the condition which leads to those affected having the dual burden of dealing with the personal consequences of the condition while also facing a doubting and even callous response from the organization they felt committed to for many years (van Vliet: 2018).

In that particular force there are "Counselling and Well-being" staff to support those in need and a website accessible to police staff anywhere, *Mind's Blue Light helpline*.

There are, then, internal and external support possibilities and these include trade unions, voluntary agencies, call centres and web-sites. There are benevolent associations in diverse societies which assist police victims of violence and / or trauma as well as their families with care and financial support if an officer dies or is invalided out of the organization. One example is the British "Police Dependants' Trust" (a charity relying on donations) which provides financial and welfare support to officers suffering from the physical or psychological effects of events and experiences occurred during their work as well as support to the families of officers killed on duty. It tackles many cases related to stress, anxiety, depression and PTSD to an extent arising from the legacy of "The Troubles" with former members of the RUC recovering from trauma (Scott-Moore: 2016).[44]

PTSD / diagnosis and treatment (Netherlands)

A major shift in recent years is the recognition of work-related psychological suffering as being as significant as physical injury while in some cases it can be more debilitating than physical injury. There was, for instance, the early professional and academic expertise of psychiatric staff at the AMC / Amsterdam Medical Centre gleaned from several decades of work in a range of countries who became specialized in trauma among war survivors, emergency workers following domestic disasters, refugees and asylum seekers – some from countries in conflict (Gersons and Olff: 2005). Then societies that have had military engaged in armed conflicts abroad or peace-keeping missions that have involved violence – including personnel from the USA, UK, the Netherlands and a range of other countries – can expect a number of veterans with stress-related disorders. In Northern Ireland alone there were some 100 army veterans who had attempted suicide and were being helped by a charity (*BBC News*: 2016, 16 October).

In the Netherlands a socially engaged group of Dutch university based psychiatrists – along with colleagues from other countries – examined the initially neglected area of volunteer personnel in NGOs in conflict zones. They worked closely with the Dutch section of *Médicins Sans Frontières – Artsen Zonder Grenzen / AZG* in the Netherlands[45] – to examine stress, risk and trauma among personnel following humanitarian missions as with major calamities, refugee crises and mass starvation (Scholte: 2013.[46] Their knowledge and experience of dealing with the psychological consequences of emergency services work domestically and abroad was instrumen-

[44] Gill Scott-Moore is CEO of the Police Dependants' Trust.

[45] This is "Doctors without Borders" in the UK. The entire organization employs over 3,500 personnel operating in some 70 countries.

[46] Scholte is a (retired) psychiatrist and academic who set up the *Equator Foundation* for the psychiatric treatment of traumatised refugees and victims of trafficking. He had long experience in post-conflict countries including Kashmir, Afghanistan, Sri Lanka, Congo, Rwanda, Darfur and Sierra Leone. He was on the board of AZG for some 10 years.

tal in setting up the specialized Dutch "Psycho-trauma Diagnostic Centre" / *Psychotrauma Diagnose Centrum* where members of the emergency services and combat veterans can be assessed.

> The Diagnostic Centre started work in 1997 and was initially only for police officers but it has expanded its scope to cover other emergency occupations (including Accident and Emergency, Fire and Rescue and Mental Health staff) as well as certain other groups such as WWII and Holocaust survivors. The Centre's main purpose is diagnosis, but also advice, and depending on the centre's assessment the client can proceed to suitable treatment. For example, around 230 police officers are assessed annually each year for stress-related trauma symptoms and in many cases the Centre's report is leads an appropriate solution or settlement. It endeavours to work from an evidence base of academic research which also feeds into courses for practitioners on prevention and recovery. The value of the diagnostic Centre is that it is completely independent and its assessments are seen as highly reliable which can lead to the individual involved receiving appropriate treatment, returning to a suitable role within the organization or some form of settlement. It does, however, remain difficult for some to return to their previous position and they may require a different placing within the organization (NRC: 2017, 24 April). A mutually agreed settlement also saves money that might be spent on legal battles or on prolonged pay-outs given that long term illness is a major financial burden for emergency services.
>
> But there are also some bitterly disputed cases where the symptoms are not accepted by the police organization's own "Contact Point for Post-Traumatic Stress Syndrome" (the Dutch refer to *PTSS* as opposed *to PTSD*). The Dutch Police Union / *Nederlandse Politiebond* (NPB) has documented this issue with a number of prominent cases of refusal to accept the symptoms in relation to granting prolonged sick-leave, compensation and early illness related pensions. Some officers who report sick on grounds of PTSD report that they can feel abandoned by former colleagues and senior personnel; face disbelief, discrediting and even ignorance about their condition; and encounter long delays in officials responding to their needs – social, financial and health related – leading to alienation from the organization.[47] This can exacerbate their condition. The NPB argues that this is related to a distant management culture based on financial stringency and with pressure on the functionaries involved to reduce expensive settlements: "Time and time again it seems that the force, to our dismay, tries every legal trick in the book to avoid yet another PTSD diagnosis" (van Vliet: 2018, 9).[48]

In short, although my main focus is on victims, the vulnerable and people at risk in relation to the functioning of LE and PH agencies, this area also takes into account

[47] Some vetting officials clearly thought that PTSD could not be triggered by a seemingly minor incident when that incident could be the reaction to a culmination of exposure to former stressful cases.

[48] There are several Dutch police unions but the *Nederlandse Politiebond* is the largest with 25,000 members.

the occupational related health and care issues of working in the LEPH area – at home and abroad – along with some other related care occupations and groups such as social workers as well as military veterans. Moreover, there is now an increasingly strong academic and practical basis on tackling the issues raised in this area and on supporting those suffering from the negative effects of their stressful profession.

Crossing boundaries: "Family liaison officers" and "forensic nurses"

While much of what I have presented conveys the cooperation between LE and PH as separate institutions in structure, culture and identity, there are also examples of dual roles which see professionals crossing previously tighter occupational boundaries. And one can see this as an inherent consequence of that intermeshing at the institutions level leading to hybrid functions and roles. For example, in the relationship between the police and victims and / or relatives of victims with regard to a criminal offence or a calamity there are in British police forces – and in many forces in other countries – specialized officers who function as "family liaison officers" or "FLOs". In the Netherlands they are known as "family detectives" because they are all detectives with an explicit forensic role and training for this task. In UK police forces, in contrast, the FLOs generally have primarily a social function and do not usually perform forensic or investigative tasks. They also usually only work part-time in that role when needed and next to their regular job: and the role is often not a permanent assignment. In the Netherlands they also function part-time in that task; but it is almost inevitable that they can sometimes also end up in a social support role rather than a clearly defined forensic function.

MH17 and Dutch "family detectives"

Following the MH 17 plane crash case as a result of a rocket attack in the Ukraine (2014), the number of family members effected was so great – there were 196 Dutch victims – that the Dutch Victim Support Agency could not readily mobilize its largely voluntary personnel who normally take on the pastoral, support role in such cases. Exceptionally in the MH17 case the family detectives became the main initial contact between the investigatory and other authorities and the family members of the victims. Although their role was primarily being a conduit for information to the families and for collecting evidence from the families related to identification of their deceased relatives, it is clear that they played an important social role as the immediate support presence for relatives given the extended process of investigation and identification (Meulenbroek and Poley: 2015). Hence they were freed to do this full-time (Punch, Hoogewoning and van Dijk: 2017). They played an important social role over a period of time and had to coordinate with Victim Support, local authorities, educational institutions, churches, sports clubs, banks and housing agencies in relation to helping the relatives with arranging matters arising from the victim's death. When the victim's remains started to be flown back to the Netherlands the officers sometimes drove family members to the airport where the military planes with coffins were to land as some relatives were too distressed to drive themselves. There was wide satisfaction expressed by relatives for the work of these family detectives:

and also for others in support roles and for those involved in the recovery operation. One relative stated:

> "On 17th July 2014 my life changed as it did for many with me. At a stroke I lost through the crash with the MH17 my dear, life-loving parents – My life was suddenly turned upside down. The extended and complex aftermath was intensive and exhausting. What exactly would I get back of my parents and when? Many people that I had never known before suddenly started to play an important role in our life. Day in and day out they tried with heart and soul to bring the victims back. What an incredible bunch of people. They have meant such a great deal to us – I'm eternally grateful to them" (Meulenbroek and Poley: 2015, 13).[49]

This particular case also shows that in exceptional circumstances it is difficult to define roles precisely in certain sensitive areas even if policy specifies that personnel should strictly confine themselves to defined roles and tasks. This further implies a measure of role and skills flexibility in the officers concerned with such delicate assignments which are of great importance to the families of victims at a most vulnerable moment. The sometimes ambivalent but often vital work of FLOs / family detectives deserves further research as it often goes unrecognized while it illustrates that police in some cases – and explicitly in the UK – take on what might be considered typical PH or voluntary agency tasks.

Forensic nurses

In certain medical facilities – A&E in hospitals or specialist clinics – there can be a duality as with forensic nursing staff specialized in dealing with sexual violence against women. There are even some US states which have laws requiring that sexual assault victims be treated by "Sexual Assault Nurse Examiners" who are specially trained to see a victim as a "portable crime scene" as well as a patient. The headline of an article on this was, "Training gives nurses role in *fighting crime*" (Byers: 2015, my emphasis): this does raise the issue as to how far the medical profession should go in "fighting crime". One such registered nurse dealt with a sexual assault survivor who had fought of her assailant including using her nails which she later bandaged: the nurse "gathered Band-Aids from Reynold's fingers along with fingernail clippings to preserve DNA and hopefully catch" the woman's attacker. About a year after the assault he was apprehended through that DNA evidence and given a heavy prison sentence (Byers: 2015). The forensic nurses' duties were to conduct an interview of

[49] This book entitled *MH17-The Voyage Home* / *MH17-De thuisreis* is based on interviews with relatives of the victims and members of the recovery, forensic and family support teams. The Dutch police magazine *Blauw* / Blue (29 November 2014) has an extensive reconstruction of the MH17 project with quotes from leading players in the LTFO – Het *Landelijk Team Forensische Opsporing* / National Team Forensic Investigations (for forensic work and victim identification): the article covers various operational elements of the project as well as communications and relations with the families. There was a session on the MH17 case at the 2016 LEPH Conference in Amsterdam and presenting on the panel was the officer responsible nationally for family detectives.

the victim alongside police and an advocate; collect potential evidence, including clothing and swabs of areas on the victim's body; and testify in court about the evidence collected.

There were other medical professionals in the past, and doubtless some still do, who do not welcome that duality with mixed concerns for confidentiality, professional ethics, suspect's rights and even individual or corporate liability say following the disputed use of evidence in a criminal trial. But it does seem to be that there is an expansion of dual roles and identities in certain areas with the crossing of traditional occupational boundaries.

Prevention

While all developments in this field are context driven and open to fluctuations, it is plain that there has been in recent decades a major institutional shift to prevention in multi-agency arrangements in a broad context including within LE and PH. Behind this adoption of prevention are a number of significant developments at the global, national and institutional levels. At the macro level there is what might be called the "humanitarian" thrust – as in the foundation of welfare states and in international agencies' policy statements – based on rights with regard to health, poverty, disease, education, discrimination, diversity and employment. And at the meso level there is the thrust within societies to tackle the substantial causes of death, ill-health and crime as, for examples, in relation to drugs, alcohol, violence and road deaths. That in turn leads to the institutional level based on a conviction that many social ills can be reduced by policies and practices – at times supported by research and experiment – and that this effort not only saves lives and prevents illness but is also valuable in reducing societal and financial costs.[50] Taking this highly varied context into account there are in a number of western societies substantial efforts at prevention, education and diversion in various areas – as in alcohol and drugs – to aid users and help to keep them out of the CJS and away from prison.

In certain areas it is easier to establish cause and effect and to effect substantial changes as in road safety and traffic related deaths and injuries. In the Netherlands, for example, there were some three decades back around 3000 fatalities per annum in traffic whereas in recent years the number has been substantially reduced to under 700 despite the considerable expansion in the traffic volume. That major reduction was related to a long-term combination of government policies, influence of automobile associations, safety lessons at school, safety promotion in the media, making roads structurally safer, visible police presence on major roads and of heavy penalties for driving under the influence and dangerous driving. In short, concerted efforts at various levels and through a range of agencies can bring about significant reductions in deaths and injuries related to traffic and bring down the personal and human costs as well as the societal cost. But this solid improvement is not a constant

[50] In San Antonio (Texas) the MHS initiated a multi-agency "Restoration Center": " – the police contributed their drug seizure money. The courts, jails, hospitals and the county government all kicked in – The savings to the County so far are about $10 million a year"(www.educationnews.org, 3 March 2016).

factor as the figures have recently been rising because of accidents related to the increasing use of electric bikes, especially by the elderly, and to the distraction of digital devices while driving: hence social change can influence and even reverse a long effort to reduce road accidents and deaths. Traffic enforcement is seen by some as not a high priority for LE but accidents can often have both a LE and PH element with serious criminal conduct while grave road accidents – say with multiple victims and a recidivist dangerous driver under the influence of drugs and / or alcohol – are a major source of trauma for survivors and for the relatives of the victims.

The key point here is that while some of these areas have a national or even international dimension which may seem difficult to alter or even influence to any great extent, there are certain measures that can be taken to address the problems arising from them. Moreover, there are often dedicated personnel in a range of agencies who are collectively trying to make a difference. For example, a major social issue is the use of alcohol and intoxicants and its relation to violence in groups, often of relatively young males (mostly under thirty). In an open society with many commercial outlets, and some clandestine ones, it is not easy to regulate sales and to control alcohol related violence. Measures can be taken on times and location of sales – as in relation to certain events (football matches, pop concerts, public holidays, etc.) – and on checking age limits. And with regard to violence there can be concerted efforts on public transport and risk areas such as in city centres in the night-time economy where there can be many cameras, improved lighting and the combined efforts of door personnel, local regulators, police and medical staff to prevent violence, react to any incident rapidly and have emergency response LE and PH staff in close proximity (Hobbs et al: 2005).

This takes us into highly complex matters which I can only touch on here as each area deserves expansion and we cannot go into detail on global developments, politics, social movements, legislation and institutional practices across societies. Illicit drugs, for example, are a substantial factor in crime and in drug-related fatalities but the trail explaining their malign influence would take us not only into scrutinizing international organized crime but also complicit state crime. The drugs topic does serve, however, to illuminate the complex and shifting backdrop to national legislation, regulatory regimes and institutional measures to prevent use and support users: but that in turn is related to ideology and beliefs with some societies strongly sanctioning both suppliers and users. In the Netherlands, in contrast, there has for several decades been a policy of effectively decriminalizing certain areas of drug use and of offering support to users: and even in the heavily punitive USA several states now allow the sale of certain soft drugs. However, the USA is now facing an epidemic of deaths which is only partly related to illegal drug supply and use but to an opioid crisis**.**

This refers to the spiralling use of prescription and non-prescription opioid drugs in North America in recent decades. In the USA they have become increasingly popular in treatment, including for pain reduction, but also as recreational drugs. There is, however, a significant chance of addiction and deaths from an overdose and overdoses – including from illegal drugs – have reached epidemic levels. By 2015 there

were more than 50,000 annual deaths from a drug overdose – causing more fatalities than in road accidents (around 40,000) or firearms use (roughly 35,000) – and there is even a related drop in life expectancy which is incredible in such a modern society. This national crisis involves a major commitment from both PH and LE and many other agencies.

There can also be research based policy which can be tried and tested: for instance, there are in several societies' specialized centres which tackle the issues of violence reduction and prevention. In the UK there is at Cardiff University the *Alcohol and Violence Research Group led by* Professor Jonathan Shepherd: this uses academic research to feed into practical approaches to reducing alcohol-related harms and violence. This practical research orientation leads to collaboration with a bevy of external partners and organisations which combine to understand, monitor and combat the causes of alcohol-related harms and violent behaviour. In Scotland, in contrast, the *Violence Reduction Unit* / VRU was, as mentioned, a police initiative. Set up in 2005 in Glasgow the VRU adopted a public health approach to violence as outlined in the WHO's *World Report on Violence and Health* (2002). It aims to reduce violent conduct through a multi-agency approach including health, education, social work and policing and it endeavours to alter both attitudes and behaviour. The unit also seeks out best practice elsewhere in order to adopt solutions to this deep-rooted problem which is such a cause of suffering and which in some forms occurs in certain locations at certain times with a high element of predictability.

There is, moreover, much evidence on crime reduction and prevention in a range of academic and other research centres. The lessons from that are that much criminal activity is differentially related to certain locations, particular communities and even specific families with inter-generational patterns. It might seem nigh impossible to influence young people from certain families and in particular groups to desist from criminal conduct but that was precisely what an ambitious Dutch multi-agency project endeavoured to achieve: because until then nothing had worked to stop them. It is called *The Top600* and was first launched in Amsterdam in 2011.

The "Top600" Amsterdam

As noted there has been strong support in the Netherlands in recent years for concerted intersectoral arrangements. A recent well-resourced example of this is the *Top600* project in Amsterdam which was strongly promoted by the Mayor, Chief of Police, Head of the Health Service and came to involve some 40 agencies. The "top 600" refers to repeat offenders regarding high impact crime / HIC who were selected for an intensive and comprehensive approach – including police, probation service, and social, health care and educational agencies, etc. – in order to achieve behavioural change (Schippers and van Dijk: 2012). The sample had some 15,000 police contacts in the previous five years and often for street robbery, raids on shops and businesses and aggressive burglary.[51] In the

[51] Part of the context fostering the moral panic (Cohen: 1972) in Amsterdam about the impotence of measures to prevent and prosecute serial offenders, was that a new generation of

latest cohort reported in van Summeren (2017) there were 27 juveniles (one aged 13) with most of the sample between 20-30 years of age: there were just six women. An important aspect was that mental health screening revealed unequivocally a strong relation between crime and mental health in the sample which is very much in line with international research. 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 to 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 for the population was highly predictable and that a combined effort had to be made to help members of the group to choose another path which potentially brings advantages, and reduced financial and social costs to society by diverting someone from "life course persistent delinquency". This in turn led to looking at family circumstances and later also at siblings at risk in the same environment. Each one of the 600 was assigned to a "director" who worked on a tailor-made trajectory for the individual in relation to bail conditions, health, budgeting of income, employment and reintegration after detention. The group is monitored every six months and the results are discussed in the Town Council (Gemeente Amsterdam: 2017). A fair number of those involved are from minority immigrant backgrounds and display resilience to integration and assimilation which impacts on their acceptance and performance at school and work. Some engage in street crime and nuisance-style offences, can terrorize areas and be disruptive in schools and a few graduate to serious organized crime often related to drugs and extreme violence.

Of the essence is that the information and approaches of the police and health partners were and are combined in a meaningful way by sharing a common framework yet enabling the diverse professionals to continue to do what they are best at within their own area. This approach is being adopted in cities across the country and in Amsterdam it has been extended to the top 400 "high potentials" who are younger and into less serious crime – but who look likely to follow the path of the 600 – making it the Top 1000. That attention has even been extended to around 200 juvenile siblings of those 400 and these youngsters, in some cases including the family, receive advice and coaching from the "Preventive Intervention Team"/ *Preventie Interventie Team*, GGZ (MHS), child protection and other agencies (*Parool*: 2015, 8 December). The Amsterdam programme is periodically evaluated and the results are mixed as family background, culture, friendships, school drop-out and involve-

relatively young criminals – mostly between 20-30 years of age and of North African background – were employing extreme violence with spray shootings in public places from automatic weapons leading to fatalities among bystanders or through mistaken identity. They are largely involved in armed robbery and drugs with currently a vicious conflict between two rival gangs in Amsterdam including placing a man's severed head outside the rival's favoured bar (Schrijver and Laumans: 2014).

ment in criminal youth groups often compete with the encouragement to avoid a criminal career or the aim to prevent recidivism (*Effectmonitor Top600*, Amsterdam City Council: 2015; *In de nesten*, Amsterdam Mental Health Service: 2014). Many of the youngsters and young adults are clearly from environments that are conducive to criminal activities and in some cases graduating to serious and violent crime. However, the stance is that it's important to put some of the sample on the path to education school, work and no crime and that the process is one long experiment that can be learned from and that can be fine-tuned. Indeed, after some five years there is evidence of a cumulative effect in that there is progress regarding less offences and warrants and more self-reliance, with a positive impact on siblings, and this is sufficient for the City Council and the professionals involved to remain committed to the approach which has been widely adopted across the Netherland.

In the Amsterdam *Top600* case, for example, there many efforts from a bevy of agencies which indicates that efforts in some areas go well beyond the LE and PH nexus and that sound, prolonged inter-agency cooperation is not only of the essence in achieving small steps but also in generating meaningful learning. The Top600 approach has brought to light some critical success factors which include:

- Enough capacity (personal, funding, supporting systems);
- Executive leadership that is aware their primary role is to create and defend enough time and creative space for their supervising officers;
- Support for each supervising officer by an multidisciplinary, skilled and carefully selected team;
- Widespread support by all partners with a clear and feasible common goal;
- Strong supportive information systems based on demand, a need to share and easy accessibility;
- Structured meetings on three levels: operational, tactical and strategic;
- Clear monitoring of both the process (who does what, in what amount, at what rate?) and the content (what does it contribute?);
- Creation of "learning teams";
- Agreement on a framework that tackles all legal issues regarding information-exchange, drawn up from a need-to-share perspective (adapted from Schippers and van Dijk: 2012);
- A culture of approachability within, and between, partners;
- Above all strong, determined leadership and support from high authorities such as a government minister, provincial / state governor, city mayor, police chief or head of MHS.

A major strength is tailor-made solutions with constant monitoring for all involved with an ethos of not giving up on someone so that it could be said that there are 600 individual versions of the Top600 scheme (van Summeren: 2017). It is, moreover, in no sense a "soft" approach as sanctions follow non-compliance such as having benefits cancelled, probation revoked or being sent to a *ISD* / "Institute for Frequent Offenders"/ *Inrichting Stelselmatige Daders*. When an adult member of the group exceeds a certain threshold of offences in the past few years and "they have repeatedly refused, avoided or thwarted (mental) health treatments they can be

sentenced to up to two years of admission in an ISD-institute. Here all the effort is aimed at finding and applying the right treatment for whatever causes the habitual criminal behaviour (Schippers and van Dijk: 2012).

In short, in a number of areas – including traffic deaths, street violence, alcohol, drugs and inter-generational crime patterns – there are varied concerted efforts, including academic applied research in diverse societies, of intervention and prevention schemes which can reduce the incidence and severity of cases and sometimes divert young people from criminal careers. The achievements may seem meagre in relation to the prevention and diversion but that has to be put in the context that drugs, alcohol, violence and crime patterns are major societal problems at the societal and even cross-cultural levels. The initiatives also raise complex ethical, legal and social issues which can make it difficult to intervene in family life and private domains. There are, however, undoubted successes to be gleaned although these may depend on intricate complex variables as well as contingencies, consistency and persistence in the efforts.

This topic is also an indication that major agencies – including LE and PH – are taking initiatives with central and local support to intervene directly in people's lives in order to change life patterns. The aims in the diverse areas are to prevent deaths, injury and damage and to divert youths from crime also exhibit a double agenda: not only to reduce the negative societal and personal damage but also to save financially through focusing on preventive measures rather than simply reacting to accidents, alcohol and drug abuse and to youths starting on criminal careers.

Measures for promoting inter-agency cooperation and effectiveness

> "The gold-dust situation is if you can achieve a position where a frontline cop can speak to a frontline nurse in real time. You can make far, far better decisions if that happens. But the solution ultimately has got to be about the mental health system having the upstream capacity to provide services and community care that is consistent with the needs of patients – and to provide an accessible, transparent mental health service which responds" (*Guardian*: 2016; 27 January)" [Michael Brown, British police expert on policing and mental health].

Generally arrangements and cooperation between agencies in the mental health area have increased considerably in many countries in recent years. But those two Amsterdam cases of suicides mentioned above in two different periods (1970s and 1990s) – one in police custody – illustrate that failures in cooperation can have the most serious of consequences. The implication is that solid agreements between law enforcement (hence wider than policing), PH and voluntary agencies are of the essence. For example, in recent years, there have been efforts made to provide front-line assistance from mental health professionals and to divert such non-criminal cases from police stations to a "place of safety" or treatment. This is now the espoused policy in the UK through the Mental Health Act (1983) Section 136: and is now also the case in the Netherlands in a number of cities.

Risk Assessment

Running through the material presented and many of the cases touched is the implicit or explicit concepts of risk and risk assessment. With harm and risk increasingly on the agenda of LEPH – it has long been a prime orientation within LE – there has been a move to use data to identify risk in diverse areas including road deaths and violence. These are not random events but often follow patterns and occur in certain locations: and attention to them increasingly involves cooperation between academia and LE and PH agencies. One example drew on a cooperative project in Australia involving researchers from Swinburne University of Technology, Victoria Police and Forensicare (the Victorian Institute of Forensic Mental Health) on *Enhancing Police Responses to Family Violence* (*Swinburne News*: 2017, 26 October). The research team at the Centre for Behavioural Science at Swinburne,

> "– had conducted research going back to 2015, and developed tools and systems to help improve family violence risk assessment and management by Victoria Police – Victoria Police Superintendent Stuart Bateson has worked closely with the project, and believes it has improved Victoria Police's operations. 'The development of an evidence based risk assessment tool has led to a significant uplift in our capability to respond to family violence and improve outcomes for victims,' said Superintendent Bateson".

This collaborative effort between police, health and academia was seen as a contribution in reducing family violence-related charges proving that a "strong evidence-based approach to identifying and responding to family violence through actuarial risk assessment is effective in addressing the complex issue of family violence in Australia" (*Swinburne News*: 2017, 26 October).

Another Australian example is the *Queensland Fixated Threat Assessment Centre* (QFTAC) which is a combined police-mental agency set up in 2013 to focus on lone, "fixated" persons. Typically they have a mental health condition but are not known to the psychiatric services or have disengaged: and there was no "empirically based procedural framework for managing fixated persons at major public figure gatherings". The research was geared to:

> "– the development of a diversionary model for assessing and managing fixated persons during major events, which combined the resources and expertise of police intelligence officers and forensic mental health practitioners. This approach effectively mitigated the risk posed by fixated individuals to delegates, staff and mentally ill intruders in the secure, armed environment of these events. The model highlights the importance for police, security and mental health services of considering fixated loners in major event planning, for the safety of the event, the public and vulnerable, mentally ill, fixated persons" (Pathé, Haworth and Lowry: 2016, 63).

Such examples have been stimulated by the expanding number of LE members taking degrees including research-based degrees; of police officers becoming involved

in research projects at times with other agencies; of police forces sponsoring research projects; and of the wide-spread attention to "evidence based policing" not only within policing but also within governments and among policy makers across a range of topics impinging on the LE and PH nexus (Punch: 2005 & 2016; Sherman: 2013; Stanko and Dawson: 2016).

Diversion

For example, there have in recent years efforts made to provide front-line assistance from mental health professionals and to divert non-violent people with apparent mental health problems to a "place of safety" or treatment. This is the espoused policy in the UK through the Mental Health Act (1983) Section 136: but in practice this still often means a police station although it is widely held that this not suitable and that efforts have to be made to find an adequate location. Hence *Liaison and Diversion* (L&D) schemes operate primarily in police custody suites and the courts with the aim of identifying and assessing people with vulnerabilities as they pass through the CJS to see that their needs are identified and that an appropriate response is reached.

Within the last few years in Amsterdam, moreover, an inter-agency agreement on mental health has been reached and as part of this an experiment has been started with a dedicated ambulance which is referred to – somewhat unfortunately – as a *psycholance*. In English the term "psycho" has a highly negative connotation which is not present in Dutch and here is meant to convey "psychiatric" cases. The ambulance has specialist psychiatric personnel on board to take people who appear to be "disturbed" or "distraught" to a place of safety. The Dutch use the term *verwarde persoon* meaning "confused person" but "distraught" is probably more appropriate to convey a cause for concern. This specialist ambulance concept for this population had earlier been pioneered in Norway but was also being considered in Amsterdam about the same time (*Huffington Post*: 2014, 26 September). In the UK Paul Jennings, mentioned above, was in 2016 also developing "an operational briefing platform for emergency service personnel and leading the development of a specialist mental health ambulance that will enable mental health nurses to respond as a blue light response service in their own right" (from his CV, LEPH Conference, Amsterdam, 2016).

The terms used for the population differ but in general they refer to people displaying apparently psychotic symptoms and are attracting attention in public, or private, places for unusual or disturbing behaviour. The police responders to the incident have to make an assessment in relation to any criminal offences, level of risk and any threatening behaviour and can then call for the specialist ambulance under specified circumstances. But it is still the case that most of those apprehended who are displaying apparent mental health symptoms are first taken into custody at a police station: this is likely if they are aggressive and / or resist being apprehended. This means the "distraught" person is searched, handcuffed, taken in a police car and placed in a cell which is clearly not the most suitable place while there are usually no mental health professionals on the premises. This doubtless also happens in cities in most other societies including the UK.

Moreover, this particular Amsterdam case is about a pilot scheme originally in one Dutch city with funding for only an experimental period while the scheme depends on gaining subsidies to continue. Commencing in 2014 the two ambulances worked from 08.00 to 24.00 but there were plans to add a third crew and to start a night duty. There are also plans to extend this measure to other cities with a background of police complaining that responding to such *verwarde* / "distraught" people is taking up more and more of their time as facilities in the community for this group close as a result of economies while some encounters are becoming increasingly violent (*AD*, 27 February 2018.) However, the estimates are that the numbers diverted are increasing and that approximately one third of such vulnerable people requiring acute care are now diverted from being taken first to a police station: but that still leaves two thirds who are apprehended and conveyed in the conventional manner (*Volkskrant*, 20 July 2015).

Control and Information Centres

There are various terms for police emergency call centres including *Control and Information Centres* and *Police Contact and Control Rooms /* CCRs in UK forces. These have increasingly become sophisticated and multi-functional call-centres for the emergency services (police, ambulance, fire service and social and psychiatric services). Given that an increasing number of people in western societies have a mobile phone the volume of calls has increased exponentially which requires careful sifting. One feature in recent years is to have diverse professionals from those services combining to vet the calls and to have joint access to a number of databases (within the laws of privacy). For example, in 2013 it was announced that several British police forces were to join an ongoing pilot scheme whereby mental health professionals were to work alongside police officers in such centres and this has led to embedding mental health professionals in the emergency CCRs with say psychiatric nurses advising call handlers and directly dealing with individual callers (Kane, Evans and Shokraneh: 2017).

Triage Schemes

Probably the most wide-spread combined LEPH initiative takes the form of inter-agency, "street triage" teams which are being set up in a number of societies whereby mental health personnel accompany officers on patrol with regard to cases involving a possible mental health issue (Kane, Evans and Shokraneh: 2017). Under the heading, "More police forces trial 'street triage' mental health scheme" (*BBC News*: 2013, 20 August) it was stated that British police forces in Leicestershire, Cleveland, MPS (London), British Transport Police / BTP, Thames Valley, West Midlands and West Yorkshire would take part. In one case in East Anglia (Norfolk and Suffolk) there was a serious emergency call on a busy Christmas Day eliciting a police, fire service and ambulance response. A mental health nurse was in the patrol car on call and her laptop gave her 24-hour access to mental health data and patient records. She commented: "It was a very serious incident that could have had terrible consequences, but that engagement with myself and the police worked brilliantly". Sitting next to an officer in a response vehicle meant she could give instructions:

> "As we respond to an incident I will be on my laptop and my phone finding out whether the individual is known to mental health services – often I will know the person myself and I can advise the officers. If the person is very unwell and cannot be managed safely I can call for a Mental Health Act assessment to see if they need to be sectioned. It's very difficult for the police to do that alone." (*Guardian*: 2017, 28 January)

Various forms of inter-agency "street triage" teams are being set up in a number of other societies. In Geelong (Victoria, Australia) there is the *Police, Ambulance and Clinical Early Response* (PACER) which is one of the Australian models aiming to develop police and mental health co-response teams (Saligari:2016). In the USA they are sometimes referred to as *Joint Intervention Teams* / JITs or *Crisis Intervention Teams* / CITs. An example of the value of CIT was given in New Windsor (New York):

> "– police officer Frank Pierri Jr. got the call on his second day on the job. Someone was in mental distress, uncooperative – and refused to open the door when police arrived. But Pierri had a weapon in his arsenal that most cops don't. In the police academy, he underwent 40 hours of crisis intervention team training, learning about mental illness and its manifestations, learning how to defuse tense situations, and about the resources available (in the region) to people with mental illness. Instead of yelling or using force to gain entry, Pierri started talking, getting the person to tell him about the problem that had triggered the distress. 'It automatically kicked in, what to do, how to speak,' Pierri said. The person was in the throes of medical and alcohol-related crises. 'The more we talked, the calmer we all were,' Pierri said, adding that police were able to convince the person to go voluntarily to a hospital for treatment. 'Everything we learned translated right onto the street'" (*The Crime Report*: 2015, 2 October).

There are further innovative efforts for the vulnerable with mental illness in Boston, Milwaukee[52], Wyoming, Portland (Oregon), San Antonio (Texas), Los Angeles and Madison (Wisconsin): and we shall take a look at these last two examples which both have federal approval as Learning Sites.

Los Angeles (California)

The Los Angeles initiative was based on keeping people with mental health problems out of the criminal justice nexus and into appropriate care.

> "By partnering beat cops with mental health clinicians, the Los Angeles Police Department [LAPD] has reduced incidences of force used on individuals with mental illness and has connected thousands of individuals with counselling and support" (Swan: 2015).

[52] Milwaukee has a joint mental-health and police response effort called the Trauma Response Team / TRT which focuses on potential trauma among juveniles following a stressful incident with a high personal threat such as domestic violence or an armed burglary or else witnessing a fatality with a high personal threat (Ewing: 2017).

The double motive of the LAPD was to cooperate with the mental health agencies in a constructive way through its "Mental Evaluation Unit" / MEU which would also save police time on repeat calls and the high cost responding to them. It would further greatly benefit some of those with non-violent mental health issues by keeping them out of court and eventually prison which would divert them from the worst possible environment: and this in turn would save the cost of inappropriate incarceration. The partnership model between police and mental health led to mounting "officer-clinician teams", often referred to elsewhere as "triage teams" or "crisis intervention teams". This was similar to initiatives elsewhere in the USA and in some other countries but the LAPD scheme has become the "nationally recognized model for police departments" in the USA. The LAPD has medical personnel and social workers functioning in joint officer-clinician teams out on patrol and for patrol officers responding on their own there is a MEU triage desk open 24 hours a day with professional advice on handling the situation.

There is no question that this model provides the complete remedy for dealing with the mentally ill in the community as some officers may not welcome the cooperation with outsiders; not all that many officers receive adequate mental health training for the role (perhaps only 10% in the USA); and the coverage of the joint teams is limited. It also does not mean that there will no longer be any contentious interactions with the mentally ill leading to inappropriate police conduct including undue violence and even death. But what can de-escalate a tense situation is that someone not in uniform says to a distraught person, "I'm not a police officer. Let me help you" (Swan: 2015).

Madison (Wisconsin)

Madison has long been a progressive PD with a strong "customer service" orientation while it has a "Mental health liaison program" whereby all officers receive mental health training. But some also volunteer or are selected to become "mental health liaison officers" with the local Mental Health Service (Dane County) and other agencies. These "Mental Health Liaison Officers" are,

> "– regularly-assigned patrol officers who respond to mental health crises when available. Their primary responsibilities include: identifying ongoing issues and coordinating follow-up efforts with partner agencies; outreach to residents in their respective districts with mental illness; serving as a point-of-contact regarding mental health systems issues; conducting trainings, attending relevant community meetings, and sharing necessary information internally and externally as appropriate. In conjunction with fellow district patrol officers, the Mental Health Liaison Officers work within and across districts to provide a coordinated, consistent, and collaborative response to persons with mental illness" (*The Crime Report*: 2015, 2 June).

Kent Police (UK)

In Kent the police withdrew from a multi-force street triage scheme mounted along with several other English forces in order to pursue a different path with

its resources. Its own triage effort involved mental health nurses going out on patrol with police officers in the city of Canterbury and this led roughly to "a 30% reduction in the number of people being sectioned by the force under the Mental Health Act" (*BBC News*: 2013, 20 August). This is an example of a pilot project in just one city within a large county with apparently a solid measure of diversion for those experiencing mental health problems. The Kent Police also set up a "call system where officers at the scene can seek the advice of a mental health expert on a 24/7 basis" and also provided "training for staff that addresses the stigma around mental health". It stated that,

> "A comprehensive understanding of mental health problems is now an integral part of the training we deliver to our officers. Experienced nurses regularly attend our new recruit programmes as well as police officer refresher training to give inputs on a range of mental health issues – Available to all officers and staff via our intranet, a series of training videos show the complexities of a range of issues including bipolar disorder, depression, confusion and schizophrenia".

Furthermore, Kent Police has become a *Dementia Friendly* force committed to meeting the criteria for a dementia-friendly community.[53]

Thames Valley Police / TVP (UK)
Within the TVP a street triage scheme has been set up together with the Oxford Health NHS Foundation initially in three cities (Aylesbury, Milton Keynes and Oxford). The mental health professionals have already worked in the Police Enquiry Centres and they advise officers on diagnosis, risk assessment and handling of crisis situations. The data for the year 2014 indicate a more appropriate response for those with acute mental health needs. Fewer people were being detained under Section 136, there was more use of alternatives to a police cell, less pressure on police resources and a reduction in pressure on the emergency mental health service especially at night while "Officers report that street triage allows them to react faster, make more informed risk assessments and hence better decisions. Officers report that they are gaining in confidence when dealing with mental health crises" (*BBC News*: 2013, 20 August).

Coalitions: Camden (New Jersey)
The multi-agency Camden Coalition project in New Jersey is a beacon of how the vulnerable should be treated in a coordinated, professional manner. This "Camden Coalition of Healthcare Providers" utilizes their ARISE initiative – referring to *Administrative Records Integration for Service Excellence* – which links,

> "police administrative data (i.e. arrests, citations, calls for service) and hospital claims data (i.e. emergency room and critical care visits) and has so far

[53] "Our dementia-friendly communities programme encourages everyone to share responsibility for ensuring that people with dementia feel understood, valued and able to contribute to their community" (Alzheimer Society UK).

found powerful evidence of 'cross-sector high utilizers' – those encountering both police and healthcare systems with regularity, and at great costs to both systems – These data, in conjunction with other analyses performed globally – provide opportunities for practitioners and researchers to experiment with new street-level interventions that may better target the risk factors of high utilisers" (Wood and Watson: 2017, 7).

Specialized units for victims of sexual violence

Many of the social problem areas we have touched on have seen the development of a range of voluntary agencies, occupational specialisms within formal LE and PH institutions and special multi-agency units and centres for specific problems. One example is in the area of sexual violence with *Sexual Assault Referral Centres* / "SARCs" (touched on above) with a dedicated team with medical expertise on sexual offences in a multidisciplinary network which has to balance medical, forensic and social aspects in the interests of the victim. And in the Netherlands there is the multi-agency "Centre Sexual Violence" / *Centrum Seksueel Geweld* of which there a national range of 16 clinics providing 24/7 coverage for victims (also mentioned above).

Finally in relation to this list of initiatives, we need to know more about such schemes and how they are evaluated. Do they become widespread and permanent; what is their relationship to other sectors of the constituent partner organizations; is there firm and consistent support from the top of the organizations; are there sectors within organizations that resist and oppose such projects? In diverse schemes LE and PH are contractual partners usually with central or local funding: and to the extent that some of these initiatives are experimental, "pilot" projects they may be reliant on favourable assessments, political swings in local councils or in parliament or local councils as well as continued budgetary support. Hence there's a feeling that they are often temporary, piecemeal, dependent on limited funding, weakly evaluated and poorly disseminated. There can also be antipathy to outside schemes – the "not invented here" syndrome – a resistance to having civilian personnel encroaching on police territory and perhaps interfering with their decision making and challenging their primary institutional focus on crime control (Swan: 2015).[54] Indeed, are the lessons learned employed to educate all staff; what is the process of mutual learning within multi-agency teams; and are all personnel suited for such schemes? In general we sense that many initiatives are not properly evaluated in any systematic fashion which hinders learning from them. It could be argued that at many institutions in the LEPH area have a poor institutional memory and are condemned to cycles of rediscovering, at some cost and energy, the lost lessons of the past. The role of those experts and practitioners with knowledge and expertise in the LEPH arena is to develop that memory and to enhance that learning.

[54] When an attempt was made in the Boston PD to introduce a "fledgling program on a smaller scale" than the LAPD scheme [the national model for partnering beat officers with mental health clinicians] a counsellor brought into the PD, Ben Linsky, said he had "struggled to gain acceptance when he first arrived – turf issues were horrendous – It took a really long time to be accepted by rank and file" (Swan: 2015).

Investigation of the crash site of MH-17 in the Ukraine

Convoy of MH-17 victims on the highway in the Netherlands (24 July 2014)

Chapter 5. Conclusion: "Smart" Care in LEPH

Institutional change in LE and PH

Academic and practitioner attention to the specific topic of LEPH is fairly recent. Its seemingly fresh promise can convey a picture of joined-up and reflective inter-agency cooperation to assist the vulnerable and to support victims. But arriving at and establishing such partnerships between agencies was often a long and complicated matter – as with domestic violence and violence against women long being neglected both societally and in inter-agency cooperation – while their continuity may now even be endangered. In short, we are looking not at steady state but rather at an area that is shifting, volatile and replete with debate, dispute and uncertainty. Indeed, both LE and PH are widely subject to the vagaries of socio-political change, new legislation, reorganizations, media exposures of failings and successive fiscal restraints. This can give the LEPH area a somewhat jerky, cyclical or even oscillating nature with a few diffuse concepts – like the infinitely elastic "community care" or "community policing" – being promoted, abandoned, reinvented or recycled with poor institutional memory, loss of competencies and then having to relearn them. And perhaps to do that with former partners that an agency has abandoned, alienated or forgotten and the relationship has to be resuscitated. It is important, then, that proponents of the LEPH area with an underlying reform thrust, continually bear in mind the vagaries of the area within increasingly neo-liberal societies that pursue significant improvements in performance yet along with harsh austerity measures (*The New York Times*: 2018, 28 May). Running through this work, then, has been the theme of institutional change in LE and PH, the altered environment influencing the interchange between them and what this has meant for those people in need who encounter the combined LEPH nexus. Moreover, to answer fully the key questions raised in this work would require attention to the changing nature of societies and the impact of those changes on the functions and roles of both LE and PH. In that macro perspective the vital topics in assessing societies are justice, injustice, poverty, diversity, discrimination, oppression, rights and accountability under the democratic rule of law. In turn, how societies function shapes inclusion and exclusion; filters access to LEPH facilities, personnel and expertise; and fosters a sense of living in a just – or unjust – society (Lerner: 1980). For instance, the UK's Equality and Human Rights Commission observed in its *Hidden in Plain Sight* review (2011):

> "The inquiry has confirmed that the cases of disability-related harassment which come to court and receive media attention are only the tip of the iceberg. Our evidence indicates that, for many disabled people, harassment is a commonplace experience – There is a systemic failure by public authorities to recognise the extent and impact of harassment and abuse of disabled people, take action to prevent it happening in the first place and intervene effectively when it does – Any serious attempt to prevent the harassment of disabled people will need to consider more than organisational change, although that will be an important precondition to progress. *The bigger challenge is to transform the way disabled people are viewed, valued and included in society*" (my emphasis).

But to pursue such complex and intertwined themes in relation to societal change – or reluctance and resistance to change – is beyond the remit of this brief overview. This is especially as the focus is primarily on a small number of western societies to the neglect of many others including those LICs – and, indeed, parts of the USA – which have weak LE and poor PH provision (Jones: 2018). However, what I have done is to examine changes in recent decades which indicate significant developments in several mostly western countries.

One central issue is whether or not those changes represent a genuine "paradigm shift": or is it perhaps merely a matter of redefinition and a new conceptual vocabulary? For instance, if we look at LE in the UK is it really the case that,

> "– rather than law-breaking, the *core business* of policing today is on something officially defined as 'Public Safety and Welfare' – mental health, child protection, missing persons and suicides"? (my emphasis).[55]

This is perhaps the hyperbole and rehashing of buzz words which is so prevalent in our media saturated societies but it rather overstates the case.

The core *value* of policing relates to serving and protecting the public within the state's democratic rule of law. Interpretation of this may be highly elastic but this paradigmatic value cannot be reduced to particular activities however sizeable they may be (Reiner: 2010). Nevertheless, there is wide and indisputable evidence that "Police have found themselves routinely serving as de-facto street corner-psychiatrists and front-line mental health workers" (Cloud and Davis: 2015, 5). Indeed, that shift relates to the fact that prisons have become *de facto* mental health institutions while in the USA prisons are facing an overwhelming "mental health crisis" which is creating a "hellish world" (*Guardian*: 2018, 31 March). But given the complex and segmented nature of contemporary policing and of the CJS in western societies, it is debateable as to how valid throughout the entire organizational chain – and within their internal disparate occupational practices and cultures – this shift is: and also how pertinent it is cross-nationally and especially in many LICs.

What we can clearly see, however, is a *redefinition* process taking place in certain western societies regarding civil and human rights – as in bringing disability into the remit of hate crime (*Guardian*: 2014, 1 December) – which is related strongly to LEPH agencies being pushed to consider seriously the predicament and needs of victims and the causes of victimization.[56] It may even be that with much "common" crime decreasing and resources diminishing, this move is a form of self-interest with

[55] As Rebecca Roberts of the Centre for Criminal Justice Studies in London states: in Blowe (2017) in a review of Vitale's book *The End of Policing* (2017).

[56] An example of this shift is from the early 1990s, referred to above in relation to "cot deaths", and is contained in the "service delivery standards" of the Essex Police (British forces were then reacting to NPM in specifying what the public could expect on certain issues): "It is our intention in cases of cot death to place a special emphasis on our support for bereaved parents – officers will do their best to *be compassionate and supportive* towards the parents and other family members" (my emphasis). This is a new perspective and vocabulary designed to change traditional behaviour in this area (personal communication Geoffrey Markham, former Assistant Chief Constable, Essex Police with the original document).

police claiming new “social” tasks and in engaging in inter-sectoral initiatives. Furthermore, governments are increasingly taking into account the societal costs, in the widest sense, of discrimination, violence, drugs, sexual harassment and domestic violence. This is evident in this multi-agency declaration in England (thus not for all of the UK), *Policing, Health and Social Care Consensus: working together to protect and prevent harm to vulnerable people* (NPCC: 2018):

> “It provides a focus for the police service, health and social care services and voluntary and community sector to work together to improve people’s health and wellbeing, prevent crime and protect the most vulnerable people in England. The *Policing Vision 2025*, published at the end of 2016, described an increasingly diverse and complex policing landscape requiring a more sophisticated approach to tackle new and evolving challenges. Whether it is child sexual exploitation, domestic abuse, cybercrime or new threats from serious and organised crime such as human trafficking or terrorism, the service acknowledges that working collaboratively across the system is key to preventing crime and protecting vulnerable groups – The social determinants of health such as housing, education, work and income overlap with the social determinants of crime. Key risk factors for poor health align closely with risk factors for offending; and those who are at risk of offending as a group are more likely to suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality. By working together and intervening early to address the common factors that bring people into contact with the police and criminal justice system and lead to poor health we can improve public safety, prevent offending and reoffending, reduce crime and help to improve outcomes for individuals and the wider community”.

However, that expressed intention does in turn pose the acutely pressing issue if the diverse agencies of LEPH can cope with the expanding demand that is generated by the promise of new-style, joined-up care and support. Cottam (2018), for instance, states of LE in the UK:

> “The police are facing something of a perfect storm. They witness every day the increasing vulnerability in the populations they serve: a result of widening inequality, the effects of modern poverty and the rise of new problems such as digital crime and modern slavery. As deep cuts to our public services take effect the police become a service of last resort called out to find that missing child, confused older person or distraught homeless youngster with increasing regularity. At the same time the police have faced their own cuts and must maintain their focus on addressing the complexity of modern crime”.

There is, then, a critical issue at the moment with the harsh reality of rising demand with lower budgets: and this is becoming acute for both LE and PH. A pressing current demand, for example, is the current mental health crisis in several societies.

This plainly accelerated in recent years in the UK:

> "UK police are spending as much as 40% of their time dealing with incidents triggered by some kind of mental health issue, against a backdrop of severe cuts in social and health services – Research by the *Guardian* shows that the overall number of incidents recorded in police logs as being related to mental health rose by a third between 2011 and 2014, a trend that looks set to continue" (*Guardian*: 2017, 28 January).

This also holds elsewhere in other societies with a significant rise in emergency calls related to mental health issues and often with a serious violence component factor. Indeed, this situation – along with alarm bells ringing – is true of the Netherlands with rising concern about violence causing serious injury and even fatalities in which the attackers have a mental health condition and with the victims viciously attacked at random. Poorly functioning care institutions with lax supervision and a shortage of experienced personnel are often blamed for such awful incidents (*NRC*: 2017, 19 December; *Parool*: 2018, 30 June).[57] In short, how much can we expect from services strapped for funds and personnel, desperately trying to maintain standards in serving the public and almost on the verge of "running on empty" (van Dijk, Hoogewoning and Punch: 2018 & 2019).[58]

Furthermore, the populations at risk are many and each one demands special knowledge and a particular approach although there may be some common elements in assessing situations and dealing with them. Then In some criminal cases relating to the vulnerable there are many suspects and hundreds of victims and the accompanying investigations and care efforts can last years. Scandals around abuse of the young, for instance, can reach back several decades and can involve various established institutions and prestigious members of elites (as in the UK, USA, Ireland, Australia and the Netherlands). This is quite unlike the standard reach and tasks of LE, and indeed the related role of PH, some two decades ago. In short, the current demands on resources and personnel are substantial and the pressures are acute.

It is even the case that at times deficiencies in one or more of the agencies can lead to a partnership failing with grave consequences. Hence I have examined a

[57] In the first of these two articles in daily newspapers the police chief of Rotterdam expresses concern about the increase in violent incidents involving *verwarde* / "disturbed" / "distraught" people (6000 in 2014 and rising): for the first time this category had been placed in the "threat overview" which itemizes " potential risk for disrupting Rotterdam society". The second article details the failures in care as, instead of being placed in a forensic institute, a "violent psychiatric patient" was taken to the Amsterdam hospital (AMC) which was not properly equipped to treat him: he subsequently stabbed to death a random victim in a metro train. There were several other violent deaths in recent years involving shortcomings in the supervision of potentially dangerous mental health clients that have raised public concern.

[58] The chief constable of one of UK's largest forces, Greater Manchester, admitted that the pressure and changing nature of calls, the shortage of personnel and lack of funding combined to mean that the public was "not getting the service they expect" (*Guardian*: 2018, 28 July).

number of such critical cases of system failure in order to learn from them; have also touched on abuses within LEPH agencies; and have as well mentioned the stresses and strains of working in such agencies and the subsequent occupational illnesses. For instance, just about everyone who was involved in the Amsterdam Vice Case, including the very young victims, was scarred by it in some way and some permanently.[59]There are, moreover, several key areas which we need to be explored in depth:

- What are the patterns of interaction when LE and PH agencies meet and function together? What are the characteristics of the diverse agencies and how do those influence what they bring to the encounters?
- What are the indicators of successful outcomes and are these employed as learning material in the respective professions?
- To what extent are the diverse interventions embedded in the respective agencies? Some were pilot schemes or temporary and / or dependent on funding. In policing especially the officers involved could be part-time and could move on to other duties so that there were issues of continuity and of relays of personnel having to learn the specifics of the area and the “rules of engagement”.
- In some cases there was mention of resistance to approaches within the LEPH area and that it was seen as a rather marginal activity to “real” policing and / or in an occupationally disputed area (as with resistance to treating sex workers as victims).[60]
- It would require a substantial effort, but it would be valuable to know which interventions seem to work best with which populations and under what circumstances: but systematic evaluations across categories are largely absent.
- To what extent is it feasible that long-term interventions, as with the Dutch Top600 project, can be mounted in other societies given their cost and close involvement in individual and family lives which may raise societal, ethical and even legal issues?
- And what features of the field and of the varied practices with diverse populations and agencies should feed into the training of LEPH personnel and related occupations?

[59] The abuser stopped his practices when the young children started to speak so that his victims could not mention their experience: it is unclear what long term consequences the abuse will have on them but the Head of the Amsterdam MHS was concerned that there might be some such consequences for some of the children (presentation, LEPH Conference 2016). Also screened for trauma were the detectives who interviewed him – and eventually got him to confess and reveal the key to the extensive material on his computer– along with those responsible for his custody.

[60] Two of the dominant features of police occupational culture are held to be cynicism and suspicion: given the sort of gruesome problems and devious types of people that police typically deal with, officers can adopt a primary attitude of disbelief regarding their accounts and a cynicism about the plight of the needy and vulnerable as suspect or victim (Crank: 1998).

In brief, there is much to be researched in many areas as we lack systematic and comparative material in many areas. Much depends on which society we are referring to and to what extent it is capable of learning, adapting and evolving in this area. For in a way our material on the vulnerable and those who aid them leads us to suggest that societies need to change to accommodate to the needs of vulnerable populations.

In particular the CJS in most societies remains a fairly insensitive and unforgiving institution: yet it should be possible to do some things differently and break the mould. In the UK, for instance, there are special courts for domestic violence. And a judge in Florida runs a court for the mentally ill.[61] In her courtroom – "where everyone is on the same side" – everything is done to reduce the intimidating – and "assembly-line" – features of stiffly formal, legalistic and adversarial courts.[62] But, alas, she is an exception and the brutal reality in the USA is that, "some 2 million adults with serious mental illnesses are put in jail every year and they remain in jail longer than others and are frequent returnees" (Torres: 2015). However, those two examples do suggest that there should be special courts for other categories such as for the elderly, those with dementia, youngsters with autism or for sexual violence. Some rape cases in the UK, USA and elsewhere turn the victim in court into the suspect and reveal extensive details on the victim and her private life which, given graphic reporting in the media and hurtful comments in the social media, form a second assault on the suspect and serve as a major disincentive for women to report sexual offences. Much is being done by many to improve matters in this area but the research of Stanko and Dawson (2016), and recent court cases in Spain and Italy, reveal that a great deal needs to be achieved within LE as well as legally and societally.

This should also draw wider attention to the *interactional* level as to how people are initially received and treated when seeking attention at a care agency, hospital or police station. The latter tend to be rather formidable and unwelcoming buildings

[61] "Kreitzmann [Wyoming MH official] said introducing mental health courts into Wyoming's justice system could help to break the cycle for her chronically incarcerated clients. Modelled after drug courts, judges in mental health courts can offer certain pre-screened defendants community-based treatment alternatives rather than jail time. If defendants fail to abide by the treatment regimen, they could go back to criminal court. US mental health courts are a relatively recent addition to problem-solving courts, and research on their efficacy is limited" (Star-Tribune: 2014, 27 April).

[62] "Knowing full well that if she listens, she might play a part in changing someone's life — something Judge Cathleen Clarke has been doing since starting Brevard County (Florida) Mental Health Court in 2003 – The court is not adversarial in the least. Everyone is there for one reason: to see someone charged with a non-violent crime get the help they need – The court is designed to allow non-violent offenders with mental illness to enter into a one-year program where they are assigned a case manager, must make all doctor and court appointments, take medications and speak weekly with a case manager in order to have their charges dropped – 'Judge Clarke is a compassionate, hard-working judge who understands the futility in continuing to prosecute certain defendants for crimes they commit due to mental illness', said Chief Judge John Harris" (Torres: 2015).

which could be changed by altering the architecture (Tillie: 2012). For example, some purpose-built police stations in the Netherlands have a long low counter in an open-plan setting to suggest transparency. The long counter means that people can spread out to tell their initial story without being overheard while there are toys in the corner with which children can play. The entire setting is designed to be spacious, transparent and welcoming and the architecture caters for special needs and privacy such as a discrete sexual violence suite: they are also state of the art working environments. But of course the most important factor is the attitude of the official behind the counter – as also in social services, hospitals and care agencies.

And that suggests *institutional change* that alters values and behaviour. For instance, a project was launched in New Haven (Connecticut) which involved staff from the Yale School of Medicine (Childhood Violent Trauma Clinic) going along with police officers to pay special attention to children exposed to violence in the home, including witnessing violence between the parents and / or the arrest of one or both parents, and perhaps also to experiencing parental or sibling abuse. In an article “Behind Broken Doors” it was maintained that not only did the Clinic provide free treatment for about 1,000 children a year but also:

> “Paring cops and clinicians has led to a cultural change in the [police] department. The way officers police their community has shifted from an old school catch-and-arrest mentality to a people’s police with a social worker component” (*The Crime Report*: 2016, 4 March).

This actually started as a police initiative and the “Child and Family Traumatic Stress Intervention” / CFTSI approach has since become the national model. One hopes that other agencies are also open to reform which changes values and practices while ideally everyone in them should be caring, considerate, competent and confident.

For these are core *institutional* characteristics that have to be inculcated in the LEPH professions. But we know that these four are not always present due to a number of factors such as weak recruitment policies, turnover of personnel, lack of training and poor supervision. Moreover, “caring and considerate” have not always been characteristics attributed to police while these are normally prominent in the ethics and professional identity of PH professions (but not at all times in all places). On the assumption that inculcating “care and consideration” is more necessary within LE than PH then the emphasis should be in making officers “caring and considerate” not only in their general role but especially in their specific functioning in relation to LEPH and the populations in need. But there is encouragement in Charman’s (2017) interviews with British police recruits after their first four years of service. In discussions about the role of the police, they placed “protection of citizens” first followed by “protect society”, then “catching criminals”, then “upholding the law” and then finally “crime fighting”. Policing and police officers, it could be argued, are now more comfortable with their social identity as “peacekeepers” rather than “crime-fighters”: at least in this UK cohort the prime adherence to crime-fighting has been shelved (Charman: 2017). Then, drawing on what has been sketched above, we

would suggest that everyone in the organization – meaning *everyone* – takes an obligatory course in mental health.[63]

- Indeed, *The President's* [Obama] *Task Force on 21st Century Policing* (2016) recommended that "CIT" [Crisis Intervention Training] be part of both recruit and in-service training for all US officers: but it is unlikely that this will be fully implemented given the devolved structure and varied local cultures within US law enforcement.[64] For the data in several societies indicate that dealing with the mentally ill is becoming more and more prominent in policing and with an increasing risk factor – as touched on above – but, at the same time, there is much evidence cross-culturally that officers do not always feel well equipped to understand, and deal with, incidents with a mental health component.[65]
- Secondly, we further suggest that every fifth officer should take a course on one of five specialisms – such as dealing with sexual violence, domestic abuse or disability hate crime – so that there is competency and understanding for dealing with those specific areas spread throughout the organization. A police officer who coordinated the first CIT training in Memphis (Tennessee) argues that this works best when a smaller group takes the lead on mental health responses:

  > "There's all kinds of specialization in law enforcement – We've got bomb technicians, narcotics, robbery. I want all the officers at the scene to understand that this CIT officer is the leader. That represents clarity, and responsibility brings about a level of accountability" (*New York Times*: 2016, 25 April).

  This makes sense but I would still argue that all officers should take CIT training but this could be combined with one in five officers being given further training and responsibility to take the lead in such specific incidents.
- Thirdly, selected supervisory staff should be trained to manage, and function within, LEPH partnerships.

In relation to the latter it is probably the case that many partnerships are routine and progress smoothly but some are large (with many agencies), highly complex, long lasting and drawing much positive media attention.

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[63] Including non-executive personnel and anyone who has contact in any way with members of the public such as private security personnel working on the front desk or in control centres.

[64] In relation to someone who is having a psychotic episode, Peggy Spagnola – Vice President of NAMI-AMICO, Orange County's [New York] affiliate of the National Alliance on Mental Illness – which advocates for people with mental illness and their families, says he or she "may hear voices commanding them to do things, and may not be able to follow what police are saying – When the police come, if they don't know it's a mental illness, they don't know what to expect – With CIT training they know how to talk them down instead of escalate – It's about body language and openness and empathy – It increases the safety of the officer, the safety of the mentally ill person, the safety of the mentally ill person's family" (*The Crime Report*: 2015, 2 October)

[65] About 85 per cent of US police departments do not offer CIT training (Gold: 2014).

But some can seriously malfunction which means alertness to any warning “red lights” that all is not well and to anyone not functioning adequately. But it can happen that the social worker is new and unsure, the A&E doctor not well qualified (and overlooks a broken back in a young child as with Baby P.) and the police officer is overworked and does not follow-up on a danger signal of a child at risk in a troubled family. It further depends on people reading the previous reports, adopting recommendations, sharing information, communicating adequately, taking the decisions promised and following through on decisions. There needs to be an ethos of responsibility whereby individuals concern themselves with what should have happened before their specific role, with fulfilling their functions professionally and competently and making sure that their role in the chain is being dealt with adequately by the next in line. And not by taking the easy way out of negative reporting: “if I don’t hear anything all is well”. But due to pressure of work, turnover of staff, inexperience, incompetence, and absences – something banal as a holiday could mean a well-documented file calling for action was ignored for weeks when weeks were vital – it could happen that proposed action was not taken. At times there can be too many weak links in the chain of agencies leading to a collective failure and at times with dire consequences.

Importantly, cooperation should never become *collusion* in taking a slippery slope, or failing to take the correct path, because of a form of group think which leads to professionals not intervening where they should have done. This means that there should be attention to the dynamics of partnerships and to the key issues of responsibility – and especially *accountability* – for the consequences of the collective behaviour. In many of the failures touched on above it was neglecting to intervene in a deteriorating situation that proved injurious and in some cases fatal. Furthermore, police officers have been granted special powers as law enforcement officials and, while they may not want to play the “police” role too heavily in the common interest of the partnership, there may be times where they feel obliged to intervene if they are say concerned that a serious risk factor is being overlooked by the other partners. In turn service-users and mental health professionals may be concerned that the involvement of the police is not only stigmatizing but can also open individuals to legal intervention. There are clearly delicate balances to be negotiated made within competing notions of care, diagnosis, treatment, harm and risk.

Essentials

In this last section I shall stand back and focus on some essentials. I have sketched the new and constantly developing field of LEPH which deserves far more attention from scholars and professionals. This will inevitably carry implications about how the state and its multiple stakeholders view this area and what this tells us about the nature of contemporary societies and especially about the functioning of the two systems – law enforcement and public health – within those societies. For a combination of reasons, then, I conclude that the field is dynamic and shifting in a number of societies and it is replete with potential for international research, prac-

tical projects and cross-disciplinary publications. Indeed, Wood and Watson (2017: 292) state that:

> "Optimism can be drawn from the knowledge that the fields of policing and public health are beginning to align. A scholarly commitment to integrating theory and methods, combined with a cross-system commitment to reducing fragmentation, can lead to improved long-term commitments for those with mental health and co-occurring vulnerabilities".

And corresponding to this at the inter-agency level there is a growing sense of mutual self-interest:

> "If we're going to have a comprehensive response looking at things like prevention and treatment, we need law enforcement, law enforcement needs public health, and each of us has a role to play" (Director of the US Office for National Drug Control Policy: quoted in Cloud and Davis: 2015, 9)

It is, however, a highly complex area that is not easily squeezed into disciplinary pigeon-holes: but that is precisely the challenge. For it touches on some of the most acute issues in contemporary society (Tesconi: 2018).

For instance, in western societies the gap between the "haves" and "have nots" has widened with increasing disparities in wealth and in what wealth can bring. Neoliberalism has driven policies so that once socially geared welfare state systems have become more restrictive and punitive with administration and delivery devolved to the private sector leading to bureaucratic indifference and pared down services (*Guardian*: 2016, 20 July). While the grinding, abject poverty of previous generations is largely absent there remain many disadvantaged people – often with unhealthy lifestyles and an accumulation of social problems – who have in recent years been pushed into long-term unemployment or poor paid, insecure work (O'Hara: 2014). Some seven million people in the UK are in poverty despite coming from working families, according to the *Monitoring poverty and social exclusion 2016* report of the New Policy Institute (2016).

Even in the affluent Netherlands with a highly competitive global economy the *CBS – Centraal Bureau voor de Statistiek* / "Statistics Netherlands" – estimates that some *one million* of the Dutch population of 18 million are living in poverty although a few years back politicians were strongly denying the existence of poverty in the country. And there is broad evidence that poverty is linked to poor mental health and that income largely determines health and longevity (Marmot: 2015). Indeed, the Policing, Health and Social Care consensus states that:

> "The social determinants of health such as housing, education, work and income overlap with the social determinants of crime. Key risk factors for poor health align closely with risk factors for offending; and those who are or are at risk of offending as a group are more likely to suffer from multiple and complex health issues, including mental and physical health problems, learning difficulties, substance misuse and increased risk of premature mortality".

Such disparities have, then, major social consequences which impinge on the LEPH institutions while welfare states which, alongside the multiple benefits they undoubtedly bring, have created huge and expensive institutions which have become open to dispute and demands for change in the harsher political climate of recent years.

PH systems, moreover, lurch from one crisis to another yet somehow manage to emerge hydra-like to fight another valiant battle in the face of under-funding, lack of capacity and seriously overworked personnel.[66] Not only is the UK's NHS in "constant crisis" but in some areas of the UK life expectancy is even falling (Dorling: 2018). And LE has always been something of a chameleon changing with the ideological wind of those in power but never straying too far from the habitual "law and order" preoccupation of its institutional genes.

This institutional roundabout was evident roughly two decades ago when many forces across the globe climbed on the bandwagon of "zero-tolerance" policing / ZTP and reverted to harsh "crook-catching" based on the well-publicized and commercially promoted New York "miracle" (Bratton and Knobler: 1998; Punch: 2007). In effect, COP and POP were shunted aside and replaced with aggressive and discriminatory "kiss the concrete" enforcement. Although this is still the favoured rhetoric of the right – Theresa May's "only cut crime" mantra – we have shown that police agencies in a number of countries have become socially conscious and geared to helping the weak, needy and vulnerable in recent years. Policing, in effect, should rebrand itself to become the *Police and Emergency Service* to convey the reality of what police do in a range of non-crime areas. In effect, that is what has happened in Scotland with policing strongly adopting and pushing a "PH" approach to violence and with encouraging results (*Guardian*, 2018, 24 July). This recent redefinitional process in reaction to the shifting landscape of LE is, of course, highly commendable.

But it is quite conceivable that, under political and financial pressures, LE will again shift in the prevailing wind and will resort to a narrow perception of " law and order" and retreat from some of its more burdensome partnerships with PH agencies except on a bare, reactive, non-reflective, emergency basis. We are simply saying that these are harsh and uncertain times for both systems and for the interaction between them. With political and social opinion moving to the far right in a number of societies, notably in the USA but also within certain EU countries, there could be bleak and retrograde steps taken that undermine much that has been achieved. Indeed, Vitale (2017) in *The End of Policing* argues that many counter arguments to the current right "law and order" orthodoxy – more police powers, harsher sanc-

[66] There have been a number of fly-on-the-wall TV documentaries about the UK's NHS in recent years. Clearly vulnerable individuals with complex health needs are interacting with over-stretched services. At peak times the operations for people requiring surgery are cancelled even when they have arrived at the hospital while some are in pain and distress; there are corridors clogged with beds as patients await treatment; and outside a jam of ambulances fill the approach road because the crews cannot deliver their patients and hence cannot leave to collect another patient. You also see dedicated and passionate professionals desperately trying against the odds to keep the hospital functioning: but it's all hands on deck (e.g. BBC TV series, *Hospita*l, 2018).

tions, tougher on immigrants – are being dismissed out of hand despite a convincing wealth of accumulated research evidence on LE along with periodic key reports on the system with recommendations for reform (*The Crime Report*: 2015, 24 June; *The President's Task Force on 21st Century Policing* (2016); Brown: 2014; Blair: 2015; CCPC: 2005; POS: 1977; Stevens: 2013; President's Commission: 1967*)*.

Fortunately one can say that next to this sometimes rather bleak and grim analysis there are many people in both systems, and in academia, conducting innovative and fruitful work. At the two LEPH conferences (2014 and 2016) I attended, and in my wider contacts in several societies, there were motivated people working with great forethought and energy to construct partnerships which make a difference in the lives of disadvantaged and vulnerable people. In this modest and limited overview I have looked at some of that engaged work, at many populations and many sorts of interventions: but it has proven difficult to do justice to all the initiatives in western societies and especially for the LICs. There remains a massive and daunting project to chart and analyse cross-nationally one of the most important topics in contemporary societies. And this should be strongly reflected in an enhanced research effort and in the broad expansion of higher education and post-experience courses reflecting the complex challenges of the LEPH field. Above all this area cries out for a comprehensive reform agenda rooted in equality, justice and fruitful innovation. Indeed, with regard to aiding the weak, damaged and vulnerable there should be practitioners within LEPH who are not only considerate, competent and confident – which ideally should go without saying – but also, and above all, *compassionate*. There are many LEPH professionals fully espousing all four and I have met some of them personally and assembled a wealth of material on their work. They not only make a significant difference in people's lives – and in some cases literally saving their lives – but it is also enlightened self-interest, and "smart justice", in reducing the growing burden on society's overstretched services. In relation to the San Antonio (Texas) "Restorative Center" mentioned in the previous chapter, for example, it was stated,

> "The effort has focused on an idea called 'smart justice' – basically, diverting people with serious mental illness out of jail and into treatment instead. It is possible because all the players in the system that dealt with mental illness – the police, county jail, mental health department, criminal courts, hospitals and homeless programs – pooled their resources to take better care of people with mental illness" (Gold: 2014).[67]

It just needs a more compassionate society to match all those professional's vigour, inventiveness and commitment in the interests of aiding the vulnerable in society by promoting joined-up care and attention through smart, persistent and constantly learning partnerships.

[67]There's an irony to this success story in that Texas is 49th in the US states on mental health funding: this is also an indicator of how local such initiatives can be amidst an environment of political indifference and malign neglect.

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"This timely report raises the profile of 'Law Enforcement and Public Health' (LEPH) as an interlocked policy area, yet one that remains in an embryonic state despite the admirable efforts of leading scholars such as Nick Crofts along with the police policy advisor Auke van Dijk. Utilizing case studies from the Netherlands, USA, Australia and the UK, Maurice Punch shows, clearly and eloquently, how weaknesses and challenges remain in the delivery and definition of LEPH as an area of policy and practice in recent years. The idea of 'Public Health', as carefully constructed in the report, captures not only police responses to mental health issues but wider multi-agency responses and attitudes to domestic abuse, sexual violence, disability and hate crime amongst other urgent social problems. The report also valuably covers prevention, diversion and triage schemes and should be of immediate interest to policy-makers, practitioners, academics and students".

Dr. John McDaniel, University of Wolverhampton

"Everyone involved in the field of law enforcement and public health – as policy maker, academic, student, practitioner or "expert through experience" – will appreciate this first overview of the developing field of LEPH practice and research. Since many problems in modern society are too complex to solve within just one field, and the demands on those fields are increasing every year with resources decreasing, collaboration between these fields is inevitable. Maurice Punch puts the fundamental thoughts behind the LEPH enterprise and its conferences – I attended those in 2018 and 2019 – into print and illustrates them with case studies from the UK, USA, Australia and the Netherlands. All who are concerned about the multi-agency approach to the needs and demands of diverse vulnerable groups and victims across societies should read this book".

A.B.J. (Sander) Wennekes MSc, Police Education Council, the Netherlands

MAURICE PUNCH is Visiting Senior Fellow, Mannheim Centre, London School of Economics and Political Science, and has published widely in the UK, the USA and the Netherlands on policing, police corruption and corporate crime.

This work outlines the field of *Law Enforcement and Public Health* (LEPH). Attention to this topic is fairly recent and an overview of themes, ideas, initiatives, successes and failures within the field has been missing.
Maurice Punch fills in this gap as far as the UK and Netherlands are concerned, and to lesser extent Australia and the USA. He starts with defining the domains of LE and PH showing that they have a history of engagement. Then, he describes more recent initiatives of inter-agency cooperation and how they came into existence, or failed to do so. Furthermore, he elaborates on the specific areas within the LEPH domain such as mental illness, sexual abuse and domestic violence. Then he turns to disasters, trauma, teams and prevention showing how LE and PH find each other in these circumstances. In his concluding chapter, Punch looks at the interactional as well as the institutional level as a basis for LEPH.

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