Redrawing the Thin Blue Line – Recognizing and Enhancing Joined up Solutions at the Intersection of Law Enforcement and Public Health

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Introduction

The health of the public requires and is based on safety and security of the person; public health as a discipline therefore promotes safety and security. The law exists to promote safety and security; the enforcement of law is therefore part of the same endeavour. These two sectors – public health and law enforcement – should be joined at the hip, with common goals and deep collaboration. That they are often not, or inadequately so, even when dealing with the same people, populations or issues, is to the detriment of both.

Although in practice the last decades have shown an unprecedented growth in collaboration between these sectors – especially in Western welfare states – it has not led to a unified political agenda. Consequently, there is a permanent and real risk with such progress, especially with neo-liberal ideology and austerity, of returning – at least temporarily but at great cost – to the specialization perspective of the industrial era. The increased worries about (state) security – with mass migration, terrorism and economic insecurity as important ingredients – may lead to a return into the trenches. While this might be unfortunate for affluent societies, it may be a disaster for developing countries. Hence the importance of forging structural collaboration based on interdisciplinary evidence.

We consider here the nature of the two sectors and their relationship, and how it can be strengthened in the pursuit of common and complementary goals. From an academic perspective, we attempt to progress understanding of this intersectoral field and help define a basis for future research.

At the boundaries of established fields

We are faced with complex social issues which are increasingly seen to have both health and law enforcement overtones and impact, such as vulnerability to violence, especially gender-based violence, particularly in the family and domestic settings; mental health

crises; alcohol and other drug dependence and associated harms, including HIV infection; dementia and the expected increase in calls for assistance; modern slavery and human trafficking. Increasingly, we are recognizing the multidimensional character of such issues. Where these issues intersect and interact – for instance, the tangled web of violence, alcohol and mental illness – the problems we face can truly be called 'wicked'.

There is a growing awareness of the importance of the intersection of law enforcement and public health in academia as demonstrated by the growing number of publications [1,2]. There is an emerging discourse in which public health and law enforcement are seen as alternative perspectives on overlapping problem spaces. This is fuelled by the growing understanding of what 'produces' both crime and ill health, among other things. There is an impressive body of knowledge in the health sector with regard to drugs, alcohol abuse, ill mental health, domestic violence, and so on. The relatively new field of brain science is providing a physiological basis for how positive behaviours might be 'hard wired' into the human brain from very early development, within the first 1001 days. The findings also demonstrate how adverse childhood experiences set up contrary neurophysiological feedback loops which make it more difficult for positive self-image and constructive behaviours and relationships to be formed in the developing child's mind. The neurophysiological understanding of adverse childhood experiences will become increasingly significant in law enforcement and public health [3,4].

This wealth of knowledge in many cases does not translate directly into an alternative approach towards urgent societal problems. This is in part related to vested interests and related ways of working. If, to mention an emblematic example, there should not be a 'war on drugs', what would the collaboration of law enforcement and public health look like? The answers to this kind of question are seldom straightforward. This underlines the importance of multidisciplinary research and the inclusion of professionals in the research design. Although there are many relations between public health and law enforcement there is no overarching conceptual framework and a related clear universe of cases. Considering this is an emerging field [5], it is sensible to concentrate on what is happening 'on the ground' and the mapping and analysis of practices will be central to academic progress with regard to this intersectoral field.

From a practice perspective, the importance of the intersection of law enforcement and public health is strongly supported by concrete observations of professionals of both sectors, who are often dealing with the same people and related issues. Both law enforcement and public health can be characterized by the professionals and organizations involved. We will concentrate on the frontline – where professionals *have to act* – where developments at the boundaries of the traditional domains are most visible and are having real consequences, and where as a consequence of that the most telling collaborations germinate.

In the same spirit as the definition of public health, *law enforcement* is broadly defined here as 'the organized and legitimate effort to (re)produce social order – as is evident in rules and norms – in order to enhance the safety and security of a society'. As mentioned, the focus is on practices in the frontline, where the principal actor is the (public) police, with the criminal justice and offender management elements. Although the so-called

pluralization of policing and the emerging safety and security web are obviously relevant developments, we concentrate here on the public police as the most important (symbolic) actor in law enforcement and as the starting point of exploring the intersection of law enforcement and public health. Contrary to popular belief, policing is not limited to catching thieves and maintaining order. It has developed sophisticated responses to protecting vulnerable individuals, groups, communities and at situations at-risk, in activities including safeguarding, surveillance, community or public safety and public protection. As in the public health field, evidence based policy making is becoming increasingly recognised and valued in the law enforcement field [6].

Compared to law enforcement, *public health* might be even harder to demarcate. Taking public health to be 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life among populations through the organized and informed efforts of society' [7], one can grasp the breadth and the diffuseness of the venture. The public health system is geared towards outcomes at the population level, as opposed to the health of an individual, with the definition of population depending on the problem at hand and the desired health outcome. Addressing inequalities in health and underlying structural issues are key concerns [8,9]. Good public health requires societal policies, interventions and services across a wide range of activity, but it also requires specialist intervention, for example in defence against infectious disease and environmental hazards, in generating evidence based health improvement policies and services, and in evaluating the effectiveness of health and care services. In public health there is no obvious candidate acting as 'a first among equals', as public health coalitions are broad and vary depending on the issue and the desired health outcome at hand.

Both law enforcement and public health work among other things with concrete interventions with an emphasis on changing behaviour, unhealthy or criminal (both definitions being moveable and negotiated). Both sectors are involved with people or populations in need, and both have a special obligation to protect the vulnerable. In their attempts to change behaviour and in their response to incidents, they can directly influence each other and the societal outcomes that are a consequence of their interventions. Importantly, what is the 'right' intervention is always context specific, regardless of general valid guidelines or rules, be it in public health or law enforcement. To refer to the latter, where the law could be seen as an (implicit) reflection of the kind of order needed to facilitate the world 'we' – or at least 'the powers that be' – would like to live in this does not translate directly into clarity on law *enforcement*. The inability of law-makers to envisage or cover every possible real event requires police not to rigorously enforce all laws, but to *apply* the law, with judgment and discretion. The same holds true for interventions in public health. Where it might be perfectly clear which hygienic regime – for example in a particularly unhealthy neighbourhood – is called for, this does not translate directly in a specific intervention. More likely, there will be a range of possible interventions that can be applied, depending on the circumstances. This requires professionals to make professional judgments on the basis of shared values and positive societal outcomes – it is this which necessitates professionals from both sectors working together.

These collaborations are mostly seen as important, but by no means without obstacles. Typically professionals in public health will draw attention to law enforcement practices that are detrimental to public health outcomes, exemplifying the so-called 'war on drugs', repressive police action with regard to sex work, and appalling handling of people in the midst of mental health crises. Conversely, law enforcement actors will state that they are dealing time and again with people who need care, and that health professionals are missing in action, not available, not interested in safety and security. In some instances, the action of one agency may be of greater benefit to the other - for example harm reduction approaches to drug treatment taking people out of the criminal justice system, or law enforcement intervening to prevent alcohol-related harm in city centres.

Such approaches require an understanding of the potential for action by the respective agencies, and a high degree of respect, dialogue and partnership. There are many practical and conceptual barriers to this. For example, an important practical barrier is that public health and law enforcement systems and cultures come from very different starting points and there are strong incentives to stay in their respective silos; or at least there is frequently a lack of incentives to engage in an intersectoral approach. A related conceptual barrier is that neither law enforcement nor public health is a self-evident concept and the intersection of both even less so. That may hamper collaborative vision- and strategy-development, as well as structural multidisciplinary research. And the practical and the conceptual are clearly related, as are the social practices and the related institutions [10].

An emerging agenda

Both public health and law enforcement are products of the process of modernization and intimately related to the (nation) state and to urbanization. In (hypothetical) small communities in which all individuals know about the condition and behaviour of others, separate institutionalized and professional law enforcement and public health would be absent. Modern public health and law enforcement are *functions* performed by the state that have replaced intricate fine meshed social relations that were lost with the advent of the anonymous city. And both public health and law enforcement were claimed and crafted as specific organizations with related core tasks, bodies of practice and knowledge, technologies, mentalities and ethics [11].

This crafting process was especially prominent in the advent of what we now see as the modern institutions of the welfare state. So, police reform – if we can properly call it that – in Britain throughout the eighteenth and nineteenth centuries was "many-faceted", originating in "many locations" and "thrashed out at many levels"." The emphasis on "policing as prevention", so central to the concept of medical police, was well established in England through a system of "parish government" that was "a pivotal arena not only for the implementation of national policies but for initiatives that strengthened the government as a whole". As well as detecting crimes and preserving the peace, the duties of the early police included enforcing liquor laws, regulating traffic, assisting Poor Law officers, fire prevention, improving the paving, lighting and cleanliness of streets, and the general detection and removal of "nuisances" and other "annoyances" [12]. It is from this amorphous situation that modern institutions emerged.

As a consequence of fundamental changes in society in the twentieth and twenty-first centuries – e.g. from industrial to networked, from modernity to postmodern or reflexive modernity – modern institutions are under pressure, not because of their lack of success but as a consequence of it. Societal problems are at the centre of the endeavours of both law enforcement and public health, rather than 'core' tasks, and with that the realization that these problems are not adequately dealt with in isolation. Traditional organizations become increasingly boundary-less [13] leading to the need of constant negotiation and sense-making by the involved professionals. Health and risk perspectives are central to both domains, and multi-agency approaches and cross-discipline developments are gradually – at least in liberal democracies – becoming the norm.

Historically, we have seen the development and recognition of an overlapping clientele of law enforcement and public health in the aftermath of deinstitutionalization and significant disinvestment in social services: the mentally ill, poorly educated, substance-dependent and sporadically housed populations are more vulnerable, more stressed, more likely to show up at hospitals, social service agencies and police stations, carrying their costly needs with them [14,15]. Clearly the discussion on ineffective and increasingly unacceptable mass incarceration – especially in the USA - has contributed to highlighting the intersection of law enforcement and public health as well [16]. At the same time there has been a successful emancipation of vulnerable populations, accompanied by a decrease in acceptance of institutional failure. The modern city and its denizens have needs or demands for government action that are no longer manageable within the legacy of service silos built in earlier times.

It is an important time to come up with ideas – visions, strategies, research, practices – that can inform the current crafting of public institutions and services. Both public health systems and policing are to a certain extent reinvented, as is evident for example with the prevalence of police reform [17]. Without exception the policy documents that guide these reforms emphasize the importance of holistic approaches that put citizens and communities first instead of the organizational logic. At the same time all organizations are struggling with how to actually do that, and what could guide their actions – if not the classic 'core tasks' – when setting priorities.

Clearly, public health and law enforcement both present an 'ideal world image', although the respective images are not self-evident and are essentially contested. So for public health this could be a society free of disease, where people are as healthy as technically possible and hence have a maximum life expectancy with the highest quality of life possible. Clearly there is no definitive solution state attached to this ideal world image and the demand for health is logically infinite: one could always invest more in further research or include extra dimensions in the definition of health. This is echoed in the oft-cited definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', as defined by the World Health Organization [18].

This open-ended definition immediately shifts attention to a discussion on values and principles in striving for a health utopia, with fundamental questions such as: who

defines what the principal health issues are and on which grounds? Should health be distributed evenly among the population? What is the weight of individual liberties in the collective health endeavour? How do we prioritize among different public health goals? At what point do we decide to invest in other social goods, such as the arts, or infrastructure, rather than in directly furthering public health?

In turn, law enforcement obviously presupposes 'the law' and much can be said about qualities of the law-making process and of laws themselves, again encompassing many possible dimensions ranging from human rights to ill-distributed consequences. Obviously, the very theme of law enforcement and public health presupposes a human rights framework. Without that, there would be no place for law enforcement to engage in public health issues. The same holds true for public health: without human rights as a foundation one could strive for a 'healthy nation' at the expense of vulnerable communities. The current campaign against drugs by the president of the Philippines serves as a gruesome warning against law enforcement and public health *without* a human rights framework.

Assuming human rights are seen as fundamental, with law enforcement the ideal world image is a social construct, more explicitly than with public health, and hence an important and permanent subject of political debate. Given its social construction and related imperfection, a society in which all members obsessively obey the law would come at the cost of fairness and freedom – however defined. Consequently, the same kind of fundamental questions as with public health immediately take centre stage: who defines it, how are the resources distributed, and so on.

The actual - and desired – relation between law enforcement and public health depends highly on the political, economic, and cultural context and is also affected by the characteristics of the targeted issue. However, it is crucial that this intersectoral field actually *is on the agenda*. There are many urgent issues where it will make a big difference whether the debate on where to invest in law enforcement and in public health are two separate discourses, or there is a discourse on interventions at the intersection of law enforcement and public health. In the next paragraph we will discuss some of these urgent issues.

Areas of common ground for law enforcement and public health

Substantive themes for the Law Enforcement & Public Health (LEPH) Conference in 2016, reflecting the priorities assigned by the burgeoning LEPH community, were mental health (many aspects), violence (especially gender-based), trauma (especially road and occupational), crises and catastrophes, infectious disease and alcohol and other drugs. However, the range of topics covered is far wider than this, and illustrative of the breadth of this LEPH relationship (see http://www.leph2016.com/program/conference-program/). Topics can explicitly be related to current political issues, like radicalisation of youth as related to terrorism or ethnic profiling by police services. There are cross-cutting themes like vulnerable populations or leadership in an intersectoral field. We exemplify some common areas here to give a general impression of the intersectoral landscape.

Community safety and security

Concepts of security are increasingly common to policy makers and practitioners in both law enforcement and public health. The 1994 Human Development Report saw security as 'freedom from fear, and freedom from want' and described food security, social and welfare security, political, economic and environmental security as well as, civil and military security [19]. Likewise, a concept of public protection is common to law enforcement and public health. The two most readily come together to identify at -risk individuals, communities and situations through child and adult safeguarding committees [20], community safety partnerships and licensing committees (e.g. Community safety and alcohol licensing example from Cardiff [21]) and in emergency planning forums [22]. Such wider notions of community safety have required much full partnership activity, which is developed to different degrees in different political administrations and cultures.

A *community development approach* can also support better community safety and health: building on the assets of local communities to minimize tensions and prejudice and promote good relationships and mobilise positive energies towards common life enhancing goals and facilities [23].

Violence

The conceptualisation of violence as a public health problem is only relatively recent [24]. The Centers for Disease Control established a Violence Epidemiology Branch to focus its public health efforts in violence prevention as late as 1983, and it has repeatedly shown the usefulness of the application of epidemiological method to problems of violence [24,25]. Violence was placed on the international public health agenda only in 1996 when the World Health Assembly adopted Resolution WHA49.25, which declared violence 'a leading worldwide public health problem.'

With this recognition there has been extensive research documenting health costs resulting from violence – in one influential review in England in 2012, it was estimated that of the nearly £30 billion cost of violence to society, more than a tenth of which was made up of direct costs to the health system [2]. Bellis et al found that violence has many characteristics fitting it to be seen as a public health issue, including the cost to the health service, its 'contagious' or 'hereditary' character, and a very strong inequality gradient [2]. Moreover, in the last three decades, a wide range of interventions has become available to the public health practitioner which are effective and efficient – all predicated on multi-agency plans for violence prevention in specific localities, involving especially police and health and welfare authorities.

Mental health

A public mental health approach seeks to build positive personal psychological assets in the community to help people build their confidence and self-esteem and be able to negotiate and express their needs without frustration or resort to violence. Police have historically been part of the management of behaviourally disordered people, especially those suffering a mental health crisis [e.g. 26]. Almost 50 years ago, there were calls to examine the utilization of police as mental health resources, 'within the context of his *[sic]* law enforcement function', with the formation of 'Family Intervention Police Teams'

[27]. Since, there have been major social structural changes – most notably deinstitutionalization, but also the impact of neoliberal political agendas – which have both increased the frequency of contact between people with mental illness and police and complicated the ability of the police to respond [28].

There has since been much work examining different models of joining a psychiatric or social work response with a law enforcement response in crises involving mental health issues. Such models include boosting police capacity in handling mental health issues through training (e.g. Crisis Intervention Training, CIT [29,30]) and various forms of partnership between police and mental health agencies. Some models use either a team composed of a police officer and a mental health professional as the basis of the response to those with acute and severe mental illness crises, avoiding criminalization of the mentally ill [31]; other models have a mobile mental health response team which the police can call in [32]. A comparative evaluation of these three models found significant benefits for both police and for the mentally ill person from all three, but significantly higher benefit from the joint response model [32]. A study comparing the three different models in three different localities in the U.S. found large differences but that 'All three programs had relatively low arrest rates when a specialized response was made' [33]. These authors came to a most important conclusion:

> Our data strongly suggest that collaborations between the criminal justice system, the mental health system, and the advocacy community plus essential services reduce the inappropriate use of U.S. jails to house persons with acute symptoms of mental illness. [33]

There are similar findings in reviews of the effectiveness of CIT [34,35]. From their review of the field, Lamb et al conclude 'Collaboration between the law enforcement and mental health systems is crucial, and the very different areas of expertise of each should be recognized and should not be confused' [36].

Sex Work

There is much evidence that demonstrates adverse impacts of police policies and practices which directly and indirectly increase HIV risks among female sex workers (FSWs), who have little power to navigate, let alone control, these cumulative environmental factors [37]. Where sex work is criminalized, FSWs experience the negative health consequences of a punitive legal environment and are afforded few legal protections; police behaviour towards FSWs extends well beyond implementing policies that criminalize sex work. For example, while not a sanctioned behaviour, police harassment of FSWs has been documented worldwide and emerges as among FSWs' most significant challenges, with police leveraging their power and the threat of arrest to extort financial bribes or sex. Police perpetrate sexual violence against FSWs in many settings, in turn compromising the sexual and mental health of those violated. Policing also directly affects FSWs' HIV/STI risk when they confiscate or destroy their condoms, a practice that has been documented extensively in the U.S. and worldwide. Despite the emergent research documenting the impact of police behaviours on FSWs and drug users, surprisingly little has actually included police, exacerbating the perceived gap between public health and public safety.

Involving police in partnerships to reduce violence against FSWs and decrease HIV risk is more than feasible – an increasing number of examples exist. A pioneer project and study in Karnataka, India, has shown that 'context-specific structural interventions can reduce police arrests, create a safer work environment for FSWs, and protect their human rights' [38]. This exemplifies the many emerging examples of structural interventions directed at police in the context of HIV prevention programmes for FSWs, even in countries where sex work is criminalised [39]. Tenni *et al* in a 2015 review of such programs found that they 'create a better understanding of the sex trade among police officers, improve access to health and social services for FSWs, and have shown a clear reduction in police violence toward FSWs' [39]. There is sufficient evidence now that even where sex work is criminalised, structural approaches involving partnerships with police to address violence can be effectively delivered to scale, to reduce harassment, arrest, and violence against FSWs [40-43].

Common agenda

On all these themes a shared agenda – and co-ordinated practices – is important for the quality of the societal outcome. There are examples of attempts to come up with such agendas. Public Health England organised a summit (October 2016) on 'creating a shared purpose for policing and health' and published a related paper entitled 'Innovation in practice: an overview of collaboration across England' [44]. In the USA the Robert Wood Johnson Foundation includes police-community relations in their framework 'Towards a culture of Health'. At the 2016 Pearls in Policing conference (Sydney) policing vulnerable populations was a central topic. These are indications that law enforcement and public health might progress beyond incidental cooperation towards an intersectoral field.

The challenge of meaningful collaboration

An analysis of health and welfare service provision to individuals with complex needs found – because of different financial and regulatory systems, roles and responsibilities, and organisational and professional cultures – great difficulty in combining medical and social models [45]. This was just within the health and welfare sectors, and did not include collaborations with law enforcement.

As collaborative experiences and cultures build, to guard against retreat into isolated specialisation we must better understand how law enforcement and public health can enhance their collaborative efforts and shared problem solving. There are no winners and losers in meaningful collaboration, and one organization does not *impose* its *will* on another. Yet collaboration between law enforcement and public health is undoubtedly competitive, political (with a big and a small 'p') and imbued with ideological motivation and meaning, as well as emotion – positive and negative. While societal problems may be at the centre of the endeavours of both law enforcement and public health, the organising principles of each differ, and their strong cultures are often at odds [17].

Moreover the objectives driving the behaviour of each side can clash. One example of such a clash can be found in public health programs aimed at prevention of transmission of HIV. Breaking the chain of transmission among people who inject drugs by provision of sterile injecting equipment is self-evident good practice in public health terms. Police can

however be suspicious of programs that make needles and syringes easier to get, removing as they see it a disincentive for injecting illicit drugs – thereby potentially increasing crime. Even if they agree with the public health outcomes, and see health benefits at the individual level, police can view needle and syringe programs as compromising the broader public safety imperatives to which they work. The essential issue here is *what is* the community *which police are protecting*? Are those who inject drugs part of the community – or are they the threat from which police must protect the community? Such clashes can be observed in relation to family violence and mental health crises, or in any other situation in which a 'perpetrator' can be identified from whom the community must be protected.

Measuring what matters

This adherence to one's own organisational objectives and world view is reinforced through competing performance indicators. It is difficult to imagine a modern public sector that is not preoccupied with the pursuit of results and the measurement of performance [46], heavily influenced by New Public Management and the agendas of managerialism, evidence-based policy, measurement and audit [47]. Encouraging effective collaboration requires moving past siloed performance frameworks toward more sophisticated means of measuring collaborative action both formally (through key performance measures) and informally (through cultural norms).

This rather simple and obvious statement hides a great deal of difficulty and complexity. To begin with, law enforcement and public health practitioners need to identify and develop a set of shared, common goals. While objectives might be identical, the ways in which success is measured will differ, and may inadvertently drive organisational intervention in counteracting ways. For example, consider violence against women and families: while both sides might care about reducing overall levels of violence, law enforcement might focus on reducing the number of call outs for domestic violence (which may be in part because numbers of calls attended by police is easy to measure). The danger lies in our performance measurements, which drive professional behaviour, and as such while fewer calls for police assistance because of violence against women might be a positive outcome in one sense, it is negative if it is because such violence is no longer reported. Arrest quotas applied in many settings as performance measures for police in dealing with illicit drug users of sex workers are further examples [48].

Often what we most care about is the hardest to measure, but rather than an argument against trying to evaluate or quantify complex action, this is a call to improve our ability to evaluate. We need to avoid the temptation to value only what we can quantify or quantify easily; the social sciences have made great strides in quantifying difficult to capture things such as environmental amenities and value of time with family, using contingent valuation and other methods. The first step in improving our measurement of collaborative performance is to identify the desired shared outcomes. Then with a commitment to serious evaluation, even when it is difficult, law enforcement and public health must go through a process of thinking about how to measure these using improved tools, data, and methods.

Performance measurement has value beyond just encouraging outcomes, however. As law enforcement and public health *feel* their way toward meaningful collaboration, measuring success through the lens of cultural performance offers us the opportunity to encourage key actors to collaborate in ways that are most conducive to dealing with societal problems holistically – as opposed to using organisational efficiency or technological effectiveness. In contrast to current managerialist performance measures across the public sector that prioritise efficiency and the meeting of targets, cultural performance measurement privileges social efficacy, the construction of meaning and affirmation of values that are achieved by engagement with social norms. Decisions to collaborate are complex, driven by motivations that are not always rational but are reflective of particular values or meanings that are attached to collaboration. Exploring these motivations can provide insights into why actors opt in or out of collaboration, but it can also help us encourage the behaviour that we need from law enforcement and public health actors if we are to deal with societal problems holistically. In this way performance indicators that focus on the *process* of collaboration at least as much as outcomes can see collaborative behaviour rewarded, transforming siloed services to better allow the pursuit of shared values.

What do we want the relationship to look like?

While law enforcement and public health are distinct in culture, methods and tools of influence, that they address the same or related problems and serve the same communities does not automatically lead to cooperation. We need two levels of linkage to support effective cooperation. One level consists of a conceptual interface between the fields, where public health and law enforcement can achieve a shared understanding of their respective contributions to each other's mission – a simple model of health and policing that shows how police activities influence health and how health can be a guide to police practice and a measure of police impact. The second level of linkage is the practical integration of police agencies within the health system, so that care and treatment are networked, complementary and consistent. This entails the development and implementation of interlocking programs and clinical standards, referral systems and practices, and diffusion of data and records across systems. This is particularly important in systems where high-risk/repeat customer strategies are being developed/deployed. This kind of link is being constructed, usually from the ground up, in processes of local experimentation and practical problem solving. Evaluation and diffusion of beneficial models and practices is the long-term purpose for police/health engagement.

We can learn much from programmatic collaboration between law enforcement and education [see e.g. 49] and between law enforcement and employment. The crime lab at the University of Chicago (https://crimelab.uchicago.edu/) is an interesting example of joint collaboration between law enforcement, education professionals, employment programs, and public health professionals. Rigorous academic evaluation is provided by locating the lab in a university environment. Effective public policy is achieved by collaboration with agencies that actually implement programs. This model is interesting to our issue of law enforcement and public health because rather than create an over-arching bureaucratic structure to bring different interests under one agency, university researchers provide a glue. If law enforcement and public health were to jointly fund and

manage a university-based research centre, for instance, university-based researchers could provide the rigor for research evaluation and the 'outsider' perspective to assist law enforcement and public health agencies to rise above bureaucratic constraints that they might face.

That is not to suggest that law enforcement and public health should avoid the more difficult task of dealing with the siloed and un-collaborative cultures of their organisations, of course, and the role of organisational leadership and (re)positioning is central to the success of such societal problem solving. Contemporary understandings of public sector leadership move beyond the traditional hierarchical models that we have come to associate with bureaucracies and paramilitary organisations such as the police. And use of (and deference to) power and authority on their own is not helpful when dealing with complex challenges. Instead, where problems span the domains of and rely on the inputs from multiple stakeholders, boundary spanning and shared leadership, inside and outside of the organisation, and at all levels, is vital [50]. Nowhere is this more evident than at the front line, and the practical interface between practitioners. Front-line professionals on both sides must regularly make decisions about how best to interact and partner with their opposite numbers. In doing so effectively they must draw on their shared loyalty to positive health and safety/security outcomes for the community. Empowering front line staff to do this is a role for formal bureaucratic leaders who must identify and encourage these shared outcomes and create a climate of innovation and problem solving, while examining the unintended consequences and deleterious impacts of their own organizational motivations. Leaders must reward and recognise the contributions of individuals who are willing to see beyond their own narrow bureaucratic boundaries; must remove hurdles to such; must create *slack* in a system driven by efficiency dividends so that people have space and time to allow for creative cross-boundary thinking; and must develop a culture of learning, accepting that when dealing with complex social problems, some initiatives will work and some will not.

This last point can be particularly troubling to law enforcement and public health when the unsuccessful intervention in question is one that either side holds close. One of the most difficult aspects of effective public policy is confronting programmatic failure. As we move toward more sophisticated measures of collaborative performance and outcome success, so we increase chances that well regarded practices on either side will be exposed as counterproductive to the improvement and health and security as a whole. This is the natural course of evidence based practice of course, that has seen policy changes on both sides: from the use of blood-letting to cure illness up until the 19th century; to the use of coercion to extract 'confessions', regrettably more recently. In both cases the weight of evidence and outcome indicators have found that such practices do more harm than good, yet there are analogous practices on both sides that may be more difficult to let go. For example, Deaton (2013) discusses the many ways in which development assistance to the third world has increased corruption, poverty and inequality, and over the last 70 years has done more harm than good [51]. But it can be difficult for proponents to accept such failure and getting rid of programs that don't work in order to free up money for things that do work is one of the most difficult challenges that bureaucracies face. Bureaucratic capture and inertia are well understood. And leaders have a role to play in challenging this.

Conclusion

In some countries there clearly is an emerging agenda on the intersectoral field of law enforcement and public health. There is a growing consensus that a holistic approach will generate the best results, but at the same time it seems very hard to achieve this in practice. There seems to be a growing gap between what we know – both in law enforcement and public health – and what we are able to achieve. This is related to the current mismatch between the classical institutions and the changed – and increased – demands for security and health. To quote Neyroud on policing [17]: 'Crime has gone down, yet the police are in a crisis'. One of the reasons for that is that the police are not delivering what is expected, and protecting vulnerable populations is an important part of that. From a public health perspective it is unsatisfactory – to say the least – that the great advances in this field are offset by, for example, an increase in ill mental health in the population or the failure to prevent domestic violence. When things go (often horribly) wrong in this intersectoral field we often conclude that a holistic approach could have prevented the incident. This does not lead inescapably to a change in practice; there is always the risk of retreating to the so-called core tasks and related protocols.

We emphasized the importance of practices and hence of the practitioners in this intersectoral field in bringing about required the change. This implies further training and professionalization. Where health is an already established profession policing is currently quickly moving into that direction, with the UK leading the way. The intersection of law enforcement and public health needs to be emphasized in further professionalization of both sectors. This requires the intersectoral field to stay on the societal and political agenda as well. And a change in discourse and institutions. It is necessary to reinvent government 'again' but instead of New Public Management it is about New Public Value: efficient, effective and legitimate *outcomes*. Calculations change fundamentally if efficiency and effectiveness are related to outcomes – like a reduction in violence – instead of being applied to the working of separate silos. As stated, measurement is important in this, especially measuring the outcome of (complex) interventions. This may require different types of – often complicated and time consuming – research which takes invariably messy practices seriously. Such measurement is crucial to the sustainability of the intersectoral field of law enforcement and public health.

We are fully aware that we concentrated in this article on affluent societies, while at the same time the most pressing needs – and highest potential gains – are to be found in less-well endorsed and/or post-conflict societies. It is about redrawing the Thin Blue Line in a way that is conducive to both security and health. We believe this to be a worthy cause that requires dedication from policymakers, academics and practitioners alike, both in the Global North as in the Global South.

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