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## Policing and Public Health—Strategies for Collaboration

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**Policing and public health** have largely been perceived by clinicians, researchers, and policy makers as 2 entirely separate approaches to reducing violence. This long-standing tradition, reinforced by the different languages of criminal justice systems (eg, deterrence, culpability, victimhood, and offending) and public health systems (eg, injury, risk factors, and epidemiology), has perhaps contributed to limited collaboration between local law enforcement agencies and public health to prevent violence. It has also probably limited collaboration between criminologists and population health researchers relative to other cross-discipline areas such as road traffic safety, prisoner health, and prevention of substance abuse.

Yet the safety of populations and individuals is a chief concern of both policing and public health. Furthermore, both citizens and law enforcement officials experience morbidity and mortality from violence, and policing actions can directly affect the provision of public health services.<sup>1</sup> In light of the need for improved multisector efforts to prevent violence, there have been calls for greater collaboration between the various disciplines that are tasked to prevent and respond to violence. However, most health professionals have limited knowledge about the rationale for partnership between the health sector and police, and how this might be done. This Viewpoint discusses strategies for such work.

### Data Sharing

Based on the discovery that official police reports contain limited information about the precise nature of each homicide, homicide review commissions have emerged in some US cities over the past 2 decades, although the number and extent of such partnerships have not been quantified.<sup>2</sup> These multisector boards, which are often convened by mayoral offices or

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police departments and which can include health professionals, review each homicide death. Based on the detailed knowledge that emerges, they seek to devise locally relevant prevention strategies.

In one program, 6 police districts in Milwaukee were randomly assigned to homicide review interventions. After the intervention was implemented, during the subsequent 17 months mean homicide counts in treatment districts decreased by 1.13 homicides per month, whereas mean homicide counts in control districts increased slightly, by 0.31 homicides per month. Statistical models adjusting for district-level covariates revealed that the homicide review commission interventions, such as increased patrol of high-risk taverns and civil penalties for, and abatement of, certain rental properties, were associated with a statistically significant reduction in homicide, whereas no statistically significant change was noted in control districts.<sup>2</sup>

Beginning in the United Kingdom and then extending to other European countries and the United States, recognition has increased that up to three-fourths of nonfatal violence that results in emergency treatment is unknown to the police. Data from the US Department of Justice's National Crime Victimization Survey, a national household survey that sampled 701 000 individuals 12 years and older from 2006 to 2010, revealed that more than one-half (52%) of all violent incidents in the United States were not reported to law enforcement.<sup>3</sup> This low level of police ascertainment of violence is largely because the police depend on injured people to report violence. Common reasons for not reporting include perceiving that the police are unable or unwilling to help and fear of reprisals by the offender.<sup>3</sup> Furthermore, despite laws mandating that health care practitioners report injuries from interpersonal violence to law enforcement authorities, a multisite study in Seattle, Memphis, and Galveston that attempted to link police and the health records of 1915 people with fire-arm injuries found that 9% of incidents were unknown to police.<sup>4</sup> Consequently, from the perspectives of both emergency health services and national crime surveys, official police data provide an incomplete picture of the magnitude and hot spots of violence in communities.

In light of underreporting, hospital-based violence surveillance has been established in the United Kingdom to identify precise violence locations, weapons used, incident times, and number of assailants. These data are anonymized and shared with police and local government partners who meet regularly in community safety boards to decide prevention responses. This approach has, for example, helped reveal gang violence locations previously unknown to municipal authorities. A 7-year study (from 2000 to 2007) of this approach that compared Cardiff, Wales, with 14 matched UK cities that did not implement the strategy found that violence-related hospital admissions declined from approximately 7 to 5 per month per 100 000 population in Cardiff compared with an increase from 5 to 8 per 100 000 in the comparison cities, a 42% relative reduction.<sup>5</sup> In the United Kingdom, such data sharing is now mandated nationally by contract with National Health Service hospitals. While this type of information sharing is not required in the United States, such an approach is currently being tested in a limited number of cities.

## Policy and Environmental Change

A second rationale for advancing collaboration between police and health institutions is that these partnerships are often the only way to enact health interventions involving public policy across jurisdictions. For example, implementation of strategies advocated by the Community Preventive Services Task Force to regulate alcohol establishments (such as restricting hours of operations or sales to minors) depends entirely on enforcement. Prospective studies of policy interventions have demonstrated little behavioral change until an enforcement component is added.<sup>6</sup> In an example of police–public health collaboration, Baltimore police officers conducted investigations of stores selling ammunition to minors, while the Baltimore Health Department used its licensing and abatement authority to achieve corrective action at such facilities, resulting in a 46% decrease in the number of businesses eligible to sell ammunition after these interventions were implemented in 2002.<sup>7</sup>

Beyond business-level policy interventions, law enforcement officials are also responsible for administering individual-level legal interventions that have been advanced by health researchers and practitioners, such as police protection orders for intimate partner violence. A time series analysis of 46 of the largest US cities from 1979 to 2003 revealed that higher police staffing levels were associated with a 32% relative reduction in total intimate partner homicides and that policies allowing the warrantless arrest of violators of domestic violence restraining orders were associated with a 16% relative reduction in intimate partner homicides.<sup>8</sup>

Beyond enforcing public policy, police–public health collaborations in some cities have also been key to generating new policy and built-environment initiatives. In Cardiff, the police–public health partnership, acting on combined emergency department and police violence data, initiated the adoption of plastic barware by tavern associations and the conversion of streets prone to interpersonal violence due to high concentration of people and alcohol outlets to pedestrian-only use, as well as proceedings to close or limit the opening hours of nightclubs. Recognizing the effectiveness of policing hotspots, the partnership also initiated placement of closed-circuit television cameras, changes in police patrol routes, and redeployment of some suburban police to urban centers.

## Training and Responding Together

Collaboration between law enforcement and health professionals is also evident in shared responses to violent incidents or police calls for service in the field.<sup>9</sup> Crisis intervention teams, which are among the most well-established models, comprise police officer strained by mental health professionals or police officers directly paired with clinical staff. Crisis intervention teams assist individuals with acute psychological problems and are particularly relevant for law enforcement agencies, because people with a history of severe mental disorders are over represented among cases of fatal force used by police officers. Crisis intervention teams have demonstrated increased appropriate referrals to mental health professionals and decreased rates of arrest.<sup>10</sup> Partnering police responders with mental health professionals or other trained patient advocates also leads to increased willingness to

engage police for assistance in the future, as demonstrated in evaluations of youth and domestic violence interventions.

The model represented by crisis intervention teams is also expanding thinking about collaborative field responses to violence. Pairing clergy with police officers is one product of this. The efficacy of “capable guardians” is well established in criminology, and the deployment of volunteer pastors paired with law enforcement officials is an example of such guardianship that is emerging in both US and UK cities.

## Conclusions

Evidence-informed police services are important to the health of citizens, but to date, neither health agencies nor police services have generally considered policing as part of a public health response to violence. However, formal police–public health partnerships recognize the distinctive yet complementary roles of both partners and provide communities with a much fuller picture of violence and its risk factors. They also provide a mechanism through which violence could be prevented more effectively, help to enact and uphold beneficial public policy, and ensure a well-balanced field response to violence that engenders community approval. Now is an opportune time to expand and improve police–public health partnerships in the United States.

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