Police Violence: Reducing the Harms of Policing Through Public Health–Informed Alternative Response Programs

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Police violence is a public health issue in need of public health solutions. Reducing police contact through public health–informed alternative response programs separate from law enforcement agencies is one strategy to reduce police perpetration of physical, emotional, and sexual violence. Such programs may improve health outcomes, especially for communities that are disproportionately harmed by the police, such as Black, Latino/a, Native American, and transgender communities; nonbinary residents; people who are drug users, sex workers, or houseless; and people who experience mental health challenges.

The use of alternative response teams is increasing across the United States. This article provides a public health rationale and framework for developing and implementing alternative response programs informed by public health principles of care, equity, and prevention.

We conclude with recommendations for public health researchers and practitioners to guide inquiries into policing as a public health problem and expand the use of public health–informed alternative response programs. (*Am J Public Health*. 2023;113(S1):S37–S42. https://doi.org/10.2105/AJPH.2022.307107)

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After decades of activism led by marginalized communities, the American Public Health Association (APHA) recently declared police violence a public health issue in need of public health solutions.[1] One intervention to reduce the harms of policing is the use of trained, unarmed, nonpolice alternative response teams to respond to emergency calls for behavioral health crises and nonviolent incidents (e.g., noise or loitering complaints, traffic incidents, or requests for general assistance).

In this article, we (1) detail how working toward health equity in the United States requires alternatives to contemporary policing, (2) describe key differences between existing response models and public health–informed alternative response teams, (3) identify strategies for aligning alternative response programs with public health values, and (4) recommend actions for public health workers.

HARMS OF POLICING AND THE NEED FOR ALTERNATIVES

Policing in the United States is historically rooted in suppressing racially marginalized groups to exploit labor, control wealth accumulation, and dismantle social movements that challenged White supremacy and structural racism.[2] Stemming from a system used to assert White dominance by consolidating resources to benefit White people in power,[2] current policing practices in the United States continue to perpetuate racial disparities by disproportionately targeting Black, Latino/a, Native American, and other marginalized groups.[3–5] These policing practices—and the resulting incarceration and ensnarement into the criminal legal system—are a root cause of health inequities.[2,6,7]

Evidence of Systemic Policing Harms

Each year, police kill more than 1000 people and injure more than 50 000 young people 15 to 34 years of age in the United States.[3,8] These deaths and injuries are patterned by race. Black people are 5 times more likely than

White people to sustain an injury by police that requires emergency room care,[1] and police violence is the sixth leading cause of death for young Black men.[4] Although police violence against Black men and boys has recently received research and media attention,[9] other racial/ethnic groups (e.g., Latino/a, Native American) and marginalized groups (e.g., people who are drug users, sex workers, transgender, or houseless or experience mental health challenges) are disproportionately affected. Data on the full extent of harms caused by police—including physical, sexual, and psychological violence—are not accurately documented or comprehensively collected.[8,10]

The harms of police violence ripple across families, communities, and society. Police violence can increase parental stress, caregiver responsibilities, job loss, and family economic hardship.[6] Policing practices have been shown to affect mental health and increase rates of adverse health conditions for people living in heavily policed communities.[5,11] Research shows that the killing of Black people at the hands of police also destabilizes Black Americans' mental health vicariously as individuals do not need to live near or know victims to be traumatized by their death.[12]

Current policing models also harm communities through aggressive escalation of incidents (e.g., traffic stops) and behavioral health crises. Since the 1960s, the US government has shifted funding for addressing social problems to local police departments.[11] This investment in police occurred even though police are not mental health or social service professionals, and 68% of law enforcement agencies have no specialized response protocol to address mental health crises.[13] When police respond to behavioral health crisis calls, they are likely to use the main tools of their training, citations and arrests.[14]

Despite limited evidence that investing in police reduces crime rates or harm to communities, state and local governments have increased funding for police over the past decades.[15,16] Coupled with the mounting evidence of harm and ongoing activism led by directly affected communities, these data have prompted many people in the United States to seek and build alternatives to armed police that support community health.[14,17,18] Given the APHA policy statement on police violence,[1] public health researchers and practitioners have essential roles in examining existing approaches and advocating for public health–informed alternative response programs to remove the harms of policing and promote public safety and well-being.[2,6,9]

Alternative Response Versus Police-Involved Programs

Increasingly, municipalities are exploring ways to reduce the harms of policing by creating community safety response programs that do not include the police. These types of response programs have been labeled "community response models."[14,17] We call them "alternative" response programs to specify that they are an "alternative to police involvement." Analysis of emergency call data shows that 33% to 68% of 911 calls are "noncriminal" and could be diverted to alternative response programs or handled administratively.[17] Recently established alternative response programs often begin by redirecting calls away from police for mental health or substance use crises.[17]

Emerging evidence suggests that these programs are efficient and effective. For instance, the country's longest-running alternative response program, Crisis Assistance Helping Out On The Streets (CAHOOTS), receives 2% of the Eugene, Oregon, police department's budget while handling 10% of calls in which police would have traditionally responded.[19,20] During the 6-month pilot of the Support Team Assisted Response (STAR) program in Denver, Colorado, there was a 34% reduction in the incidents the STAR team was designated to respond to, as well as a reduction in the number of crimes within the geographic boundaries of the intervention. Also, STAR was implemented at a quarter of the cost of police response.[14] Overall, alternative response teams are more likely to respond to calls for service with care (e.g., linkage to health services, de-escalation) versus criminalization.[14,18]

The absence of public health–informed approaches and advocacy has meant that the most frequent types of reforms used, crisis intervention teams, expand the role of police in mental health crises rather than funding a separate response team with adequately trained social service providers. There are more than 12 000 local police departments in the United States, within which more than 3000 crisis intervention teams have been trained since the 1980s.[21] Another police-involved reform often implemented is the co-response model, wherein police are dispatched with mental health practitioners to behavioral health crises. Quantitative evaluations of co-response programs have shown mixed results regarding arrest rates between co-response and police-only teams,[22,23] and rigorous evaluations of crisis intervention team models have revealed that they do not significantly

affect arrest or use-of-force rates among officers who have received the training.[24] Thus, the most commonly used reforms still respond with an armed officer and do not diminish the criminalization of people in mental health crisis.

Alternative response programs will likely increase across the United States as a result of recent funding by the Biden administration in Section 9813 of the American Rescue Plan for "community-based mobile crisis intervention services." Although these programs have the potential to reduce the harms of policing by reducing the scope of police response, this growing programmatic solution has wide variation, and there is an urgent need to use public health data and principles to inform these investments.

PUBLIC HEALTH–INFORMED ALTERNATIVE RESPONSE PROGRAMS

Existing alternative response programs vary in personnel, scope, and operation. Public health–informed alternative response teams can respond to a range of situations, including mental health or substance use crises, nonviolent incidents (e.g., noise or loitering complaints, traffic incidents, requests for general assistance), and low-level offenses (e.g., trespass or indecent exposure).[14,17,18] These response teams typically include people trained as social workers or medics and community members trained in crisis intervention or de-escalation. In this section, we highlight 3 key strategies based on public health values and the evidence reviewed in the preceding section to guide a public health–informed alternative response program.

The first strategy is to involve directly impacted communities in program design, implementation, oversight, and evaluation. A core principle of public health program design is that affected communities should be at the center of any design process. In this case, impacted communities would include those disproportionately harmed by police. This process should involve broad community engagement, hiring and empowering community members as key decision makers and implementers in the program.

Community engagement was critical to developing the Street Crisis Response Team (SCRT) program in San Francisco, California.[25] Community-based organizations and directly affected individuals were involved in planning and launching this pilot initiative. This engagement resulted in teams having a geographic focus to emphasize relationship building within different communities and instituting follow-up support after an initial crisis response.

Beyond the design, members from these communities should be integrated into an alternative response program as responders or other staff. The SCRT program includes a community paramedic, a behavioral health clinician, and a peer or person with lived experience.[25] The CAHOOTS program also specifically hires people with lived experience or work experience in de-escalation who respond alongside a medic.[20] Similarly, the STAR team consists of a mental health worker and a paramedic.[14]

Finally, all programs need ongoing oversight and evaluation to ensure that program goals and design are enacted appropriately and minimize harm. Members from directly affected communities need to be able to indicate which evaluation questions are most important and keep the program and its staff accountable for any harm. In Denver, after the initial success of a pilot program, the crisis response team expanded and was placed within the department of public health. However, the lack of inclusion of community members and organizations in decision making—particularly on a promised community advisory committee—has fostered distrust with community-based organizations. Alienated from this work, community members are now considering parallel response programs that are more responsive to community needs.[26]

The second strategy is to develop a program that operates independently of law enforcement agencies and the broader criminal legal system. Ample evidence demonstrates that police surveillance, harassment, and violence harm a community's mental and physical health.[3,6,8] Similarly, police contact is an entry point to the criminal–legal system, which traps historically marginalized groups into systems of parole, detention, jails, and prisons, which are also detrimental to health.[1,27] A public health–informed alternative response program must operate independently from these punitive and harmful systems, work to diminish their impact, and be linked to supportive public health and social services. To be considered an alternative response program, the program cannot exist within a police department, include police as first responders, or co-respond with police.

Structuring independence from police and the criminal legal system occurs at multiple points within alternative response program development. The control and operation of existing alternative response programs differ as a result of the varying concerns, needs, and power of local advocates and the responsiveness of government officials. For example, San Francisco's SCRT is

administered by the Department of Public Health in partnership with the fire department,[25] an example of a program housed within the municipal government. Alternatively, community groups in Oakland, California, pushed to house the Mobile Assistance Community Responders (MACRO) program within a community-based agency.[18] After the Oakland City Council decided to locate MACRO within the fire department, community advocates successfully pushed for a resolution establishing community control of the program.[18] The CAHOOTS program in Eugene is housed within a nonprofit medical clinic and contracted by the local government for crisis response services.[20]

In addition, some communities have proposed establishing alternative response teams as entirely new city entities, for example the Department of Community Safety and Violence Prevention in Brooklyn Center, Minnesota, and the Community Safety Department in Durham, North Carolina. By contrast, efforts such as Mental Health First in Oakland and Sacramento, California, have been developed by grassroots organizers and are funded and operated by local communities entirely separate from the municipal government.[18]

Beyond where programs are housed, whether and how alternative response teams receive 911 calls is another critical juncture for reducing or eliminating interactions with police. Ideally, an alternative response program has its own emergency number (e.g., 311). Yet, even with a separate number, alternative response programs may seek to be first responders to specific types of calls for service received by 911 call centers. Clear training protocols for 911 dispatchers are necessary so that police are not the default responders to behavioral health crises or any other calls for service deemed appropriate for the alternative response team to address. Police response to calls in which alternatives were expected or requested may erode trust between alternative response teams and directly impacted communities, threatening program success. It is also important to establish whether law enforcement operates local 911 call centers given that this varies widely across the United States. In those instances, it is crucial to prevent law enforcement from accessing call records or influencing diversion protocols.

The third strategy is to secure adequate program and social service funding by diverting funds from police. If an alternative response program does not have sufficient resources to respond in times of crisis, community members could view it as a failure. Funding should be allocated not only for program operations but also to equitably compensate directly impacted community members involved in the program's design, implementation, evaluation, and oversight.

In addition, if the broader ecosystem of social services is underfunded,[2,7,28] the impact of connecting people to supportive social services will be limited. Funds should be allocated to multiple social systems given that the ultimate success of alternative response teams depends on connecting people to critical support services. Although many municipalities face budgetary constraints, evidence shows that alternative programs can divert responsibilities from the local police (e.g., CAHOOTS, STAR).[14,19] Reallocating public funds toward programs aligned with public health principles and the social determinants of health is critical. The funding for these alternative programs should shift resources away from police budgets as the scope of police work decreases.

This is contentious territory. Although calls to defund the police have grown, actual budgets have not decreased.[29] Even where the scope of police work has diminished, police budgets have not. For example, although the CAHOOTS program has diverted a significant portion of calls from the police, the police budget has not decreased commensurately with the police workload.[19,20] When the STAR program expanded in Denver, the police chief noted its impact but did not decrease the police budget.[18] Movements for alternative response programs and robust social services need municipal budgets to shift funds from punitive and harmful systems into public health–oriented preventive systems.

RECOMMENDATIONS FOR ACTION

Alternative unarmed response programs represent a potential public health intervention to reduce the harms of policing but only if they are planned, implemented, and adopted with public health values and principles—as described in the preceding section—at the forefront. We share 3 recommendations for public health workers (e.g., researchers and practitioners) to support the expansion of public health–informed programs.

First, public health workers must consider police violence when identifying the causes of health issues and health inequities in local communities. For too long, public health entities have ignored policing as a root cause of health inequities. Public health workers can identify how armed policing and its sequelae contribute to health problems in local communities and require an urgent public health response, such as a public health–informed alternative response program.

Second, public health workers can advocate for public health–informed alternative response teams in their local area, guided by the 3 strategies in the preceding section. After further education (e.g., a review of APHA policy statements and research[1,27] and the first rigorous evaluation of an alternative response program[14] and a thorough assessment of different alternative programs by directly impacted community advocates and researchers[18]), public health leaders should communicate with local elected officials that policing is a public health issue that warrants intervention. Public safety is frequently considered an issue in which police have expertise. However, the social determinants of health literature suggests that many public safety issues are exacerbated by armed police and a lack of supportive social services.[1,7] Public health offers a critical framing that can reorient power and resources toward care, equity, and prevention and away from punitive and violent systems.

Finally, public health workers should conduct rigorous evaluations of alternative response programs in collaboration with community partners to identify their potential causal role in improving health and addressing health inequities.[14] It is critical to partner with directly impacted communities and individuals to ask the following questions: What are the effects of reducing police interactions and using alternative first responders? What are the characteristics of alternative response programs that improve health and reduce health inequities? What key supports are necessary to implement such programs?

CONCLUSION

Over the past decade, public health research has demonstrated empirically that policing is a public health issue. We now need to expand our efforts using public health values, skills, and data to advocate for public health–informed programs that are alternatives to policing. Substantial public health research demonstrates that police perpetrate harm, contribute to criminalization, and inhibit linkages to supportive social services. It is time for public health to reorient public safety programs and resources toward initiatives that do not involve the police and are rooted in care, equity, and prevention. AJPH

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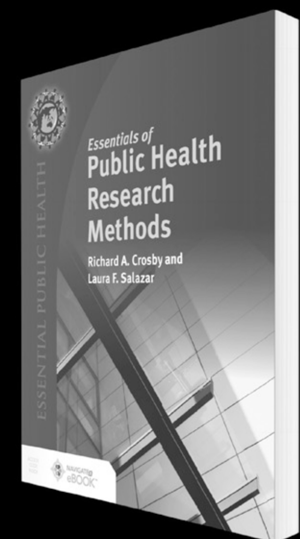

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