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RACISM, EQUITY AND DISPARITIES IN TRAUMA (S ROGERS AND T ZAKRISON, SECTION EDITORS)

Compounding Trauma: the Intersections of Racism, Law Enforcement, and Injury

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Abstract

Purpose of Review Traumatic injury sits at the nexus of law enforcement and structural racism. This narrative review aims to explore the major impacts of law enforcement on health, its intersections with US structural racism, and their joint impacts on traumatic injury and injury care.

Recent Findings Many of the same forces of systemic disadvantage that put Black people, other people of color, and other marginalized groups at risk for violent injury also expose these same individuals and communities to intensive policing. Recent evidence speaks to the broad impact of police exposure and police violence on individual and community physical and mental health. Moreover, injured patients who are exposed to law enforcement during their care are at risk for erosion of trust in and relationships with their healthcare providers. To optimize the role of law enforcement agencies in injury prevention, collaboration across sectors and with communities is essential.

Summary A broad approach to the prevention of injury and violence must incorporate an understanding of the intersecting impacts of law enforcement and structural racism on health and traumatic injury. Clinicians who seek to provide trauma-informed injury care should incorporate an understanding of the role of law enforcement in individual and community health.

Keywords Trauma · Law enforcement · Structural racism · Health disparities

Introduction

The Law Enforcement Code of Ethics, adopted in 1957 by the International Association of Chiefs of Police, states that a law enforcement officer's "fundamental duty is to serve the community; to safeguard lives and property; to protect the innocent against deception, the weak against oppression or intimidation and the peaceful against violence or disorder; and to respect the constitutional rights of all to liberty, equality, and justice" [1]. This mission complements the definition of public health given by C.E.A. Winslow in 1920: not only "preventing disease, prolonging life, and promoting physical health" but also "the development of the social machinery which will ensure to every individual in the community … his birthright of health and longevity" [2]. As it is currently structured and practiced in the USA, however, law enforcement and the criminal legal system pose serious challenges to individual and community health and contribute to the broad, systemic disempowerment and criminalization of Black people, with pronounced adverse effects on the well-being of people of color and other marginalized groups [3••, 4, 5].

This narrative review aims to explore the major impacts of law enforcement on health, its intersections with US structural racism, and their joint impacts on traumatic injury and injury care. The impacts of law enforcement on

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health include not only the potential to prevent or interrupt violence, but also injuries and deaths caused by police, the adverse mental and physical health impacts of exposure to intensive policing, and to the downstream harms of incarceration for individuals, families, and communities [6, 7]. Where policing is invasive, or where it overlaps with healthcare delivery, it may compromise access to and trust in healthcare providers and institutions [8, 9••].

The harms of policing have not developed by chance, nor are they inevitable. The history of law enforcement in the USA includes the legacy of slave patrols [10], but in the last half century, the US criminal legal system has expanded its reach [11]. This expansion has taken place in the context of chronic disinvestment in social services that has left police responsible for everything from traffic stops and noise complaints to evictions, overdoses, and psychiatric emergencies [12]. In policing, a key aspect of this expansion is the growth of "order maintenance" or "broken windows" strategies. These approaches to policing draw on the assumption that minor disorder portends serious crime and violence. Police forces are then tasked with maintaining order, leading to frequent stops and arrests for low-level offenses. Unfortunately, this intensive approach to policing has not been clearly shown to reduce crime [12], but has contributed to a fivefold increase in the proportion of the population that is incarcerated [13]. As Michelle Alexander has argued in *The New Jim Crow*, mass incarceration has served to substitute for segregation and other forms of legally explicit racism [14]. Thus while Black Americans comprise only 13% of the population, they make up 40% of the prison population [15].

As Rich and Grey argue in their 2005 article [16], heightened feelings of insecurity and stress, and the onset of PTSD, depression, and other mental health consequences of traumatic injury can lead patients to use drugs to manage symptoms and stress and carry weapons out of concern for personal safety. Some may participate in risky activities to re-establish respect and authority in their social circles [16]. These coping strategies can increase risk of further violent injury, violence perpetration, arrest, and incarceration [17]. By summarizing the intersecting impacts of law enforcement and structural racism on health and traumatic injury, we hope both to inform a broad approach to the prevention of injury and violence, and to provide contexts for clinicians working to provide trauma-informed care to injured patients whose history often includes adverse exposures to the criminal legal system.

Injuries and Deaths Caused by Police

Perhaps the most direct impact of policing on injury is the approximately 1,000 civilians killed by police each year (4% of homicides) [18, 19•, 20, 21]. By contrast, in 2021, 12% of the 526 deaths in the line of duty for US police officers were due to firearm injury (including unintentional injury), while 69% were due to COVID-19. Ninety-five percent of people killed by police are men. Black men are 2.5 times more likely to be killed by police than white men, Native American men 1.5 times, and Latino men 1.3 times more likely. Black women are 1.4 times more likely than white women to be killed by police. Asian men and women are both half as likely as white men and women to be killed by police [3••, 22•, 23••].

While there is no comprehensive data source that accurately reflects fatalities and nonfatal injuries caused by police [24], healthcare data suggests at least 50,000 Americans visit an Emergency Department each year for an injury caused by police [25], with common causes of injuries including being struck or hit, tasers, and tear gas [25, 26]. A recent analysis of the national trauma databank revealed 1,091 civilians shot by law enforcement officers over three years. The majority of those shot by officers and treated in participating trauma centers were male and were civilians, but unfortunately this study did not evaluate race [27]. Racial disparities do extend to nonfatal injuries [28, 29]. While the ratio of injuries to arrests are roughly consistent across racial and ethnic groups [26], underlying disparities in arrest rates lead to disproportionately high injury rates among Black, Native American, and Latinx individuals.

The harms of police killings also extend beyond the victims and their families to broad, negative effects on the mental health of Black Americans [30••, 31]. Police violence leads to "collective anger, grief, and hopelessness" in affected communities [4, 32]. Excessive police use of force accompanied by chronically inadequate apprehension and prosecution of perpetrators of violence adds to feelings of powerlessness in Black communities [4]. In addition to promoting violence by impairing police-community cooperation, intensive policing can impair individual and community health through direct effects on mental health and well-being, and by deterring individuals from seeking healthcare [6, 9••].

Efforts to understand and prevent law enforcement-associated injuries and deaths are limited by a paucity of data on the frequency and circumstances of these injuries, which are underestimated in national vital statistics data [19•, 20, 24]. The National Violent Death Reporting System (NVDRS) collects detailed data on the circumstances of violent deaths from healthcare, law enforcement, and other agencies. NVDRS counts have been validated with crowdsourced data sources, and as the system expands to include all 50 states, will provide valuable detail on killings by police [18, 19•], allowing researchers, communities, and policy makers require an in-depth understanding of the circumstances, practices, and policies that contribute to these injuries, and of their alternatives.

Law Enforcement Presence in Trauma and Emergency Care Spaces

Trauma patients often encounter law enforcement officers in the course of their clinical care. This exposure can complicate both their treatment and their experience of care, and puts patients at risk for retraumatization, in contradiction to the principles of trauma-informed care. While patients who seek law enforcement assistance should of course be allowed to do so, police presence concurrent to care can weaken collaborative decision-making between patients and providers, decrease information-sharing, and exacerbate barriers to accessing medication and resources for recovery [33], as well as interfering with patient privacy [34•]. Patients have reported intentionally minimizing symptoms and withholding accurate information from clinicians out of fear this information would be shared with police officers [33]. Law enforcement presence in hospitals may also reinforce clinicians' negative perceptions of injured patients who may be perceived as criminals or to blame for their own injuries [35].

The overlap of law enforcement and clinical care can impinge upon patients' legal rights and opportunities, as clinicians and hospitals commonly provide access to patients' protected health information and their belongings. While patients may have the right to consent to police questioning, medical vulnerability and clinician involvement may impede their ability to protect themselves [36••].

Emergency Department staff also call upon police to provide protection from patient or visitor violence. The American College of Emergency Physicians recommendations for preventing workplace violence include deployment of security personnel, surveillance, and coordination with local law enforcement [37, 38], but the efficacy of this strategy is unclear [39, 40]. Proven strategies to decrease workplace violence include interdisciplinary teams trained in patient-centered care and de-escalation techniques [41–44, 45•, 46]. Consistently, increased law enforcement presence has been associated with increased perception of safety from clinicians [47–50], but little is known about its impact on concrete safety metrics. Isolated, disastrous examples include at least two cases of patients shot and killed by police within the hospital [51, 52]. Moreover, the impact of police presence on the experiences of patients, ancillary staff, and visitors has been little explored, nor have the potentially divergent perspectives of clinicians of color.

Racial Disparities in Exposure to Law Enforcement

Where law enforcement and criminal justice are seen as effective, community members are more likely to trust and rely on police and are more likely to cooperate with investigations that may contribute to public safety. Municipal and state police agencies are only part of a complex criminal legal system in the USA, which includes federal law enforcement, courts, and correctional institutions, but they are generally the first and most frequent point of contact for civilians. Incidents of police violence impair that trust, leading to fewer 911 calls and less information-sharing [53]. Communities of color and poor communities are often characterized by both chronic over-policing and ineffective criminal justice that can further exacerbate these dynamics [14, 32, 54].

Criminalization of poverty is a key route to criminal legal exposure. In the context of inadequate housing support and aggressive eviction policies across the USA, housing unstable and homeless individuals are often cited and charged for minor offenses like sleeping or urinating in public, best understood as crimes of survival [55]. The USA is also one of only two nations to currently use a cash bail system. As an individual under arrest can be jailed indefinitely if they cannot supply an often-arbitrary monetary sum, 3 in 4 individuals in local jails have not been convicted. These detentions can last months or years, further interrupting educational or employment opportunities, disrupting and separating families, and widening racial inequalities [56, 57]. Furthermore, the majority of people in the federal criminal justice system have not actually been convicted of a crime and are imprisoned via guilty plea, with just 2% of federal criminal defendants going to trial in 2018 [58].

Mental illness and substance use are key health concerns that are often shunted to the expansive criminal legal system, rather than to care spaces. The USA has 14 public psychiatric beds per 100,000 people, the same number as in 1850 [59]. Those who experience a psychiatric crisis in public are often arrested. And without access to financial support, crimes of survival are common. Nationwide, 40% of individuals with a severe mental illness will have spent some time in their lives in either jail, prison, or community corrections [60]. However, only one in three individuals in prison and one in six individuals in jail reported receiving mental health services while incarcerated [61]. Indeed, individuals are at higher risk for recidivism, hospitalization, and suicide upon release [62, 63].

Since the start of the "War on Drugs" in 1973, drug offenses have become the largest category of arrest, tripling since 1982 to 1.6 million in 2018 [64]. Despite similar rates of drug use among racial and ethnic groups, Black and Latinx Americans are more often arrested, prosecuted, and convicted than white Americans, and serve longer sentences [65], with the arrest rate for Black individuals more than threefold higher than for white individuals [66]. Differential enforcement accounts for a portion of this disparity, but structural inequity is also key. Beginning in 1986, for example, possession of 5 g of crack cocaine, which was

more commonly used by poor and Black people, triggered a 5-year sentence in federal prison. It took 500 g of powder cocaine, more commonly used by wealthy and white people, to garner the same sentence [67].

Differential exposure to policing and the criminal legal system constitutes a form of structural racism that contributes directly to individual and community harm, but also to the disparate impact of incarceration on the health of individuals and communities of color.

Impact of Incarceration on Health

In addition to the fundamental harm of loss of freedom, incarceration has negative impacts on the health of individuals during and after their incarceration and on the health of their families and communities. Incarcerated individuals have elevated risks of chronic conditions including cardiovascular disease, hypertension, diabetes, kidney disease, hepatitis, and HIV [68–70]. One in three people in prison and two out of five people in jail have a least one disability including deficits in hearing, vision, cognition, ambulation, self-care, and independent living [71]. There are no uniform standards or independent oversight for health care delivered in jails and prisons, and inadequate care is common [72, 73]. Additionally, a recent multi-center study found that nearly half of incarcerated individuals with surgical diagnoses were due to trauma, highlighting the risk of self-harm and assault while incarcerated [74].

There is a 12-fold increase in all-cause mortality in the first 2 weeks after release from prison [75]. In the longer term, formerly incarcerated individuals often lack access to education and employment. They are excluded from many jobs, grants, and federal assistance programs. Stigma based on their status as formerly incarcerated compounds these disadvantages and threatens families' economic stability [76, 77]. Financial strain and poverty caused by legal expenses due to arrests and incarcerations affect the health of Black people by limiting access to healthy food, safe housing, and healthcare [4]. Incarceration of a family member negatively affects the well-being and life expectancy of family members [78•, 79, 80]. Community level incarceration rates have been associated with pre-term births and low-weight births among women living in areas with high rates of incarceration [81].

Role of Law Enforcement in Injury Prevention

Police investigation has the potential to prevent injury due to recurrent or escalating violence. To address the upstream causes of violence proactively, law enforcement agencies are most effective when they collaborate with other sectors and communities [82]. The Cardiff Model is the most prominent example of cross-sector effort for injury and violence prevention. Named for its birthplace in Cardiff, Wales, this approach combines healthcare data with law enforcement data in space and time to identify local "hotspots" of violence [83, 84]. Successful implementation sites in Europe and the USA have found that combining these data sources more accurately depicts the social and structural conditions contributing to violence [85–87]. This in turn enables cross-sector design of locally relevant prevention strategies. For example, by combining data from a trauma center registry and police report registry, a specific commercial street with bars and restaurants may be identified as the nexus of a rising rate of late-night assaults that are causing injuries treated within the local emergency department [88]. Interventions might include restrictive licensing for businesses serving alcohol, or the redesign of the safety features of pedestrian pathways. This strategy draws on the success of cross-sector traffic injury prevention efforts that have reduced injuries by developing interventions focused on the environment in which injuries occur, like roadway features, rather than efforts to educate and impact individual driver knowledge and practices [89].

Strategies to Reduce Harm Associated with Law Enforcement

Mass incarceration, injuries, illness, and deaths are not inevitable consequences of law enforcement. The USA has the highest rate of police killings among comparator countries [90], and the circumstances surrounding these deaths can inform prevention. In 2014–2015 in the USA, fewer than half of the individuals killed threatened an officer with a firearm, but more than half were impaired or suicidal at the time of the incident, suggesting the opportunity for alternative response strategies [91••]. Strategies to reduce injuries and deaths associated with law enforcement fall into two categories: those designed to reduce civilian contact with police or those designed to reduce risk of injury or death during those interactions. Reducing contact with police can include decreasing or redefining crime and eliminating police involvement in non-crime events. For example, more than half a million Americans were arrested for marijuana possession in 2019, with people of color more often arrested and more harshly sentenced [92]. In addition to the avoidable harms of incarceration, incidents of police violence that began with a marijuana-related stop or arrest are not uncommon [93, 94]. As states that have legalized medical or recreational marijuana have not seen increases in other property or violent crimes, this type of decriminalization is a promising strategy for reducing harm [95].

Reducing our reliance on police to enforce social order is a key strategy to reduce exposure to law enforcement [96]. Police respond to nearly all 911 calls including those of mental health crises, and 1 in 5 people killed by police died during a mental health crisis [91••]. Communities around the country are exploring specialized unarmed mental health response teams to decrease risk of injury and to improve access to mental healthcare. The CAHOOTS program has operated in Eugene, Oregon since the late 1980s, and its specialized teams now respond to up to 20% of 911 calls [97]. Sweden has developed similar specialized response units including mental health ambulances [98]. Likewise, some US cities have introduced efforts to limit police involvement in minor traffic violations [99]. Internationally, unarmed professionals are often deployed to respond to minor crimes and may issue fines but not make arrests [98].

Reducing risk of police contact can also involve changes to the way police are organized, trained, armed, and monitored. Whereas many countries have one or a few national police forces, policing in the USA is decentralized and training ranges widely. US police are more commonly heavily armed than those in other countries. In countries such as England, Ireland, and New Zealand, police firearms are generally limited to specially-trained units tasked with responding to designated violent incidents [98]. Countries that have had success in improving the relationship between law enforcement and the public have integrated community policing techniques and civilian oversight to promote accountability. In the USA, police misconduct or violence is primarily investigated by the police agency itself, and recent moves to strengthen civilian oversight are promising [98]. For example, half of all agencies require officers to file a report when they point a gun at a civilian even if they do not shoot, and this requirement is associated with fewer civilian deaths [100]. Likewise, police agencies with more policies limiting use of force cause fewer civilian deaths [101].

Conclusions

Traumatic injury sits at the nexus of law enforcement and structural racism. Many of the same forces of systemic disadvantage that put Black people, other people of color, and other marginalized groups at risk for violent injury also expose these same individuals and communities to intensive policing. Patients may be injured by law enforcement, or may be at risk of criminalization during or after their injuries. Traumatic injuries can contribute to future risk of policing and incarceration, all exacerbating racial health disparities. To achieve the goal of zero preventable deaths, trauma clinicians, researchers, and injury prevention professionals must understand and work to end police violence in all its forms.

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Declarations

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