AMERICAN PUBLIC HEALTH ASSOCIATION

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ADVANCING RACIAL EQUITY SERIES

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WEBINAR: REBORN NOT REFORMED: RE-IMAGINING POLICING FOR THE PUBLIC'S HEALTH

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TUESDAY
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The webinar convened at 12:30 p.m. Eastern Daylight Time, Daniel Webster, Moderator, presiding.

PRESENT

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P-R-O-C-E-E-D-I-N-G-S

(12:30 p.m.)

MR. FINE: Hello, everyone. I am Mighty Fine, the Director of Public Health Practice, Professional Development at the American Public Health Association. And I am excited to welcome you to the webinar Reborn Not Reformed: Re-Imagining Policing for the Public's Health. It's the third installment in our Advancing Racial Equity Webinar Series.

And while we had planned to host a webinar focused on violence prevention broadly, given the current climate, we felt it prudent to focus specifically on police violence.

Today's webinar will showcase various perspectives and viewpoints on this issue. And while they are not necessarily official endorsements of APHA, I encourage everyone to listen, reflect, even teach from what you gather from today's presentations. We don't have all the answers, but that shouldn't stop us from asking the questions and exploring the possibilities.

I also want to note that what we are

experiencing around police violence and the voices that are elevated and calling for change is not about a moment, but more about a movement where we collectively are working to shift to an anti-racist culture in all facets in which skin color is no longer weaponized.

APHA is pleased to be co-sponsoring this webinar with the Bloomberg American Health Initiative. And representing them today is our moderator Daniel Webster. And Daniel is the Bloomberg Professor of American Health at the Johns Hopkins Bloomberg School of Public Health, where he directs the Center for Gun Policy and Research.

He is a co-editor and contributor to Reducing Gun Violence in America, informing policy with evidence and analysis.

He was honored to receive APHA's David Rall Award for Science-Based Advocacy in 2015; the Baltimore City Health Equity Award in 2016; and the Johns Hopkins University Distinguished Alumni Award in 2017.

So without further ado, Daniel, please take it away.

DR. WEBSTER: Thanks, Mighty.

Before we get started with presentations, I want to go over a few housekeeping items.

Closed captioning is available for our webinar. And instructions for accessing closed captioning are in the chat.

The webinar is being recorded. All registrants will receive a follow-up email with a link to the recording and slides which will be posted at www.apha.org\racialequity within the next week.

Today's webinar has been approved for 1.5 continuing education credits for CHES, CNE, CME, and CPH. And none of the speakers have any relevant financial relationships to disclose.

If you want CE, continuing education, you must be registered with your first and last name and participate for the entire webinar. All registrants -- registered participants will receive an email within a few days with information on how to claim credits and the relevant deadlines.

We'll take questions at the end of all

the presentations. You can ask questions by using the Q&A function. The chat function is disabled for participants and being used for announcements only.

At the end of the webinar you'll be redirected to a survey. Please take a moment to fill out this 2-minute questionnaire to help us improve our future webinars following the conversation on Twitter, using #RacismOrHealth and #APHAWebinar.

Now I'd like to share some of my own remarks just before we head to our initial speakers. Thank you.

Just to put into some context, if it's not clear to anyone participating here, we have very high rates of homicide, and it's quite unusual for high-income nations, as this slide underscores. This discrepancy, our exceptionalism when it comes to fatal violence, is particularly acute when it comes to gun homicide that I think there's an important contextual factor here for understanding police violence as well.

Next slide, please.

There are enormous racial disparities in homicides. Much higher homicide, firearm homicide rates and overall homicide rates for Blacks versus Whites. And it accounts for the leading cause of death for Black males ages 15 to 34; second leading cause of death for Black males ages 1 to 4 and 10 to 14.

And it's also one of the most important causes of the disparity in life expectancy among males between Blacks and Whites.

Next slide, please.

Of course, it's also well-known and established that there's enormous discrepancies when it comes to the risk of being killed by police along racial lines, Blacks having a rate roughly three times higher than that of Whites, with Hispanics in the middle.

Next slide.

Now, public health has long used laws as one of the many tools that we have to address threats to public health and safety. It's actually a motivation for many laws that we have on the books is the whole idea that certain laws, anyway, are

needed to protect public health and safety.

And there are success stories, of course, of use of law and their enforcement: laws against speeding or drunk driving; laws against carrying concealed firearms in public places; and now, of course, we're thinking about laws relevant to wearing masks and limiting large gatherings in enclosed places.

Next.

But, of course, laws and police as protectors can also be protectors of privilege and tools of oppression. There's enormous racial disparities that contribute to mass incarceration in the United States and result in trauma: far more car and street stops; more arrests; prosecutions are more common; and the sentencing, enormous sentencing disparities as well.

And I have already shared some of the discrepancies when it comes to rates of police killing civilians.

The health impacts, you know, we can have a whole hour talking about all the health impacts of these issues. But, we know that a little

over a thousand deaths per year by police at least; enormous mental health consequences of the style of policing that we have and with PTSD and other mental health issues; a huge problem with suicides stemming from those interactions with law enforcement. And, of course, now we're in a pandemic where putting more people in jails and prisons really greatly increases our risk for spreading this deadly disease.

Next.

So I think we may have missed a slide. No, okay. I think, I think something may have gotten out of order.

So we have many approaches that we're going to talk about when we think about public health and what we have to offer. We focus on the capacity to heal rather than to use coercion to address some of the problems that connect to crime and violence. But, importantly, we also look at the structural, socio-structural issues, the role of race, and public policy.

My area, of course, is in firearms, so I wanted to note as we set the stage for this that

92 percent of the instances in which civilians die at the hands of police it's police shooting them. And a little over half of the individuals who are shot also are armed with a gun at that time. So firearms play a role, a huge role in this problem.

Next slide, please.

One area of firearm policy we've been looking at is the role of licensing gun purchasers. And we find much, much lower rates for civilians being killed by law enforcement when those measures are in place. The bottom line here is that there are a number of public policies that we need to put in place to increase safety that means we will rely less upon police, and particularly lethal forms of policing.

Next.

I think that we're going to go to our next speaker. Bear with me just one second.

So I'd like to introduce our first presenter, Dr. Keon Gilbert. He is an associate professor at St. Louis University's College of Public Health and Social Justice in the Department of Behavioral Science and Health Education. And he

co-directs the Institute for Healing Justice and Equity.

Dr. Gilbert uses his interdisciplinary training to engage in research in several areas: social capital, health disparities, African American men's health, and interventions to prevent chronic diseases. His work investigates the intersection of racial identity, racial socialization, structural racism as an important, yet unexplored, social determinant of African American males' health across the life course.

Part of understanding this intersection is to understand cultural and structural changes within African American communities over time, and better understand the opportunities and limitations of male participation in formal organizations, social networks, and systems of support where they live, work, and play.

He's co-editor of Racism: Science & Tools for the Public Health Professional, published by American Public Health Association Press.

I turn it over to Keon.

DR. GILBERT: Great. Thank you, Daniel.

And my thanks to APHA, Mighty, and Kelly for helping to organize this session and this important discussion about police violence.

So the title of my presentation, Visible and Invisible Trends in Racialized and Gendered Structural Violence in Black Health.

Next slide.

Just quickly, my presentation will cover briefly the context of violence and criminalization of Black people in the United States, understanding trends and patterns of racialized and gendered police violence, describing some of the health effects of structural violence in communities, and provide a few models to move research towards anti-racist interventions.

When I think about some of the origins of policing, I start to think about some of the words of Toni Morrison who, in 1993, told us that oppressive language does more than represent violence; it is violence; it does more than represent the limits of knowledge; it limits knowledge. Sexist language, racist language, theistic language, all are typical of policing languages

of mastery and cannot, and do not permit new knowledge or encourage the mutual exchange of ideas.

What I would like to present is some research that challenges these notions by beginning with thinking origins of modern policing from 1619 to beyond.

So as you can see in the slide that there's been this move from the informal citizen patrols to uniformed officers and more formalized policing to maintain order, populations, through the use of paid personnel, and some sense of accountability to a government authority.

Formal policing has been used to maintain social control from real or perceived increases in crime, rioting, and controlling perceived dangerous groups. During slavery, these were codified in -- Slave Patrols were codified in Slave Codes, later in Black Codes after 1865, as the nation started to see a number of revolts from those who were enslaved, resisting slavery in a number of different ways.

Communities were encouraged to enforce capturing these individuals who ran away, or

initiated or incited revolts, to maintain order, the culture of the Southern life and plantation life, and to protect economic stability.

Next slide.

As you can see, some of this is exemplified in lynching. Lynching was a way of social control, of controlling movement, confining Blacks to plantations, as well as confining Blacks to Southern areas. And as you can, that there were a number of Black men that were killed as a result of lynching. And from the map, you can see that lynchings were heavily concentrated in the southeastern region of the country.

On the next slide you'll see -- next slide -- on the next slide you'll see that the overlay of lynchings and slavery overlap pretty well, again heavily concentrated in the southeastern corridor of the United States, also in the areas that we call the Black Belt or even the Stroke Belt.

Next slide.

When we think about ways to justify modern policing or the movements of modern policing, violent crimes are such a way of thinking about it, or language

that suggests that violent crimes have increased over time. As you can see from this figure, violent crimes have actually decreased over time.

And when we think about those who are offenders and victims of crimes, you can see that there are quite, not sort of drastic differences between Blacks and Whites in terms of those who are offenders and victims of violent crimes. So violent crimes are more intra-community and intra-racial than they are across communities and across different racial ethnic groups.

Next slide.

When we think about modern policing, again, it is used as a way to protect wealthy neighborhoods, to physically relegate Black residents to Black neighborhoods and Black communities; it helps protect the notion of White supremacy in forms such as racial profiling.

As Daniel pointed out, and as others will today, there are a number of groups that have a higher odds or higher likelihood of being killed by police. That includes Black men, Black women, American Indian men, American Indian women, and

Latino men. And the risk of being killed by police is structured by race, gender, age, and place.

This figure here from Naa Oyo Kwate's work, Racism Still Exists, was one way of integrating or suggesting that we can use social marketing as a way of informing communities about the harms of structural violence in their communities, and to also measure the effects of structural violence on communities.

And in her work that you can see cited below, you can check out the harmful effects. And we'll talk about some of those in the next coming slides.

Next slide.

What I will spend the rest of my time talking to you about is a little bit about my work that helps you understand patterns and trends in racialized and gendered police violence and then structural violence.

Next slide.

The first idea I'll talk to you about is Race, Law, and Health. This is actually a project facilitated by an MPH student who is now employed

full-time at Washington University, Nicole Ackermann, who worked with Melody Goodman as her primary mentor, who is now at New York University, and also by Marcello Pagano at Harvard University.

The study used locally sourced data from the Tampa Bay Times to understand Stand Your Ground. We identified 204 cases that were supplemented with online data, court documents, and news reports. We wanted to identify patterns of racial bias in the justice system that may exacerbate racial disparities in the form of higher rates of what we called justified violent acts towards non-Whites.

The outcome of interest was conviction. And the independent variables that we examined were race of the victim, if the defendant could retreat from the situation, if the defendant pursued the victim, if the victim was unarmed, and who initiated the confrontation.

For those of you that recall, Stand Your Ground laws were under heavy examination after the death of Trayvon Martin.

Next slide.

The results showed that Blacks were 84

percent of victims of cases in our Stand Your Ground database. The race of the victim was the significant predictor of case outcomes. After controlling for other variables, defendants were two times more likely to be convicted in a case that involved White victims, comparing those to cases involving non-White victims.

The study showed that institutional and personally mediated racism were in play in the application of Stand Your Ground defenses. Stand Your Ground defenses were implemented as a way of people invoking the sense of fear, often White fear, or racialized fear, as a way of protecting their homes or protecting themselves in certain places, and justifying the killings in many cases of Black people.

And as you can see, this suggests that those who use those cases, use Stand Your Ground defenses, White victims were more likely -- if you killed a White person, you're more likely to be convicted.

Next slide.

The next study talks about what happens

when you live in an over-policed or hypersurveilled area. Aggressive policing elicits surveillance stress. Police contact has long been considered unpleasant and a stressful life event, and it has negative health effects, both physically and mentally.

Surveillance is linked to mass incarceration, which we've talked about and will continue to talk about today; movements of social control; ethno-racial -- and takes place in ethno-racial and low-resourced communities.

Lethal policing fosters the shared experience of illness across neighborhood residents. These patterns are structured by race and gender as a result of the criminalization of Black and Brown people in various neighborhoods.

Next slide.

In a study made by Alyasah Sewell, who is at Emery University, they identified legal intervention, death, and illness in a study called Lethal Intervention and Death Illness from a spillover study. He created a multi-level database, merging individual level data and community level

data from the United Hospital Fund in NYC, including four neighborhoods.

A LID is a measure that identifies if someone lives in a neighborhood where at least three legal intervention deaths have been documented. And this data comes from 2003 and 2012.

Models allow for comparisons of five illness conditions for people living in the neighborhoods, with a high count of LIDs to those illnesses -- to those illness conditions of those in the neighborhoods where LIDs are more rare.

Next slide.

The results show that living in lethally surveilled areas is linked to greater risks of high blood pressure and obesity for all neighborhood residents; it's a greater risk for obesity for women. Women face a 30 to 54 percent greater risk of diabetes, high blood pressure, and obesity compared to men. Lethal killings affect women and men differently.

For women they experience network marginalization where they are connected to those who are more likely to be policed. They become

their caretakers, express worry and concern, and are subjected to police sexual abuse, as we see in unhealthier and hypersurveilled areas.

Next slide.

Next I'll talk to you about the fatal interactions with police study led by Otis Johnson at Washington University, collaborators from St. Louis University and New York University as well, and Harvard.

The FIPS database includes details about 1700 fatal interactions with police that occurred in jurisdictions across the U.S. during a 20-month period between 2013 and 2015. This combines data from fatal encounters in the Killed By Police databases.

Next slide.

The study shows that income inequality within areas in which a FIP occurred is related to increased relative odds that males of color, and Hispanic males more specifically, will be killed by police. Low levels of racial segregation appeared to dramatically reduce the odds of a FIP for Black males, with higher levels of segregation

increased the odds for Hispanic males.

When we take in neighborhoods factors or consider neighborhood factors, this increases the odds that an unarmed Black male will be killed by police, and increases the odds to 6.22.

Unarmed Black males being killed by police decreased when law enforcement agencies had non-White officers. For Hispanic males, the odds were increased 2.6 times when agencies had higher percentages of Hispanic officers.

So we see that there is a racial, and ethnic, and gender effect taking place in this particular study. And also when we think about agency-level factors, how that relates to how police treat men of color of different racial and ethnic groups.

Next slide.

In Raj Chetty's work on intergenerational study of economic opportunity which compared Black and White boys, he found a number of interesting findings. Black boys have lower earnings than White boys in 99 percent of Census tracts; Black boys and White boys have better

outcomes in, quote-unquote, good neighborhoods, those neighborhoods that we characterize as being safe, as being healthy, having low poverty.

But the Black/White gap is bigger in such areas. Within these low poverty areas there are two factors associated with better outcomes for Black boys: greater father presence, and less racial discrimination.

Neighborhoods have causal childhood exposure effects. Black boys who move to, quote-unquote, good areas at a younger age do better.

So we see not only an intergenerational effect here in his work, but also we see a neighborhood context effect. And to understand it a little bit more, on the next couple of slides we'll talk about why this may be the case, and also what may counter these results to some extent.

In a study looking at racial composition over the life course, examining separate and unequal environments and the risk for heart disease for Black men, we measure racial composition in several social environments across the life course, for example, the racial composition of the neighborhood

someone grew up in; the racial composition of schools, junior high school, high school; the racial composition of workplaces, and even religious spaces.

In a small sample of 118 Black men recruited from a clinical study in St. Louis, we identified racial composition of segregated neighborhoods and segregated spaces. And the study showed that neighborhoods and occupational workplaces increased the risk for hypertension by four times and three times respectively. The study showed that exposures to racial residential segregation and segregated workplaces become a cumulative risk for hypertension.

The study shows that low integration and the exposure to opportunity in other time points of life suggests a cumulative burden of discrimination, and also how that relates to increased risk for hypertension and heart disease for Black men.

So we can see that, not only thinking about neighborhoods, but other spaces is important in terms of the risk for chronic diseases as well

as structural violence.

In other work that I've done looking at racial composition as it relates to health behaviors, we can see that middle class Black women and middle class Black men have different experiences depending on where they live. In spaces and places where Black women feel safer, they are more likely to be physically active. In places and spaces where Black men feel less safe, they're less likely to be physically active.

If we apply public health critical race theory to this, we have to identify and think about the primacy of racialization, also how race and gender are social constructs. We have to challenge our conventional approaches to understanding these characteristics, these variables, and these lived experiences, and also place them within the context of social violence, and how living in these particular spaces and are characterized by high crime lead to higher rates of police surveillance and police violence.

Next slide.

A few models that help us challenge our

ways of knowing and our ways of thinking are environmental affordances to address discriminatory actions and stressful social life events and conditions. Environmental affordances reminds us that coping and living in hypersurveilled or lethally surveilled neighborhoods, while finding ways to manage life, often with limited resources available to you can lead to your untimely death, such as in the cases of Tamir Rice and Ahmaud Arbery.

Our life course theories and life course perspectives helps us to understand not only the risk factors such as adverse childhood experiences, but also the racial composition of particular neighborhoods and the different things that we can do to intervene early in life course to ensure that people can live healthy lives over time.

Intersectionality reminds us to think about race, gender, social class, and place, and also how that can place you at a higher risk of police violence, such as in the cases of Breonna Taylor and Botham Jean.

Critical race theory reminds us to explore racialization and its influences of the

historic recurring patterns of racial relations, also the social constructions of knowledge, and how we must challenge our existing methods and practices in public health and other disciplines to better understand these intersections.

And, finally, racial capitalism. It connects racialized exploitation and the capital accumulation as fundamental causes of health inequalities. When we tie labor to the racialized experiences of many of those living in America, we can understand and see why they may be at a higher risk.

And it reminds us in the words of Audre Lorde and cautions us against addressing just single issues. We must become anti-racist and embrace the Black Lives Matter agenda that challenges and abolishes the status quo in our methods and in our research.

Thank you so much for your time. And I will turn it over to Rashawn Ray.

DR. RAY: So I'm Rashawn Ray. I'm a David Rubenstein Fellow at The Brookings Institution. And I'm also a professor of sociology at the

University of Maryland.

What I've done over the past decade is done a lot of work on policing. And one thing that I've realized is that bad apples simply don't come from anywhere, instead they come oftentimes from rotten trees. And what we just heard from Dr. Gilbert is aiming to address those rotten trees and, actually, where those rotten trees come from.

To be very realistic, we know that policing, particularly in the South, has origins in Slave Patrols. And that legacy has continued to this day.

Obviously, we are here thinking about what happened to George Floyd. But there are many people who never get a hashtag that is highlighted in the work that we're doing.

Of course, as we know, there are many people who have had a series of incidents with the police. And in particular, we can think about Walter Scott, Freddie Gray, Alton Sterling, Sandra Bland, Korryn Gaines. That's an incident in Baltimore. If people haven't heard about it, they should look it up.

One of the big things that people have to note is as I go through the civilian payouts for police misconduct is that taxpayers have been on the hook for these particular monies. So in other words, this money doesn't come out of the police department budget; it comes out of the general funds for cities.

And in certain cities, like Chicago, that has spent over $650 million over the past two decades, cities like St. Louis and Baltimore that have spent about $50 million, imagine if this money went toward education, equity, and work infrastructure.

Not only would we see a decrease in crime, because research overwhelmingly documents that education and work decreases crime, not necessarily more policing, but also it would be fiscally responsible and a market-driven approach to what's going on.

Eventually, George Floyd's family will receive a civil payout for the dehumanization of his body and his murder. And the same money that they've paid in in taxes will be used to pay them

back.

One of the things that I'm arguing, that you will hear me say at the end, is shifting civilian payouts for police misconduct away from taxpayer money into police department insurance policies.

Now, when we start talking about health and policing and how they come together -- and Dr. Gilbert has laid out a series of these things very, very well -- this graphic is one that I like to highlight, where we continue to see this same disparity over time.

If you look on the top line, that's the percentage by race. On the bottom line, that's the percentage of people by race who were not attacking or killed at the time that they were killed by police. These data come from police officers themselves, from FBI data.

And what this graphic shows is that Black people are 3.5 times more likely than Whites to be killed by police when they are not attacking or have a weapon. That's the crutch of what we're talking about here is that particular statistic.

We also know that every 40 hours in the

United States that a Black person is killed by police. Ask Breonna Taylor.

We also know that Black teenagers are 21 times more likely than White teenagers to be killed by police. Ask Tamir Rice if we even want to consider a 12-year-old to be a teenager, but also Antwon Rose in Pittsburgh.

And this is one of the fundamental problems. We know how many people get the flu every year. We're still trying to figure out COVID. That's another story for another day. But we also know that the CDC collects information on how many people are killed by jellyfish every year. But we don't know how many people are killed are police.

We only have data from, like, about 20 states and only covering about 40 percent of the 18,000 law enforcement agencies in the United States that actually report this information. This is something that should be mandated. It shouldn't be up for discussion about whether or not we have information and data so that public health scholars and social scientists can analyze this information and better help explain the trends that are happening

as it relates to policing.

As Dr. Gilbert also laid out, we know that justifiable homicide is something that's increased over time. If we look at it from about 20 years ago, we know that justifiable homicides increased about 50 to 75 percent. And these are just the justifiable homicides. There are another half because every single year police officers kill over 1,000 people in the United States. That these are justifiable homicides, ruled as death by legal intervention depending on if you're talking about the FBI or the Department of Justice. These are killings that are ruled as justifiable.

Whereas, when we talk about unjustifiable killings, oftentimes police officers are still not brought forth when it comes to criminal charges. And because of qualified immunity, they definitely are not pursued in civil court. And, again, taxpayers are on the hook for this.

But as we also heard, violent crime has not corresponded to these increases. This is looking at violent crime since 1990, we see that violent crime has plummeted, not corresponding to

the number of people who are killed by police.

We also heard that when it comes to stop and frisk one of the things that people oftentimes highlight is they like to say, oh, well the reason why Blacks in a particular area, and Latinos to a certain extent are over-policed is because they live in neighborhoods where we're more likely to see crime.

Well, if this was actually the case, this study that was done in New York City of about 700,000 police stops, what it found was that only 2 percent of those 700,000 people stopped led to the discovery of contraband, and only about 6 percent of those stops led to an arrest or a summons. Most of them were arrested due to resisting arrest.

Now, this is the problem: not only were these people stopped, not only were these people profiled, but if you look on the left you'll see that 51 percent of the time these stops were of Black people, and a third were of Latinos, even though when we look in the City of New York, just in the specifically in the city, that only about a quarter of the city are made up of Black residents.

And then we also know that the number of times that force was used, that about 80,000 times force was used on Blacks, and over 50,000 times force was used on Latinos. This is the reason why New York State ruled stop and frisk to be unconstitutional, because it became clear that this wasn't necessarily about aiming to necessarily stop crime, but it was about policing and profiling a particular group of people.

As we heard from Dr. Gilbert as well, we have an article that just came out with Dr. Sewell that highlighted the ways that policing extends beyond just who is killed or accosted by the police, but it actually impacts people who are living in those neighborhoods, even when controlling for crime. We know that men are more likely to suffer as it relates to their mental health, whereas women are more likely to suffer as it relates to their physical health: higher levels of obesity, high blood pressures, more likely to be diagnosed with diabetes.

So we see the ways that policing extends to have illness spillovers as it relates to impacting

people's everyday lives.

Some of the work that we've done at the University of Maryland, I direct the Lab for Applied Social Science Research. We call it LASSR. We aim to connect -- we aim to connect social science research with policymakers, primarily by using innovative research products such as our innovative virtual reality decision making program.

We put officers through implicit association tests. We also put them through surveys and, more importantly, through fully immersive virtual reality programs to be able to examine how their attitudes, their physiology manifests in their behaviors and their interactions with people.

One of the most startling findings is that we find overwhelming racial bias against Black people, that officers are more likely to exhibit strong preference for Blacks with weapons relative to Whites with weapons. This graphic you're seeing is not a mistake. Across race and across gender, officers hold these biases against Black people.

So when you hear officers say oh, I thought they had a weapon, or I thought that they

were going to do something, in their mind they might actually be thinking that. And this is the way that we see Blackness become weaponized, and the way that Black bodies become overly criminalized relative to other bodies.

So Black people need not have a weapon, need not be attacking, like George Floyd and like others, and we still see that disparity that goes back to the fact that Black people are 3.5 times more likely than Whites to be killed by police when they are not attacking or have a weapon.

We also know that right now there are, there's a lot of momentum for what's called the Defund the Police Movement. I actually did some analysis on this. The way that I like to think about it is really about reallocating and shifting funds. And I'll explain that in my remaining time.

But this is one of the main issues. When it comes to response rates, not only are Black and Latino neighborhoods overly policed, but when they actually call 911 for someone to come and help them during an emergency we see that the response rates are slower, and fewer officers are deployed.

So part of the reason why people want to see other social service agents responding to them is because of this particular outcome that we see playing out.

We also know that 9 out of 10 calls for service are for nonviolent calls. So it could be argued -- and I know this from doing hundreds of interviews with my colleagues in Maryland about what police officers think about their jobs -- many of them do not think they should be responding to so many mental health and addiction calls. These calls could be rerouted to mental health and addiction specialists.

This is what people call reallocating. And we're seeing this across the country, from Prince George's County, Maryland, to L.A. and Minneapolis in terms of how we think through funding for police. One big thing people have to realize is that in a lot of the areas that I just mentioned, police represent over one-third of all of the general fund money. So in other words, out of every $3.00, at least $1.00 goes to law enforcement.

And this is the other problem. When it comes to the violent crime clearance rate, it's

abhorrent. About 40 percent of murders go unsolved every year; 66 percent of rapes; 70 percent of robberies; and about 50 percent of aggravated assault. If police officers have more time to focus on these violent incidents, and other people respond to less violent incidents, I think we would see the clearance rate increase.

Here is a graphic showing how much money is spent in these various places. You can see in major cities across the United States how much money is spent when it comes to policing. And what we have to think about from a market-driven approach is whether or not we're getting that return on investment.

So part of it is not just thinking about reallocating, but also reinvesting in communities and shifting funding.

As I mentioned, we developed an innovative virtual reality program where we put officers through it to help them improve their decision making. We know that officers are more likely to exhibit bias against Blacks, they are also more likely to give harsher language to Black

women relative to White women. And we can measure a series of things: their heart rate, their stress level, their body movement, and we can even track their eyes.

Finally, we know that officers suffer as it relates to their mental health. So as much as we're focusing on their interactions with civilians, police officers need help themselves. The research that I have done shows that about 80 percent of officers suffer from chronic stress, and about a sixth, one out of six suffer from suicidal thoughts and substance abuse problems. And this is the kicker: 90 percent of them never seek help.

So these -- this is the simple of it. What I think we need are a series of things.

First, we need to restructure civilian payouts; two, for the money to come out of police department insurance policies.

We need a bad apple list so that officers could never work again after they have engaged in egregious forms of misconduct.

And then we also need good apple protections for officers to be able to speak up.

We need to reallocate funding. We need to think consciously about how we put civilians on internal trial boards for misconduct. And then we need to look at officers themselves as it relates to where they live as well as their own mental health.

Thank you.

DR. WEBSTER: Thank you very much, Rashawn.

Now I'd like to introduce our next speaker, Kanwarpal Dhaliwal. She is firstborn in the U.S. to Punjab immigrants who were caught and cradled in global shifts from British colonial occupation to U.S. empire building. The forces of globalization have been both protective and predatory for her and her family and her community of origin.

These places of privilege and subjugation guide Kanwarpal's purpose, which is to contribute to movements, communities, and legacies of liberation that honor and heal the ancestors who fought for her existence and survival, and to forge a world that is just and gentle for future generations.

Currently, she is applying this perspective as associate director and co-founder of the RYSE Youth Center in Richmond, California, where she supports and guides the implementation and integration of healing-centered practices grounded in racial justice and liberation across all of RYSE's program areas.

She also develops, promotes, and advocates for policies, investments, practices, and research that enlivens healing justice and liberation across the fields and sectors in which RYSE works.

MS. DHALIWAL: Thank you, Daniel. Hello, everybody. It's great to be here. I appreciate the invitation. I appreciate the space to share RYSE's work, and the space to continue to grapple and contend with the ways in which policing, supremacy, oppression, and dehumanization continue, and the opportunities and the necessities to rupture and dream new ways of being.

I'm going to actually start with a video of RYSE so you can get a sense of who we are because, really, what we know is the work that we really

have to do is about being in a relationship and about really considering who we want to be in this world, who we want to be as public health and other systems of care.

So the video's about two minutes. So feel free to take some breaths, take a stretch. I know we're about halfway through the webinar, so make yourself at home for the next few minutes.

(Video played.)

MS. DHALIWAL: So thank you for taking the time to hear from our young people. The video was actually created by RYSE members with support from our staff. RYSE was born out of young people of color organizing to shift conditions of violence, of oppression, of dehumanization. And I'm always so thankful and grateful to be able to be a trusted steward and representative of our organization and of the movements we're a part of.

And I also want to continue to honor the young people who fought for this space that we know as RYSE. They did so knowing that they would never directly benefit from the program.

So it was 14-year-olds, 16-year-olds,

18-year-olds thinking about legacy and what they wanted to make sure that their younger siblings, cousins, and the younger generation had. And I, as someone who is not a young person, is honored to be a part of that legacy.

And so I have a number of slides. I'm not going to read them verbatim. But what I want to share here is, as Drs. Gilbert and Ray have been talking about the ways in which police, law enforcement, and policing impact and burden Black and Brown communities, certainly that is no different than the community that RYSE is in in Richmond, California, but we also have to contend with the ways in which other systems outside of law enforcement also engage in policing of young people, and of Black and Brown young people, and that there's a relationship and connection between all these systems.

So we are grappling with over-surveillance at multiple levels and in multiple spaces.

And so I'm going to move on to talk about these conditions in the context of our work. And

I want to invite folks here to really be uncomfortable, be unsure, grapple with what we're hearing because we don't really have time to waste and sort of have pleasantries around the harm and the violence that our communities are enduring, and to really lift up the resistance of who we are.

And so I'm going to share with you, again in these 10 minutes that I have, some things that I think are pretty direct and pretty apparent for us.

And one thing is that over and over again as an organization that works with young people, in service to young people, we are constantly up against systems, public health systems, child welfare systems, mental health systems, and certainly criminal/legal systems that continue and constantly and incessantly check our behavior. And so we are under a constant scrutiny of how we are acting, how we are behaving. But there's no regard or acknowledgment of the systems of dehumanization that actually impact our behavior.

And so we are dealing with the fact that there is an overwhelming gaze on Black people,

Indigenous people, people of color's behavior and even our existence, and really trying to contain, control our behavior without actually acknowledging the systems of control that we actually survive in, that we die in, that we even succeed in. And we really, we have seen, we know firsthand that these systems surveil, harm, and kill us.

We pose Black, Indigenous, people of color, BIPOCs, always, almost always and solely as risk, burden; right? And so when we think about health outcomes, social determinants of health, health inequities, it is generally Black and Brown folks are always on sort of the side of the problem statement where we need to be fixed. Right?

And so we also feel like what needs to happen is we need to actually shift the gaze to look at the metrics and the supremacy of Whiteness, of predominantly White institutions that are actually controlling our behaviors, that are dictating what outcomes we need to have, and that we need to shift this to actually look at some of the pathologies of Whiteness that create the burdens that we're in.

We also know that in these systems that are compliant to White supremacy, when I talk about White supremacy, I'm talking about these systems whose metrics of compliance, self-efficacy, civic engagement, readiness to learn, readiness to work, resilience, grit, that we can actually adhere to all these tenets, and our livelihood and our lives are still not guaranteed.

And we know this because there's too many names to actually have to share about who have been killed, and especially while being compliant. And so for us as an organization how do we hold young people of color's safety, their fortitude, their pain without actually asking or forcing them to be compliant to systems that don't serve them.

And I think that that is something that as public health we must grapple with. Do we want to be a system maintaining the kind of sort of field? And what are we going to do to rupture and resist the ways in which that we actually benefit from supremacy, and the intersecting ways in which policing occurs?

There are a couple of examples that I

can give to this. You know, we run a hospital violence intervention program so young people who are injured by illegal injury, or if they're stabbed, we provide support, recovery, stabilization support starting at, you know, we meet them at bedside.

And what I'll say is that the places that we get funding from, that sort of scrutinize our work, one of the key outcomes we always get asked about is the sort of how did we -- how do we make sure there's not retaliation.

And for us, that feels like a really dehumanizing, racist inquiry in that shouldn't the first question be is, how are our young folks doing? How are they feeling? What do they need?

So we automatically assume culpability when a young person, when a young Black person is harmed. The outcome and the metric we look at is are they going to retaliate versus what do they need.

And this runs constant through all kinds of ways in which whether we're doing any sort of community health education, education and career supports, youth organizing or leadership, these

are the kinds of things that might seem sort of neutral, innocuous, not harmful. But over and over again they codify these systems of supremacy that public health is certainly sort of grounded and inculcated in.

Another example I'll give is a few years back some of you may have heard or know that in California, in the Bay Area, I think about ten different law enforcement jurisdictions were implicated in sex trafficking of young women. One of, the young person who's at the center of this, who's from Richmond, our police department in Richmond was also implicated. And we were the only organization, the only service provider that actually made a public statement about the police needing to be out of schools at least while the investigation is going on.

So this is a young woman who was violated, was harmed by the police. And we saw no words, no words of acknowledgment from the different providers. We have, you know, anti-human trafficking task force, we have all these committees set up to look at sort of the harms of trafficking.

But there was not one word of acknowledgment about what the law enforcement agency has done and the kind of harm it has created to this young person, but also to young people throughout the community.

So I'm giving you examples to share that the video you see, that's the condition and context that we're working in. But I also want to acknowledge and say that while we know that the work around resilience is gaining sort of steam and momentum, I want us to be really cautious around actually taking that on because for Black and Brown folks, we actually have nothing to prove about our existence or how we sort of make it through.

We are actually not supposed to be here. I am not supposed to be on this webinar. My colleagues are not supposed to be here. The systems are designed for that.

So for us, that is our baseline. Do not ask us to talk about how we increase our young people's resilience because for us that means increasing our compliance and complicity to systems that honestly don't give a shit about us. So for us, it is our baseline. It is not our benchmark.

And this is, again, where we see public health and adjacent systems redefining the ways in which oppression, and racism, and supremacy play out.

Here are just some examples directly from young people when we ask and we inquire about what does it mean to actually be engaged in a way that speaks to where they are, and this acknowledgment of sort of the institutional violence and the institutional harm that they feel is so critical.

What we hear from our young people over and over again is they come to RYSE because we say the things they wish adults would actually say in other places and spaces. What was mentioned by Dr. Gilbert and the quote from Toni Morrison was that language is so critical. Naming what is going on is so critical and so important. And so we have to work from that place, not a place of how can I work with you to contort your behavior to match up and calibrate with a system that does not care for you.

I'm not going to go over this slide too much. But I did want to share we do identify as a public health organization, a community mental

health organization, and certainly a racial justice organization.

So we are grounded in sort of key frameworks and tenets of public health, but really growing and grinding towards a liberatory public health in which we really understand that there's no sort of separation, we cannot sort of confound factors in our lives, we can't slice and dice different pieces of our lives to then create the kind of data that we need to get the funding we need.

We know that that's the game we have to play. But we are also really committed to making sure that we, that we complete our lives, we complicate and work in the messiness. And so we want to push the field that we're including public health to do that.

And so you'll see the ways in which we do that really, again, grounded in these ideas of love, rage, intersectionality, relationship as the center, and really sort of understanding that our worth is actually to repair, to redistribute, and to reimagine the systems in the world we deserve

and that we dream.

This is our interacting layers of trauma and healing. So I'm going to share the next few slides before I end.

It is the ways in which as an organization we both respond to these conditions in context of dehumanization. So, you know, shared, like, what we see as really the weapons of public health, the weaponry of evidence-based practices, reductionist outcomes, metrics of compliance.

So we also then, know it's important, we have to actually assert and affirm the ways in which we move in the world as Black people, as Brown people, as Indigenous people, as queer folks, as poor folks, and not be reliant on or only responding to the ways in which supremacy and White supremacy only want us to be.

And so you can see here that our work is really characterized by these interacting layers of trauma and healing where we sort of really name, you know, trauma and distress, our political structural atmosphere. And so then, our healing and our liberation must be that as well.

And so this is the overarching frame of our work.

We also as an organization, understanding, again, like when we think about policing and surveilling, the idea of a logic model does not actually portend to liberation. A logic model or a theory of change feels like it's change within, again, a system, and systems actually not interested in our liberation.

So RYSE a few years back has developed with young people, with our community partners, our theory of liberation. And you can see our key kind of outcome areas or aims.

I'll also share that as an organization that continues to learn and to become and stay strident in our values, we're actually considering, like, how do we even sort of move this from the theory of liberation to our liberation praxis, because even theory keeps it stagnant and keeps it sort of elevated in a place where it's unreachable. So we continue to learn and iterate as we grow as an organization.

And so when we think about outcomes,

when we think about metrics of compliance, you know, what I want is to sort of move towards is how do we think about the metrics of liberation, but also metrics of reckoning, that if we start really shifting the gaze to White supremacy, pathologies of whiteness, that we actually what would it mean as public health to start really sort of focusing on the ways in which we work to have White people commit less racial harm, that White people increase their resilience just throughout the systems that protect them.

And that systems and predominantly White systems apologize and amend the racial harms. Like, what a shift in our fields to actually focus on that versus the behaviors and the sort of health status of Black and Brown folks, and that we're really looking to have, sort of, again, whiteness be interrogated.

And for those of us who are not in White bodies, we have our own conditioning and unlearning and healing we have to do to the ways in which we've been muted and have had to comport to whiteness.

And these last few slides I'll just share.

Here's ways in which as an organization we engage in this notion of beloved community. How do we build loving relationships to build loving communities so that we can build loving power to, again, dream and realize the systems we deserve. So as an organization we acknowledge White supremacy, anti-blackness, intersecting forms of oppression where we can.

And we also make mistakes. We stumble. We don't have -- we don't believe there is a toolkit. We have to be in relationship and be in healthy struggle, and also be willing to sort of know that we're going to mess up and be vulnerable.

You can see we prioritize relationships, so all of our programs at RYSE are platforms to build those loving relationships. So for us, we might need some funder outcomes, like, you know, we engage 50 young people in tutoring or in sort of, you know, going through these sort of college prep classes. But if those young folks don't feel a sense of connection, love, and belonging, we have failed as an organization.

It doesn't matter to us if we've met

the funder outcomes, we have to be bolder and bigger than any of those to really move this work with meaning, with love and with rage.

I will share that RYSE, in investing in collective care we are a staff of 37 people. Over a third of our staff have come up through our membership. So our program managers, coordinators, and assistants were members. And we really believe in that kind of sort of leadership pipeline.

If young people sign up at RYSE, they need to see themselves as running RYSE. And it's not -- And that's the transformational work, so that we're not just a transactional service provider but that young people really feel like they own all the spaces they're in.

And like I said, we are an organization that learning and relationship are key to how we continue to do the work, a key to how young people keep coming back and keep trusting us to be in space with us.

So I appreciate the time to share. I hope that folks felt somewhat moved. You might have felt somewhat uncomfortable or unsure. All

of that is welcome because that's what it's going to take to really sort of reckon and reimagine the world that we need.

Thank you.

DR. WEBSTER: Thank you.

Now I'd like to introduce Omid Bagheri Garakani. He's Director of Equity and Community Partnership at JustLead Washington, which works to build a network of advocates and organizations for equity and justice within the legal community in Washington State, and is clinical faculty at the University of Washington School of Public Health.

MR. GARAKANI: Thank you, Dr. Webster. Hello, hello. Thank you very much. Thank you for, APHA for bringing this conversation together, and it's an honor to be a part of the discussion with you all.

I'd like to continue our conversation today, exploring further the how of addressing policing as a public health issue. And I would do that discussing the APHA's own policy resolution of law enforcement violence that myself many others developed.

The resolution that appropriately frames in a public health context, the evidence-based and the national conversation we're having today, around policing and the role of public health in that as well.

So this, you know, the context, this foundation that my panelists have been laying down has been one, it's fine for me, and it really lays the groundwork for the time I'll have with you today, in the next ten minutes or so.

And this context is why myself and many others in alignment and partnership with those in the community who have been doing anti-policing work, began an effort in 2015 to create an evidence-based policy resolution on policing and its harm to public health.

And to support all levels of government to advance policy approaches that are upstream, and focuses on structural determinants of policing rather then reformists or individual behavior-based strategies.

So, you know, what emerged from this effort was this statement, the end police violence

collective, which myself and other public health workers, professionals, organizers, are a part of.

And pictured here, you know, is the march in 2018 outside of the San Diego Convention Center during the APHA annual conference when this statement passed. Too again, underscore that public health can do this work around policing from our offices and in the streets.

And I want to recognize the individuals and the communities who have lived with the harms of police violence. Who have organized against it far longer then, you know, the statement that I'm going to speak to has existed.

But, who have deep expertise. And because of this, throughout the adoption process of the statement, we both received endorsements from, and developed this statement collaboratively with groups organizing around police violence from the community outside of the APHA, like Youth Justice Coalition LA, Critical Resistance. This is something that is not a requirement of the APHA policy sustainment process, but one that we felt was critical for this work.

So now we have this statement that at the time was explicitly aligned with grassroots social movements. And because of that, it still is.

And we did this while gathering the latest public health research and peer-reviewed sources on policing health and how to address it on a structural level.

So getting right into it, the overview of the statement. Well, in this moment as demands for an end to violent policing are met with more violent policing, we see the way that system policing is wielded again, to protect the status quo and who stand to benefit from the system as it is. The same systems that are creating the health inequities that we are all tirelessly in our own work working against.

So as been stated today already, you know, the origins of policing are in state patrols. In the north and the south, and have been used historically to thwart labor strikes and uprisings.

So we see a continuation of that today. And, you know, the statement itself frames this

and it's -- and I encourage folks to read the full statement, because I'll only give you the overview of this today.

But it advocates for fundamental shifts to the systems all together. Again, upstream structural approaches, prioritizing investments into public health above all else, while pursuing and building new systems of community safety to demote the role of police as an effective response to social problems. Which essentially my co-panelists are speaking to as well.

So the statement in particular, you know, understanding it as a tool for social control, means that it seeks control of communities deemed marginal by society, and protect the power of those deemed superior.

So when we discuss the physical and psychological violence, the system of law enforcement subjects, we see disproportionate deaths, injuries, trauma and stress on these particular groups.

Black and brown communities, indigenous communities, other communities of color, but also

immigrants. If we think of ICE, Immigrations and Customs Enforcement, as well as the ways it works with local law enforcement towards policing and individuals experiencing houselessness, people with disabilities, LGBTQ communities, people who use drugs, sex workers, and of course people at the intersection of more than one of these groups may face additional harms.

But considering other public health issues affecting these groups, we can see how disproportionate harm by policing only augments or worsens inequities that these groups face rather then solving them.

And as these groups experience disproportionate harm from policing, public health at large is harmed as collateral damage.

And so what I want to speak to, let me just pop all these up, is discussing the action steps of the policy in particular.

So given how the system of policing originated, and how it functions today and the subsequent harms, we can see how and understand why society almost exclusively delegates law

enforcement as the primary role of ensuring community safety.

But this doesn't necessarily lead to the health outcomes we all are wanting and working for. So, for example, if we were to look at how the presence of policing in schools has increased in recent decades under the assumption that police in schools make schools safer.

What we'd actually see is a significant investment of federal funds being put towards fortifying school law enforcement collaborations, where there's actually no evidence that suggests that police make schools safer.

And given the realities of the school to prison pipeline, and harm policing inflicts, we see the opposite is true. By further exposing students to structural violence and other state-sponsored harm.

So, you know, kind of discussing the action steps and it's major categories, we first have oversight and accountability. So the statement raises concerns discussing how oversight and accountability is hindered or blocked.

Police union contracts, state-based law enforcement officer's bill of rights, these are significant factors that allow for the health impact of policing to remain undercover for investigation through public health interventions to be made.

You know, in terms of the data that Dr. Ray earlier was speaking to, you know, this statement in particular notes the suppression of law enforcement data related to deaths and injury, and how police departments are not required to report this data publically, and you know about less than 40 percent overall do.

But the -- and the statement itself uses data from the Counted, there's the U.K. based Guardian, Crowd Source resource for police violence, deaths, and injury data, to point out and speak to how there is no complete and official national system to collect U.S. data on the number of people killed and injured by police.

So the takeaway here is, and we see calls from the public health community across the board, that we need to make law enforcement related deaths and injury a notifiable condition which will allow

public health departments to systematically document this data related to policing harm, and do it on its own using existing public health infrastructure.

The action steps also focus on decriminalization. So when you understand policing in context of how the prison industrial complex operates, we see then how the exploitive nature of capitalism seeks to make money off of criminalizing people rather then humanizing them.

Mass criminalization, slapping the legal category of crime on behaviors associated with structural marginalization and oppression, only leads to structural health inequities.

So this is not about actual public safety, but the illusion of safety while black and brown communities and other marginalized communities continue to be controlled, harmed, and brought into the criminal legal system for profit and prison labor.

So with policing and the decriminalization approach, this statement indicates that by doing so, we can reach improved

health outcomes by reducing law enforcement contact between law enforcement and community members.

Removing the pretext for police to be a presence in people's lives. Which inherently means law enforcement violence.

The statement also speaks to divest and invest. Or right now nationally essentially of the defund conversation.

And you know, what this statement poses in particular is reallocating that funding and investing in the social determinants of health.

So the typical concerns raised here is increasing funding will lead to issues of public safety, funding for law enforcement that is.

But the statement presents the body of evidence indicates that across different communities and settings, when the footprint of police is decreased, meaning the police budgets and size decrease, the data associated with crime as the system defines it, remains stable in fact.

So reallocating that funding to the social determinants of health is leaning on what we already know as public health people.

We know that if housing, education, and jobs, economic opportunity, food access, health care, every other social determinant of health that we can think of was resourced equitably for all communities, and particular black indigenous and other marginalized communities most harmed by policing, we'd have healthier communities and we'd have more just communities.

So this approach has been linked to reductions and the evidence speaks to findings that link this approach to reductions in community trauma and to personal harm and overall improvements in community health and safety.

The statement also speaks in particular to community safety and certain reformists, police reforms.

For example, community oriented policing, use of tasers, and other conducted electrical weapons, body cameras, and so forth, implicit bias trainings, all these reforms have been touted countless times over the years to address harms of police to improve health outcomes associated with policing.

And even have been implemented and promoted alongside ongoing law enforcement violence. So the statement finds these individual level approaches specifically do not work in improving health outcomes.

And I want to direct you to a resource from -- one of our community resources. You'll notice links on all of these slides and that can be shared afterwards and for you to view yourself.

But, one resource from one of our community partners, Critical Resistance that Reforms Don't Work tinyurl.com, explains how police reforms like these often have several things in common, money going into police budgets, the footprint of policing expands.

Or when the approach itself rides on the assumption that police presence will automatically increase safety. And all of these are components and features of reformist reforms.

Now, as part of the focus on structural intervention, the statement describes evidence that new systems of community safety can work without reliance on law enforcement.

So, for example, community-based violence intervention programs that employ unarmed outreach workers for example, who detect and interrupt potentially violent conflicts that have been -- studies focusing on these have, findings have led to how these pieces have significantly decreased the number of homicides and nonfatal shootings in neighborhoods where these events are common. Where these experiences are highest in certain communities.

So we have an evidence -- we have the evidence to pursue these approaches. And they are necessarily a public health approach.

So, you know, in summary what we're speaking to is that, you know, decriminalization, reallocating funds, building new systems of community safety that are community led and shaped by those most harmed by policing, all of these are interventions we can work towards.

And we also have to remember that in the presence of police across different neighborhoods is not the same. More affluent and whiter communities already do not have a constant

police presence that other communities do.

And specifically I mean, black and brown and business communities, poor and working class communities.

If you're trying to imagine what would reduced police presence might look like, well think of the many more affluent and whiter neighborhoods in your community that are adequately resourced for that they need to be healthy.

They don't have police doing patrols constantly up and down the main drag in those neighborhoods.

So as I'm kind of nearing the end here, you know, the statement has been used, it's an APHA policy statement that's meant to be used, and it's been used in a lot of different arenas, in policy and city council meetings to support the expansion of the system of policing and again, advocating for public health approaches instead.

It has been used to remove policing from schools. Which we've seen done in Minneapolis, Denver, Portland, Oregon, Portland, Maine, Oakland, San Francisco, Seattle, the list is ongoing across

the nation.

And we've seen in education ahead of change, I use it in my course at the University of Washington, School of Public Health, to understand how policing and structural violence in a public health context can be addressed with a public health approach.

We see it in research. Reference cited empirical publications. Shifting discourse towards what we research and now we research, challenging the role of policing as that automatic safety component.

So, and in practice. So when we center our community voices most affected by policing to public health practice, we are necessarily practicing community based public health strategies.

And that is going to be really key for us to approach policing and structural violence associated with policing as a public health issue.

So my last slide here, I just want to speak to, you know, with increased conversation on abolition nationally, and I want to clearly point

out that, you know, for our conversations, for us to understand as a public health field and community, abolition is public health.

And I'll share a quote from an abolitionist and scholar, Ruth Wilson Gilmore, who said, abolition is about presence, not absence. It's about building life affirming institutions.

So we as a public health community should be partners in building life affirming institutions, not complicit in institutions that do the opposite.

So presence here is what we, again, already know create healthy and just communities. Investments in the social determinants of health while we work towards the absence of all kinds of structural violence and state-sponsored harm.

Abolition is typically deemed as realistic, not realistic or practical, yet its feasibility is determined by the willingness of many to commit to co-creating a different world. That liberatory public health world that Kanwarpal was speaking too just a moment ago.

The body of evidence within the statement supports a public health and abolitionist approach

to address law enforcement violence. This will not be accomplished overnight.

Yet public health can't support co-creating that world where no system or institution seeks to address harm using punishment, surveillance, coercion, and imprisonment.

Public health can play a proactive role in divesting from what is not working. And investing in what does.

And so we can say that defunding is a public health strategy. And abolition is a vision and path we can walk on.

And if you pursue the action steps of the policy statement, you will find you yourself on a road towards both public health and that vision of abolition and addressing state-sponsored violence.

So I say as I close out here, use the statement. Listen to and work with members of your own community.

Aspire to practice that a community, that accountable community-based public health practice that we need to address law enforcement

violence.

And I hope all are empowered and what I've shared today can guide you in using this statement however way you can. Citing it, discussing it, use it as your access point to the current moment and to the longstanding black led multiracial movement against policing state violence that's been happening for centuries.

The statement aligns with this work and us, as public health workers, understanding how we can publically support with action is key.

Our work is ensuring as a public health community, we do not intentionally or unintentionally expand the size of power of police or any system that is bringing harm.

So as a field, we can challenge the notion that the only way to deal with harm is through punishment, coercion, and policing, which leads to the various health harms and statistics we've been learning about today.

And leads to the righteous uprisings that we're seeing again swell up across the country. And I want to mention that, you know, in terms

of this work, you know, folks that visit tinyurl.com/publichealthpledge, just to sign and read the pledge that, of over 400 and counting plus folks who have committed to co-creating that world, that liberatory public health.

And acknowledge that what we need is public health and that we can't police our way to public health.

So as I said before, I'm here representing the work of many, many in the End Police Violence Collective, many of you who have spoken and strongly advocated for this statement when it was up for a vote in 2018 and the process leading up to it, and the many community partners we work with who shared their expertise.

We will keep building. And I thank you for your time today.

DR. WEBSTER: Thank you, Omid. And thank you to all our presenters. We're running behind on time.

I want to let you know we're going to extend the webinar for about five minutes to entertain questions. So please stay on the line if you're

able to.

Before we open up for questions and answers, I want to take a little bit of time to share an APHA resource that addressed racial equity more broadly titled Racism: Science and Tools for the Public Health Professional.

The publication is built on the racial health equity work that public health advocates and others have been doing for decades, and available on APHA's website.

I'd also like to share an opportunity that's offered through the Bloomberg American Health Initiative, that's cosponsoring today's webinar.

The Bloomberg Fellows Program offers full tuition scholarships to earn an MPH from Johns Hopkins Bloomberg School of Public Health. The initiative accepts fellows working in its five focus areas, which are highlighted at the bottom of the page.

If you or someone on your team is interested in the opportunity, go to Americanhealth.jhu.edu to learn more.

And I also I will note that this same

group that I'm engaged with, the Bloomberg Fellows, we are discussing this very issue right now in a series of weekly seminars.

So there's also upcoming webinars coming up. So we welcome your feedback on this webinar in the post webinar survey.

Now I want to get to some questions, and invite the panelists to turn on their videos now. Which I will do myself as well.

Okay. So I'm going to share one question that was sent in. How do you respond to people who say that higher rates of police violence are associated with higher rates of crime in the black community?

Dr. Gilbert or Dr. Ray? Anybody want to take a crack at that?

DR. RAY: So I think part of what people have to recognize is the study that Dr. Gilbert and I highlighted. Highlighted the fact that if that was the case, what we would actually see are a couple of things.

First we would say -- we would see crime going down in certain places more dramatically.

The second thing we would see is police officers being more accurate with who they actually stop.

We actually don't see that at all. Overwhelmingly the people who police officers stop, aren't committing crimes.

So if this was actually about stopping crime, which no matter what type of neighborhoods people live in, people want to see that happen. We actually don't see that outcome.

The other thing that's important, two other things that I'll quickly say, police officers are actually more accurate at predicting the criminality of white people relative to black people and Latinos.

Now, does that mean that white people are more likely to commit crime relative to blacks and Latinos? No, not necessarily.

What it means though, is that police officers are using a different script. When it's a white person, they actually look at their behavior to see if their behavior is in line with the training they've received about what a criminal might do.

When they interact with a black or Latino

person, they're primarily using their skin tone as a metric by which to stop them.

The other thing that is important that when it comes to this particular outcome, is that when we actually control for racial composition, we see that even in predominantly black places where crime is not there, we still see over policing in those neighborhoods.

And we also see that there is an underutilization and under-response as it comes to social services. As we heard from Omid and others.

And I think these are some of the things that people need to recognize. The final thing that's so, so important, simply because your neighbor engages in crime, that does not give police the justification to over-police you.

You don't have anything to do with what your neighbor might be doing. And I think we have to recognize that.

That we don't do those same sort of things in predominantly white or affluent neighborhoods. But for some reason we aim to justify it when it comes to black, Latino, or low income neighborhoods.

And that's what we need to change.

DR. GILBERT: Just real quickly, I'll add, some earlier work in thinking about crime and policing, from Richard Quinney's work, The Social Reality of Crime, really sort of frames this question in a lot of different ways.

Where, you know, people engage in all kinds of behaviors, in the same behaviors. The difference is, is what gets criminalized and who gets criminalized for engaging in those behaviors as Rashawn already mentioned.

And part of that is, we're really good at thinking about the determinants, or social determinants of crime, especially as it relates to poverty and low access to a number of resources.

And we use that, or police use that as a way of sort of doing some of the things that they've done here in the St. Louis area, of thinking about hotspot policing.

Where you create these zones. Where there is supposedly high crime and you over-police in those areas.

And what we often find is, of course,

if you're starting to look for crime or criminal behavior, or you start to associate certain behaviors based on skin tone, then you're going to over-police and then you're going to arrest people for a number of different offenses.

And we've seen this throughout time and throughout history, of the ways that police over-criminalize and over-police these particular neighborhoods.

DR. WEBSTER: Thank you. I'm going to go onto another question here. Can any of the presenters speak to whether defunding the police could lead to no policing of white people and over policing black people?

That is to say, if you have fewer resources, are they going to be even more concentrated within the black neighborhoods, leading to the same kind of problems?

MR. GARAKANI: I'll take a jump at that one. I -- well one, I guess part of the question also speaks to maybe that that currently is not the case.

And so certainly, you know, in terms

of policing and where their activity currently is, it already is disproportionate. And a high activity in black and brown communities.

And you know, part of what we -- and I can't recall now of who specifically spoke to it, but you know, just this argument around reallocation of resources, bloated police budgets that are not leading to the improvements in health outcomes that we are seeking.

I think that reallocation of resources is a multilayered conversation. And I don't think it could be quite as simply put that a continuation of the problem with the intentions of, you know, the defunding arguments when we can actually invest in public health, in social determinants of health.

Ensure people have what they actually need to be healthy and safe for themselves and each other, I think that is a completely different reality that we can pursue with strategies that are, you know, encompassed with the defunding approach.

DR. GILBERT: Yeah. I'll just very briefly say also that probably a few of us would be satisfied with defund. And that's the end of

the discussion.

I think the real point of this whole webinar and conversation is to re-imagine what public safety looks like, and how the police play a role in that, as opposed to lead and control it.

So it could be that the policing, what policing looks like now, could be and maybe should be very different. Independent of sort of this racial allocation.

MS. DHALIWAL: Yeah. Again, I'll add, I think for us, you know, we as a community-based organization, we -- our young people rely on us to have a relationship with police and law enforcement.

Because the reality is, they still have to engage with those systems. And what we've been told, and what's expected is that we can serve as the steward, the platform, the buffer, the mitigator of harm.

So young people come to us and say, I might be picked up. Can I -- I'd rather be picked up at RYSE then be caught on the streets, because I don't know what they're going to do to me.

But our work and our responsibility is then to share that. And to name that out loud, that that's actually sort of the fear. It's not enough to say okay, then we just have to have a relationship and be quiet about it.

And to defund then also means we have to also potentially defund some of these so-called sort of systems of care as well.

So we can't send young people to behavioral health in our county, because it's immensely racist. And when we do, they get mad at us for that.

So I don't want to defund one system for -- one dehumanizing system for another without doing the messy complicated work that defunding the police has to be coupled with dismantling white supremacy.

And so that's the same conversation. They're not different. And I think that's the piece that if we only move too re-imagining without reckoning the harms, we are just going to reify the systems that we're in.

And so -- and that is for again, like

I said, I think white folks have a lot of reckoning to do around the complicity and the benefit of the system.

And for those of us who don't embody white bodies, our own work and conditioning to heal and to resist and to not comply. And white people need to really not comply.

DR. WEBSTER: So I'm just going to jump to the final question, because we're running out of time here.

But, it connects to what we've just been talking about. And that is, somebody asked that defund the police, a lot of people don't understand that. And perhaps are a little scared by it perhaps.

How do you distinctly describe what the vision is? What the vision is for a new form of public safety that people will understand maybe better then defund the police?

Anyone just want to jump in?

DR. RAY: Well, I mean, defund the police simply means to reallocate funding. So as I was saying during my presentation, it doesn't mean to completely abolish.

There are people who think that policing should be abolished. And then there are people who think that policing should be abolished in its current form, and I think that's part of re-imagining.

But, defund simply means reallocate funding. And I think that Congresswoman Karen Bass said it best, that instead of thinking about defunding, let's think about reinvesting in communities.

Because as I laid out, over a third of general funds goes to policing. The question is, from a market driven approach, when we look at the data and the evidence-based approach, do we see those responses?

Do we see the same outcomes? And it doesn't. Part of the conundrum here is that some people receive the policing that they need, that they want, the responses from social services that they deserve. And other people don't.

And that's fundamentally what we're trying to change. So defund the police simply means to reallocate.

We're seeing it across the country.

From LA deciding to shift about 100 million dollars away from the Sheriff's Department to other resources.

We also see it in Prince George's County where they took 20 million dollars that was going to go to a training facility for law enforcement, and instead they're creating a mental health facility for residents.

So reallocate is the term. And we actually see it a lot more then we'd actually like to admit. If people search defund the police, one of the first things that will pop up is an article that I wrote at Brookings called, What is Defund the Police, and Does it Have Merit?

And I lay out these series of things. And I recommend for people to look at the piece.

DR. WEBSTER: Thank you very much. Any other last thoughts on that question?

MS. DHALIWAL: Yes. I would just say that I would ask the question back about what's underneath that fear around defunding the police?

I think, you know, what Dr. Ray shared, really critical. But, also we have defunded so

many systems even thought they might be sort of broken and tattered.

Like but that have provided some kind of safety net. We've been very okay with doing that, with education, with social services.

So what does that mean? And because of the assumptions we make about policing, about criminality, about containing black and brown bodies.

I think that's where the reflection, and again, connecting it to the ways in which the supremacy is insidious. Even in the questions and the fears we have around defunding is critical.

DR. GILBERT: I'll just quick -- oh, sorry.

DR. WEBSTER: So -- go ahead. Go ahead.

DR. GILBERT: I'll just quickly add, as a number of cities and counties are declaring racism as a public health issue, we -- part of that really needs to think about sort of how does white supremacy exist across these localities?

And part of that is thinking about different ways that policing can be re-imagined.

And so if you're interested in declaring racism as a public health issue, you have to link it to this particular issue specifically.

DR. WEBSTER: Okay.

MR. GARAKANI: If I could quickly touch on this last one. I know this is probably going to be the last comment.

But, I guess I just want to underscore, you know, in Seattle a navigation team that is police led to criminalize and remove homeless encampments was recently defunded.

And so the conversation there is, what are the structural determinants of houselessness? Of why people are experiencing homelessness?

So defunding is about instead using that resource to actually ensure people have housing. And work towards a world where there's no need for policing.

And I think that orientation is really key. In addition to the framings, you know, Kanwarpal is speaking to in terms of how policing has been racialized.

But, I just want to underscore the fact

that if we can have that orientation working ourselves, and working out the role of police out of a job, and build new systems for community safety, then we are moving towards a path of investing in community public health, and particularly black and brown communities and other communities who are inequitably under-resourced.

DR. WEBSTER: Thank you, Omid. I think that's a great statement to end on here.

I want to thank our presenters for your really great presentations and offering of your data and wisdom on these issues. And I want to thank APHA staff who worked so hard on the event.

And for those who participated, and particularly those shared questions. We hope that your activism doesn't end with listening to this. But, you'll join in being actively anti-racist and advancing racial equity.

I want to remind folks that the recording and the slides from today's webinar are going to be available at APHA.org/racialequity within a week.

We'd also really appreciate it if you complete the webinar survey, which you'll be

redirected too in just a moment.

Thank you for tuning in today. This concludes the webinar.

(Whereupon, the above-entitled matter went off the record at 2:10 p.m.)